ARTICLE 5. MEDICAID SERVICES

Rule 1. General Provisions

405 IAC 5-1-1 Intent and purpose

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-7-1-1; IC 12-13-7-3; IC 12-15-5-1; IC 12-15-5-2

Sec. 1. (a) Under IC 12-7-1-1, Title XIX of the federal Social Security Act, and federal regulations adopted thereunder (as adopted by IC 12-13-7-3), the office with the advice of its medical staff, hereby adopts and promulgates this article to:

(1) interpret and implement the provisions of IC 12-15-5-1 and IC 12-15-21-3;

(2) ensure the efficient, economical, and medically reasonable operation of a medical assistance program (hereinafter referred to as Medicaid) in Indiana; and

(3) safeguard against overutilization, fraud, abuse, and utilization and provision of services and supplies that are not medically necessary.

(b) The purposes for this article are accomplished in this article by means of the following:

(1) A rule describing the prior authorization process mandated by IC 12-15-21-3(1).

(2) A rule interpreting the definition of provider as set out in IC 12-7-2-149.

(3) Rules describing the services that require prior authorization by the office under IC 12-15-21-3(1).

(4) Rules describing the criteria to be applied by the office in the prior authorization or denial of services under IC 12-15-21-3(1).

(5) Rules describing the limitations consistent with medically necessary services on the duration of services to be provided under IC 12-15-21-3(3).

(6) Rules interpreting IC 12-15-5-2 by listing specific services that are not covered by Medicaid because federal financial participation is not available for such services or such services are not medically necessary in view of alternative services available under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-1-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3299; filed Sep 27, 1999, 8:55 a.m.: 23 IR 307; 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)

405 IAC 5-1-2 Nondiscrimination

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. (a) All providers of care and suppliers of services under Medicaid must comply with the requirements of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

(b) No provider may discriminate in the provision of Medicaid services with regard to age, race, creed, color, national origin, sex, or handicap. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; 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)*

405 IAC 5-1-3 Freedom of choice of provider

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 12-15-11-2

Sec. 3. Except as provided in 405 IAC 1-1-2(b), all members shall have freedom of choice in the selection of a provider of service among qualified providers who meet the requirements of this article and who have executed a provider agreement under IC 12-15-11-2. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; 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)

405 IAC 5-1-4 Solicitation of services

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. 4. (a) Solicitation, or a fraudulent, misleading, or coercive offer by a provider to provide a service to a member, is prohibited. Examples of solicitation include, but are not limited to, the following:

(1) Door-to-door solicitation.

(2) Screenings of large or entire inpatient populations of long term care facilities, hospitals, institutions for mental diseases, ICFs/IID, or CRFs/DD, except where such screenings are specifically mandated by law.

(3) The use of any advertisement prohibited by federal or state statute or regulation.

(4) Any other type of inducement or solicitation to cause a member to receive a service that the member either does not want or does not need.

(b) Solicitation of early and periodic screening, diagnostic, and treatment services, as specified in 405 IAC 5-15, do not violate the solicitation prohibitions in this section. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; 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)*

405 IAC 5-1-5 Global fee billing; codes

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. 5. (a) Providers must submit one (1) billing for a related group of procedures and services provided to a member.

(b) The Centers for Medicare and Medicaid Service's Common Procedure Coding System (HCPCS) and International Classification of Diseases 10th Revision Clinical Modification (ICD-10-CM) codes shall be used by providers when submitting medical claims to the contractor for adjudication. American Dental Association codes from the Current Dental Terminology Users Manual shall be used by providers when submitting dental claims to the contractor for adjudication. Providers must use the most up-to-date versions of these coding classifications.

(c) Medicaid claims filed by pharmacy providers on the drug claim form/format must utilize an appropriately configured National Drug Code (NDC), Universal Package Code (UPC), Health Related Item Code (HRI), or state-assigned code. When services are billed that have been prior authorized, the procedure code from the prior authorization form shall be utilized. On UB-92 forms, use the appropriate UB-92 Revenue Codes, as well as the narrative descriptions of services, and the appropriate diagnostic and procedure code contained in ICD-10-CM.

(d) Documentation in the medical records maintained by the provider must substantiate that the procedure or service is medically necessary and the code selected or description given by the provider. This is subject to postpayment audit and review. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2131; 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)*

405 IAC 5-1-6 New or experimental product, service, or technology

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. 6. (a) A provider may request consideration for coverage of any new or experimental product, service, or technology not specifically covered in this article. Such a request must be submitted by the provider to the office along with a detailed written

statement, along with all available supporting documentation, justifying how such product, service, or technology is medically necessary.

(b) This section does not apply to legend drugs. *(Office of the Secretary of Family and Social Services; 405 IAC 5-1-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3300; 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)*

Rule 2. Definitions

405 IAC 5-2-1 Applicability

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

Sec. 1. The definitions in this rule apply throughout this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)*

405 IAC 5-2-2 "ADA" defined (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-3 "Attending provider" defined

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. "Attending provider" means the provider who is providing specialized or general medical care to the Medicaid member. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)*

405 IAC 5-2-4 "Contractor" defined (Repealed)

Sec. 4. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-5 "County office of family and children", "county office", or "OFC" defined (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-6 "Covered service" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-5

Sec. 6. "Covered service" means a service or supply provided by a provider for a member for which payment is available under Medicaid subject to the limitations of this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)

405 IAC 5-2-7 "CPT" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-5

Sec. 7. "CPT" means current procedural terminology. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)*

405 IAC 5-2-7.1 "Curative care services" defined

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 7.1. "Curative care services" means services, utilized to achieve a disease free state, that are related to the treatment of the medical condition for which diagnosis of terminal illness has been made. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-7.1; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-2-8 "DRG" defined (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-9 "Emergency service" defined

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. 9. "Emergency service" means a service provided to a member after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)

405 IAC 5-2-10 "EPSDT" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-128; IC 12-13-7-3; IC 12-15

Sec. 10. "EPSDT" means early and periodic screening, diagnostic, and treatment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3301; 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)*

405 IAC 5-2-10.1 "Hospice" defined

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10.1. "Hospice" means a person or health care provider who owns or operates a hospice program or facility, or both, that uses an interdisciplinary team directed by a licensed physician to provide a program of planned and continuous care for hospice program patients and their families. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; 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)*

405 IAC 5-2-10.2 "Hospice program" defined

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10.2. "Hospice program" means a specialized form of interdisciplinary health care that is designed to alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phase of a terminal illness or disease. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; 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)*

405 IAC 5-2-10.5 "HCPCS" defined

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. 10.5. "HCPCS" means Healthcare Common Procedure Coding System as set forth in 45 CFR 162.1002. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-10.5; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-11 "Indiana Medicaid program" or "Medicaid" defined (Repealed)

Sec. 11. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-11.5 "ICF/IID" defined

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

Sec. 11.5. "ICF/IID" or "ICFs/IID" has the meaning set forth in 405 IAC 1-1-1(f). *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-11.5; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-12 "Inpatient services" defined

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. 12. "Inpatient services" means only those services provided to a member while the member is registered as an inpatient in an acute care or psychiatric hospital. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)*

405 IAC 5-2-13 "ICD-10-CM" defined

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. 13. "ICD-10-CM" means International Classification of Diseases – 10th Revision–Clinical Modification as set forth in 45 CFR 162.1002. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)*

405 IAC 5-2-13.1 "IEP" defined

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 20-18-2-9

Sec. 13.1. "IEP" means individualized education program and has the meaning set forth in IC 20-18-2-9. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13.1; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-2-13.2 "IEP nursing services" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13.2. "IEP nursing services" means medically necessary services provided by a registered nurse who is employed by or under contract with a Medicaid participating school corporation for a member pursuant to his or her IEP. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13.2; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-13.3 "IEP transportation services" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13.3. "IEP transportation services" means:

(1) a trip from home to school and the return trip on a day when the student receives another Medicaid covered IEP service other than transportation; or

(2) from school or home to an off-site Medicaid service provider for an IEP covered service and the return trip.

The term also includes transportation of a student who resides in an area that does not have school bus service when that student's IEP stipulates a medical need for transportation. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-13.3; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-2-14 "HCPCS" defined (Repealed)

Sec. 14. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-15 "Level of care" defined

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. "Level of care", in an inpatient hospital setting, means the reimbursement methodology used to pay providers for

the services rendered, including diagnosis related group, psychiatric, rehabilitation, and burn. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)*

405 IAC 5-2-15.5 "Medicaid" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-128; IC 12-13-7-3; IC 12-15

Sec. 15.5. "Medicaid" has the meaning set forth in 405 IAC 1-1-1(i). *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-15.5; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-16 "Medical policy" defined

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. 16. "Medical policy" means those parameters for coverage of and reimbursement for services and supplies furnished to members that are set out in this article, the provider manual, and provider bulletins. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-16; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-17 "Medically necessary service" defined

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. 17. "Medically necessary service" as used in this title means a covered service (as defined in section 6 of this rule) that is required for the care or well-being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable by the office, it must:

(1) be medically necessary, as determined by the office, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and

(2) not be listed in this title as a noncovered service, or otherwise excluded from coverage.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-17; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; 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)

405 IAC 5-2-17.5 "Member" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-158; IC 12-13-7-3; IC 12-15

Sec. 17.5. "Member" has the meaning set forth in 405 IAC 1-1-1(j). *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-17.5; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-18 "Office" defined

Authority: IC 12-15-1-10; IC 12-15-1-15; IC 12-15-21-2
Affected: IC 12-7-2-134; IC 12-13-7-3; IC 12-15

Sec. 18. "Office" has the meaning set forth in 405 IAC 1-1-1(m). *(Office of the Secretary of Family and Social Services;*

405 IAC 5-2-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)

405 IAC 5-2-19 "Outpatient services" defined

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. 19. "Outpatient services" means those services provided to a member who is not registered as an inpatient in an acute care or psychiatric hospital except as specifically referenced in a given section. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-19; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)*

405 IAC 5-2-20 "Prior authorization" defined

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. 20. "Prior authorization" means the procedure for the office's prior review and authorization, modification, or denial of payment for covered services within Medicaid allowable charges based upon criteria as described in 405 IAC 5-3 and throughout this title. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-20; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; 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)*

405 IAC 5-2-21 "Provider" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 21. "Provider" has the meaning set forth in 405 IAC 1-1-1(p). *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-21; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3302; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-22 "Provider agreement" defined

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. 22. "Provider agreement" means a contract or certification agreement between a provider and the office setting out the terms and conditions of a provider's participation in Medicaid, which must be signed by such provider prior to any reimbursement for providing covered services to members. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-22; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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)*

405 IAC 5-2-23 "Recipient" defined (Repealed)

Sec. 23. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-24 "Reimbursement" defined

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. 24. "Reimbursement" means such payment made to the provider by the office pursuant to federal and state law, as compensation for providing covered services to members. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-24; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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)*

405 IAC 5-2-25 "RVU" defined (Repealed)

Sec. 25. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-2-26 "School corporation" defined

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 20-18-2-16

Sec. 26. "School corporation" has the meaning set forth in IC 20-18-2-16. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-26; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-2-27 "Telehealth services" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 27. "Telehealth services" means the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across a distance. *(Office of the Secretary of Family and Social Services; 405 IAC 5-2-27; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)*

405 IAC 5-2-28 "Telemedicine services" defined

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 28. "Telemedicine services" means a specific method of delivery of services, including medical exams and consultations and behavioral health evaluations and treatment, including those for substance abuse, using videoconferencing equipment to allow a provider to render an examination or other service to a patient at a distant location. The term does not include the use of the following:

(1) A telephone transmitter for transtelephonic monitoring.

(2) A telephone or any other means of communication for the consultation from one (1) provider to another provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-2-28; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)

405 IAC 5-2-29 "Usual and customary charge" defined

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. 29. "Usual and customary charge" has the meaning set forth in 405 IAC 1-1-1(s). *(Office of the Secretary of Family*

and Social Services; 405 IAC 5-2-29; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 3. Prior Authorization

405 IAC 5-3-1 Prior authorization; generally

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 1. (a) Except as provided in section 2 of this rule, prior to providing any Medicaid service that requires prior authorization, the provider must submit a properly completed Medicaid prior authorization request and receive written notice indicating the approval for provision of such service.

(b) It is the responsibility of the provider to submit new requests for prior authorization for ongoing services in a timely manner before the current authorization period expires in order to ensure that services are not interrupted. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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)*

405 IAC 5-3-2 Prior authorization by telephone

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 2. (a) Prior authorization for selected services is available by telephone when the request is initiated by a provider authorized to request prior authorization as listed in section 10 of this rule. A prior authorization request form is not necessary for these selected services. Additional written substantiation and documentation may be required by the office. Notification of approval or denial will be given at the time the telephone call is made for the following:

(1) Inpatient hospital admission and concurrent review, when required under this rule.

(2) Continuation of emergency treatment for those conditions listed in section 13 of this rule on an inpatient basis originally without prior authorization subject to retrospective medical necessity review.

(b) Prior authorization may be obtained by telephone provided a properly completed prior authorization request form is subsequently submitted for the following:

(1) Medically necessary services or supplies to facilitate discharge from or prevent admission to a general hospital.

(2) Equipment repairs necessary for life support or safe mobility of the patient.

(3) Services when a delay of beginning the services could reasonably be expected to result in a serious deterioration of the patient's medical condition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-3-3 Prior authorization based on false information

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 3. Services authorized on the basis of false information supplied by the provider or the provider's agent that the provider or the provider's agent knew or should have reasonably known to be false are not reimbursable. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; 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)*

405 IAC 5-3-4 Audit

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 4. Retrospective audit shall include postpayment review of the medical record to determine whether the service was medically necessary as defined in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3303; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

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).

(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)

405 IAC 5-3-6 Telephone 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. 6. A telephone review shall include the following:
(1) Initiation of phone request by a provider authorized to request prior authorization as listed in section 10 of this rule.
(2) The name, address, age, and Medicaid number of the member.
(3) The name, address, telephone number, and provider number of the provider.
(4) Diagnosis and related information.
(5) Services or supplies requested (CPT or HCPCS code).
(6) Name of suggested provider of services or supplies.
(7) Member specific clinical information required to establish that the service is medically necessary, including the following:
(A) Prior history, including results of diagnostic studies.
(B) Prior treatment.
(C) Rationale for treatment plan.
(D) Comorbid conditions.
(E) Treatment plan.
(F) Progress.
(G) Date of onset of medical conditions.
(8) 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.
(9) For emergency admissions, the following information is required, where applicable:
(A) Type of accident.
(B) Accident date.
(10) Diagnosis code.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; 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)

405 IAC 5-3-7 Determination of member eligibility

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 7. The provider assumes responsibility for verifying the member's eligibility on the service date. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; 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)*

405 IAC 5-3-8 Limitations

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 8. (a) Any Medicaid service requiring prior authorization, which is provided without first receiving prior authorization, shall not be reimbursed by Medicaid. Prior authorization will be monitored by concurrent or postpayment review.

(b) Any authorization of a service by the office is limited to authorization for payment of Medicaid allowable charges and is not an authorization of the provider's estimated fees.

(c) Notwithstanding any prior authorization by the office, the provision of all services and supplies shall comply with the provider agreement, the appropriate provider manual applicable at the time such services or supplies were provided, all other Medicaid policy documents issued to providers, and any applicable state or federal statute or regulation. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3304; 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)*

405 IAC 5-3-9 Prior authorization after services have begun

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 9. Prior authorization will be given after services have begun or supplies have been delivered only under the following circumstances:

(1) Pending or retroactive member eligibility. The prior authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.

(2) Mechanical or administrative delays or errors by the office.

(3) Services rendered outside Indiana by a provider who has not yet received a provider manual.

(4) Transportation services authorized under 405 IAC 5-30. The prior authorization request must be submitted within twelve (12) months of the date of service.

(5) The provider was unaware that the member was eligible for services at the time services were rendered. Prior authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member identification (RID) number.

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

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; 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)

405 IAC 5-3-10 Providers who may submit prior authorization requests

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 10. Except as otherwise provided in this title, prior authorization requests may be submitted by any of the following:

(1) Doctor of medicine.

(2) Doctor of osteopathy.

(3) Dentist.

(4) Optometrist.

(5) Podiatrist.

(6) Chiropractor.

(7) Psychologist endorsed as a health service provider in psychology (HSPP).

(8) Home health agency.

(9) Hospitals.

(10) For drugs subject to prior authorization, any provider with prescriptive authority under Indiana law.

Requests from other provider types will not be accepted except for transportation services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-3-11 Criteria for prior authorization

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-30-1

Sec. 11. The office's decision to authorize, modify, or deny a given request for prior authorization shall include consideration of the following:

(1) Individual case-by-case review of the completed Medicaid prior authorization request form.

(2) The medical and social information provided on the request form or documentation accompanying the request form.

(3) Review of criteria set out in this section for the service requested.

(4) If the service is medically necessary as defined in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; 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)

405 IAC 5-3-12 Prior authorization; exceptions

Authority: IC 12-15
Affected: IC 12-15-30-1

Sec. 12. Notwithstanding any other provision of this rule, prior authorization by the office is not required under the following circumstances:

(1) When a service is provided to a member as an emergency service, "emergency service" means a service provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in:

(A) placing the patient's health in serious jeopardy;

(B) serious impairment to bodily functions; or

(C) serious dysfunction of any bodily organ or part.

(2) When a member's physician determines that an inpatient hospital setting is no longer necessary, but that Medicaid covered services should continue after the member is discharged from inpatient hospital care, such services may continue for a period not to exceed one hundred twenty (120) hours within thirty (30) calendar days of discharge without prior authorization, if the physician has specifically ordered such services in writing upon discharge from the hospital. Services provided under this section are subject to all appropriate limitations set out in this rule. This exemption does not apply to durable medical equipment, neuropsychological and psychological testing, or out-of-state medical services. Prior authorization by the office must be obtained for reimbursement beyond the one hundred twenty (120) hours within thirty (30) calendar days of discharge period. Physical, speech, respiratory, and occupational therapies may continue for a period not to exceed thirty (30) hours, sessions, or visits in thirty (30) calendar days without prior authorization if the physician has specifically ordered such services in writing upon discharge or transfer from the hospital. Prior authorization by the office must be obtained for reimbursement beyond the thirty (30) hours, sessions, or visits in the thirty (30) calendar day period for physical, speech, respiratory, and occupational therapies.

(3) The IEP serves as the prior authorization for IEP nursing services and IEP transportation services when provided by a Medicaid participating school corporation in accordance with 405 IAC 5-22-2 and 405 IAC 5-30-11. No additional prior authorization is required.

(Office of the Secretary of Family and Social Services; 405 IAC 5-3-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3305; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 60; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-3-13 Services requiring prior authorization

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13. (a) Medicaid reimbursement is available for the following services with prior authorization:
(1) Reduction mammoplasties.
(2) Rhinoplasty or bridge repair of the nose when related to a significant obstructive breathing problem.
(3) Intersex surgery.
(4) Blepharoplasties for a significant obstructive vision problem.
(5) Sliding mandibular osteotomies for prognathism or micrognathism.
(6) Reconstructive or plastic surgery.
(7) Bone marrow or stem cell transplants.
(8) All organ transplants covered by Medicaid.
(9) Home health services.
(10) Maxillofacial surgeries related to diseases and conditions of the jaws and contiguous structures.
(11) Temporomandibular joint surgery.
(12) Submucous resection of nasal septum and septoplasty when associated with significant obstruction.
(13) Weight reduction surgery, including gastroplasty and related gastrointestinal surgery.
(14) Any procedure ordinarily rendered on an outpatient basis, when rendered on an inpatient basis.
(15) All dental admissions.
(16) Brand medically necessary drugs.
(17) Psychiatric inpatient admissions, including admissions for substance abuse.
(18) Rehabilitation inpatient admissions.
(19) Orthodontic procedures for members under twenty-one (21) years of age for cases of craniofacial deformity or cleft palate.
(20) Genetic testing for detection of cancer of the breast or breasts or ovaries.
(21) Medicaid rehabilitation option services, except for crisis intervention.
(22) Partial hospitalization, as provided under 405 IAC 5-20-8.
(23) Neuropsychological and psychological testing.
(24) As otherwise specified in this article.

(b) If any of the surgeries listed in this section are performed during a hospital stay for another condition, prior authorization is required for the surgical procedure.

(c) Requests for prior authorization for the surgical procedures in this section will be reviewed to determine if said procedure is medically necessary on a case-by-case basis in accordance with this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; filed Sep 1, 2000, 2:16 p.m.: 24 IR 14; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1613; filed Feb 26, 2004, 3:45 p.m.: 27 IR 2244; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2132; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1903; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 18, 2009, 11:32 a.m.: 20090916-IR-405080192FRA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA; 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)*

405 IAC 5-3-14 Prior authorization decision; time limit

Authority: IC 12-15
Affected: IC 12-15-30-1

Sec. 14. Decisions by the office regarding prior authorization will be made as expeditiously as possible considering the circumstances of each request. If no decision is made by the office for a completed prior authorization request within seven (7) calendar days of receipt of all documentation specified in sections 5 and 9(1) of this rule, authorization is deemed to be granted within the coverage and limitations specified in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-3-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jun 16, 2011, 8:50 a.m.: 20110713-IR-405100195FRA; 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)*

Rule 4. Provider Enrollment

405 IAC 5-4-1 Enrollment of providers

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

Sec. 1. (a) In order to receive reimbursement under the Indiana Medicaid program, a provider must be enrolled to participate as a Medicaid 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 the Indiana Medicaid program and completed such forms as may be required by the department.

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

(4) The provider has received a provider number from the Medicaid contractor.

(b) Out-of-state institutional or individual providers must be duly certified, licensed, registered, or authorized as required by the state in which the provider is located and must fulfill the conditions listed in subsection (a)(2) through (a)(4) before receiving any Indiana Medicaid payment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-4-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3306; 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)*

405 IAC 5-4-2 Provider agreement requirements for transportation services

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 20-27

Sec. 2. (a) The office will enter into a Medicaid transportation provider agreement only with a distinct transportation business entity that makes transportation services available to the general public and whose 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. All providers must complete an Indiana Medicaid provider agreement. In addition, providers must satisfy the specific requirements in this section.

(b) With respect to ambulance service, in accordance with IC 16-1-39 *[IC 16-1 was repealed by P.L.2-1993, SECTION 209, effective April 20, 1993.]*, vehicles and staff that provide emergency services must be certified by the emergency medical services commission to be eligible for Medicaid reimbursement for transports involving either advanced life support or basic life support services that are emergency in nature. Failure to maintain the emergency medical services commission certification on all vehicles involved in transporting Medicaid recipients will result in termination of the Medicaid provider agreement.

(c) Common transportation carriers except for taxicab and not-for-profit transportation entities, in order to be eligible to participate as providers, must continuously comply with all state statutes, rules, and local ordinances governing public

transportation. In addition, each provider applicant or enrolled provider must submit proof of, and maintain throughout its period of participation, the following:

(1) Certification by the Indiana motor carrier authority.

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

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

(d) Taxicab transportation entities, in order to be eligible to participate as providers, must continuously comply with all federal and state statutes, rules, and local ordinances governing their operation. In addition, each provider applicant or enrolled provider must submit proof of and maintain throughout its period of participation the following:

(1) 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.

(2) 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.

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

(e) Not-for-profit transportation entities, in order to be eligible as providers, must continuously comply with all federal and state statutes, rules, and local ordinances governing their operation. In addition, each provider applicant or enrolled provider must submit proof of, and maintain throughout its period of participation, the following:

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

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

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

(f) 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. *(Office of the Secretary of Family and Social Services; 405 IAC 5-4-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3307; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-4-3 Enrollment of a family member as a transportation provider

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. When a recipient must make frequent trips to medical services and that travel creates undue financial hardship for the family, a family member may be enrolled as a Medicaid transportation provider. If no family member is available to provide this service, a close associate, or the recipient, if medically able, may be enrolled as a family member transportation provider. 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 county OFC prior authorization. To be eligible to participate in Medicaid as a family member transportation provider, the individual must meet the following requirements:

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

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

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

(4) Be enrolled as a family member Medicaid transportation provider. The county OFC, on behalf of the family member, must submit the enrollment request to the office or its designee for its approval.

(5) Each request for enrollment of a family member provider should include the following information:

(A) The recipient'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.

(Office of the Secretary of Family and Social Services; 405 IAC 5-4-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3307; 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)

405 IAC 5-4-4 Enrollment of a nursing facility; conditions for reimbursement for certified beds (Voided)

Sec. 4. *(Voided by P.L.158-2007, SECTION 3, effective May 4, 2007.)*

Rule 5. Out-of-State Services

405 IAC 5-5-1 Out-of-state services; 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. 1. Medicaid reimbursement is available for the following services provided outside Indiana:
(1) Acute general hospital care.
(2) Physician services.
(3) Dental services.
(4) Pharmacy services.
(5) Transportation services.
(6) Therapy services.
(7) Podiatry services.
(8) Chiropractic services.
(9) Durable medical equipment and supplies.
(10) Hospice services, subject to the conditions in 405 IAC 5-34-3.
(11) Diagnostic services, including genetic testing.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3308; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1904; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 5-5-2 Prior authorization requirements for out-of-state services

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. (a) The services listed in section 1 of this rule require prior authorization except as follows:
(1) Emergency services provided out-of-state are exempt from prior authorization; however, continuation of inpatient treatment and hospitalization is subject to the prior authorization requirements of Indiana.
(2) Members of the adoption assistance program placed outside of Indiana will receive approval for all routine medical and dental care provided out-of-state.
(3) Recipients may obtain services listed in section 1 of this rule in the following designated out-of-state cities subject to the prior authorization requirements for in-state services set out in this article:
(A) Louisville, Kentucky.
(B) Cincinnati, Ohio.
(C) Harrison, Ohio.
(D) Hamilton, Ohio.
(E) Oxford, Ohio.
(F) Sturgis, Michigan.
(G) Watseka, Illinois.

(H) Danville, Illinois.
(I) Owensboro, Kentucky.
(4) Recipients may obtain services in Chicago, Illinois, subject to all of the following conditions:
(A) The recipient's physician determines the service is medically necessary.
(B) Transportation to an appropriate Indiana facility would cause undue hardship to the patient or the patient's family.
(C) The service is not available in the immediate area.
(D) The recipient's physician complies with all of the criteria set forth in this article, in accordance with the state plan and 42 CFR 456.3.

(b) Prior authorization will not be approved for the following services outside of Indiana and are not covered outside of Indiana for designated cities listed in subsection (a)(3) through (a)(4):
(1) Nursing facilities, ICFs/IID, or home health agency services.
(2) Any other type of long term care facility, including facilities directly associated with or part of an acute general hospital.

(c) Prior authorization may be granted for any time period from one (1) day to one (1) year for out-of-state medical services listed in section 1 of this rule if the service is medically necessary and any one (1) of the following criteria is also met:
(1) The service is not available in Indiana. However, care provided by out-of-state Veterans Administration and Shrine hospitals is an exception to this requirement.
(2) The member has received services from the provider previously.
(3) Transportation to an appropriate Indiana facility would cause undue expense or hardship to the member or Medicaid.
(4) The out-of-state provider is a regional treatment center or distributor.
(5) The out-of-state provider is significantly less expensive than the Indiana providers, for example, large laboratories versus an individual pathologist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3308; filed Sep 27, 1999, 8:55 a.m.: 23 IR 309; 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)

405 IAC 5-5-3 Out-of-state suppliers of medical equipment

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. In order to be treated as an in-state provider for purposes of prior authorization any out-of-state supplier of medical equipment must comply with the following:
(1) Maintain an Indiana business office, staffed during regular business hours, with telephone service.
(2) Provide service, maintenance, and replacements for Indiana members whose equipment has malfunctioned.
(3) Qualify with the Indiana secretary of state as a foreign corporation.

(Office of the Secretary of Family and Social Services; 405 IAC 5-5-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; 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)

Rule 6. Restricted Utilization

405 IAC 5-6-1 Restricted utilization; generally

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. 1. Certain members will have restricted utilization information linked to their Medicaid cards when it has been determined that services must be controlled. Providers or services that the member may or may not use can be identified through the automated voice response or eligibility verification system. *(Office of the Secretary of Family and Social Services; 405 IAC 5-6-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; 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)

405 IAC 5-6-2 Exceptions; emergency situations and referrals

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) A provider other than the one to whom the member is restricted may provide treatment to the member without a referral from the authorized provider if the diagnosis is an emergency diagnosis.

(b) A provider other than the one to whom the member is restricted may provide services to the member if the authorized provider has referred the member. *(Office of the Secretary of Family and Social Services; 405 IAC 5-6-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; 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)*

Rule 7. Administrative Review and Appeals of Prior Authorization Determinations

405 IAC 5-7-1 Appeals of prior authorization determinations

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. 1. (a) Members may appeal the denial or modification of prior authorization of any Medicaid covered service under 405 IAC 1.1.

(b) Any provider submitting a request for prior authorization under 405 IAC 5-3, which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after exhausting the administrative remedies provided in this rule.

(c) When there is insufficient information submitted to render a decision, a prior authorization request will be suspended for up to thirty (30) days, and the office will request additional information from the provider. Suspension is not a final decision on the merits of the request and is not appealable. If the provider does not submit the additional information requested within thirty (30) days, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b). *(Office of the Secretary of Family and Social Services; 405 IAC 5-7-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 378; 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)*

405 IAC 5-7-2 Provider requests for administrative review

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) A provider authorized to submit prior authorization requests who wishes review of denial or modification of a prior authorization decision must request an administrative review before filing an appeal under 405 IAC 1.1.

(b) An administrative review request must be initiated within seven (7) working days of the receipt of modification or denial by the provider who submitted the prior authorization request. The request shall be submitted in writing to the office; telephonic requests will not be accepted. *(Office of the Secretary of Family and Social Services; 405 IAC 5-7-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; 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)*

405 IAC 5-7-3 Conduct of administrative review

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) The Medicaid contractor will perform the review.

(b) The review will assess medical information pertinent to the case in question.

(c) The review decision of the Medicaid contractor will be rendered within seven (7) working days of request. The time limit for issuance of a decision does not commence until the provider submits a complete request, including all necessary documentation required by the contractor to render a decision.

(d) The requesting provider and member will receive written notification of the decision containing the following:

(1) The determination reached by the Medicaid contractor, and the rationale for the decision.

(2) Provider and member appeal rights through the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-7-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3309; 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)

Rule 8. Consultations and Second Opinions

405 IAC 5-8-1 Reimbursement

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. 1. Medicaid reimbursement is available for consultations subject to the limitations contained in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; 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)*

405 IAC 5-8-2 "Consultation" defined

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. As used in this rule, "consultation" means the rendering of a medical opinion by a physician for a specific member, regarding evaluation or management of a condition, requested by another physician. It requires the consultant physician to examine the patient, unless the applicable standard of care does not require a physical examination. A confirmatory consultation means a second or third opinion. Reimbursement is available for consultative pathology and radiology services under 405 IAC 5-18 and 405 IAC 5-27, where the consultant physician does not examine the patient. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; 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)*

405 IAC 5-8-3 Restrictions

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) A consultation cannot be used for the evaluation of a nonphysician referred or self-referred member.

(b) An office or other outpatient consultation must address a specific condition not previously diagnosed or managed by the consulting physician. If an additional request for an opinion or advice regarding the same or a new problem is received from the attending physician and documented in the medical record, the office consultation codes may be used by the consulting physician again.

(c) Reimbursement for an initial consultation is limited to one (1) per consultant, per member, per inpatient hospital or nursing facility admission.

(d) Follow-up inpatient consultations may be billed if visits are needed to complete the initial consultation, or if subsequent consultative visits are requested by the attending physician. These consultative visits include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status.

(e) Reimbursement is not available if a member is referred for management of a condition or the consulting physician assumes patient management. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; 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)*

405 IAC 5-8-4 Confirmatory consultations

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. 4. (a) A confirmatory consultation is the rendering of a second or third medical opinion, completed by a physician for a specific member, regarding evaluation or management of a condition.

(b) A confirmatory consultation may be billed to Medicaid only when it is specifically requested by another physician or the office.

(c) A confirmatory consultation to substantiate that the service is medically necessary may be required as part of the prior authorization process. *(Office of the Secretary of Family and Social Services; 405 IAC 5-8-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; 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)*

Rule 9. Evaluation and Management Services

405 IAC 5-9-1 Limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 1. Medicaid reimbursement is available for office visits limited to a maximum of thirty (30) per calendar year, per member, per provider without prior authorization and subject to the restrictions in section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-9-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 14, 2005, 10:25 a.m.: 28 IR 2132; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 5, 2010, 2:10 p.m.: 20101201-IR-405090928FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-9-2 Restrictions

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. (a) Office visits should be appropriate to the diagnosis and treatment given and properly coded.

(b) New patient office visits are limited to one (1) per member, per provider within the last three (3) years. For purposes of this subsection, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the last three (3) years.

(c) If a physician uses an emergency room as a substitute for his or her office for nonemergency services, these visits should be billed as an office visit and will be reimbursed as such.

(d) If a surgical procedure is performed during the course of an office visit, it should be considered that the surgical fee

includes the medical visit unless the member has never been seen by the provider prior to the surgical procedure, or the determination to perform surgery is made during the evaluation of the patient. If an evaluation of a separate clinical condition is performed on the same day as the surgery, both the evaluation and the surgery may be separately billed. *(Office of the Secretary of Family and Social Services; 405 IAC 5-9-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3310; 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)*

405 IAC 5-9-3 Office visits exceeding established parameters

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. Medicaid reimbursement is available for office visits exceeding the established parameters subject to prior authorization requirements at 405 IAC 5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 5-9-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; 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)*

Rule 10. Anesthesia Services

405 IAC 5-10-1 Providers eligible for reimbursement

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 1. Anesthesia is a Medicaid covered service only when rendered by the following providers:

(1) An Indiana Medicaid enrolled physician other than the operating surgeon or surgeon's assistant.

(2) An Indiana Medicaid enrolled practitioner who has a license that allows him or her to administer anesthesia under Indiana law.

(3) An Indiana Medicaid enrolled certified registered nurse anesthetist who practices within the scope of practice of his or her profession in accordance with IC 25-22.5-1-2(a)(13) and who holds a certificate from either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.

(4) An Indiana Medicaid enrolled anesthesiologist assistant who is in compliance with all applicable requirements of state law, including any licensure requirements the state imposes on nonphysician anesthetists and who is a graduate of an educational program that meets all of the following criteria:

(A) Accredited by the Committee on Allied Health Education and Accreditation.

(B) Based at a medical school.

(C) Is of at least two (2) years in duration and included clinical and theory based anesthesia education.

(Office of the Secretary of Family and Social Services; 405 IAC 5-10-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; 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)

405 IAC 5-10-2 "Anesthetist" defined

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 2. As used in this rule, "anesthetist" means an anesthesiologist assistant (AA) or a certified registered nurse anesthetist (CRNA). *(Office of the Secretary of Family and Social Services; 405 IAC 5-10-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; 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)*

405 IAC 5-10-3 Reimbursement parameters

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 3. (a) Services rendered by an anesthetist shall be reimbursed as follows:

(1) Directly to the CRNA, provided that the CRNA has a provider number based on current state registered nurse licensure and is certified or recertified by the Council on Certification of Nurse Anesthetists at the time services were rendered.

(2) Directly to the AA, provided that the AA has a provider number based upon a current state license.

(3) To an anesthesiologist or a professional corporation employing the anesthetist or anesthesiologist at the time services were rendered.

(4) To a hospital or other health care facility employing the anesthetist or anesthesiologist at the time services were rendered.

(b) When an anesthetic is administered for multiple surgical procedures performed during the same operative session, reimbursement will be predicated on the allowed Medicaid payment for the surgical procedure having the highest anesthesia relative value unit.

(c) Anesthesia services must be billed using the coding system required by the office. Anesthesia services performed during separate operative sessions must be billed separately. Each service must be coded on a separate line in order to allow base value. This does not apply to extra services performed during the same anesthesia services.

(d) Anesthesia services associated with canceled surgery will not be reimbursed.

(e) Local anesthesia (therapeutic or regional blocks) will be reimbursed as a surgical procedure. Time units or modifying factors associated with local anesthesia are not reimbursable. Reimbursement for local anesthesia (therapeutic or regional blocks) administered by the surgeon in conjunction with a surgical procedure is included in the fee for the surgical procedure.

(f) The following services will be reimbursed as surgical procedures:

(1) Cardiopulmonary resuscitation.

(2) Elective external cardioversion.

(3) Administration of blood or blood components.

(g) If reimbursement for a surgical procedure has been disallowed due to lack of prior authorization, reimbursement for the anesthesia service will also be disallowed.

(h) Reimbursement is not available for equipment or supplies provided by either an anesthetist or anesthesiologist. Costs associated with equipment or supplies are the responsibility of the facility in which the anesthesia services are provided.

(i) Reimbursement is available for medical direction of a procedure involving an anesthetist only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two (2), three (3), or four (4) concurrent procedures involving qualified anesthetists. Reimbursement is not available for medical direction in cases in which an anesthesiologist is concurrently administering anesthesia and providing medical direction.

(j) For single anesthesia sessions involving both an anesthesiologist and an anesthetist, the procedures performed during the session are considered personally performed by the anesthesiologist unless the office has received documentation that the involvement of both the anesthesiologist and the anesthetist in the procedure was medically necessary. In cases in which the office receives the medically necessary documentation, reimbursement may be made for the services of each practitioner. *(Office of the Secretary of Family and Social Services; 405 IAC 5-10-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3311; 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)*

405 IAC 5-10-4 Anesthesia administered during labor/delivery

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 4. Anesthesia administered by the attending physician, during labor or delivery (spinals, epidurals, pudendal, caudal, paracervical blocks, etc.) are considered to be part of the delivery fee. If the anaesthesia is administered by another licensed anesthesia provider, that is, physician, anesthesiologist, or anesthetist, payment will be allowed for the procedures listed in this

section under 405 IAC 1-11.5. *(Office of the Secretary of Family and Social Services, 405 IAC 5-10-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; 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)*

405 IAC 5-10-5 Noncovered services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15-2; IC 12-15-5; IC 12-15-30; IC 25-22.5-1-2

Sec. 5. The following services are not reimbursed separately under Medicaid when provided in conjunction with anesthesia services:

(1) Noninvasive electrocardiogram monitoring.
(2) Blood pressure monitoring.
(3) Monitoring of data scope.
(4) Intubation factor postoperative.

(Office of the Secretary of Family and Social Services; 405 IAC 5-10-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3312; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

Rule 11. Case Management Services for Pregnant Women (Repealed)

(Repealed by Office of the Secretary of Family and Social Services; filed Mar 28, 2012, 12:58 p.m.: 20120425-IR-405110419FRA)

Rule 12. Chiropractic Services

405 IAC 5-12-1 Reimbursement

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; IC 25-10-1-1

Sec. 1. (a) Medicaid reimbursement is available for covered services provided by a licensed chiropractor, enrolled as a provider, when rendered within the scope of the practice of chiropractic as defined in IC 25-10-1-1 and 846 IAC 1-3, subject to the restrictions and limitations as described in the rule.

(b) Reimbursement is not available for any chiropractic services provided outside the scope of IC 25-10-1-1 and 846 IAC 1-3, or for any chiropractic service for which federal financial participation is not available. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; 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)*

405 IAC 5-12-2 Office visits

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; IC 25-10-1-1

Sec. 2. Medicaid reimbursement is available for chiropractic office visits and spinal manipulation treatments or physical medicine treatments, subject to the following restrictions:

(1) Reimbursement is limited to a total of fifty (50) office visits or treatments per member per year, which includes a maximum reimbursement of no more than five (5) office visits per member per year.
(2) Reimbursement is not available for the following types of extended or comprehensive office visits:
    (A) New patient detailed.
    (B) New patient comprehensive.
    (C) Established patient detailed.

(D) Established patient comprehensive.

(3) New patient office visits are reimbursable only once per provider per lifetime of the member. As used in this section, "new patient" means one who has not received any professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years.

(Office of the Secretary of Family and Social Services; 405 IAC 5-12-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2861; 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)

405 IAC 5-12-3 Chiropractic x-ray services

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; IC 25-10-1-1

Sec. 3. Medicaid reimbursement is available for chiropractic x-ray services, subject to the following restrictions:

(1) Reimbursement is limited to one (1) series of full spine x-rays per member per year. Component x-rays of the series are individually reimbursable; however, if components are billed separately, total reimbursement is limited to the allowable amount for the series. Prior authorization is not required.

(2) Reimbursement for localized spine series x-rays, and for x-rays of the joints or extremities, is allowable only when the x-rays are necessitated by a condition-related diagnosis. Prior authorization is not required.

(3) Diagnostic radiological exams of the head and vascular system, as defined by the applicable procedure code, are not reimbursable.

(4) Diagnostic ultrasound exams, as defined by the applicable procedure code, are not reimbursable.

(5) X-rays that may be necessitated by the failure of another practitioner to forward, upon request, x-rays or related documentation to a chiropractic provider, are not reimbursable. Chiropractors are entitled to receive x-rays from other providers at no charge to the member upon a member's written request to the other providers and upon reasonable notice.

(Office of the Secretary of Family and Social Services; 405 IAC 5-12-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2861; 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)

405 IAC 5-12-4 Laboratory services

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; IC 25-10-1-1

Sec. 4. Laboratory services are reimbursable only when such services are necessitated by a condition-related diagnosis. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; 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)*

405 IAC 5-12-5 Muscle testing services

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; IC 25-10-1-1

Sec. 5. Muscle testing services, either manual or electrical, are reimbursable only if prior authorization has been obtained. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; 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)*

405 IAC 5-12-6 Electromyography services (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed May 1, 2003, 10:45 a.m.: 26 IR 2862)*

405 IAC 5-12-7 Durable medical equipment

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; IC 25-10-1-1

Sec. 7. Medicaid reimbursement is not available for durable medical equipment (DME) provided by chiropractors. *(Office of the Secretary of Family and Social Services; 405 IAC 5-12-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 1, 2003, 10:45 a.m.: 26 IR 2862; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

Rule 13. Intermediate Care Facilities for the Mentally Retarded

405 IAC 5-13-1 Policy; definitions

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 12-15-32

Sec. 1. (a) Medicaid reimbursement is available for services provided by a certified intermediate care facility for individuals with intellectual disabilities (ICF/IID) when such services have been rendered to a member whose reimbursement has been approved by the office. Such services must be provided in accordance with IC 12-15-32, 42 CFR 483.400-480, and this rule.

(b) As used in this rule, "small ICF/IID" means a certified intermediate care facility for individuals with intellectual disabilities that:

(1) provides ICF/IID services for not less than four (4) and not more than eight (8) developmentally disabled persons in a residential setting; and

(2) meets the federal requirements for an ICF/IID group home.

(c) As used in this section, "large private ICF/IID" means an institution certified as an intermediate care facility for individuals with intellectual disabilities that:

(1) is not owned or operated, or both, by an agency of federal, state, or local government; and

(2) serves more than eight (8) developmentally disabled persons.

(d) As used in this rule, "large state ICF/IID" means a state owned or operated facility that provides ICF/IID services for more than eight (8) developmentally disabled persons in an institutional setting. *(Office of the Secretary of Family and Social Services; 405 IAC 5-13-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; 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)*

405 IAC 5-13-2 Reimbursement

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. (a) Medicaid reimbursement is available for services provided by a state owned ICF/IID in accordance with 405 IAC 1-4.

(b) Medicaid reimbursement is available for services provided by a large private or small ICF/IID in accordance with 405 IAC 1-12.

(c) The ICF/IID per diem rate covers those services and products furnished by the facility for the usual care and treatment of such patients.

(d) Requests for reimbursement of ICF/IID services shall be expressed in units of full days. A day begins at midnight and ends twenty-four (24) hours later. The midnight-to-midnight method is to be used when reporting days of service, even if the health facility uses a different definition for statistical or other purposes. The day of discharge is not covered. *(Office of the Secretary of Family and Social Services; 405 IAC 5-13-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3315; 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)

405 IAC 5-13-3 Services included in the per diem rate for large private and small ICFs/IID

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. The per diem rate for large private and small ICFs/IID shall include the following services:

(1) Room and board, which includes the following:
- (A) Routine and special dietary services.
- (B) Personal laundry services.
- (C) Room accommodations.

(2) Nursing services and supervision of health services.

(3) Habilitation services as defined by 405 IAC 5-21.6-2(g) provided in a setting approved by the office that are required by the resident's program plan of active treatment developed in accordance with 42 CFR 483.440, including, but not limited to, the following:
- (A) Training in activities of daily living.
- (B) Training in the development of self-help and social skills.
- (C) Development of program and evaluation plans.
- (D) Development and execution of activity schedules.
- (E) Vocational/habilitation services.

(4) All medical and nonmedical supplies and equipment furnished by the facility for the usual care and treatment of residents are covered in the per diem rate and may not be billed separately to Medicaid by the facility or by a pharmacy or other provider.

(5) Physical and occupational therapy, speech pathology, and audiology services provided by a licensed therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate. Therapy services provided away from the facility must meet the criteria outlined in 405 IAC 5-22. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.

(6) The reasonable cost of necessary transportation for the member is included in the per diem rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services. Emergency transportation services must be billed to Medicaid directly by the transportation provider.

(7) Durable medical equipment (DME) as defined in 405 IAC 5-19-2 and associated repair costs, including, but not limited to:
- (A) ice bags;
- (B) bed rails;
- (C) canes;
- (D) walkers;
- (E) crutches;
- (F) standard wheelchairs; or
- (G) traction equipment;

are covered in the per diem rate and may not be billed to Medicaid by the facility, a pharmacy, or any other provider. Any other type of nonstandard DME requires prior authorization by the office and must be billed to Medicaid by the DME provider. Facilities shall not require members to purchase or rent DME with their personal funds. DME purchased with Medicaid funds becomes the property of the office. The facility must notify the office when the member no longer needs the equipment.

(8) Mental health services provided by the ICF/IID are included in the all-inclusive residential per diem rate. These services include the following:

(A) Behavior management services and consulting.
(B) Psychiatric services.
(C) Psychological services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3316; filed Sep 27, 1999, 8:55 a.m.: 23 IR 310; 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)

405 IAC 5-13-4 Services included in the per diem rate for large state ICFs/MR; exceptions

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. 4. (a) The per diem rate for a large state ICF/MR shall include the following services:
(1) Room and board (room accommodations, dietary services, and laundry services).
(2) Medical services.
(3) Mental health services.
(4) Dental services.
(5) Therapy and habilitation services.
(6) Durable medical equipment (DME).
(7) Medical and nonmedical supplies.
(8) Pharmaceutical products.
(9) Transportation.
(10) Optometric services.

(b) The services set out in subsection (a) provided to a Medicaid resident residing in a large state ICF/MR are reimbursed through the per diem rate except as follows:

(1) Hospital services rendered due to an acute illness or injury may be billed to Medicaid directly by the hospital. Individual exceptions to other medical care that must be rendered by practitioners outside the facility require prior authorization from the office.

(2) Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the office. Dental services prior authorized by the office must be billed to the Medicaid program directly by the outside dental provider. Admission of a recipient to a hospital for the purpose of performing dental services requires prior authorization by the office.

(3) DME and associated repair costs, including, but not limited to:
(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs; or
(G) traction equipment;

are covered in the per diem rate and may not be billed separately to Medicaid. Any other type of nonstandard DME requires prior authorization by the office and must be billed to Medicaid directly by the DME provider. Facilities cannot require recipients to purchase or rent such equipment with their personal funds. DME purchased by Medicaid becomes the property of the office. Such DME must be returned to the local county office of family and children when the recipient no longer requires the DME.

(4) Transportation services, except for emergency medical transportation services, are covered in the per diem rate. Transportation for emergency medical services must be billed to Medicaid directly by the transportation provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3316; filed Sep 27, 1999, 8:55 a.m.: 23 IR 311; 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)

405 IAC 5-13-5 Prior authorization for services rendered outside the large state ICF/MR

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. 5. (a) Medical care rendered by practitioners outside the large state ICF/MR requires prior authorization.

(b) Prior authorization will not be given for medical services included in the per diem rate.

(c) Written evidence of physician involvement and personal patient evaluation in the progress notes and attached to the prior authorization form is required to document the medical necessity of the service.

(d) Prior authorization will include consideration of the following:

(1) Review of the properly completed Medicaid prior review and authorization request form substantiating both of the following:

(A) Medical necessity of the service.

(B) Explanation of why the service cannot be rendered at the facility.

(2) Review of criteria for the specific medical service requested as set forth in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3317; 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)

405 IAC 5-13-6 Reserving beds

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 reserving beds in an ICF/IID for members, at one-half (1/2) the regular per diem rate, when one (1) of the following conditions is present:

(1) Hospitalization must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total length of time allowed for payment of a reserved bed for a single hospital stay shall be fifteen (15) days. If the member requires hospitalization longer than the fifteen (15) consecutive days, the member must be discharged from the facility. If the member is discharged from the ICF/IID following a hospitalization in excess of fifteen (15) consecutive days, the ICF/IID is still responsible for appropriate discharge planning if the ICF/IID does not intend to provide ongoing services following the hospitalization for those individuals who continue to require ICF/IID level of services. A physician's order for hospitalization must be maintained in the member's file at the facility.

(2) A leave of absence must be for therapeutic reasons, as prescribed by the attending provider and as indicated in the member's habilitation plan. The total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that member in that year. A physician's order for the therapeutic leave must be maintained in the member's file at the facility.

(b) Although prior authorization is not required to reserve a bed, a physician's order for the hospitalization or leave must be maintained in the member's file at the ICF/IID to obtain reimbursement at the reserved rate.

(c) If readmission is required, guidelines should be followed as outlined in admission procedures in sections 7 and 8 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-13-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3317; 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)*

405 IAC 5-13-7 Admission and placement; large private and small ICFs/IID

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) Admissions to large private and small ICFs/IID shall be based upon a determination of the need for such care by the office. The interdisciplinary professional team from the proposed placement facility shall review a comprehensive evaluation covering physical, emotional, social, and cognitive factors, as required by federal law, to ensure the facility can meet the needs of the member.

(b) The interdisciplinary professional team includes a physician, a certified social worker, and other professionals, one (1) of whom is a qualified intellectual disability professional.

(c) A qualified intellectual disability professional is a person as defined in 42 CFR 483.430.

(d) The following guidelines are applicable for admission and readmission of a member to a large private or small ICF/IID:

(1) The office must authorize Medicaid payment for each member in the large private and small ICF/IID. This process must be completed prior to the first Medicaid payment. Determination of appropriate reimbursement is based on the documentation required by this subsection.

(2) Admission to all large private and small ICF/IID facilities requires diagnostic evaluation, including social and psychological components.

(3) The ICF/IID must submit a form approved by the office, completed by the physician, for each Medicaid applicant or member for whom services are required. The need for care and placement during any payment period must be included in the medical evaluation. The payment period will not be approved for any period of time that precedes the date the physician signs the Form 450B certifying the need for ICF/IID services.

(4) Both member and provider must have been eligible to participate in Medicaid during any period for which Medicaid reimbursement is requested.

(5) A physician must certify the patient's need for ICF/IID care at the time of admission. The first recertification must take place within twelve (12) months from the date of admission certification. Subsequent recertifications must occur annually thereafter, or more often, as determined by the interdisciplinary team.

(6) The certification must specify the level of care required by the member, and the recertification must clearly indicate the need for care to continue at this level. The certification must be signed by the physician and dated at the time of signature. Subsequent recertifications must be signed by a physician, a physician assistant, or a nurse practitioner and dated at the time of signature. (A STAMPED SIGNATURE WILL NOT BE ACCEPTED.)

(7) The admission certification and the three (3) latest recertifications must be kept in the member's active medical record. All other recertification must be kept on file in the facility and be available for review purposes.

(8) Pursuant to 42 CFR 483.440(c)(3), the interdisciplinary professional team must, within thirty (30) days after admission, review and update the preadmission evaluation.

(9) The individual program plan must be reviewed at least by the qualified intellectual disability professional and revised as necessary as required by 42 CFR 483.440(f).

(10) At least annually, the comprehensive functional assessment of each individual must be reviewed by the interdisciplinary team for relevancy and updated as needed in accordance with 42 CFR 483.440(f)(2).

(Office of the Secretary of Family and Social Services; 405 IAC 5-13-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3318; filed Sep 27, 1999, 8:55 a.m.: 23 IR 312; 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)

405 IAC 5-13-8 Admission to large state ICFs/IID

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 12-15-5; IC 12-15-30

Sec. 8. Admissions to large state ICFs/IID shall be based upon a determination of the need for such care by the division of disability, aging, and rehabilitative services/bureau of developmental disabilities services. The interdisciplinary professional team from the proposed placement facility, as required by federal law, shall review the comprehensive evaluation covering physical, emotional, social, and cognitive factors to ensure the member's needs are met. The office must authorize the reimbursement of each member prior to the first Medicaid payment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-13-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3318; filed Sep 27, 1999, 8:55 a.m.: 23 IR 312; 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)

405 IAC 5-13-9 Inspection of care review team inspection (Repealed)

Sec. 9. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-13-10 Transfer to another ICF/IID

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. 10. (a) A form as prescribed by 405 IAC 5-13-7(d)(3) *[section 7(d)(3) of this rule]* must be submitted to the office for any transfer to another ICF/IID facility. If a diagnosis and evaluation was completed within the last twelve (12) months prior to the date of transfer, it must be submitted.

(b) Each facility is a separate provider and is issued an individual provider number. Each facility must use its assigned provider number. Therefore, transfers between facilities must be done in accordance with procedures outlined in this section.

(c) For large state ICFs/IID, if the recipient is transferred to a noncertified unit, the admission procedure as described in section 8 of this rule must be followed for any readmission to the large state ICF/IID in order to determine reimbursement. *(Office of the Secretary of Family and Social Services; 405 IAC 5-13-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; 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)*

Rule 14. Dental Services

405 IAC 5-14-1 Policy

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15

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

(b) For those members twenty-one (21) years of age and over, all covered services will require prior authorization except the following:

(1) Diagnostic and preventative services.
(2) Direct restorations.
(3) Treatment of lesions.
(4) Periodontal services for the following immuno-compromised individuals:
  (A) Transplant patients.
  (B) Pregnant women.
  (C) Diabetic patients.
(5) Extractions.
(6) Emergency and trauma care.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1546; filed Aug 17, 2007, 3:23 p.m.: 20070912-IR-405060005FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:01 p.m.: 20110608-IR-405100795FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; filed Sep 2, 2016, 12:26 p.m.: 20160928-IR-405150450FRA)

405 IAC 5-14-2 Covered services

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. The following are covered dental services under Medicaid:
(1) Evaluations.
(2) Radiographs.
(3) Prophylaxis.
(4) Topical fluoride for members twenty (20) years of age and younger.
(5) Sealant for permanent molars and premolars for members twenty (20) years of age and younger.
(6) Amalgam.
(7) Unilateral and bilateral space maintainers for members twenty (20) years of age and younger.
(8) Resin anteriors and posteriors.
(9) Recement crowns.
(10) Steel crown primary.
(11) Stainless steel crown permanent.
(12) Therapeutic pulpotomy.
(13) Extractions.
(14) Oral biopsies.
(15) Alveoplasty.
(16) Excision of lesions.
(17) Excision of benign tumor.
(18) Odontogenic cyst removal.
(19) Nonodontogenic cyst removal.
(20) Incise and drain abscess.
(21) Fracture simple stabilize.
(22) Compound fracture of the mandible.
(23) Compound fracture of the maxilla.
(24) Repair of wounds.
(25) Suturing.
(26) Emergency treatment dental pain.
(27) Analgesia for members twenty (20) years of age and younger.
(28) Drugs and medicaments.
(29) Periodontic procedures.
(30) Other dental services as medically necessary to treat members eligible for the EPSDT program.
(31) General anesthesia.
(32) Intravenous (IV) sedation covered only for oral surgical services.
(33) Dentures and partials.
(34) Orthodontic services for members twenty (20) years of age and under only.
(35) Physician fluoride varnish services for members younger than four (4) years of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2862; 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 Sep 2, 2016, 12:26 p.m.: 20160928-IR-405150450FRA)

405 IAC 5-14-3 Diagnostic services

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. Medicaid reimbursement is available for diagnostic services, including initial and periodic evaluations, prophylaxis, radiographs, and emergency treatments, with the following limitations:

(1) Either a full mouth series or panorex is limited to one (1) set per member every three (3) years.

(2) Bitewing radiographs are limited to one (1) set per member every twelve (12) months. One (1) set of bitewings is defined as either:

(A) four (4) horizontal films; or

(B) seven (7) to eight (8) vertical films.

(3) Intraoral radiographs are limited to one (1) first film and seven (7) additional films, per member every twelve (12) months.

(4) Temporomandibular joint arthrograms, other temporomandibular films, tomographic surveys, and cephalometric films are no longer covered in a dental office.

(5) A comprehensive or detailed oral evaluation is limited to one (1) per lifetime, per member, per provider, with an annual limit of two (2) per member.

(6) A periodic or limited oral evaluation is limited to one (1) every six (6) months, per member, any provider.

(7) Mouth gum cultures and sensitivity tests are not covered.

(8) Oral hygiene instructions:

(A) are reimbursed in the Medicaid payment allowance for diagnostic services; and

(B) may not be billed separately to Medicaid.

(9) Payment for the writing of prescriptions:

(A) is included in the reimbursement for diagnostic services; and

(B) may not be billed separately to Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; filed Aug 17, 2007, 3:23 p.m.: 20070912-IR-405060005FRA; 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)

405 IAC 5-14-4 Topical fluoride

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. 4. Reimbursement is available for one (1) topical application of fluoride every six (6) months per member from the time of first tooth eruption. Topical applications of fluoride are not covered for members twenty-one (21) years of age or older. Brush-in fluoride (topical application of fluoride phosphate) is not a covered service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; 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 Sep 2, 2016, 12:26 p.m.: 20160928-IR-405150450FRA)*

405 IAC 5-14-5 Treatment of dental caries

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. 5. Treatment of dental caries with amalgam, composites, or resin restorations or stainless steel crowns is covered. The use of pit sealants on permanent molars and premolars only is a covered service for members under twenty-one (21) years of age. There is a limit of one (1) treatment per tooth, per lifetime. Margination of restorations and occlusal adjustments are not covered. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; 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)*

405 IAC 5-14-6 Prophylaxis

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. Prophylaxis is a covered service in accordance with the following limitations:

(1) One (1) unit every six (6) months for noninstitutionalized members twelve (12) months of age up to their twenty-first birthday.

(2) One (1) unit every twelve (12) months for noninstitutionalized members twenty-one (21) years of age and older.

(3) Institutionalized members may receive up to one (1) unit every six (6) months.

(4) Prophylaxis is not covered for members under twelve (12) months of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2863; 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)

405 IAC 5-14-7 Periodontal root planing and scaling

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. Periodontal root planing and scaling for members over three (3) years of age and under twenty-one (21) years of age, or for institutionalized members, is limited to four (4) units every two (2) years. For noninstitutionalized members twenty-one (21) years of age and older, periodontal root planing and scaling is limited to four (4) units per lifetime. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3320; 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)*

405 IAC 5-14-8 Extractions

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. Medicaid reimbursement is available for extraction of teeth. Extraction of teeth must be medically necessary, and the diagnosis must support extraction. If multiple extractions are performed on the same date of service, the maximum allowable payment for additional teeth will be reduced by ten percent (10%) of the maximum allowable for the first tooth. Payment for preoperative and postoperative care is included in the allowance for the operative procedure and may not be billed separately to Medicaid. Payment for placement of sutures or tissue trim, or both, in simple extractions is included in the reimbursement fee for the extractions and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; 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)*

405 IAC 5-14-9 Space maintenance

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 is available for space maintenance in children with deciduous molar teeth subject to the following restrictions:

(1) Space maintenance for children under three (3) years of age requires prior authorization by the office. Space maintenance for missing permanent teeth requires prior authorization by the office.

(2) Adjustment to space maintainers, bands, and all other appliances is included in the reimbursement for the service and may not be billed separately to Medicaid.

(3) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; 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)*

405 IAC 5-14-10 Pulpcap (Repealed)

Sec. 10. *(Repealed by Office of the Secretary of Family and Social Services; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2865)*

405 IAC 5-14-11 Analgesia

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. 11. Nitrous oxide analgesia is covered only for those twenty (20) years of age and younger. Preanesthetic medication is a covered service for all ages. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-14-12 Infection control

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. 12. Infection control is not a covered service. All routine supplies and services should be included in the reimbursement amount for the procedure. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; 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)*

405 IAC 5-14-13 Emergency treatment of dental pain

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. 13. Palliative treatment of facial pain, such as abscess, incision, and drainage, is limited to emergency treatment only. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-13; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; 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)*

405 IAC 5-14-14 Office visits

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. 14. Payment for office visits is not covered. Reimbursement is available only for covered services actually performed. Covered services provided outside the office will be reimbursed at the fee allowed for the same service provided in the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; 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)*

405 IAC 5-14-15 General anesthesia and intravenous sedation

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. 15. (a) Medicaid reimbursement is available for general anesthesia. General anesthesia for members twenty-one (21) years of age and older may only be provided in a hospital (inpatient or outpatient) or ambulatory surgical center and must include documentation of the following in the patient's record to be eligible for reimbursement:

(1) Specific reasons why such services are needed, including specific justification if such services are to be provided on an outpatient basis.

(2) Documentation that the member cannot receive necessary dental services unless general anesthesia is administered. For example, a member may be unable to cooperate with the dentist due to physical or mental disability.

(b) Medicaid reimbursement is available for intravenous sedation in a dental office when provided for oral surgical services only. Documentation in the patient's record must include specific reasons why such services are needed, if such services are to be provided on an outpatient basis. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; 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)*

405 IAC 5-14-16 Periodontics; surgical

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. 16. Periodontic surgery is a covered service only for cases of drug-induced periodontal hyperplasia. Documentation in the patient's record must substantiate that the service was provided for drug-induced periodontal hyperplasia. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-16; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-14-17 Oral surgery

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. 17. No oral surgical procedures shall be reimbursed other than those listed in this rule and as defined by provider bulletin. Placement of sutures or tissue trim, or both, in a simple extraction does not constitute a surgical extraction. Multiple simple extractions with placement of sutures or tissue trim, or both, performed in either office or hospital shall not be reimbursed as surgical extractions. Payment of preoperative and postoperative care is included in the reimbursement for the operative procedure and may not be billed separately to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-17; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-14-18 Hospital admissions for covered dental services or procedures

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. 18. The patient's record must document that admission of a member to a hospital for the purpose of performing any elective dental service, or any elective dental service performed on an inpatient basis, is a medically necessary service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-18; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Apr 16, 2003, 10:50 a.m.: 26 IR 2864; 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)

405 IAC 5-14-19 Prior authorization for early and periodic screening, diagnostic, and treatment covered services

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. 19. Prior authorization must be obtained for services not listed in section 2 of this rule but which are medically necessary to treat members eligible for the EPSDT. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-19; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; 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)*

405 IAC 5-14-20 Dental services provided in a state owned ICF/IID

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. 20. Dental services that can be provided in a state owned ICF/IID shall be included in the per diem rate and do not require prior authorization. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization according to the following:

(1) Dental services prior authorized by the contractor must be billed to Medicaid directly by the outside dental provider.
(2) Prior authorization shall not be given for dental services provided off-site that are included within the per diem rate.
(3) Documentation on the Medicaid dental prior authorization request must substantiate:
    (A) the dental service is medically necessary; and
    (B) an explanation of why the service cannot be rendered at the facility.
(4) The office will review criteria for prior authorization set forth in this rule for the specific dental service requested.

(Office of the Secretary of Family and Social Services; 405 IAC 5-14-20; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; 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)

405 IAC 5-14-21 Maxillofacial surgery

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. 21. Providers shall be required, based upon the facts of the case, to obtain a second or third opinion substantiating the medically necessary service or approach for maxillofacial surgery related to diseases and conditions of the jaws and contiguous structures. The second opinion is required regardless of the surgical setting in which the surgery is to be performed, such as an ambulatory surgical treatment center, a hospital, or a clinic. *(Office of the Secretary of Family and Social Services; 405 IAC 5-14-21; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3322; 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)*

Rule 15. Early and Periodic Screening, Diagnostic, and Treatment Services

405 IAC 5-15-1 Policy

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. 1. EPSDT is a federally mandated preventive health care program covered by Medicaid. The purpose of EPSDT is to facilitate the introduction of young members into a continuing health care system that will detect abnormalities before such abnormalities become chronic or debilitating. EPSDT program services are covered by Medicaid subject to the limitations set forth in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-2 Initial screening

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. An initial screening shall be performed by the EPSDT screening provider when referred by the office or upon the initial request of the member for EPSDT services in accordance with the Indiana EPSDT program recommended screening procedures schedule (hereafter referred to as periodicity schedule). A screening or any portion of a screening is not required where medical contraindications are documented. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-3 Periodic screening

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) Periodic screenings shall be provided by the EPSDT screening provider in accordance with the office's EPSDT periodicity schedule as long as the member chooses to participate in the EPSDT program, or until the member reaches his or her twenty-first birthday.

(b) A periodic screening shall include the following:

(1) A comprehensive health and developmental history, including assessment of both physical and mental health development.

(2) A comprehensive unclothed physical exam.

(3) A nutritional assessment.

(4) A developmental assessment.

(5) Appropriate vision and hearing testing.

(6) Dental screening.

(7) Health education, including anticipatory guidance.

(8) In addition to the required procedures listed in this subsection, the periodic screening shall include administration of or referral for any other test, procedure, or immunization that is medically necessary or clinically indicated.

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)

405 IAC 5-15-4 Treatment

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. 4. Any treatment found medically necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements for the services set out in this article. However, if a service is not

covered under the state plan, it is still available to EPSDT eligible members subject to prior authorization requirements if it is medically necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-5 Prior authorization

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. 5. Prior authorization is not required for screening services. Treatment services are subject to the same prior authorization requirements for the services as set out in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-6 Member and provider participation

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. 6. (a) Any member under twenty-one (21) years of age may participate in the EPSDT program. Each member will be informed about the program by the office in accordance with federal regulations. Participation in EPSDT by members is voluntary.

(b) Individual physicians, physician group practices, hospitals, or physician-directed clinics who are enrolled as providers may provide a complete EPSDT screen.

(c) Any enrolled provider may provide EPSDT diagnostic and/or treatment services within the scope of his or her practice upon referral from the screening provider. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-7 Screening referrals

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. 7. Providers of services who perform screening or treatment services as a result of an EPSDT screening referral shall be subject to the same limitations for such services as set out in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-15-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)*

405 IAC 5-15-8 EPSDT periodicity and screening schedule

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. 8.

Every child and family is unique, therefore this Periodicity and Screening Schedule has been designed as a preventive health care plan for children with the absence of any significant health problems who are growing and developing in satisfactory fashion. This Schedule may need to be adjusted to meet the health care needs of specific patients.

This Periodicity Schedule reflects recommendations of the American Academy of Pediatrics along with those of the Hoosier Healthwise Clinical Advisory Committee and is meant to be a guide for Indiana Medicaid Providers participating in the EPSDT - HealthWatch Program. This program emphasizes the importance of early and periodic screening for specific conditions, as outlined below, and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this Schedule.

	INFANCY[3]								EARLY CHILDHOOD[3]					MIDDLE CHILDHOOD[3]				ADOLESCENCE[3]				
AGE[4]	NEWBORN[1]	2-4d[2]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY: INITIAL/INTERVAL	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																						
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●											
Blood Pressure												●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																						
Vision[5]	S	S	S	S	S	S	S	S	S	S	S	O[5]	O	O	S	S	O	O	S	S	O	S
Hearing[5]	S/R	S	S	S	S	S	S	◄	►	►	►	►	O	O	S	S	O[6]	O[6]	S	S	O[6]	S
DEVELOPMENTAL/ BEHAVIOR ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[8]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL																						
Immunization[9]	●	►	►	●	●	●		◄	●	►			◄	●	►			●	►			
Lead Screening[10]							●	►			●	R	R	R	R	R	R	R	R	R	R	R
Hematocrit or Hemoglobin			◄	►	►	►	●				●			●				◄	11	►		
Urinalysis														●				◄	12	►		
PROCEDURES - PATIENTS AT RISK																						
Tuberculin Test[13]								R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sickle Cell Test[14]	●																					
Drug/HIV Testing[15]	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening[16]																		R	R	R	R	R
Pelvic Exam																		R	R	◄	17 ►	R
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Injury Prevention	●			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Dental Referral								◄	►	►	●	●	●	●	●	●	●	●	●	●	●	●
Dental Observation[18]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn Infant Screen[19]	◄	►																				

[1]Breastfeeding encouraged and supported.

[2]For newborns discharged in less than 48 hours after delivery.

[3]Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.

[4]If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

[5]If the patient is uncooperative, rescreen within six months. If objective vision methods indicate, refer to optometrist/ophthalmologist.

[6]Not to be duplicated if done in school system.

[7]By history and appropriate physical examination: if suspicious, by specific objective developmental testing.

[8]At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.

[9]According to the schedule currently recommended by the American Academy of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.

[10]Blood lead screening, as recommended by the AAP at indicated intervals and for patients at risk.

[11]All menstruating adolescents should be screened.

[12]A dipstick urinalysis for leukocytes for male and female adolescents.

[13]Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of skin testing should be according to the degree of risk.

[14]Should be performed one time only, when clinically indicated, or if not done in the newborn screen.

[15]Should be done on newborns and annually for those at risk, with patient/parent consent.

[16]All sexually active patients should be screened for sexually transmitted diseases (STDs).

[17]All sexually active females should have a pelvic examination. A pelvic exam and routine pap smear should be offered between the ages of 18 and 21 as part of an active preventive health plan.

[18]Dental referral may include flouride treatments.

[19]Must be done 48 hours after birth.

Please consult the EPSDT - HealthWatch Program Provider Manual for immunization schedules and risk factor definitions.

Key: ● = to be performed R = to be performed on patients at risk S = subjective, by history O = objective, by a standard testing method
◄► = range during which a service may be provided, with the dot or number indicating the preferred age

(Office of the Secretary of Family and Social Services; 405 IAC 5-15-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3323; 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)

Rule 16. Home Health Agency and Clinic Services

405 IAC 5-16-1 Providers eligible for reimbursement

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. 1. Services provided to a member by:
(1) home health agencies;
(2) clinics;
(3) federally qualified health centers;
(4) free-standing surgical centers;
(5) therapy centers;
(6) rehabilitation centers; or
(7) other such facilities;
are covered subject to the limitations set out in this rule and 405 IAC 5-22. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; 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)*

405 IAC 5-16-2 Home health agency services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. Medicaid reimbursement is available to home health agencies for:
(1) skilled nursing services provided by a registered nurse or licensed practical nurse;
(2) home health aide services;
(3) physical, occupational, and respiratory therapy services;
(4) speech pathology services;
(5) renal dialysis; and
(6) telehealth services;
when such services are provided within the limitations listed in sections 3 and 3.1 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 16; 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 Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)*

405 IAC 5-16-3 Prior authorization for home health agency services; generally

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 home health services require prior authorization by the office, except the following:
(1) Services provided by a registered nurse, licensed practical nurse, or home health aide, which have been ordered in writing by a physician prior to the patient's discharge from a hospital, and that do not exceed one hundred twenty (120) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.

(2) Any combination of therapy services ordered in writing by a physician prior to the patient's discharge from a hospital and that do not exceed thirty (30) units within thirty (30) calendar days of discharge from a hospital. These services may not continue beyond thirty (30) calendar days unless prior authorization is received.

(b) Prior authorization requests for home health agency services may be submitted by an authorized representative of the home health agency. Written prior authorization forms must contain the information specified in 405 IAC 5-3-5. Telephone requests for the prior authorization of services will be conducted in accordance with 405 IAC 5-3-2 and 405 IAC 5-3-6.

(c) The following information must be submitted with the written prior authorization request form and may also be requested as written documentation to supplement telephone requests for prior authorization:

(1) Copy of the written plan of treatment, signed by the attending physician.

(2) Estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.

(d) Prior authorization will include consideration of the following, if applicable:

(1) Review of the information provided in the prior authorization form, or telephone request for prior authorization, and any additional required or requested documentation.

(2) Review of the following factors when determining the appropriate services, units of service, and length of period for prior authorized services for home care members:

(A) Severity of illness and symptoms.

(B) Stability of the condition and symptoms.

(C) Change in medical condition that affects the type or units of service that can be authorized.

(D) Treatment plan, including identified goals.

(E) Intensity of care required to meet needs.

(F) Complexity of needs.

(G) Amount of time required to complete treatment tasks.

(H) Rehabilitation potential.

(I) Whether the services required in the current care plan are consistent with prior care plans.

(J) Need for instructing the member on self-care techniques in the home or need for instructing the caregiver on caring for the member in the home, or both.

(K) Other caregiving services received by the recipient, including, but not limited to, services provided by Medicare, Medicaid Waiver Programs, CHOICE, vocational rehabilitation, and private insurance programs.

(L) Caregivers available to provide care for the member, including consideration of the following:

(i) Number of caregivers available.

(ii) Whether the caregiver works outside the home.

(iii) Whether the caregiver attends school outside of the home.

(iv) Reasonably predictable or long term physical limitations of the caregiver that limit the ability of the caregiver to provide care to the member.

(v) Whether the caregiver has additional child care responsibilities.

(vi) How and when the units of service requested will be used to assist the caregiver in meeting the member's medical needs.

(M) Whether the member works or attends school outside of the home, including what assistance is required.

(N) Special situations when additional home health units may be authorized on a short term basis, including the following:

(i) Significant deterioration in the condition of the member, particularly if additional units will prevent an inpatient or extended inpatient hospital admission.

(ii) Major illness or injury of the caregiver with expectation of recovery, including, but not limited to:

(AA) illness or injury that requires an inpatient acute care stay;

(BB) chemotherapy or radiation treatments; or

(CC) a broken limb, which would impair the caregiver's ability to lift the member.

(iii) Temporary, but significant, change in the home situation, including, but not limited to:

(AA) a caregiver's call to military duty; or

(BB) temporary unavailability due to employment responsibilities.

(iv) Significant permanent change in the home situation, including, but not limited to, death or divorce with loss of a caregiver. Additional units of service may be authorized to assist in providing a transition.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3325; filed Aug 27, 1999, 10:15 a.m.: 23 IR 17; 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)

405 IAC 5-16-3.1 Home health agency services; limitations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 3.1. (a) In addition to the prior authorization requirements as outlined in section 3 of this rule, services provided by a registered nurse, licensed practical nurse, home health aide, or renal dialysis aide employed by a home health agency must be as follows:

(1) Prescribed or ordered in writing by a physician.

(2) Provided in accordance with a written plan of treatment developed by the attending physician.

(3) Intermittent or part time, except for ventilator-dependent patients who have a developed plan of home health care.

(4) Health-related nursing care. Homemaker, chore services, and sitter/companion service are not covered, except as specified under applicable Medicaid waiver programs.

(5) Medically necessary.

(6) Less expensive than any alternate modes of care.

(b) In addition to the prior authorization requirements as outlined in section 3 of this rule, physical therapy, occupational therapy, respiratory therapy, and speech pathology must be as follows:

(1) Provided by an appropriately licensed, certified, or registered therapist employed or contracted by the home health agency.

(2) Ordered or prescribed in writing by a physician.

(3) Provided in accordance with a written plan of treatment developed cooperatively between the therapist and the attending physician.

(4) Medically necessary. Educational activities, such as the remediation of learning disabilities, are not covered by Medicaid.

(5) Provided in accordance with 405 IAC 5-22.

(c) Nursing services, which do not meet the definition of emergency services at 405 IAC 5-2-9, are covered without prior authorization when provided to a member for whom home health services have been currently authorized when the attending physician orders a one (1) time home visit due to a change in the patient's medical condition to prevent deterioration of the patient's medical condition, for example, reanchoring a foley catheter, obtaining a laboratory specimen, administering an injection, or assessing a reported change with signs and symptoms of potential for serious deterioration.

(d) In addition to the limitations as outlined in subsection (a) and section 3 of this rule, telehealth services provided by a home health agency are subject to the following requirements:

(1) The member must be receiving home health services.

(2) To initially qualify for telehealth services, the member must have had two (2) or more of the following events related to one (1) of the conditions listed in subdivision (3) within the previous twelve (12) months:

(A) An emergency room visit.

(B) An inpatient hospital stay.

(3) The member must have one (1) or more of the following conditions:

(A) Chronic obstructive pulmonary disease.

(B) Congestive heart failure.

(C) Diabetes.

Additional qualifying conditions may be added by the office upon satisfying the notice requirements set forth in IC 12-15-13-6.

(4) An emergency room visit resulting in an inpatient hospital admission does not constitute two (2) separate events for purposes of meeting the requirements of subdivision (2).

(5) In any telehealth encounter, a licensed registered nurse must perform the reading of transmitted health information provided to the member in accordance with the written order of the physician.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-3.1; filed Aug 27, 1999, 10:15 a.m.: 23 IR 18; 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 Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-16-4 Rehabilitation center services; limitations

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. 4. Medicaid reimbursement is available for rehabilitation center services provided by appropriately licensed, certified, or registered staff members subject to the following limitations:

(1) All rehabilitation center services require prior authorization by the department, except those services ordered in writing by a physician prior to the patient's discharge from a hospital. Any combination of therapy services ordered in writing may not exceed thirty (30) hours, sessions, or visits in thirty (30) calendar days unless prior authorization is obtained from the department.

(2) All services must be ordered in writing by a physician.

(3) All services must be provided in accordance with a written plan of care developed cooperatively between the therapist or psychologist and the attending physician.

(4) All services must be medically necessary. Educational services, including, but not limited to, the remediation of learning disabilities are not covered by Medicaid.

(5) All therapies provided in a rehabilitation center must be provided in accordance with 405 IAC 5-22.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; 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)

405 IAC 5-16-5 Rural health clinics and federally qualified health clinics; reimbursement

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. 5. Medicaid reimbursement is available to rural health clinics (RHCs) and federally qualified health clinics (FQHCs) for services provided by the following providers:

(1) A physician.

(2) A physician assistant.

(3) A nurse practitioner.

(4) A clinical psychologist.

(5) A clinical social worker.

Reimbursement is also available for services and supplies incident to such services as would otherwise be covered if furnished by a physician or as an incident to a physician's services. Services to a homebound individual are only available in the case of those FQHCs that are located in an area that has a shortage of home health agencies as determined by the office. Any other ambulatory service included in the Medicaid state plan is considered a covered FQHC service if the FQHC offers such a service. FQHC services are defined the same as the services provided by RHCs. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; 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)*

405 IAC 5-16-6 Freestanding clinics and surgical centers; limitations

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. 6. Medicaid reimbursement is available to freestanding clinics and surgical centers for services provided to members subject to the following limitations:

(1) Prior authorization is required for all services and supplies the charges for which exceed the cost limits or utilization parameters set out in this article.

(2) Medicaid reimbursement is not available for facility charges if the services provided are such that they ordinarily could have been provided in a physician's office. Such services provided outside a physician's office will be reimbursed at the fee allowed for the same service provided in the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; 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)

Rule 16.5. Freestanding Birthing Center Services

405 IAC 5-16.5-1 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2; IC 16-18-2-36.5; IC 16-21-2; IC 25-23-1-13.1

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "Certified nurse midwife" means a person licensed to practice as a nurse midwife under IC 25-23-1-13.1.

(c) "Freestanding birthing center" means a health facility that is:

(1) not a hospital licensed under IC 16-21-2;

(2) where childbirth is planned to occur away from a pregnant woman's residence;

(3) licensed or otherwise approved by the state to provide prenatal labor and delivery or postpartum care and other ambulatory services; and

(4) intended for the sole purpose of delivering a normal, uncomplicated, or low-risk pregnancy.

(d) "Freestanding birthing center services" means services furnished to a recipient at a birthing center as defined in IC 16-18-2-36.5 and this rule.

(e) "Low-risk pregnancy" has the meaning set forth in 410 IAC 27-1-15.5. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-1; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-16.5-2 Policy; scope

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 2. (a) The purpose of this rule is to establish a reimbursement methodology for services provided by freestanding birthing centers covered by Medicaid.

(b) A provider's continued participation in Medicaid and the receipt of payment for services are contingent on the provider's:

(1) maintaining state licensure of the birthing center; and

(2) conforming with:

(A) the provider agreement entered into by the provider and the office; and

(B) this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-2; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-16.5-3 Reimbursement

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 3. (a) Covered freestanding birthing center services shall be reimbursed in accordance with this section.

(1) Services, including prenatal labor and delivery, that would otherwise be performed in a hospital setting shall be reimbursed to a freestanding birthing center at a flat rate determined by the office.

(2) A labor management fee when the patient is transferred to a hospital before the delivery is completed shall be paid to a freestanding birthing center at a flat rate determined by the office.

(3) The services of physicians and certified nurse midwives shall be reimbursed in accordance with 405 IAC 1-11.5.

(b) Medicaid reimbursement is available to a freestanding birthing center for services provided to members subject to the limitations in this rule and 410 IAC 27. *(Office of the Secretary of Family and Social Services; 405 IAC 5-16.5-3; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-16.5-4 Limitations

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-2

Sec. 4. (a) Services provided in a birthing center shall be limited in the following manner:

(1) A member must be considered as having a normal, uncomplicated, or low-risk pregnancy.

(2) A delivery shall be performed by a:

(A) certified nurse midwife; or

(B) physician.

(3) Surgical services are limited to episiotomy and episiotomy repair and shall not include operative obstetrics or cesarean sections.

(4) Labor shall not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor.

(5) Systemic analgesia may be administered. Local anesthesia may be administered for pudendal block and episiotomy repair.

(6) General and conductive anesthesia shall not be administered at a freestanding birthing center.

(7) A birthing center shall not routinely keep a member in the facility for in excess of twenty-four (24) hours.

(b) Medicaid reimbursement is not available for birthing center facility services if the services provided are such that the services ordinarily could have been provided in a physician's office. If such services are provided at a freestanding birthing center, the services will be reimbursed at the fee or rate allowed for the same service provided in a physician's office.

(c) Freestanding birthing center services rendered in a member's home are noncovered services. *(Office of the Secretary of Family and Social Services, 405 IAC 5-16.5-4; filed Nov 19, 2013, 2:11 p.m.: 20131218-IR-405120004FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

Rule 17. Hospital Services

405 IAC 5-17-1 Reimbursement; limitations

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. 1. (a) Inpatient and outpatient hospital services are covered when such services are provided or prescribed and documented by a physician and when the services are medically necessary for the diagnosis or treatment of the member's condition, subject to the limitations set out in this article.

(b) Reimbursement shall be made only for covered services. In addition, if an inpatient procedure requires prior authorization and prior authorization is either not obtained or denied, reimbursement for the inpatient procedure and any associated services, including inpatient days, shall be denied.

(c) Reimbursement is not available for reserving a bed during a therapeutic leave of absence from an acute care hospital.

(d) Reimbursement for inpatient hospital services is available only when it is determined to be medically necessary for the services to be performed only in an inpatient hospital setting.

(e) Reimbursement will be denied for any days of the hospital stay during which the inpatient hospitalization is found not to have been medically necessary.

(f) Reimbursement under the level of care methodology described in 405 IAC 1-10.5 will be made for the lesser of:

(1) the number of days actually used; or

(2) the number of days prior authorized by the office.

(g) The member's medical condition, as described and documented in the medical record by the primary or attending physician must justify the intensity of service provided.

(h) All transfers, including interfacility transfers where the transferring or receiving facility or unit is paid according to the level of care methodology as described in 405 IAC 1-10.5 will be subject to retrospective review. *(Office of the Secretary of Family and Social Services; 405 IAC 5-17-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3326; 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)*

405 IAC 5-17-2 Prior authorization; generally

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Prior authorization is required for all nonemergent inpatient hospital admissions of Medicaid eligible members. Nonemergent inpatient hospital admissions include all elective or planned inpatient hospital admissions and inpatient hospital admissions for which the patient's condition permitted adequate time to schedule the availability of a suitable accommodation. The following are exempt from this requirement:

(1) Inpatient hospital admissions when covered by Medicare.

(2) Routine vaginal and cesarean section deliveries.

(b) Prior authorization is required for all Medicaid covered rehabilitation, burn, and psychiatric inpatient stays that are reimbursed under the level of care methodology described in 405 IAC 1-10.5 as well as substance abuse stays that are reimbursed under the DRG methodology described at 405 IAC 1-10.5.

(c) Any surgical procedure usually performed on an outpatient basis, when scheduled as an inpatient procedure, must be prior authorized. The length of stay for the inpatient admission is determined by the appropriate diagnosis related group, but will be subject to retrospective review to determine if the services were medically necessary.

(d) Criteria for determining that the inpatient admission is medically necessary shall include the following:

(1) Technical or medical difficulties during the outpatient procedure as documented in the medical record.

(2) Presence of physical or mental conditions that make prolonged preoperative or postoperative observations by a nurse or skilled medical personnel a necessity.

(3) Performance of another procedure simultaneously, which itself requires hospitalization.

(4) Likelihood of another procedure following the initial procedure, which would require hospitalization.

(e) Days that are not prior authorized under the level of care methodology as required by this rule will not be covered by Medicaid.

(f) In addition to the prior authorization requirements set forth in this section, prior authorization is also required for the procedures listed in 405 IAC 5-3-13. *(Office of the Secretary of Family and Social Services; 405 IAC 5-17-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 3:58 p.m.: 20110608-IR-405100791FRA; 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)*

405 IAC 5-17-3 Emergency; weekend inpatient admissions

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. Emergency inpatient admissions for diagnoses reimbursed under the level of care payment methodology and emergency substance abuse inpatient admissions must be reported to the office within forty-eight (48) hours of admission, not including Saturdays, Sundays, or legal holidays, in order to receive Medicaid reimbursement. At that time, the same standards for prior authorization will be applied as would have been applied if the authorization had been requested before the admission. *(Office of the Secretary of Family and Social Services; 405 IAC 5-17-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; 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)*

405 IAC 5-17-4 Physical rehabilitation services

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. 4. (a) Medicaid reimbursement is available for physical rehabilitation services when such services are prior authorized subject to this section.

(b) Prior to admission to a physical rehabilitation unit, an assessment of the patient's total rehabilitative potential must be completed and documented in the medical record.

(c) Medicaid reimbursement is available for physical rehabilitation admission based on the following conditions:

(1) The patient is medically stable.
(2) The patient is responsive to verbal or visual stimuli.
(3) The patient has sufficient mental alertness to participate in the program.
(4) The patient's premorbid condition indicates a potential for rehabilitation.
(5) The expectation for improvement is reasonable.
(6) The criteria listed in 405 IAC 5-32 are met.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; 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)

405 IAC 5-17-5 Inpatient detoxification, rehabilitation, and aftercare for chemical dependency

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. 5. (a) Medicaid reimbursement is available for inpatient detoxification, rehabilitation, and aftercare for chemical dependency when such services are prior authorized subject to this section.

(b) Admission to a general hospital floor is not indicated unless the medical services are required for life support and cannot be rendered in a substance abuse treatment unit or facility.

(c) Prior authorization for inpatient detoxification, rehabilitation, and aftercare for chemical dependency shall include consideration of the following:

(1) All requests for prior authorization will be reviewed on a case-by-case basis.
(2) The treatment, evaluation, and detoxification are based on the stated medical condition.
(3) The need for safe withdrawal from alcohol or other drugs.
(4) A history of recent convulsions or poorly controlled convulsive disorder.
(5) Reasonable evidence that detoxification and aftercare cannot be accomplished in an outpatient setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-17-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3327; 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)

Rule 18. Laboratory Services

405 IAC 5-18-1 Clinical diagnostic laboratory services; reimbursement

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. Most clinical diagnostic laboratory procedures, performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients, will be reimbursed on the basis of fee schedules established by Medicare. For purposes of this fee schedule, clinical diagnostic services include all laboratory tests. Laboratory procedures are subject to the Clinical Laboratories Improvement Act (CLIA) rules and regulations. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; 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)*

405 IAC 5-18-2 Reimbursement restrictions

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. (a) A fee will be reimbursed by Medicaid for separate charges made by physicians, independent laboratories, or hospital laboratories for the drawing of or collection of specimens. These services are covered only in circumstances when a blood sample is drawn through venipuncture or where a urine sample is collected by catheterization.

(b) Billings on the claim form for specimen collection fees must be itemized. Only one (1) charge per day for each patient shall be allowed for venipuncture. A charge for catheterization will be allowed for each patient encounter, that is, there is no per day or per claim limitation.

(c) Handling or conveyance of a specimen will be reimbursed by Medicaid if these services are billed by a physician, chiropractor, or podiatrist. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; 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)*

405 IAC 5-18-3 Inpatient and outpatient laboratory facilities; 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. 3. (a) To be eligible for reimbursement, a laboratory service must be ordered in writing by a physician or other practitioner authorized to do so under state law.

(b) Laboratories performing the services must bill Medicaid directly unless otherwise approved by the Centers for Medicare and Medicaid Services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-18-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-18-4 Nonanatomical laboratory procedures

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. 4. (a) The interpretation of laboratory procedures that do not require the services of a physician are not reimbursable. Medicaid reimbursement is available for the interpretation of laboratory results that require the expertise of a physician as indicated by current medical practice standards and in accordance with appropriate CPT codes.

(b) Consultative pathology services are reimbursable if they:

(1) are requested by the member's attending physician in writing;

(2) relate to a test result that lies outside the clinically significant normal or expected range in view of the condition of the member;
(3) result in a written narrative report included in the member's medical record; and
(4) require the exercise of medical judgment by the consultant physician.

(Office of the Secretary of Family and Social Services; 405 IAC 5-18-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3328; 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)

Rule 19. Medical Supplies and Equipment

405 IAC 5-19-1 Medical supplies

Authority: IC 12-15
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 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)*

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

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 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)

405 IAC 5-19-3 Reimbursement parameters for durable medical equipment

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-13-6

Sec. 3. (a) Medicaid reimbursement is available for the rental or purchase of DME subject to the restrictions listed in this rule.

(b) DME and associated repair costs, including, but not limited to:

(1) ice bags;

(2) bed rails;

(3) canes;

(4) walkers;

(5) crutches;

(6) standard wheelchairs;

(7) traction equipment; or

(8) oxygen and equipment and supplies for its delivery;

for the usual care and treatment of members in long-term care facilities are reimbursed in the facility's per diem rate and may not be billed to Medicaid by the facility, pharmacy, or other provider. Nonstandard or custom/special equipment and associated repair costs require prior authorization by the office and may be billed separately to Medicaid, when authorized. Facilities cannot require members to purchase or rent such equipment with their personal funds.

(c) Reimbursement of DME is equal to the lower of the provider's submitted charges, not to exceed the provider's usual and customary charges, or the Medicaid allowable amount. The Medicaid allowable 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, 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).

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

(e) The total payment for the rental period may not exceed the purchase price.

(f) Items identified by the office that require frequent or substantial servicing will be paid on a rental basis only. No purchase payment will be made.

(g) All DME must be ordered in writing by a physician. The written order must be kept on file for audit purposes. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3329; 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)*

405 IAC 5-19-4 Repair of purchased 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. 4. Medicaid reimbursement is available for the repair of purchased DME, subject to this rule. All repairs of purchased DME require prior authorization by the office. Medicaid will not make payment for repair of equipment that is still under warranty. No payment shall be authorized for repair necessitated by member misuse or abuse. Repair of rental equipment is the responsibility of the rental provider. Payment for maintenance charges for properly functioning equipment is not covered by Medicaid. Repair costs for DME included in a long term care facility's per diem rate is also included in the per diem rate. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-4; 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)*

405 IAC 5-19-5 Reimbursement for replacement 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. 5. Subject to the criteria set forth in section 7 of this rule, Medicaid will pay for replacement of DME items. Notwithstanding such criteria, authorization for large DME, such as nonstandard or custom/special wheelchairs, hospital beds, and lifts, will not be given more than once every five (5) years per member unless there is a change in the member's medical needs, documented in writing by the requesting provider, significant enough to warrant a different type of equipment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; 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 Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-19-6 Durable medical equipment subject to 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. 6. (a) Prior authorization by the office is required for all DME rented or purchased with Medicaid funds, except for the following:

(1) Cervical collars.
(2) Back supportive devices such as corsets.
(3) Hernia trusses.
(4) Oxygen and supplies and equipment for its delivery for nursing facility residents.
(5) Parenteral infusion pumps when used in conjunction with parenteral hyperalimentation, including central venous catheters.

(b) Prior authorization is required for oxygen concentrators, except when used for nursing facility residents who have been certified as needing oxygen services by a physician.

(c) All oxygen equipment and supplies, including concentrators and portable liquid oxygen equipment, require prior authorization for members in a home setting. The member's need for oxygen must be certified by a physician. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; 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)*

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.

(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)

405 IAC 5-19-8 Ownership of 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. 8. DME purchased with Medicaid funds becomes the property of the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; 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)*

405 IAC 5-19-9 Wheelchairs and similar motorized vehicles

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. 9. (a) Medicaid reimbursement is available for wheelchairs or similar motorized vehicles, subject to the restrictions listed in this section, and requires prior authorization.

(b) Motorized vehicles are covered only when the member is enrolled in a school, sheltered workshop, or work setting, or if the member is left alone for significant periods of time. It must be documented that the member can safely operate the vehicle and that the member does not have the upper extremity function necessary to operate a manual wheelchair.

(c) Requests for wheelchairs or similar motorized vehicles require a completed medical clearance form submitted with the prior authorization request before the requests shall be reviewed. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3330; 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)*

405 IAC 5-19-10 Braces and orthopedic shoes

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. 10. Medicaid reimbursement is available for the following:

(1) Braces for the leg, arm, back, and neck.

(2) Orthopedic shoes and corrective shoe features.

(3) Corrective features built into shoes, such as heels, lifts, and wedges.

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

405 IAC 5-19-11 Prosthetic devices

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. 11. Medicaid reimbursement is available for prosthetic devices under the following conditions:

(1) All prosthetic devices must be ordered in writing by a physician, optometrist, or dentist.

(2) Prior authorization by the office is required for all basic prosthetic components and repairs. Once the basic prosthesis is approved, all customizing features will be exempt from prior authorization.

(3) Prosthetic devices dispensed for solely cosmetic reasons, for example, hairpieces or makeup, are not covered by Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-19-12 Home hemodialysis 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. 12. (a) Medicaid reimbursement is available for home hemodialysis equipment, including plumbing and water conditioner installation.

(b) Payment for removal and reinstallation of equipment due to member relocation is limited to moves made necessary by circumstances beyond the member's control. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-12; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; 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)*

405 IAC 5-19-13 Hearing aids; purchase

Authority: IC 12-15
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 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 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)

405 IAC 5-19-14 Hearing aids; maintenance and repair

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 14. Medicaid reimbursement is available for the maintenance or repair of hearing aids under the following conditions:
(1) Repairs for hearing aids and ear molds do not require prior authorization; however, reimbursement for such repairs shall not be made more often than once every twelve (12) months. Repairs may be prior authorized more frequently for members under twenty-one (21) years of age if circumstances are documented justifying need.
(2) Batteries, sound hooks, tubing, and cords do not require prior authorization.
(3) Medicaid payment is not available for repair of hearing aids still under warranty.
(4) Routine servicing of functioning hearing aids is not covered by Medicaid.
(5) No payment shall be made for repair or replacement of hearing aids necessitated by member misuse or abuse whether intentional or unintentional.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-14; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; 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)

405 IAC 5-19-15 Hearing aids; replacement

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 15. Medicaid reimbursement is available for the replacement of hearing aids under the following conditions:
(1) Medicaid reimbursement is available for the replacement of hearing aids subject to section 14 of this rule.
(2) Requests for replacement of hearing aids must:
(A) document a change in the member's hearing status; and
(B) state the purchase date and condition of the current hearing aid.
(3) Hearing aids shall not be replaced prior to five (5) years from the purchase date. Replacements may be prior authorized more frequently for members under twenty-one (21) years of age if medically necessary and supported by documentation justifying the same.

(Office of the Secretary of Family and Social Services; 405 IAC 5-19-15; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3331; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-19-16 Augmentative communication devices

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. 16. (a) As used in this section, "augmentative communication device" means a device or system that compensates for the loss or impairment of a speech function due to a congenital condition, an acquired disability, or a progressive neurological disease. The term includes only that equipment used for the purpose of communication, including both electronic and nonelectronic devices.
(b) As used in this section, "communication device" refers to an augmentative communication device.
(c) Medicaid reimbursement is available for a communication device subject to the following:
(1) The device must be ordered in writing by a medical doctor or doctor of osteopathy.
(2) Prior authorization is required for a communication device. Documentation supporting that the device is medically necessary must be provided on, or attached to, the prior authorization request form submitted by the requesting practitioner. A clinical evaluation by a speech pathologist, substantiating the communication device is medically necessary, must be

submitted as part of the prior authorization request.

(d) Authorization of reimbursement for a communication device may be granted only upon satisfaction of all of the following:

(1) Documentation must be presented that substantiates the member has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the member, in the absence of a communication device, cannot effectively make himself or herself understood by others in his or her communication environment.

(3) Documentation must be presented that substantiates the member's medical condition is such that at least two (2) years of use of the device by the member can reasonably be expected.

(4) Documentation must be presented that:

(A) identifies all communication devices that would meet the member's communication needs, taking into account the physical and cognitive strengths and weaknesses of the member and the member's communication environment; and

(B) recommends the least expensive communication device among those in clause (A).

(5) If authorization is requested for a computer or computerized device, the intended use of the computer or computerized device must be compensation for loss or impairment of communication function.

(e) Reimbursement for repair or replacement of a communication device is available in accordance with section 5 of this rule.

(f) Subject to prior authorization, rehabilitation engineering services necessary to mount or make adjustments to a communication device are covered; and speech therapy services as medically necessary to aid the member in the effective use of a communication device are covered subject to this rule and 405 IAC 5-22. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-16; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-19-17 Pneumatic artificial voicing systems

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. 17. (a) Medicaid reimbursement is available for a pneumatic artificial voicing system or an artificial larynx, subject to prior authorization. Prior authorization will be granted only upon satisfaction of the following:

(1) Documentation must be presented that substantiates the member has demonstrated sufficient mental and physical capabilities to benefit from the use of the system.

(2) Documentation must be presented that substantiates the member has demonstrated sufficient articulation and language skills to benefit from the use of the system.

(b) When a pneumatic artificial voicing system or an artificial larynx is provided on an inpatient basis, the attendant costs are considered to be included in the established per diem rate for the hospital or long term care facility and are not to be separately billed to Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-19-17; 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)*

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)

Rule 20. Mental Health Services

405 IAC 5-20-1 Reimbursement limitations

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. 1. (a) Medicaid reimbursement is available for mental health services provided by licensed physicians, psychiatric hospitals, general hospitals, psychiatric residential treatment facilities for children under twenty-one (21) years of age, outpatient mental health facilities, and psychologists endorsed as health service providers in psychology subject to the limitations set out in this rule. For purposes of this rule, "psychiatric residential treatment facility" or "PRTF" means a facility that meets the requirements set forth in section 3.1 of this rule.

(b) Reimbursement for inpatient psychiatric services is not available in institutions for mental diseases for a member under sixty-five (65) years of age unless the member is under twenty-one (21) years of age, or under twenty-two (22) years of age and had begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday.

(c) Medicaid reimbursement is available for inpatient psychiatric services provided to an individual between twenty-two (22) and sixty-five (65) years of age in a certified psychiatric hospital of sixteen (16) beds or less.

(d) Prior authorization is required for all inpatient psychiatric admissions including admissions for substance abuse. *(Office of the Secretary of Family and Social Services; 405 IAC 5-20-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; 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)*

405 IAC 5-20-2 Reserving beds in psychiatric hospitals and psychiatric residential treatment facilities

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. (a) Medicaid reimbursement is available for reserving beds in a psychiatric hospital (and not in a general acute care hospital) for hospitalization of members at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the facility.

(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days. If the member requires hospitalization longer than the fifteen (15) consecutive days, the member must be discharged from the facility.

(3) A physician's order for the hospitalization must be maintained in the member's file at the facility.

(b) Medicaid reimbursement is available for reserving beds in a PRTF for hospitalization of members under twenty-one (21) years of age at one-half (1/2) the regular per diem rate subject to all of the following conditions:

(1) Hospitalization is ordered by the physician for treatment of an acute condition that cannot be treated in the PRTF.

(2) The total length of time allowed for payment of a reserved bed for a single hospital stay is four (4) days. If the member requires hospitalization longer than the four (4) consecutive days, the member must be discharged from the PRTF.

(3) A physician's order for the hospitalization must be maintained in the member's file at the PRTF.

(4) In no instance will Medicaid reimburse a PRTF for reserving beds for Medicaid members when the facility has an occupancy rate of less than ninety percent (90%).

(c) Medicaid reimbursement is available for reserving beds in a psychiatric hospital, but not in a general care hospital, for the therapeutic leaves of absence of members at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the member's habilitation plan.

(2) In a psychiatric hospital, the total length of time allotted for therapeutic leaves in any calendar year shall be sixty (60) days per member. If the member is absent from the psychiatric hospital for more than sixty (60) days per year, no further Medicaid reimbursement shall be available for reserving a bed for that member in that year.

(3) A physician's order for therapeutic leave must be maintained in the member's file at the facility.

(d) Medicaid reimbursement is available for reserving beds in a PRTF for therapeutic leaves of absence of members under twenty-one (21) years of age at one-half (1/2) the regular per diem rate when all of the following conditions are present:

(1) A leave of absence must be for therapeutic reasons as prescribed by the attending physician and as indicated in the member's habilitation plan.

(2) A physician's order for therapeutic leave must be maintained in the member's file at the facility.

(3) In a PRFT, the total length of time allotted for therapeutic leaves in any calendar year shall be fourteen (14) days per member. If the member is absent from the PRTF for more than fourteen (14) days per year, no further Medicaid reimbursement shall be available for reserving a bed for therapeutic leave for that member in that year.

(4) In no instance will Medicaid reimburse a PRTF for reserving beds for members when the facility has an occupancy rate of less than ninety percent (90%).

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2476; 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)

405 IAC 5-20-3 Requirements for psychiatric hospitals

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. 3. Psychiatric hospitals must meet the following conditions in order to be reimbursed for inpatient services:

(1) The facility must be certified and a provider.

(2) The facility must maintain special medical records for psychiatric hospitals as required by 42 CFR 482.61, effective October 1, 1995, (not including secondary Code of Federal Regulations citations therein).

(3) The facility must provide services under the direction of a licensed physician.

(4) The facility must meet federal certification standards for psychiatric hospitals.

(5) The facility must meet utilization review requirements. The overall operation of a utilization review plan of a facility is monitored by the survey personnel of the Indiana state department of health as contracted by the office. The hospital will be visited by the inspection of care team annually to review medical and treatment records.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3333; 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)

405 IAC 5-20-3.1 PRTF; requirements

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. 3.1. PRTFs must meet the following conditions in order to be reimbursed for inpatient services:

(1) The facility must be licensed as a private secure facility under 465 IAC 2-11.

(2) The facility must be accredited by one (1) of the following:

(A) The Joint Commission on Accreditation of Healthcare Organizations.

(B) The American Osteopathic Association.

(C) The Council on Accreditation of Services for Families and Children.

(3) The facility must comply with all requirements in 42 CFR 483, Subpart G governing the use of restraint and seclusion.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-3.1; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-20-4 Individually developed plan of care

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. 4. (a) Each Medicaid eligible member admitted to a psychiatric hospital or PRTF must have an individually developed plan of care. In the case of a person between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less or a person sixty-five (65) years of age and over, the plan of care must be developed by the attending or staff physician. For a person under twenty-one (21) years of age, the plan of care must be developed by the physician and interdisciplinary team. In all cases, the plans of care must be developed not later than fourteen (14) days after admission. For a member who becomes eligible for Medicaid after admission to a facility, the plan of care must be prepared to cover all periods for which Medicaid coverage is claimed and as follows:

(1) The individual plan of care for a member between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a member sixty-five (65) years of age and over shall set forth treatment objectives and prescribe an integrated program of appropriate therapies, activities, and experiences designed to meet these objectives. The plan shall be based upon a diagnostic evaluation that includes examination of the medical, psychological, social, and behavioral aspects of the member's situation. It shall include, at an appropriate time, a postdischarge plan and plan for coordination of inpatient services with partial discharge plans and appropriate related services in the member's community to ensure continuity of care when returned to the member's family and community upon discharge. The plan of care shall be reviewed and updated at least every ninety (90) days by the member's attending or staff physician for determinations that the services provided were and are required on an inpatient basis and for recommendations as to necessary adjustments in the plan as indicated by the member's overall adjustment as an inpatient. The quarterly plan of care must be in writing and made a part of the member's record.

(2) The individual plan of care for a member under twenty-one (21) years of age shall comply with the requirements as set forth in 42 CFR 441.155. Additionally, the periodic update of the plan of care must be in writing and made a part of the member's record. Recertification is required at least every sixty (60) days. Initial evaluative examinations are exempt from prior authorization.

(b) The interdisciplinary team required to develop the plan of care for an individual under twenty-one (21) years of age shall include at least one (1) of the persons identified in subdivisions (1) through (3) and one (1) of the persons identified in subdivision (4) as follows:

(1) A board certified or eligible psychiatrist.

(2) A psychologist endorsed as a health service provider in psychology (HSPP) and a physician licensed to practice medicine or osteopathy.

(3) A physician licensed to practice medicine or osteopathy with specialized training and experience in the diagnosis and treatment of mental diseases and a psychologist endorsed as an HSPP or a licensed psychologist.

(4) One (1) of the following (deemed to be other professionals qualified to make determinations as to mental health conditions and treatments thereof):

(A) A licensed, clinical social worker, a licensed marital and family therapist, a licensed mental health counselor, or a person holding a master's degree in social work, marital and family therapy, or mental health counseling.

(B) An advanced practice nurse or a registered nurse who has specialized training or one (1) year experience in treating the mentally ill.

(C) An occupational therapist registered with the National Association of Occupational Therapists and who has specialized training or one (1) year of experience in treating the mentally ill.

(D) A psychologist endorsed as an HSPP or a licensed psychologist.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3334; filed Sep 27, 1999, 8:55 a.m.: 23 IR 314; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2477; 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)

405 IAC 5-20-5 Certification of need for admission

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. Medicaid reimbursement is available for services in an inpatient psychiatric facility only when the member's need for admission has been certified. The certification of need must be completed as follows:

(1) By the attending physician or staff physician for a member between twenty-two (22) and sixty-five (65) years of age in a psychiatric hospital of sixteen (16) beds or less and for a member sixty-five (65) years of age and over.

(2) In accordance with 42 CFR 441.152(a), effective October 1, 1995 (not including secondary Code of Federal Regulations citations therein) and 42 CFR 441.153, effective October 1, 1995 (not including tertiary Code of Federal Regulations citations resulting therefrom) for an individual twenty-one (21) years of age and under.

(3) By telephone precertification review prior to admission for an individual who is a member of Medicaid when admitted to the facility as a nonemergency admission, to be followed by a written certification of need within ten (10) working days of admission.

(4) By telephone precertification review within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, to be followed by a written certification of need within fourteen (14) working days of admission. If the provider fails to call within forty-eight (48) hours of an emergency admission, not including Saturdays, Sundays, and legal holidays, Medicaid reimbursement shall be denied for the period from admission to the actual date of notification.

(5) In writing within ten (10) working days after receiving notification of an eligibility determination for an individual applying for Medicaid while in the facility and covering the entire period for which Medicaid reimbursement is being sought.

(6) In writing at least every sixty (60) days after admission, or as requested by the office to recertify that the member continues to require inpatient psychiatric hospital services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; 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)

405 IAC 5-20-6 Emergency admissions

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 for emergency admissions only in cases of a sudden onset of a psychiatric condition manifesting itself by acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in one (1) of the following:

(1) Danger to the individual.

(2) Danger to others.

(3) Death of the individual.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; 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)

405 IAC 5-20-7 Unnecessary 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. 7. Medicaid reimbursement will be denied for any days during which the inpatient psychiatric hospitalization or stay in a PRTF is found not to have been medically necessary. Telephone precertifications substantiating that the service is medically necessary will provide a basis for Medicaid reimbursement only if adequately supported by the written certification of need submitted in accordance with section 5 of this rule. If the required written documentation is not submitted within the specified time frame, Medicaid reimbursement will be denied. *(Office of the Secretary of Family and Social Services; 405 IAC 5-20-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2478; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-20-8 Outpatient mental health services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 8. Medicaid reimbursement is available for outpatient mental health services provided by licensed physicians, psychiatric hospitals, psychiatric wings of acute care hospitals, outpatient mental health facilities, and psychologists endorsed as a health service provider in psychology (HSPP). Outpatient mental health services rendered by a medical doctor, doctor of osteopathy, or HSPP are subject to the following limitations:

(1) Outpatient mental health services rendered by a medical doctor or doctor of osteopathy are subject to the limitations set out in 405 IAC 5-25.

(2) Subject to prior authorization by the office Medicaid will reimburse physician or HSPP directed outpatient mental health services for group, family, and individual outpatient psychotherapy when the services are provided by one (1) of the following practitioners:

(A) A licensed psychologist.

(B) A licensed independent practice school psychologist.

(C) A licensed clinical social worker.

(D) A licensed marital and family therapist.

(E) A licensed mental health counselor.

(F) A person holding a master's degree in social work, marital and family therapy, or mental health counseling, except that partial hospitalization services provided by such person shall not be reimbursed by Medicaid.

(G) An advanced practice nurse who is a licensed, registered nurse with a master's degree in nursing with a major in psychiatric or mental health nursing from an accredited school of nursing.

(3) The physician, psychiatrist, or HSPP is responsible for certifying the diagnosis and for supervising the plan of treatment described as follows:

(A) The physician, psychiatrist, or HSPP is responsible for seeing the member during the intake process or reviewing the medical information obtained by the practitioner listed in subdivision (2) within seven (7) days of the intake

process. This review by the physician, psychiatrist, or HSPP must be documented in writing.

(B) The physician, psychiatrist, or HSPP must again see the member or review the medical information and certify the service is medically necessary on the basis of medical information provided by the practitioner listed in subdivision (2) at intervals not to exceed ninety (90) days. This review must be documented in writing.

(4) Medicaid will reimburse partial hospitalization services under the following conditions and subject to prior authorization:

(A) Partial hospitalization programs must be highly intensive, time-limited medical services that either provide a transition from inpatient psychiatric hospitalization to community-based care, or serve as a substitute for an inpatient admission. Partial hospitalization programs are highly individualized with treatment goals that are measurable and medically necessary. Treatment goals must include specific time frames for achievement of goals, and treatment goals must be directly related to the reason for admission.

(B) Partial hospitalization programs must have the ability to reliably contract for safety. Members with clear intent to seriously harm the self or others are not candidates for partial hospitalization services.

(C) Services may be provided for consumers of all ages who are not at imminent risk of harm to self or others. Members who currently reside in a group home or other residential care setting are not eligible for partial hospitalization services. Members must have a diagnosed or suspected behavioral health condition and one (1) of the following:

(i) A short-term deficit in daily functioning.

(ii) An assessment of the member indicating a high probability of serious deterioration of the member's general medical or behavioral health.

(D) Program standards shall be as follows:

(i) Services must be ordered and authorized by a psychiatrist.

(ii) Services require prior authorization pursuant to 405 IAC 5-3-13(a).

(iii) A face-to-face evaluation and an assignment of a behavioral health diagnosis must take place within twenty-four (24) hours following admission to the program.

(iv) A psychiatrist must actively participate in the case review and monitoring of care.

(v) Documentation of active oversight and monitoring of progress by a physician, a psychiatrist, or an HSPP must appear in the member's clinical record.

(vi) At least one (1) individual psychotherapy service or group psychotherapy service must be delivered daily.

(vii) For members under eighteen (18) years of age, documentation of active psychotherapy must appear in the member's clinical record.

(viii) For members under eighteen (18) years of age, a minimum of one (1) family encounter per five (5) business days of episode of care is required.

(ix) Programs must include four (4) to six (6) hours of active treatment per day and be provided at least four (4) days per week.

(x) Programs must not mix members receiving partial hospitalization services with members receiving outpatient behavioral health services.

(E) Exclusions shall be as follows:

(i) Members at imminent risk of harm to self or others are not eligible for services.

(ii) Members who concurrently reside in a group home or other residential care setting are not eligible for services.

(iii) Members who cannot actively engage in psychotherapy are not eligible for services.

(iv) Members with withdrawal risk or symptoms of a substance-related disorder whose needs cannot be managed at this level of care or who need detoxification services.

(v) Members who by virtue of age or medical condition cannot actively participate in group therapies are not eligible for services.

(5) Medicaid will reimburse for evaluation and group, family, and individual psychotherapy when provided by a psychologist endorsed as an HSPP.

(6) Subject to prior authorization by the office, Medicaid will reimburse for neuropsychological and psychological testing when the services are provided by one (1) of the following practitioners:

(A) A physician.
(B) An HSPP.
(C) A practitioner listed in subdivision (7).

(7) The following practitioners may only administer neuropsychological and psychological testing under the direct supervision of a physician or HSPP:
(A) A licensed psychologist.
(B) A licensed independent practice school psychologist.
(C) A person holding a master's degree in a mental health field and one (1) of the following:
(i) A certified specialist in psychometry (CSP).
(ii) Two thousand (2,000) hours of experience, under direct supervision of a physician or HSPP, in administering the type of test being performed.

(8) The physician and HSPP are responsible for the interpretation and reporting of the testing performed.

(9) The physician and HSPP must provide direct supervision and maintain documentation to support the education, training, and hours of experience for any practitioner providing services under their supervision. A cosignature by the physician or HSPP is required for services rendered by one (1) of the practitioners listed in subdivision (7).

(10) Prior authorization is required for mental health services provided in an outpatient or office setting that exceed twenty (20) units per member, per provider, per rolling twelve (12) month period of time, except neuropsychological and psychological testing, which is subject to prior authorization as stated in subdivision (4)(D)(ii).

(11) The following are services that are not reimbursable by Medicaid:
(A) Daycare.
(B) Hypnosis.
(C) Biofeedback.
(D) Missed appointments.

(12) All outpatient services rendered must be identified and itemized on the Medicaid claim form. Additionally, the length of time of each therapy session must be indicated on the claim form. The medical record documentation must identify the services and the length of time of each therapy session. This information must be available for audit purposes.

(13) A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization form and available for audit purposes.

(14) For psychiatric diagnostic interview examinations, Medicaid reimbursement is available for one (1) unit per member, per provider, per rolling twelve (12) month period of time, except as follows:
(A) A maximum of two (2) units per rolling twelve (12) month period of time per member, per provider, may be reimbursed without prior authorization, when a member is separately evaluated by both a physician or HSPP and a midlevel practitioner.
(B) Of the two (2) units allowed without prior authorization, as stated in clause (A), one (1) unit must be provided by the physician or HSPP and one (1) unit must be provided by the midlevel practitioner.
(C) All additional units require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-20-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3335; filed Sep 27, 1999, 8:55 a.m.: 23 IR 315; filed Jun 9, 2000, 9:55 a.m.: 23 IR 2707; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 28, 2001, 9:56 a.m.: 25 IR 61; errata filed Nov 21, 2001, 11:33 p.m.: 25 IR 1184; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; filed Jul 19, 2010, 11:24 a.m.: 20100818-IR-405090087FRA; 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)

Rule 21. Community Mental Health Rehabilitation Services

405 IAC 5-21-1 Definitions (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-2 Reimbursement (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-3 Outpatient services (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-4 Partial hospitalization services (Repealed)

Sec. 4. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-5 Case management services (Repealed)

Sec. 5. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-6 Diagnosis; plan of treatment (Repealed)

Sec. 6. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

405 IAC 5-21-7 Prior authorization (Repealed)

Sec. 7. *(Repealed by Office of the Secretary of Family and Social Services; filed Aug 18, 2009, 11:32 a.m.: 20090916-IR-405080192FRA)*

405 IAC 5-21-8 Assertive community treatment intensive case management (Repealed)

Sec. 8. *(Repealed by Office of the Secretary of Family and Social Services; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA)*

Rule 21.5. Medicaid Rehabilitation Option Services

405 IAC 5-21.5-1 Definitions

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. (a) As used in this rule, "Medicaid rehabilitation option" or "MRO" refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the maximum reduction of a mental disability and the restoration of a member's best possible functional level.

(b) As used in this rule, "licensed professional" means any of the following persons:

(1) A licensed psychiatrist.

(2) A licensed physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) A licensed clinical social worker (LCSW).
(5) A licensed mental health counselor (LMHC).
(6) A licensed marriage and family therapist (LMFT).
(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.
(c) As used in this rule, "qualified behavioral health professional" or "QBHP" means any of the following persons:
(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, as defined under subsection (b), with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines:
(A) In psychiatric or mental health nursing from an accredited university, plus a license as a registered nurse in Indiana.
(B) In pastoral counseling from an accredited university.
(C) In rehabilitation counseling from an accredited university.
(2) An individual who is under the supervision of a licensed professional, as defined under subsection (b), is eligible for and working towards licensure, and has completed a master's or doctoral degree, or both, in any of the following disciplines:
(A) In social work from a university accredited by the Council on Social Work Education.
(B) In psychology from an accredited university.
(C) In mental health counseling from an accredited university.
(D) In marital and family therapy from an accredited university.
(3) A licensed independent practice school psychologist under the supervision of a licensed professional, as defined in subsection (b).
(4) An authorized health care professional (AHCP), as used in this rule, means any of the following persons:
(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.
(d) As used in this rule, "other behavioral health professional" or "OBHP" means any of the following persons:
(1) An individual with an associate or bachelor degree, or equivalent behavioral health experience, meeting minimum competency standards set forth by a behavioral health service provider and supervised by either a licensed professional, as defined under subsection (b), or a QBHP, as defined under subsection (c).
(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5 supervised by either a licensed professional, as defined under subsection (b), or a QBHP, as defined under subsection (c).
(e) As used in this rule, "approved division of mental health and addiction (DMHA) assessment tool" refers to a state designated, member-appropriate instrument for a provider's assessment of member functional impairment.
(f) As used in this rule, "clinic option" refers to services defined under 405 IAC 5-20-8.
(g) As used in this rule, "detoxification services" refer to services defined under 440 IAC 9-2-4.
(h) As used in this rule, "level of need" refers to a recommended intensity of behavioral health services, based on a pattern of a member's and family's needs, as assessed using a standardized assessment instrument.
(i) As used in this rule, "rehabilitative" refers to the federal definition of rehabilitative, as defined under 42 CFR 440.130(d).
(j) As used in this rule, "nonprofessional caregiver" refers to an individual who does not receive compensation for providing care or services to a Medicaid member.
(k) As used in this rule, "professional caregiver" refers to an individual who receives payment for providing services to a Medicaid member. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-1; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.5-2 Reimbursement
Authority: IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-29

Sec. 2. (a) The office will reimburse MRO services for members who meet specific diagnosis and level of need criteria under the approved DMHA assessment tool. The listing of diagnostic and level of need criteria approved for reimbursement shall be as follows:

(1) Will be listed and published in a provider manual by the office.

(2) May be updated by the office as needed.

(b) Services are provided:

(1) through a behavioral health service provider that is enrolled as a provider that offers a full continuum of care as defined under IC 12-7-2-40.6 and 440 IAC 9; these providers may subcontract for services as appropriate; and

(2) by personnel who meet appropriate federal, state, and local regulations for their respective disciplines or are under the supervision or direction of a licensed professional or QBHP.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-2; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-3 Behavioral health rehabilitation services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 3. (a) The services reimbursable as behavioral health rehabilitation services are clinical behavioral health services that are provided for members, families, or groups of persons who are living in the community and who need aid on an intermittent basis for emotional disturbances, mental illness, or addiction. Behavioral health rehabilitation services are as follows:

(1) Behavioral health counseling and therapy.

(2) Medication training and support.

(3) Skills training and development.

(4) Behavioral health level of need redetermination.

(5) Crisis intervention.

(6) Child and adolescent intensive resiliency services.

(7) Adult intensive rehabilitative services.

(8) Intensive outpatient alcohol or drug treatment.

(9) Alcohol or drug (substance-related disorder) counseling.

(10) Peer recovery services.

(11) Case management.

(12) Psychiatric assessment and intervention.

(b) Outpatient behavioral health rehabilitation services may include clinical attention in the member's home, workplace, emergency room, or wherever needed.

(c) Outpatient behavioral health rehabilitation services are rehabilitative in nature and must be indicated in an individualized integrated care plan.

(d) Level of need requirements and maximum allowable units:

(1) will be listed and published in a provider manual by the office; and

(2) may be updated by the office as needed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-3; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-4 Behavioral health counseling and therapy

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-23.6-10.5

Sec. 4. (a) The services reimbursable as individual or group behavioral health counseling and therapy consist of a series of

time-limited, structured, face-to-face sessions that work toward the goals identified in the individualized integrated care plan. The service must be provided at the member's home or at other locations outside the clinic setting as follows:

(1) Requirements for individual or group behavioral health counseling and therapy services shall be as follows:

(A) Services may be provided for members of all ages.

(B) Providers must meet the either of the following qualifications:

(i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

(ii) A QBHP.

(2) Programming standards shall be as follows:

(A) The service requires face-to-face contact.

(B) The member is the focus of the service.

(C) Documentation must support how the service benefits the member, including when services are provided in a group setting.

(D) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(E) Service goals must be rehabilitative in nature.

(F) When provided in a group setting, services must be provided in an age appropriate setting for a member less than eighteen (18) years of age.

(3) Exclusions shall be as follows:

(A) Services provided in a clinic setting and services provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.

(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.

(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.

(b) The services reimbursable as family or couple behavioral health counseling and therapy consist of a series of time-limited, structured, and face-to-face sessions, with or without the member present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. The service must be provided at home or other locations outside the clinic setting as follows:

(1) Requirements for family or couple behavioral health counseling and therapy services shall be as follows:

(A) Services may be provided for members of all ages.

(B) Providers must meet either of the following qualifications:

(i) A licensed professional, except for a licensed clinical addiction counselor, as defined under IC 25-23.6-10.5.

(ii) A QBHP.

(C) Services may be delivered in an individual or group setting.

(2) Programming standards shall be as follows:

(A) The service requires face-to-face contact.

(B) The member is the focus of the service.

(C) Documentation must support how the service benefits the member, including when the member is not present and when services are provided in a group setting.

(D) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(E) Service goals must be rehabilitative in nature.

(F) When provided in a group setting, services must be provided in an age appropriate setting for a member less than eighteen (18) years of age.

(3) Exclusions shall be as follows:

(A) Services provided in a clinic setting and service provided as a part of school-based services are not billable under the MRO program, and must be billed to the clinic option.

(B) Licensed clinical addiction counselors, as defined under IC 25-23.6-10.5, may not provide this service.

(C) If medication management is a component of the service session, then medication training and support may not be billed separately for the same visit by the same provider.

(D) Services may not be provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-4; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-5 Medication training and support

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 5. (a) The services reimbursable as individual medication training and support involve face-to-face contact with the member for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing or medical assessments. This service also includes certain related nonface-to-face activities. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for members of all ages.

(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in an individual setting that includes monitoring self-administration of prescribed medications and monitoring side effects.

(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) Services may also include the following services that are not required to be provided face-to-face with the member:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the member and physician.

(E) The member is the focus of the service.

(F) Documentation must support how the service benefits the member.

(G) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(B) Coaching and instruction regarding member self-administration of medications is not reimbursable under medication training and support.

(b) The services reimbursable as group medication training and support involve face-to-face contact with the member for the purpose of providing education and training about medications and medication side effects. Requirements for medication

training and support services shall be as follows:

(1) Services may be provided for members twelve (12) years of age and older.

(2) Medication training and support services must be within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).

(D) A licensed practical nurse (LPN).

(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in a group setting that includes education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.

(B) When provided in the clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.

(C) When provided in a residential treatment setting, this service may include components of medication management services.

(D) Services must be provided in an age appropriate setting for a member less than eighteen (18) years of age receiving services.

(E) The member is the focus of the service.

(F) Documentation must support how the service benefits the member, including when services are provided in a group setting.

(G) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) Services may not be provided for members under the age of twelve (12) years in a group setting.

(B) If clinic option medication management, counseling, or psychotherapy is provided and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(C) Coaching and instruction regarding member self-administration of medications is not reimbursable under medication training and support.

(D) The following services are excluded:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that the member follows through, and receives lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the member and physician.

(c) The services reimbursable as family or couple medication training and support with or without the member present may take place with a family member or other nonprofessional caregiver in an individual setting, and involve face-to-face contact for the purpose of monitoring medication compliance, providing education and training about medications, monitoring medication side effects, and providing other nursing and medical assessments. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for members of all ages.

(2) Medication training and support services must be provided within the scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.

(B) An authorized health care professional (AHCP).

(C) A licensed registered nurse (RN).
(D) A licensed practical nurse (LPN).
(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in an individual setting with family members or other nonprofessional caregivers on behalf of the member.
(B) When provided in a clinic setting, this service may support, but not duplicate, activities associated with medication management activities available under the clinic option.
(C) When provided in a residential treatment setting, this service may include components of medication management services.
(D) Services may also include the following services that are not required to be provided face-to-face with the member:
(i) Transcribing physician or AHCP medication orders.
(ii) Setting or filling medication boxes.
(iii) Consulting with the attending physician or AHCP regarding medication-related issues.
(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.
(v) Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders.
(vi) Follow-up reporting of lab and clinical test results to the member and physician.
(E) The member is the focus of the service.
(F) Documentation must support how the service benefits the member, including when the member is not present.
(G) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.
(H) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.
(B) Coaching and instruction regarding member self-administration of medications is not reimbursable under medication training and support.
(C) Services may not be provided to professional caregivers.

(d) The services reimbursable as family or couple medication training and support with or without the member present may take place with a family member or other nonprofessional caregiver in a group setting, and involve face-to-face contact for the purpose of providing education and training about medications and medication side effects. Requirements for medication training and support services shall be as follows:

(1) Services may be provided for members of all ages.

(2) Medication training and support services must be provided within the provider's scope of practice as defined by federal and state law. Providers must meet any of the following qualifications:

(A) A licensed physician.
(B) An authorized health care professional (AHCP).
(C) A licensed registered nurse (RN).
(D) A licensed practical nurse (LPN).
(E) A medical assistant (MA) who has graduated from a two (2) year clinical program.

(3) Programming standards shall be as follows:

(A) Services must be provided face-to-face in a group setting with family members or other nonprofessional caregivers on behalf of a member. Services include education and training on the administration of prescribed medications and side effects, or conducting medication groups or classes.
(B) When provided in a clinic setting, this service may support, but may not duplicate, activities associated with medication management activities available under the clinic option.
(C) When provided in a residential treatment setting, this service may include components of medication management

services.

(D) The member is the focus of the service.

(E) Documentation must support how the service benefits the member, including when the member is not present and when services are provided in a group setting.

(F) Services must result in demonstrated movement towards, or achievement of, the member's treatment goals identified in the individualized integrated care plan.

(G) Service goals must be rehabilitative in nature.

(H) Services must be provided in an age appropriate setting for a member less than eighteen (18) years of age.

(4) Exclusions shall be as follows:

(A) If clinic option medication management, counseling, or psychotherapy is provided, and medication management is a component, then medication training and support may not be billed separately for the same visit by the same provider.

(B) Coaching and instruction regarding member self-administration of medications is not reimbursable under medication training and support.

(C) The following services are excluded:

(i) Transcribing physician or AHCP medication orders.

(ii) Setting or filling medication boxes.

(iii) Consulting with the attending physician or AHCP regarding medication-related issues.

(iv) Ensuring linkage that lab or other prescribed clinical orders are sent.

(v) Ensuring that members follow through and receive lab work and services pursuant to other clinical orders.

(vi) Follow-up reporting of lab and clinical test results to the member and the physician.

(D) Services may not be provided to professional caregivers.

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405 IAC 5-21.5-6 Skills training and development

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) The services reimbursable as individual or group skills training and development involve face-to-face contact that results in the development of skills directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of the member's progress in achieving those skills. Requirements for individual or group skills training and development shall be as follows:

(1) Services may be provided for members of all ages.

(2) Services may be provided in an individual setting or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(4) Programming standards shall be as follows:

(A) The service requires face-to-face contact with the member.

(B) Members are expected to show a benefit from services, with the understanding that improvement may be incremental.

(C) Services must result in demonstrated movement towards, or achievement of, the member's treatment goals identified in the individualized integrated care plan.

(D) Services are rehabilitative in nature and time limited.

(E) The member is the focus of the service.

(F) Documentation must support how the service benefits the member, including when the service is provided in a

group setting.

(G) When provided in a group setting, services must be provided in an age appropriate setting for a member less than eighteen (18) years of age.

(5) Exclusions shall be as follows:

(A) Services that are habilitative in nature, except for the achievement of developmental milestones for members less than eighteen (18) years of age that would have occurred absent an emotional disturbance.

(B) Skill building activities not identified in the individualized integrated care plan.

(C) Job coaching.

(D) Activities purely for recreation or diversion.

(E) Academic tutoring.

(6) Individual and group skills training and development services are not reimbursable if delivered on the same day as child and adolescent intensive rehabilitative services or adult intensive rehabilitative services.

(b) The services reimbursable as family or couple skills training and development with or without the member present involve face-to-face contact with family members or nonprofessional caregivers that result in the development of skills for the member directed toward eliminating psychosocial barriers. The development of skills is provided through structured interventions for attaining goals identified in the individualized integrated care plan and the monitoring of progress in achieving those skills. Requirements for these services without the member present shall be as follows:

(1) Services may be provided for family members or other nonprofessional caregivers supporting a member.

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(4) Programming standards shall be as follows:

(A) The services require face-to-face contact with family members or nonprofessional caregivers on behalf of the member.

(B) Members are expected to show benefit from services, with the understanding that improvement may be incremental.

(C) Services must result in demonstrated movement towards, or achievement of, the member's treatment goals identified in the individualized integrated care plan.

(D) Services must be rehabilitative in nature and time limited.

(E) The member is the focus of the service.

(F) Documentation must support how the service benefits the member, including when the member is not present and when the service is provided in a group setting.

(G) When provided in a group setting, services must be provided in an age appropriate setting for members less than eighteen (18) years of age.

(5) Exclusions shall be as follows:

(A) Skills training that is habilitative in nature, except for the achievement of developmental milestones for members less than eighteen (18) years of age that would have occurred absent an emotional disturbance.

(B) Skill building activities not identified in the individualized integrated care plan.

(C) Job coaching.

(D) Activities purely for recreation or diversion.

(E) Academic tutoring.

(F) Services may not be provided to professional caregivers.

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405 IAC 5-21.5-7 Behavioral health level of need redetermination

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 7. (a) The services reimbursable as behavioral health level of need redetermination are services associated with the DMHA approved assessment tool required to determine level of need, assign an MRO service package, and make changes to the individualized integrated care plan.

(b) The redetermination requires face-to-face contact with the member and may include face-to-face or telephone collateral contacts with family members or nonprofessional caretakers, which result in a completed redetermination.

(c) Requirements for behavioral health level of need redetermination services shall be as follows:

(1) Services may be provided for members of all ages.

(2) Services must be provided by individuals meeting DMHA training competency standards for the use of the DMHA-approved assessment tool.

(3) The DMHA assessment tool must be completed at least every six (6) months for the purpose of determining the continued need for MRO services.

(4) Reassessment may occur when there is a significant event or change in member status.

(5) Exclusions shall be as follows:

(A) MRO redetermination should not be duplicative of assessments available with clinic option services.

(B) This service may not be billed as part of the initial bio-psychosocial assessment when a member is entering treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-7; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-8 Crisis intervention

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 8. (a) The services reimbursable as crisis intervention services are short-term emergency behavioral health services, available twenty-four (24) hours per day, seven (7) days per week.

(b) These services include crisis assessment, planning, and counseling specific to the crisis, intervention at the site of the crisis when clinically appropriate, and pre-hospital assessment.

(c) The goal of crisis services is to resolve the crisis and transition the member to routine care through stabilization of the acute crisis and linkage to necessary services. This service may be provided in an emergency room, crisis clinic setting, or in the community.

(d) The requirements for crisis intervention services shall be as follows:

(1) Services may be provided for all Medicaid members who are as follows:

(A) At imminent risk of harm to self or others.

(B) Experiencing a new symptom that places the member at risk.

(2) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(C) An OBHP.

(e) Program standards shall be as follows:

(1) The consulting physician, AHCP, or HSPP must be accessible twenty-four (24) hours per day, seven (7) days per week.

(2) Services are provided face-to-face with the member.

(3) Services may include contacts with the family and other nonprofessional caretakers to coordinate community service systems. Contacts are not required to be face-to-face and must be in addition to face-to-face contact with the member.

(4) Services should be limited to occasions when a member suffers an acute episode despite the provision of other community

behavioral health services.
(5) The intervention should be member-centered and delivered on an individual basis.
(6) These services are available to any Medicaid eligible individual in crisis, as defined in this section.
(7) Documentation of action to facilitate a face-to-face visit must be made within one (1) hour of the initial contact with the provider for members at imminent risk of harm to self or others.
(8) Documentation of action to facilitate a face-to-face visit must be made within four (4) hours of initial contact with the provider for members experiencing a new symptom that places the member at risk.
(9) Crisis intervention does not require prior authorization.
(10) The individualized integrated care plan must be updated to reflect the crisis intervention for members currently active with the provider.
(11) A brief individualized integrated care plan must be developed and certified for members new to the provider, with a full individualized integrated care plan developed following the resolution of the crisis.
(f) Exclusions shall be as follows:
(1) Interventions targeted to groups are not billable as crisis intervention.
(2) Time spent in an inpatient setting is not billable as crisis intervention.
(3) Interventions to address an established problem or need documented in the individualized integrated care plan may not be billed under crisis intervention.
(4) Routine intakes provided without an appointment or after traditional hours do not constitute crisis intervention.
(5) Declared disaster crisis activities and services delivered by a disaster crisis team are excluded.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-8; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-9 Child and adolescent intensive resiliency services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 9. (a) The services reimbursable as child and adolescent intensive resiliency services (CAIRS) are time-limited, nonresidential services provided to children or adolescents in a clinically supervised setting that provides an integrated system of individual, family, and group interventions based on an individualized integrated care plan.

(b) Services are designed to alleviate emotional or behavioral problems. Services are curriculum-based with goals that include reintegration into age appropriate community settings.

(c) The requirements for CAIRS shall be as follows:
(1) Services may be provided for members at least five (5) years of age and less than eighteen (18) years of age with severe emotional disturbance who:
(A) need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.
(2) Services may be provided to members eighteen (18) years of age and older and less than twenty-one (21) years of age with prior authorization.
(d) Services may be provided in a facility provided by a school district.
(e) Providers must meet any of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.
(f) Programming standards shall be as follows:
(1) Services must be authorized by a physician or an HSPP.
(2) Direct services must be supervised by a licensed professional.

(3) Services are provided in close coordination with the educational program provided by a local school district.
(4) Clinical oversight must be provided by a licensed physician, who is on-site weekly and available to program staff when not physically present.
(5) Member goals and a transitional plan must be designed to reintegrate the member into the school setting.
(6) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(7) A weekly review and update of the member's progress is prepared and is documented in the member's clinical record.
(8) Services must be provided in an age appropriate setting for a member eighteen (18) years of age and under.
(9) The member is the focus of the service.
(10) Documentation must support how the service benefits the member, including when provided in a group setting.
(11) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.
(12) Service goals must be rehabilitative in nature.
(13) Services must be provided in an age appropriate setting for members less than eighteen (18) years of age receiving services.
(g) Exclusions from reimbursement shall be as follows:
(1) Services for members less than five (5) years of age.
(2) Services without a prior authorization for members eighteen (18) years of age and older, but less than twenty-one (21) years of age.
(3) Services that are purely recreational or diversionary in nature or have no therapeutic or programmatic content.
(4) Formal educational or vocational services.
(5) CAIRS will not be reimbursed for a member who receives both CAIRS and adult intensive rehabilitative services on the same day.
(6) CAIRS will not be reimbursed for a member who receives both CAIRS and individual or group skills training and development on the same day.

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405 IAC 5-21.5-10 Adult intensive rehabilitative services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 10. (a) The services reimbursable as adult intensive rehabilitative services (AIRS) are time-limited, nonresidential services provided in a clinically supervised setting to a member who requires structured rehabilitative services in order to maintain the member on an outpatient basis.
(b) Services are curriculum based and designed to alleviate emotional or behavioral problems with the goals of:
(1) reintegrating the member into the community;
(2) increasing social connectedness beyond a clinical setting; or
(3) employment.
(c) The requirements for AIRS shall be as follows:
(1) Services may be provided for members who:
(A) are at least eighteen (18) years of age with serious mental illness who need structured therapeutic and rehabilitative services;
(B) have significant impairment in day-to-day personal, social, or vocational functioning;
(C) do not require acute stabilization, including inpatient or detoxification services; and
(D) are not at imminent risk of harm to self or others.
(2) Services may be provided to members less than eighteen (18) years of age, but not less than sixteen (16) years of age with prior authorization.
(d) Providers must meet any of the following qualifications:

(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.
(e) Programming standards shall be as follows:
(1) Services must be authorized by a physician or an HSPP.
(2) Direct services must be supervised by a licensed professional.
(3) Clinical oversight must be provided by a licensed physician, who is on-site weekly and is available to program staff when not physically present.
(4) Member goals must be designed to facilitate community integration, employment, and use of natural supports.
(5) Therapeutic services include clinical therapies, psycho-educational groups, and rehabilitative activities.
(6) A weekly review and update of progress takes place and is documented in the member's clinical record.
(7) Services must be provided in an age appropriate setting for members less than eighteen (18) years of age receiving services.
(8) The member is the focus of the service.
(9) Documentation must support how the service benefits the member, including when provided in a group setting.
(10) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.
(11) Service goals must be rehabilitative in nature.
(f) Exclusions from reimbursement shall be as follows:
(1) Services that are purely recreational or diversionary in nature or that do not have therapeutic or programmatic content.
(2) Formal educational or vocational services.
(3) AIRS will not be reimbursed for a member who receives both AIRS and individual or group skills training and development on the same day.
(4) AIRS will not be reimbursed for a member who receives both AIRS and CAIRS on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-10; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-11 Intensive alcohol or drug (substance-related disorder) outpatient treatment

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 11. (a) The services reimbursable as intensive alcohol or drug outpatient treatment services are treatment programs that operate at least three (3) hours per day, and at least three (3) days per week, and are based on an individualized integrated care plan.

(b) Services are planned and organized with addiction professionals and clinicians providing multiple treatment service components for the rehabilitation of alcohol and drug abuse or dependence in a group setting.

(c) Requirements for intensive alcohol or drug outpatient treatment shall be as follows:
(1) Services may be provided for members of all ages with a substance-related disorder; minimal or manageable medical conditions; minimal or manageable withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the member from benefiting from this level of care.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.
(d) Programming standards shall be as follows:
(1) Regularly scheduled sessions within a structured program must be at least three (3) hours per day and at least three (3) days per week.
(2) The program shall include the following components:

(A) Referral to twelve (12) step programs, peer and other community supports.
(B) Education on addiction disorders.
(C) Skills training in communication, anger management, stress management, and relapse prevention.
(D) Individual, group, and family counseling. Counseling must be provided by a licensed professional or QBHP.
(3) An individual who is a licensed professional is responsible for the overall management of the clinical program.
(4) Treatment must be individualized.
(5) Services must be provided in an age appropriate setting for a member less than eighteen (18) years of age receiving services.
(6) At least one (1) of the direct service providers must be a licensed addiction counselor or a licensed clinical addiction counselor.
(7) The member if *[sic, is]* the focus of the service.
(8) Documentation must support how the service benefits the member, including when the service is provided in a group setting.
(9) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.
(10) Service goals must be rehabilitative in nature.
(e) Exclusions shall be as follows:
(1) Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.
(2) Members at imminent risk of harm to self or others.
(3) Intensive outpatient treatment will not be reimbursed for members who receive group addiction counseling or family/couple group addiction counseling on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-11; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-12 Alcohol or drug (substance-related disorder) counseling

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 12. (a) The services reimbursable as individual or group alcohol or drug counseling are services where addiction professionals and clinicians provide counseling intervention that work toward goals identified in the individualized integrated care plan. Services are designed to be a less intensive alternative to intensive outpatient treatment as follows:
(1) The requirements for alcohol or drug counseling shall be as follows:
(A) Services may be provided for members of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the member from benefiting from this level of care.
(B) Providers must meet any of the following qualifications:
(i) A licensed professional.
(ii) A QBHP.
(C) Programming standards shall be as follows:
(i) The member is the focus of the service.
(ii) Documentation must support how the service specifically benefits the member, including when services are provided in a group setting.
(iii) Services must demonstrate progress toward or achievement of member treatment goals identified in the individualized integrated care plan.
(iv) Service goals must be rehabilitative in nature.
(v) Services are intended to be a less intensive alternative to intensive outpatient treatment.
(vi) Services must be provided in an age appropriate setting for a member less than eighteen (18) years of age

receiving services.

(vii) A licensed professional must supervise the program and approve the content and curriculum of the program.

(viii) Treatment must consist of regularly scheduled services.

(2) Exclusions shall be as follows:

(A) Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.

(B) Members at imminent risk of harm to self or others.

(C) Group addiction counseling will not be reimbursed for members who receive intensive outpatient treatment on the same day.

(D) Counseling sessions that consist of education only services will not be reimbursed.

(b) The services reimbursable as family or couple alcohol or drug counseling are services where addiction professionals and clinicians provide face-to-face counseling intervention, with or without the member present, that work toward the goals identified in the individualized integrated care plan. The face-to-face interaction may be with family members or nonprofessional caregivers. Services are designed to be a less intensive alternative to intensive outpatient treatment. The requirements for alcohol or drug counseling shall be as follows:

(1) Services may be provided for family members or nonprofessional caregivers of members of all ages with a substance-related disorder and with minimal or manageable medical conditions; minimal withdrawal risk; or emotional, behavioral, and cognitive conditions that will not prevent the member from benefiting from this level of care.

(2) Services may be provided in an individual or group setting.

(3) Providers must meet any of the following qualifications:

(A) A licensed professional.

(B) A QBHP.

(4) Programming standards shall be as follows:

(A) The member is the focus of treatment.

(B) Documentation must support how the service specifically benefits the member, including services provided in a group setting or without the member present.

(C) Services must demonstrate progress toward or achievement of the member's treatment goals identified in the individualized integrated care plan.

(D) Service goals must be rehabilitative in nature.

(E) Services are intended to be a less intensive alternative to outpatient treatment services.

(F) Services must be provided in an age appropriate setting for a member eighteen (18) years of age and under receiving services.

(G) A licensed professional must supervise the program and approve the content and curriculum of the program.

(H) Treatment must consist of regularly scheduled services.

(5) Exclusions shall be as follows:

(A) Members with withdrawal risk or symptoms whose needs cannot be managed at this level of care or who need detoxification services.

(B) Members at imminent risk of harm to self or others.

(C) Services may not be provided to professional caregivers.

(D) Counseling sessions that consist of education only services will not be reimbursed.

(E) Family or couple group alcohol or drug counseling will not be reimbursed for members who receive intensive outpatient treatment on the same day.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-12; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-13 Peer recovery services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 13. The services reimbursable as peer recovery services are face-to-face, structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Requirements for peer recovery services shall be as follows:

(1) Services may be provided for members eighteen (18) years of age and older. Services may be provided for members age sixteen (16) or seventeen (17) with prior authorization. Services shall not be provided to or for a member less than sixteen (16) years of age.

(2) Services must be provided by individuals meeting DMHA training and competency standards for certified recovery specialists. Individuals providing peer recovery services must be under the supervision of a licensed professional or a QBHP.

(3) Programming standards shall be as follows:

(A) Services must be identified in the individualized integrated care plan and must correspond to specific treatment goals.

(B) Services must be provided face-to-face and include the following components:

(i) Assisting members with developing individualized integrated care plans and other formal mentoring activities aimed at increasing the active participation of members in person-centered planning and delivery of individualized services.

(ii) Assisting members with the development of psychiatric advanced directives.

(iii) Supporting members in problem solving related to reintegration into the community.

(iv) Education and promotion of recovery and anti-stigma activities.

(C) Documentation must support how the service specifically benefits the member.

(D) The member is the focus of the treatment.

(E) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(F) Service goals must be rehabilitative in nature.

(G) Services must be provided in an age appropriate setting for a member eighteen (18) years of age and under receiving services.

(4) Exclusions shall be as follows:

(A) Services that are purely recreational or diversionary in nature, or have no therapeutic or programmatic content, may not be reimbursed.

(B) Interventions targeted to groups are not billable as peer recovery services.

(C) Activities that may be billed under skills training and development or case management services are not billable under peer recover services.

(D) Services are not reimbursable for members less than sixteen (16) years of age.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-13; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-14 Case management services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 14. The services reimbursable as case management services are services that help members gain access to needed medical, social, educational, and other services. Case management services include the assessment of the eligible member to determine service needs, development of an individualized integrated care plan, referral and related activities to help the member obtain needed services, monitoring and follow-up, and evaluation. Case management is a service on behalf of the member, not to the member, and is management of the case, not the member. Requirements for case management services shall be as follows:

(1) Services may be provided for members of all ages.
(2) Providers must meet any of the following qualifications:
(A) A licensed professional.
(B) A QBHP.
(C) An OBHP.
(3) Programming standards shall be as follows:
(A) Medicaid case management services must provide direct assistance in gaining access to needed medical, social, educational, and other services.
(B) Case management services include:
(i) development of an individualized integrated care plan;
(ii) limited referrals to services; and
(iii) activities or contacts necessary to ensure that the individualized integrated care plan is effectively implemented and adequately addresses the mental health or addiction needs of the member.
(C) Services specifically may include the following:
(i) Needs assessment focusing on needs identification of the member in order to determine the need for any medical, educational, social, or other services.
(ii) Development of an individualized integrated care plan to identify the rehabilitative activities and assistance needed to accomplish the objectives of the plan.
(iii) Referral or linkage to activities that help link the member with services that are capable of providing needed rehabilitative services.
(iv) Monitoring or follow-up with the member, family members, nonprofessional caregivers, providers, or other entities, including making necessary adjustments in the individualized integrated care plan and service arrangement with providers.
(v) Evaluation consistent with the needs of the member; time devoted to formal supervision of the case between case manager and licensed supervisor are included activities and should be documented accordingly.
(D) Exclusions shall be as follows:
(i) Activities billed under behavioral health level of need redetermination.
(ii) The actual or direct provision of medical services or medical treatment.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-14; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-15 Psychiatric assessment and intervention

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 15. The services reimbursable as psychiatric assessment and intervention services are face-to-face and nonface-to-face activities that are designed to provide psychiatric assessment, consultation, and intervention services to members. Requirements for psychiatric assessment and intervention services shall be as follows:
(1) Services may be provided for members eighteen (18) years and older with a history of multiple hospitalizations and severe challenges in maintaining independent living within the community. Services may be prior authorized for members less than eighteen (18) years of age.
(2) Providers must meet any of the following qualifications:
(A) A physician.
(B) An AHCP.
(3) Programming standards shall be as follows:
(A) Service delivery may include both face-to-face and certain nonface-to-face activities.
(B) Psychiatric assessment services are intensive and must be available twenty-four (24) hours per day, seven (7) days per week, and with emergency response.

(C) Services must include, but are not limited to, the following:

(i) Symptom assessment and intervention to observe, monitor, and care for the physical, nutritional, behavioral health, and related psychosocial issues, problems, or crises manifested in the course of a member's treatment.

(ii) Monitoring a member's medical and other health issues that are either directly related to a mental health disorder or a substance related disorder, or to the treatment of the disorder.

(iii) Consultation on assessment, service planning, and implementation with other members of the member's treatment team, the member's family, and nonprofessional caregivers.

(D) The member is the focus of the service.

(E) Documentation must support how the service benefits the member.

(F) Services must demonstrate movement toward or achievement of member treatment goals identified in the individualized integrated care plan.

(G) Service goals must be rehabilitative in nature.

(4) Exclusions shall be as follows:

(A) Medication management activities provided in a clinic setting that may be reimbursed under the clinic option.

(B) Services that may be reimbursed under the clinic option.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-15; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.5-16 Diagnosis; individualized integrated care plan

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 16. The supervising physician or HSPP bears the ultimate responsibility for certifying the diagnosis and individualized integrated care plan for MRO services. The supervising physician or HSPP is responsible for seeing the patient during the intake process or reviewing information submitted by a licensed professional, QBHP, or OBHP and approving the individualized integrated care plan within seven (7) days. The supervising physician or HSPP must provide face-to-face visits with the patient or review the individualized integrated care plan at intervals not to exceed ninety (90) days. These reviews must be documented and signed by the physician or HSPP assuming responsibility for the care plan. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-16; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-21.5-17 Prior authorization

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 17. (a) MRO services are packaged according to diagnosis and level of need. Diagnosis and level of need qualifications for service packages, and services included within each service package:

(1) will be listed and published in a provider manual by the OMPP; and

(2) may be updated by the OMPP as needed.

(b) Prior authorization is required as follows:

(1) A member uses all units of one (1) or more of the services authorized in the service package within the defined service package term, and additional units of that service are needed.

(2) A member needs a service that is not authorized within a service package.

(3) A service package provided through a certified DMHA ACT team.

(4) A member who is denied an MRO service package may submit prior authorization for a specific MRO service.

(5) Services may be prior authorized for retroactive Medicaid eligibility periods.

(c) Providers who may submit prior authorization, as referenced in 405 IAC 5-3-13, include any of the following:

(1) A doctor of medicine.

(2) A doctor of osteopathy.
(3) An HSPP.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.5-17; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 21.6. Adult Mental Health Habilitation Services Program

405 IAC 5-21.6-1 General provisions
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. The intent of this rule is to provide home and community-based treatment options to individuals with serious mental illness who may benefit most from a habilitation approach to care to assist in maintaining the individual in the community. Eligibility for services and the provision of services are based upon an individual's meeting specific AMHH needs-based criteria. AMHH services will be:
(1) provided through a state plan; and
(2) delivered by service provider agencies meeting specific state-defined criteria.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-1; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA)

405 IAC 5-21.6-2 Definitions
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 2. (a) The definitions in this section apply throughout this rule.
(b) "Adult mental health habilitation" or "AMHH" services refers to medical or remedial services recommended by a physician or other licensed professional, within the scope of his or her practice, for the habilitation of a mental health disability and the restoration or maintenance of an individual's best possible functional level. Services are clinical and supportive behavioral health services that are provided for individuals, families, or groups of adult persons who:
(1) are living in the community; and
(2) need aid on a routine basis for a mental illness or co-occurring mental illness and addiction disorders.
(c) "AMHH behavioral health habilitation services" include the following:
(1) Adult day services.
(2) Home and community-based habilitation and support.
(3) Respite care.
(4) Therapy and behavior support services.
(5) Addiction counseling.
(6) Peer support services.
(7) Supported community engagement services.
(8) Care coordination.
(9) Medication training and support.
(d) "Authorized health care professional" or "AHCP" means any of the following persons:
(1) A physician assistant with authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.
(2) A nurse practitioner or clinical nurse specialist, with prescriptive authority and performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.
(e) "Detoxification services" means services or activities that are provided to a member during his or her withdrawal from

alcohol and other addictive drugs, while under the direct supervision of a physician or clinical nurse specialist.

(f) "DMHA" means the division of mental health and addiction.

(g) "Habilitation services" means activities that are designed to assist members in acquiring, retaining, and improving the following skills necessary to reside successfully in a community setting:

(1) Self-help.

(2) Socialization.

(3) Adaptive skills.

(h) "Individualized integrated care plan" or "IICP" means a treatment plan that:

(1) integrates all components and aspects of care that are:

(A) deemed medically necessary;

(B) clinically indicated; and

(C) provided in the most appropriate setting to achieve the member's goals;

(2) includes all indicated medical and support services needed by the member in order to:

(A) remain in the community;

(B) function at the highest level of independence possible; and

(C) achieve goals identified in the IICP;

(3) is developed for each member;

(4) is developed with the member; and

(5) reflects the member's desires and choices.

(i) "Level of need" means a recommended intensity of behavioral health services based on a pattern of a member's needs, as determined by using a standardized assessment tool.

(j) "Licensed professional" means any of the following persons:

(1) A licensed psychiatrist.

(2) A licensed physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) A licensed clinical social worker (LCSW).

(5) A licensed mental health counselor (LMHC).

(6) A licensed marriage and family therapist (LMFT).

(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

(k) "Medicaid rehabilitation services" means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of that individual's practice under state law, for:

(1) maximum reduction of physical or mental health disability; and

(2) restoration to a member's best possible level of functioning.

(l) "Nonprofessional caregiver" means any individual who does not receive compensation for providing care or services to a member.

(m) "Office-approved behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and office-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a member.

(n) "Other behavioral health professional" or "OBHP" means any of the following:

(1) An individual with an associate's or bachelor's degree, or equivalent behavioral health experience:

(A) meeting minimum competency standards set forth by a behavioral health service provider; and

(B) supervised by either a licensed professional or a QBHP.

(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5, supervised by either a licensed professional or a QBHP.

(o) "Professional caregiver" means an individual who receives payment for providing services and supports to a member.

(p) "Provider agency" means any office-approved agency that meets the qualifications and criteria to become an AMHH provider agency, as required by this rule.

(q) "Provider staff" means any individual working under an office-approved AMHH provider agency that meets the qualifications and requirements mandated by the AMHH service being provided, as defined in this rule.

(r) "Qualified behavioral health professional" or "QBHP" means any of the following:

(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or doctoral degree, or both, in any of the following disciplines from an accredited university:

(A) Psychiatric or mental health nursing, plus a license as a registered nurse in Indiana.

(B) Pastoral counseling.

(C) Rehabilitation counseling.

(2) An individual who:

(A) is under the supervision of a licensed professional;

(B) is eligible for and working towards professional licensure; and

(C) has completed a master's or doctoral degree, or both, in any of the following disciplines from an accredited university:

(i) Social work from a university accredited by the Council on Social Work Education.

(ii) Psychology.

(iii) Mental health counseling.

(iv) Marital and family therapy.

(3) A licensed, independent practice, school psychologist under the supervision of a licensed professional.

(4) An authorized health care professional (AHCP) who is one (1) of the following:

(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority, performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician pursuant to IC 25-23-1.

(s) "Skills training" means services or activities to further the reinforcement, management, adaptation, and retention of skills necessary for a member to live successfully in the community.

(t) "State evaluation team" means the office independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for AMHH applicants and members and will be responsible for making final determinations regarding the following:

(1) Eligibility of applicants for AMHH services.

(2) Authorization for AMHH services for eligible members.

(3) Continued eligibility determination for AMHH members.

(4) Appropriate service delivery to AMHH members, as a result of conducting quality improvement reviews of AMHH service provider agencies.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-2; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-3 Applicants and the application process

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 3. (a) In order for an individual to receive services under this rule, an AMHH eligible provider agency, in collaboration with the individual seeking services, must submit an application in the manner required by the office.

(b) Each applicant for AMHH services must receive a face-to-face evaluation using the:

(1) office-approved behavioral health assessment tool; and

(2) application form developed by the office.

(c) The application form and supporting documentation may include the following information about the applicant:

(1) Current and historical health status.

(2) Behavioral health issues.

(3) Functional needs.

(d) An application must, at a minimum, include documentation indicating the following:

(1) The applicant is requesting the service or services listed on the proposed IICP submitted with the application.

(2) The applicant chose, from a randomized list of eligible AMHH service providers in the applicant's community, a provider to deliver the office authorized AMHH services under this rule.

(e) Upon receipt of the application and supporting clinical documentation, the state evaluation team will assess the submitted information and determine whether or not the applicant meets the core eligibility criteria for receiving AMHH services.

(f) The responsibility for eligibility determination and approval of all proposed AMHH services included in the IICP is retained by the state evaluation team, in order to prevent a conflict of interests.

(g) Any approval or denial of services under this rule will be communicated to the:

(1) applicant or the applicant's authorized representative; and

(2) referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-3; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-4 Eligibility

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5; IC 25-33-1-5.1

Sec. 4. (a) An applicant may be eligible for participation in the AMHH services program if the applicant meets all of the following core criteria:

(1) The applicant is enrolled in Medicaid.

(2) The applicant is at least thirty-five (35) years of age or older.

(3) The applicant is unlikely to make improvements in a variety of life domains, with such a determination being based on the state evaluation team's review of all relevant referral materials.

(4) Based upon the office-approved behavioral health assessment tool, the applicant has a recommendation for intensive community-based care, as indicated by a rating level of four (4) or higher.

(5) The applicant has been diagnosed with an AMHH-eligible primary mental health diagnosis, which may include, but is not limited to, any of the following general categories:

(A) Schizophrenic disorder.

(B) Major depressive disorder.

(C) Bipolar disorder.

(D) Delusional disorder.

(E) Psychotic disorder.

(6) The applicant either:

(A) resides in a community-based setting that is not an institutional setting; or

(B) will be discharged from an institutional setting back to a community-based setting.

(7) Based on the behavioral health clinical evaluation, the applicant must meet all of the following needs-based criteria:

(A) Without ongoing habilitation services, as demonstrated by written attestation from a psychiatrist or a health services provider in psychology (HSPP) as defined in IC 25-33-1-5.1, the applicant will likely deteriorate and be at risk of institutionalization.

(B) The applicant demonstrates the need for significant assistance in major life domains related to the applicant's mental illness, for example, the following:

(i) Physical problems.

(ii) Social functioning.

(iii) Basic living skills.

(iv) Self-care.

(v) A potential for harm to the self or to others.

(C) The applicant demonstrates significant needs related to the applicant's behavioral health.

(D) The applicant demonstrates:

(i) significant impairment in self-management of the applicant's mental illness; or

(ii) significant needs for assistance with mental illness management.

(E) The applicant demonstrates a lack of sufficient natural supports to assist with mental illness management.

(F) The applicant is not a danger to the self or others at the time the application for AMHH service eligibility is submitted for state review and determination.

(b) For purposes of this section, the following definitions apply:

(1) "Assistance" means any kind of support given, due to a mental health condition or disorder, including, but not limited to, the following:

(A) Mentoring.

(B) Supervision.

(C) Reminders.

(D) Verbal cuing.

(E) Hands-on assistance.

(2) "Significant" means an assessed need for immediate or intensive action due to a serious or disabling need.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-4; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-5 Eligibility period; renewal

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 5. (a) A member who is approved to receive AMHH services under this rule shall be eligible for such services for up to a twelve (12) month period, as long as eligibility and needs-based criteria continue to be met.

(b) A reevaluation will be conducted at least every twelve (12) months and shall include the following:

(1) A face-to-face holistic clinical and biopsychosocial evaluation completed by an office-approved AMHH service provider.

(2) Administration of the office-approved behavioral assessment tool to determine whether the member still meets the level of need for intensive community-based services, as demonstrated by a rating level of four (4) or higher.

(3) Assessment of the member's progress towards meeting treatment goals on the IICP.

(4) Documentation that the member continues to meet AMHH financial, target group eligibility, and needs-based criteria.

(5) An updated referral application.

(6) An updated IICP documenting the member's choice of AMHH service or services and AMHH service providers.

(c) The state evaluation team will review and assess the renewal application and reevaluation results to determine whether the member continues to meet AMHH eligibility.

(d) Any approval or denial of eligibility and services under this rule will be communicated to the:

(1) applicant or the applicant's authorized representative; and

(2) referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-5; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-6 Clinical documentation requirements

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 6. (a) To be reimbursable under this rule, the AMHH service must be supported by clinical documentation that is maintained in the member's clinical record.

(b) The documentation required to support billing for an AMHH services must meet the following standards:

(1) Focus on recovery and habilitation.

(2) Emphasize member strengths.

(3) Reflect progress toward the habilitation goals reflected in the member's IICP.

(4) Be updated with every member encounter when billing is submitted for reimbursement.

(5) Be written and signed by the agency staff rendering services.
(c) For a member participating in any AMHH service, the clinical documentation must contain the following information:
(1) The type of service being provided.
(2) The names and qualifications of the staff providing the service.
(3) The location or setting where the service was provided.
(4) The focus of the session or service delivered to or on behalf of the member.
(5) The member's symptoms, needs, goals, or issues addressed during the session.
(6) The duration of the service (actual time spent).
(7) Start and end time of the service.
(8) The member's IICP goal or goals being addressed during the session.
(9) The progress made toward meeting habilitation goals noted on the IICP.
(10) The date of service rendered, including month, day, and year.
(d) The content of the documentation must support the amount of time billed.
(e) For members participating in AMHH services in a group setting, documentation must be provided for each encounter and must include the following:
(1) The focus of the group or session.
(2) The member's level of activity in the group session.
(3) How the service:
(A) benefits the member; and
(B) assists the member in reaching the member's habilitation goals.
(f) For AMHH services provided on behalf of the member without the member present, documentation must be provided for each encounter and must include the following information:
(1) The name or names of the person or persons attending the session and each person's relationship to the member.
(2) How the service:
(A) benefits the member; and
(B) assists the member in reaching the member's habilitation goals.
(g) In addition to the requirements listed in this section, specific requirements for selected service types may be required and are reflected in other sections of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-6; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.6-7 Coverage requirements; limits

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 7. (a) For an AMHH service to be reimbursable under this rule, the service must:
(1) be listed in this rule as a covered service;
(2) be habilitative in nature;
(3) promote member stability;
(4) demonstrate the member's movement toward the individual goals identified in the member's IICP; and
(5) continue to provide a benefit to the member.
(b) The following services are covered under the AMHH services program according to the coverage criteria, limitations, and procedures specified in this rule:
(1) Adult day services.
(2) Home and community-based habilitation and support.
(3) Respite care.
(4) Therapy and behavioral support services.
(5) Addiction counseling (substance-related disorder).
(6) Peer support services.
(7) Supported community engagement services.

(8) Care coordination services.
(9) Medication training and support.
(c) The following services will not be covered and are not eligible for reimbursement under this rule:
(1) A service provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities.
(2) A service that is provided while the member is in an institutional or noncommunity-based setting.
(3) A service provided as a diversionary, leisurely, or recreational activity that is not a component of an authorized respite care service.
(4) A service that is provided in a manner that is not within the scope or limitations of an AMHH service.
(5) A service that is not documented as a covered or approved service on the member's office-approved IICP.
(6) A service that is not supported by documentation in the member's clinical record.
(7) A service provided that exceeds the defined limits of the service, including service quantity, limits, duration, or frequency.
(8) An activity that is excluded from the service scope or definition.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-7; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-8 Adult day services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-14.5; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 8. (a) The services reimbursable as adult day services consist of community-based group programs designed to meet the needs of adults with significant behavioral health impairments as identified in a member's IICP. These comprehensive, nonresidential programs provide health, wellness, social, and therapeutic activities. The day services are delivered in a structured, supportive environment and provide the member with supervision, support services, and personal care as required by the member's IICP.
(b) Adult day services may include any of the following services as they relate to the member's IICP:
(1) Care planning.
(2) Treatment.
(3) Monitoring of weight, blood glucose level, and blood pressure.
(4) Medication administration.
(5) Nutritional assessment and planning provided by a certified dietitian.
(6) Individual or group exercise training.
(7) Reinforcement of established skills and may include activities of daily living.
(8) Other social activities.
(c) Provider staff of adult day services must meet any of the following qualifications:
(1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.
(3) Be an OBHP.
(d) The agency staff member providing adult day services must receive supervision by a licensed professional.
(e) Medication administration provided as an adult day service must be delivered within the individual's scope of practice, as defined by federal and state law, by an agency staff member who meets one (1) of the following qualifications:
(1) A licensed physician.
(2) An authorized health care professional (AHCP).
(3) A registered nurse.
(4) A licensed practical nurse (LPN).
(5) A medical assistant who has graduated from a two-year clinical program.
(f) A certified dietitian providing nutritional assessment and planning as a part of the adult day service must meet the qualifications in IC 25-14.5.
(g) Adult day service standards include all of the following requirements:

(1) The service requires face-to-face contact with the member.
(2) The member must be the focus of the service delivered.
(3) Clinical oversight must be provided by a licensed physician, who is:
(A) on-site at least once a week; and
(B) available to program staff when not physically present on-site.
(4) Each service must be documented in the member's clinical record.
(5) At least weekly, a designated clinical staff member must:
(A) review the member's progress toward meeting habilitative goals; and
(B) document the member's progress in the clinical record.
(h) Services provided in a residential setting are not reimbursable as adult day services under this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-8; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.6-9 Home and community-based habilitation and support services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 9. (a) The services available as home and community-based habilitation and support services are intended to:
(1) provide skills training to reinforce established skills (and may include activities of daily living);
(2) assist in the management, adaptation, and retention of skills necessary to support the member's needs; and
(3) assist the member to gain an understanding of the self-management of behavioral and medical health conditions.
(b) The services may be reimbursable as either of the following:
(1) Services provided to an individual in either an individual setting or a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting with or without the individual present.
(c) The services reimbursable under individual or any other subcategory of the service with the member present must meet the following requirements:
(1) Involve face-to-face contact directed at the health, safety, and welfare of the individual.
(2) Be provided in the individual's home or living environment or other community-based settings outside of a clinic or office environment.
(d) The services reimbursable under either a family setting or as a couple, with or without the member present, must meet the following requirements:
(1) Involve face-to-face contact with family members or nonprofessional caregivers directed at the health, safety, and welfare of the member and assisting in the acquisition, improvement, and retention of skills necessary to support members to live successfully in the community.
(2) Include training and education about the treatment regimens appropriate to the member to instruct:
(A) a parent;
(B) another family member identified in the IICP; or
(C) a primary caregiver.
(3) Improve the ability of the parent, family member, or primary caregiver to provide care to or for the member.
(4) Be focused on the member and be linked to the needs and goals identified on the member's IICP.
(e) Agency staff must meet any of the following qualifications to provide services under this section:
(1) Be a licensed professional, except for a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.
(3) Be an OBHP.
(f) Home and community-based habilitation and support service standards include the following:
(1) Face-to-face contact with the member, family members, or nonprofessional caregivers in an individual setting or group setting.
(2) Activities that include:

(A) implementation of the IICP;
(B) assistance with personal care; or
(C) coordination and facilitation of medical and nonmedical services to meet health care needs.
(3) Services under this subsection may include, but are not limited, to the following:
(A) Skills training in:
(i) food planning and preparation;
(ii) money management; and
(iii) maintenance of living environment.
(B) Training in the appropriate use of community services.
(C) Training in skills needed to locate and maintain a home.
(D) Medication-related education and training by nonmedical staff.
(g) The following services are not reimbursable under this section:
(1) Job coaching.
(2) Activities purely for recreation or diversion.
(3) Academic tutoring.
(4) A service provided to a professional caregiver.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-9; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-10 Respite care services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 10. (a) The services reimbursable as respite care services are provided to a member who is:
(1) unable to care for himself or herself; and
(2) living with a nonprofessional caregiver.
(b) The service provided under this section shall be furnished on a short-term basis because of a nonprofessional caregiver's absence or need for relief.
(c) The service may be provided in any of the following locations:
(1) A member's home or place of residence.
(2) A caregiver's home.
(3) A nonprivate residential setting such as a group home or adult foster care.
(d) Provider staff delivering service under this section must meet one (1) of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.
(e) Medication administration provided within the respite care service must be provided within the scope of practice, as defined by federal and state law, by an agency staff member who meets one (1) of the following qualifications:
(1) A physician.
(2) An advanced practice nurse (APN).
(3) A physician assistant (PA).
(4) A registered nurse (RN).
(5) A licensed practical nurse (LPN).
(f) Respite care service standards include the following:
(1) The member must be living with a nonprofessional caregiver.
(2) The location of services and the level of professional care are based on the needs of the member of the service, including the regular monitoring of medications or behavioral symptoms as identified in the member's IICP.
(3) Services must be provided in the least restrictive environment available and ensure the health and welfare of the member.
(4) Services shall not be used as a substitute for regular care in order to allow the member's caregiver to:

(A) attend school;
(B) hold a job; or
(C) engage in employment or employment search related activities.
(5) Respite care must not duplicate any other service being provided under the member's IICP.
(g) The following services are not reimbursable under this section:
(1) Services provided to a member living in an office-licensed residential facility.
(2) Services provided to a member who receives in-home support from a professional caregiver, rather than a nonpaid caregiver.
(3) Respite care services provided by either of the following:
(A) Any relative who is the primary caregiver of the member.
(B) Anyone living in the member's home or residence.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-10; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-11 Therapy and behavioral support services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 11. (a) The services reimbursable as therapy and behavioral support services include the following:
(1) Services provided in an individual or a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the member present.
(b) Services provided to a member must be:
(1) time-limited;
(2) structured; and
(3) provided in a face-to-face session.
(c) Services provided must meet the following requirements:
(1) Be provided either at home or at locations outside the clinic setting.
(2) Be provided in an individual setting or a group setting.
(3) Be a face-to-face interaction with the member, family members, or nonprofessional caregivers supporting a member.
(4) The member must be the focus of the service.
(d) Provider staff delivering services under this subsection must meet one (1) of the following qualifications:
(1) Be a licensed professional, as defined in this rule, except not a licensed clinical addiction counselor as defined under IC 25-23.6-10.5.
(2) Be a QBHP.
(e) Therapy and behavioral support service standards include the following:
(1) Observation of the member and environment for purposes of the development of the IICP.
(2) Development of a person-centered behavioral support plan and subsequent revisions that may be a part of the IICP.
(3) Therapy and support activities include, but are not limited to, the following:
(A) Assertiveness training.
(B) Stress reduction techniques.
(C) Development of socially accepted behaviors.
(D) Implementation of a behavior support plan for staff, family members, roommates, and other appropriate individuals.
(f) The services are not reimbursable under this section if provided in a clinic setting. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-11; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.6-12 Addiction counseling services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 12. (a) The services reimbursable as addiction counseling services include the following:
(1) Services provided to the member either individually or in a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or group setting, with or without the member present.
(b) Services shall meet the following standards:
(1) Be provided face-to-face with the member, family members, or nonprofessional caregivers.
(2) Be provided by qualified addiction professionals or other clinicians.
(3) Include any of the following:
(A) Education on addiction disorders.
(B) Skills training in:
(i) communication;
(ii) anger management;
(iii) stress management; and
(iv) relapse prevention.
(C) Referral to community recovery support programs, if available.
(c) Services under this section may be provided to adult members with:
(1) a substance-related disorder; and
(2) any of the following:
(A) Minimal or manageable medical conditions.
(B) Minimal withdrawal risk.
(C) Emotional, behavioral, and cognitive conditions that will not prevent the member from benefitting from this service.
(d) All services may be provided in an individual or group setting, but the member must always be the focus of addiction counseling.
(e) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed professional as defined under this rule.
(2) A QBHP.
(f) The following services are not reimbursable under this section:
(1) Services provided to a member with withdrawal risk or symptoms.
(2) Services provided to a member:
(A) whose needs cannot be managed safely with AMHH services; or
(B) who needs detoxification services.
(3) Services provided to a member who is determined to be at imminent risk of harm to the self or to others.
(4) Addiction counseling sessions that consist only of education.
(5) Services provided to professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-12; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-13 Peer support services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 13. (a) The services reimbursable as peer support services must be:
(1) provided face-to-face;
(2) structured; and

(3) scheduled activities that promote all of the following:
(A) Socialization.
(B) Recovery.
(C) Self-advocacy.
(D) Development of natural supports.
(E) Maintenance of community living skills.
(b) The provider agency staff member delivering services under this section must meet one (1) of the following qualifications:
(1) The office training and competency standards for a certified recovery specialist.
(2) Be an individual under the supervision of a:
(A) licensed professional; or
(B) QBHP.
(c) At a minimum, the services provided under this section must include components that:
(1) assist members with:
(A) developing IICPs; and
(B) other formal mentoring activities aimed at increasing the active participation of members in person-centered planning and delivery of individualized services;
(2) assist members with the development of psychiatric advanced directives;
(3) support members in problem-solving related to reintegration into the community; and
(4) provide education to members and promote the recovery process and anti-stigma activities.
(d) The following services are not reimbursable under this section:
(1) Services provided in group settings.
(2) Activities billable under home and community-based habilitation services.
(3) Care coordination services.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-13; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-14 Supported community engagement services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 14. (a) Services reimbursable as supported community engagement services must meet the following requirements:
(1) Be provided face-to-face with the member in an individual setting.
(2) Consist of services that engage a member in meaningful community involvement in activities such as volunteerism or community service.
(3) Consist of services aimed at developing skills and opportunities that lead to improved integration of the member into the community through increased community engagement.
(b) The provider agency staff member delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.
(c) Supported community engagement service standards include the following:
(1) The service is provided to a member who:
(A) may benefit from community engagement; and
(B) is unlikely to achieve this involvement without the provision of support.
(2) Assistance is provided to the member in developing relationships with community organizations specific to the member's interests and needs.
(3) The service is for the purpose of achieving a generalized skill or behavior that may prepare the member for an employment setting and may include, but is not limited to, focus on the following concepts:
(A) Attendance.

(B) Task completion.
(C) Problem solving.
(D) Safety.
(d) The following services are not reimbursable under this section:
(1) A provider agency's compensation to a member.
(2) Training in specific job tasks.
(3) Services provided to a member who is currently competitively employed.
(4) Vocational rehabilitation services funded under the Rehabilitation Act of 1973.
(5) Services provided in a group setting.
(6) Services that include explicit employment objectives.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-14; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-15 Care coordination services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 15. (a) The services reimbursable as care coordination services consist of services that assist a member in gaining access to needed medical, social, educational, and other services, including the following:
(1) Direct assistance in gaining access to services.
(2) Coordination of care.
(3) Oversight of the member's care in the AMHH services program.
(4) Linkage of the member to appropriate services.
(b) For purposes of this section, care coordination includes the following services:
(1) Needs assessment.
(2) IICP development.
(3) Referral and linkage.
(4) Monitoring and follow-up.
(5) Evaluation.
(c) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.
(d) Agency staff providing services must provide:
(1) direct assistance in gaining access to necessary medical, social, educational, and other services; and
(2) referrals to services, activities, or contacts necessary to ensure that the IICP:
(A) is effectively implemented; and
(B) adequately addresses the mental health or addiction needs, or both, of the eligible member.
(e) The following services may be provided under the care coordination services identified under subsection (b):
(1) A needs assessment consists of identifying the member's needs for any medical, educational, social, or other services. Specific assessment activities necessary to form a complete needs assessment of the member may include:
(A) documenting the member's history;
(B) identifying the member's needs;
(C) completing related documentation; or
(D) gathering information from other sources, such as:
(i) family members; or
(ii) medical providers.
(2) The IICP development activities include the development of a written IICP based upon the information collected through the needs assessment phase. The IICP shall identify the habilitation activities and assistance needed to accomplish the

member's objectives.

(3) Referral and linkage include activities that help link the member with:

(A) medical providers;

(B) social service providers;

(C) educational providers; and

(D) other programs and services that are capable of providing habilitative services that meet the member's needs.

(4) Monitoring and follow-up activities:

(A) include making contacts necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the member; and

(B) may include activities and contacts with the following individuals:

(i) The member.

(ii) Family members or others who have a significant relationship with the member.

(iii) Nonprofessional caregivers.

(iv) Providers.

(v) Other entities.

(5) Evaluation activities include face-to-face contact with the member at least every ninety (90) days for the following reasons:

(A) To ensure the IICP is effectively implemented and adequately addresses the member's needs.

(B) To determine if the services are consistent with the IICP and any changes to the IICP.

(C) To make changes or adjustments to the IICP in order to meet the member's ongoing needs.

(D) To evaluate or reevaluate the member's progress toward achieving the IICP's objectives.

(f) The time devoted to formal supervision between the care coordinator and the licensed supervisor to review the member's care and treatment shall be:

(1) an included care coordination activity;

(2) documented accordingly in the member's clinical record; and

(3) billed under only one (1) provider staff member.

(g) The following services are not reimbursable under this section:

(1) The direct delivery of medical, clinical, or other direct services.

(2) Services provided in a group setting, including, but not limited to, the following:

(A) Training in daily living skills.

(B) Training in work or social skills.

(C) Grooming and other personal services.

(D) Training in housekeeping, laundry, and cooking.

(E) Transportation services.

(F) Individual, group, or family therapy services.

(G) Crisis intervention services.

(3) Services that go beyond assisting a member in gaining access to needed services including, but not limited to, the following:

(A) Paying bills.

(B) Balancing the member's checkbook.

(C) Traveling to and from appointments with a member or members.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-15; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-16 Medication training and support services

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 16. (a) The services reimbursable as medication training and support services include the following:

(1) Services provided to the member in an individual or in a group setting.
(2) Services provided to family members or other nonprofessional caregivers in an individual or a group setting with or without the member present.
(b) The following services are reimbursable and must be provided face-to-face in either an individual or a group setting:
(1) Monitoring medication compliance.
(2) Medication training and support.
(3) Monitoring medication side effects.
(4) Providing other nursing or medical assessments.
(c) A provider agency may receive reimbursement for training family members or nonprofessional caregivers to perform the activities identified in this section.
(d) When provided to family members or other nonprofessional caregivers, the service:
(1) must focus on and be on behalf of the member; and
(2) may include the training of family members or nonprofessional caregivers to:
(A) monitor the member's medication compliance;
(B) assist with the administration of prescribed medications; and
(C) monitor side effects, including:
(i) weight;
(ii) blood glucose level; and
(iii) blood pressure.
(e) Medication training and support may also include the following services that are not required to be provided face-to-face with the member:
(1) Transcribing medication orders of the following:
(A) A physician.
(B) An AHCP.
(2) Setting or filling medication boxes.
(3) Consulting with the attending provider or AHCP regarding medication-related issues.
(4) Ensuring linkage that lab and other prescribed clinical orders are sent.
(5) Ensuring that the member follows through and receives lab work and services pursuant to other clinical orders.
(6) Follow-up reporting of lab and clinical test results to the member and physician.
(f) Services provided that are not face-to-face with the member must meet the following standards:
(1) The member must be the focus of the service.
(2) Documentation must support how the service benefits the member.
(g) When provided in a clinic setting, medication training and support may compliment, but not duplicate, activities associated with medication management activities available under the Medicaid clinic option.
(h) When provided in a residential treatment setting, medication training and support may include components of medication management services as defined under the Medicaid clinic option.
(i) Provider staff delivering services under this section must meet one (1) of the following qualifications:
(1) A licensed physician.
(2) An AHCP.
(3) A licensed registered nurse (RN).
(4) A licensed practical nurse (LPN).
(5) A medical assistant (MA) who has graduated from a two-year clinical program.
(j) The services under this section must be provided within the practitioner's scope of practice as defined by federal and state law.
(k) The following services are not reimbursable under this section:
(1) Medication management, counseling, or psychotherapy when medication management is a component of the service.
(2) Medication training and support that is billed separately for the same visit by the same provider.
(3) Coaching and instruction regarding a member's self-administration of medications.
(4) Services provided to paid, professional caregivers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-16; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-17 AMHH provider agency requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 17. (a) In order to provide AMHH services under this rule, a provider must be authorized by the office as an AMHH services provider agency.

(b) Provider agencies under this rule must attest that the individual provider staff member delivering an AMHH service meets the service-specific provider requirements and qualifications as defined within this rule.

(c) The office has deemed state-certified community mental health centers (CMHCs) as being in good standing as office-approved AMHH services provider agencies.

(d) Any provider wishing to apply to become an AMHH provider agency must:

(1) complete an AMHH provider agency application; and

(2) submit the application to the office for review and consideration.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-17; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-18 Fair hearings and appeals

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

Sec. 18. (a) Any of the following may appeal an action by the office state evaluation team and request an administrative hearing:

(1) An applicant.

(2) A member of services under this rule.

(3) A duly authorized representative of the following:

(A) An applicant.

(B) A member.

(b) An individual, an applicant, or a member appealing an action under this rule must follow the appeal processes and procedures in 405 IAC 1.1.

(c) Administrative hearings and appeals by an applicant or member are governed by the procedures, time limits, provisions, and requirements set out in 405 IAC 1.1.

(d) In the event that the state evaluation team denies an applicant eligibility for AMHH services or authorization for a submitted IICP requesting AMHH services, the state evaluation team shall notify the following individuals of the AMHH denial determination:

(1) The applicant.

(2) The member of AMHH services under this rule.

(3) The duly authorized representative of the applicant or the member, if applicable.

(4) The AMHH provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-18; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.6-19 Complaints and grievances

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

Sec. 19. (a) Any of the following shall have the right to file a written complaint or a written grievance with the state or the

office:

(1) An applicant.

(2) A member.

(3) A duly authorized representative or representatives of an applicant or a member.

(b) A complaint or grievance regarding an AMHH provider agency or a provider shall be accepted by the following means:

(1) The family/consumer section on the DMHA website.

(2) The consumer service line (800-901-1133).

(3) In-person via a DMHA staff member.

(4) A written complaint or e-mail submitted to the DMHA.

(c) Upon receipt of a complaint or a grievance, the office shall:

(1) log the complaint or grievance; and

(2) initiate an investigation.

(d) After the investigation is complete, the office shall notify the individual or the member filing the complaint or grievance of the office's findings.

(e) The office decision with regard to a complaint or a grievance:

(1) may not be appealed; and

(2) does not grant any appeal rights to the individual or the member filing a complaint or grievance.

(f) The filing of a complaint or grievance is not a prerequisite to filing an appeal under section 18 of this rule.

(g) If the office sends a letter to a provider agency under this section stating its findings regarding a complaint or a grievance of an applicant or a member, the following shall apply:

(1) The office may require the provider agency to correct an identified deficiency within a timeline established by the office.

(2) A provider agency's failure to correct the deficiency within the established timeline may result in sanctions up to, and including, decertification of the provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.6-19; filed Dec 16, 2013, 9:11 a.m.: 20140115-IR-405130183FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 21.7. Child Mental Health Wraparound Services

405 IAC 5-21.7-1 General provisions

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. (a) This rule provides child mental health wraparound (CMHW) services, which are intensive, home and community-based intervention services provided according to a systems of care philosophy within a wraparound model of service delivery.

(b) The CMHW service program includes the delivery of coordinated, highly individualized wraparound services and interventions that do the following:

(1) Address the member's unique needs.

(2) Build upon the strengths of the member and the member's family or support group.

(3) Assist the member and the member's family in achieving positive outcomes in their lives.

(c) CMHW services are provided by qualified, specially trained service providers who engage the member and the member's family in an assessment and treatment planning process characterized by the formation of a child and family wraparound team (team).

(d) The team is developed by the member and family to provide the support and resources needed to assist in developing and implementing an individualized plan of care.

(e) Members of the child and family team are selected by the member and family and may include, but are not limited to, the following:

(1) The member and family who will lead the treatment planning process.

(2) The wraparound facilitator who will coordinate service delivery and assist the member and the member's family in linking with community and natural supports.

(3) The CMHW and non-CMHW service providers, who will provide the member and the member's family with resources and supports in the treatment process.

(4) Any individual whom the member and the member's family select to support or assist them in implementation of the CMHW services plan of care.

(f) The CMHW services program will make available to the member an array of interventions, which may include, but are not limited to, the following:

(1) Behavioral health and support services.

(2) Crisis planning and intervention.

(3) Parent coaching and education.

(4) Community resources and supports.

(g) The state's purposes for providing CMHW services are to:

(1) serve eligible members with serious emotional disturbances; and

(2) enable them to benefit from receiving intensive wraparound services within their home and community with natural family supports.

(h) CMHW services available for eligible members include the following:

(1) Wraparound facilitation.

(2) Habilitation.

(3) Respite care.

(4) Training and support for unpaid caregivers.

(i) CMHW services will be administered, evaluated, and monitored by the office.

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

405 IAC 5-21.7-2 Definitions

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

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Access site" means a office-approved agency that will provide CMHW services applicants and families the following:

(1) Information about CMHW services and eligibility criteria.

(2) Assistance in applying for CMHW services.

(3) Linkage to the most appropriate services, based upon an applicant's identified needs.

(c) "Applicant" refers to a child who is assessed for meeting eligibility criteria for enrollment in CMHW services.

(d) "Behavioral health assessment tool" means a state designated, individually appropriate assessment tool that is:

(1) approved by the office; and

(2) administered by a qualified individual who is trained and certified by the office to administer the tool.

(e) "Behavioral recommendation" means a recommended intensity of behavioral health services that is derived from administration of the office-approved behavioral health assessment tool, as follows:

(1) The recommendation is based on an algorithm derived from the patterns of assessment ratings, in multiple life domains, from administration of the assessment tool with the applicant or member and family member.

(2) This algorithm does the following:

(A) Implements the criteria for a level of need.

(B) Indicates the appropriate intensity of behavioral health services recommended for the member.

(f) "Child and family wraparound team" or "team" means a wraparound treatment team or support team developed as follows:

(1) By a member enrolled in CMHW services and the member's family.

(2) To assist a member and the member's family in developing and implementing an individualized plan of care.

(g) "Child mental health wraparound" or "CMHW" services mean intensive, home and community-based, behavioral health wraparound services and interventions that meet the following requirements:

(1) The services are recommended by a physician or other licensed professional, within the scope of his or her practice.

(2) The services and interventions are intended for the:

(A) treatment of a mental health disability; and

(B) restoration of a member's best possible functional level.

(3) The services include clinical and supportive behavioral health services provided for eligible members who are:

(A) living with their family in the community; and

(B) at risk of an out-of-home placement, due to their mental illness and the disruptive patterns of their behavior.

(4) The services are provided in accordance with wraparound principles and a system of care philosophy.

(h) "CMHW service provider" means a service provider or agency that:

(1) has successfully completed CMHW services provider authorization and training; and

(2) meets all qualifications and standards required by the office.

(i) "Corrective action" means an action imposed upon the provider by the office for noncompliance with CMHW services policies and procedures.

(j) "Crisis plan" means a plan of action prepared by the member, the member's family, and the team that specifies the following:

(1) Potential crises the member may experience.

(2) The planned interventions and resources available to the member and family to assist in deescalating a crisis situation.

(k) "DMHA" refers to the Indiana division of mental health and addiction, which is responsible for operating the CMHW services program. For purposes of this rule, use of the term "the DMHA" includes the following:

(1) Staff hired by the DMHA.

(2) An entity under contract with the DMHA to provide a service or to complete administrative tasks or functions assigned by the DMHA and required under this rule.

(l) "Eligibility determination form" means the written notice provided to the access site, documenting an office determination regarding the meeting of eligibility for level of need and participation in the CMHW services program by an applicant or member. The access site shall share this information with the applicant or member, including the following information that accompanies the eligibility determination form:

(1) Approval or denial of the applicant's or member's level of care or eligibility to participate in the CMHW services program.

(2) CMHW services approved or denied by the office.

(3) The effective dates and reasons for the action or actions taken.

(4) The applicant's or member's appeal and fair hearing rights and procedural information.

(m) "Family" refers to the legal guardian or caretaker responsible for the care of a member.

(n) "Licensed professional" means any of the following persons:

(1) A licensed psychiatrist.

(2) A licensed physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) A licensed clinical social worker (LCSW).

(5) A licensed mental health counselor (LMHC).

(6) A licensed marriage and family therapist (LMFT).

(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

(o) "Member" means a person receiving CMHW services.

(p) "Plan of care" means the individualized treatment plan that integrates all components and aspects of care, including services that are deemed medically necessary or clinically indicated and all medical and behavioral support services and interventions needed to assist the member in the following:

(1) To remain in the home or community.

(2) To function at the highest level of independence possible.

(3) To achieve treatment goals.

(q) "Qualified professional" means a provider who is a licensed professional as defined in this subsection or supervised by a licensed professional.

(r) "Qualifying SED work experience" means work directly with the SED population in a way that builds functional skills,

such as the following:

(1) Group counseling, one-on-one counseling, provision of skills training, or provision of therapeutic recreational activities.

(2) The provision of therapeutic foster care, or work in a capacity that may not involve mental health care, but where the work is targeted at a defined SED population.

(3) Experience in case management, therapy, or skills training, in conjunction with a mental health center is also considered as qualifying SED work experience.

(s) "Seriously emotionally disturbed" or "SED" refers to severe functional impairments due to a mental illness, as defined in 440 IAC 8-2-4.

(t) "System of care" refers to a comprehensive spectrum of mental health and other necessary services that are organized into a coordinated network to meet the multiple and changing needs of children and their families, and includes the following concepts regarding care delivery:

(1) Family-driven and child-guided.

(2) Individualized and community-based.

(3) Culturally and linguistically competent.

(u) "Unpaid caregiver" means a person, family member, neighbor, friend, co-worker, or companion who provides uncompensated care, training, guidance, companionship, or support to an enrolled CMHW services member.

(v) "Wraparound facilitator" means an individual who facilitates and supervises the delivery of wraparound services for a CMHW services member.

(w) "Wraparound model of service delivery" means a practice model that is a team-based process for planning and implementing formal and informal services, interventions, and supports for children with complex needs. Services are provided in a manner that is consistent with and guided by a system of care philosophy that builds on the collective action of a committed group of family, friends, community, professionals, and cross-system supports mobilizing resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit for the family vision and story, team mission, strengths, underlying needs, resources, and strategies. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-2; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-21.7-3 Applicants and the application process

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

Sec. 3. (a) The purpose of the application process is to provide families with a means to explore whether their child may be eligible for and benefit from CMHW services.

(b) A referral application for CMHW services must be made in the manner required by the office.

(c) Access sites, which are office-approved CMHW service agencies, provide a local point of access in order for applicants and their families to complete the CMHW services application process that includes the following:

(1) Completion of the CMHW services application.

(2) A face-to-face evaluation and administration of the behavioral health assessment tool to assist the office in determining whether an applicant meets the eligibility and needs-based criteria for enrollment in CMHW services.

(d) The office, which makes the final eligibility determination for all applicants for CMHW services, shall do the following:

(1) Review the applicant's application, evaluation, and behavioral health assessment tool findings.

(2) Notify the access site regarding the office eligibility determination with an eligibility determination form.

(e) The eligibility determination form shall include the following, as applicable:

(1) Approval of the applicant for enrollment in CMHW services, if the eligibility and needs-based criteria are met.

(2) Denial of the applicant for enrollment in CMHW services if either the eligibility criteria or the needs-based criteria is not met.

(3) Initial office-approved plan of care.

(f) The access site shall do the following:

(1) Notify the family regarding the office approval or denial of the applicant for the CMHW services program.

(2) Provide the family with information regarding the family's rights, including information regarding how to appeal the office eligibility determination, if so desired.

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

405 IAC 5-21.7-4 Independent assessment and evaluation

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

Sec. 4. (a) Each applicant completing the application process for CMHW services shall undergo a face-to-face assessment and evaluation by an access site.

(b) The purpose of the assessment and evaluation is to determine whether an applicant meets the CMHW services eligibility and needs-based criteria.

(c) The assessment shall include administration of the office-approved behavioral assessment tool in order to:

(1) assess an applicant's strengths, needs, and functional impairment or impairments; and

(2) assist in determining an applicant's level of need for CMHW services, based upon the assessment results and algorithm for a behavioral recommendation.

(d) The assessment or evaluation and clinical documentation gathered by the access site and submitted to the office for review and determination of an applicant's eligibility will include, but are not limited to, the following:

(1) Current and historical behavioral health needs, including treatment history and confirmation of mental health diagnoses.

(2) Evaluation findings and behavioral recommendation from administration of the office-approved behavioral assessment tool.

(3) Assessment of an applicant's functional strengths and needs.

(4) Assessment of the strengths and needs of the family.

(5) Documentation of an applicant's meeting target group and financial eligibility criteria.

(6) Documentation demonstrating that the applicant does not meet CMHW services exclusionary criteria.

(7) Information about the individual's current and historical health status and needs.

(8) Information to satisfy the state's data collection requirements.

(9) Any additional information or documentation needed to support a determination that the applicant meets eligibility and needs-based criteria required to access CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-4; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-5 Eligibility and needs-based criteria

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

Sec. 5. (a) To be enrolled in the CMHW services program, the applicant must meet the following target group eligibility criteria:

(1) The applicant meets age criteria, which is six (6) through seventeen (17) years of age.

(2) The applicant meets the criteria for two (2) or more American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders-IV-TR (or subsequent revision) diagnoses.

(3) The applicant does not meet any of the following CMHW services exclusionary criteria:

(A) Primary substance abuse disorder.

(B) Primary or secondary pervasive developmental disorder (autism spectrum disorder).

(C) Primary attention deficit hyperactivity disorder.

(D) Intellectual disability or disabilities.

(E) Dual diagnosis of serious emotional disturbance and intellectual disabilities.

(b) In addition to meeting the target group eligibility criteria, the applicant must also meet CMHW services needs-based

criteria, which include the following:

(1) The applicant is experiencing significant emotional or functional impairments, or both, that impact the level of functioning at home or in the community, as a result of a mental illness, and supported by a behavioral recommendation of a 4, 5, or 6 from the administered office-approved behavioral assessment tool.

(2) The applicant that meets a 4, 5, or 6 behavioral recommendation on the behavioral assessment tool must also demonstrate dysfunctional patterns of behavior due to one (1) or more of the following behavioral or emotional needs identified on the behavioral assessment tool:

(A) Adjustment to trauma.

(B) Psychosis.

(C) Debilitating anxiety.

(D) Conduct problems.

(E) Sexual aggression.

(F) Fire-setting.

(3) The applicant demonstrates significant needs in at least one (1) of the family or caregiver areas, as indicated on the office-approved behavioral assessment tool, which results in a negative impact on the applicant's mental illness:

(A) Mental health.

(B) Supervision issues.

(C) Family stress.

(D) Substance abuse.

(4) The applicant does not meet any of the following exclusionary criteria:

(A) The applicant is at imminent risk of harm to himself or herself or to others.

(B) The applicant is identified as feasibly unable to receive intensive community-based services without compromising his or her safety, or the safety of others.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-5; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-21.7-6 Individualized plan of care

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

Sec. 6. (a) The plan of care is an individualized treatment plan that integrates all components and aspects of care, including services, interventions, and supports that are deemed medically necessary or clinically indicated.

(b) The plan of care must include all indicated medical and behavioral support services needed by a member in order to assist the member in the following:

(1) Remaining in the home or community.

(2) Functioning at the highest level of independence possible.

(3) Achieving treatment goals.

(c) The CMHW services plan of care developed within the team, with member and family input and inclusion, must meet the following criteria:

(1) Be developed for each member based upon the member's unique strengths and needs, as ascertained in the evaluation or assessment.

(2) Reflect the member's and the family's preferences and choices for services and providers.

(3) Contain goals that delineate the following:

(A) Clear objectives.

(B) Resources, including the child and family team member or members that will assist the member in meeting each goal.

(C) Service duration and frequency, based upon the member's level of need and functional impairments.

(d) In addition to the plan of care, the team shall develop a crisis plan that includes the following components:

(1) Anticipated crisis or crises that the member may experience based upon historical information.

(2) Potential triggers that may lead to a crisis situation involving the member.

(3) Interventions that have either worked or not worked in deescalating a crisis situation in the past.

(4) The plan of action for the member, the member's family, and members of the child and family team in the event of a crisis.

(5) Identified resources available to assist the member and the member's family in the event of a crisis.

(e) The plan of care and the crisis plan must be submitted to the office for review and approval prior to the delivery of CMHW services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-6; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.7-7 Member freedom of choice

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

Sec. 7. The member and the member's family have freedom of choice regarding the following aspects of CMHW service delivery:

(1) Determining who will participate in the team.

(2) Identifying the plan of care goals and the method for achieving those goals.

(3) Selecting the CMHW services, as supported by the member's assessment and level of need that will be included in the plan of care.

(4) Choosing the office-certified CMHW service provider or providers who will provide, oversee, and monitor implementation of the plan of care.

(5) Changing the CMHW service provider or providers at any time during the member's enrollment in the CMHW services program.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-7; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-8 Eligibility period

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

Sec. 8. (a) Ongoing eligibility for CMHW services is dependent upon the member continuing to meet eligibility and needs-based criteria for the CMHW services program.

(b) A member shall be eligible to receive CMHW services, as documented in the plan of care, for up to a twelve (12) month period, as long as eligibility and needs-based criteria continue to be met.

(c) Administration of the office-approved behavioral assessment tool must occur every six (6) months from the date of last administration of the tool to evaluate a member's level of need and response to CMHW services.

(d) The office-approved wraparound facilitator must complete a face-to-face reevaluation of the member at least every twelve (12) months with input and participation from the child and family team, including the member and the member's family.

(e) The face-to-face evaluation of the member shall include, but is not limited to, the following:

(1) Administration of the office-approved behavioral assessment tool to determine whether the member continues to meet the level of need and the needs-based criteria for CMHW services.

(2) Evaluation of the member's response to CMHW services and progress towards meeting treatment goals on the plan of care.

(3) Evaluation of the member's strengths, needs, and functional impairments.

(4) Documentation that the member continues to meet the following eligibility criteria as defined in 405 IAC 5-21.7-5:

(A) Financial criteria.

(B) Target group eligibility.

(C) Needs-based criteria.

(5) The proposed updated plan of care and the crisis plan for office review and approval.

(f) The office reviews the evaluation findings to assess and determine a member's continued eligibility for CMHW services.

(g) The office shall notify the wraparound facilitator regarding the results of the review determination and the member's continued eligibility for services, which may include the following:

(1) Approval of the member for continued enrollment in CMHW services, if the member continues to meet CMHW services' eligibility and needs-based criteria.

(2) Denial of the member's enrollment in CMHW services if the eligibility criteria or the needs-based criteria are not met.

(3) Approval of the plan of care for continued CMHW services.

(h) The wraparound facilitator shall notify the member and the member's family regarding the office's determination of CMHW services eligibility as follows:

(1) By providing an eligibility determination form that documents the office's eligibility determination of approval or denial of the child for CMHW services.

(2) By providing the family with information regarding the fair hearings and appeals process.

(i) If the member no longer meets the level of need, or is otherwise deemed ineligible for CMHW services, the wraparound facilitator and team shall work together with the member and the member's family to develop and implement a transition plan. The transition plan shall assist the member in moving from CMHW services to community-based services appropriate for the member's current level of need. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-8; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.7-9 Coverage requirements and limits

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

Sec. 9. (a) In order for a service provider to be reimbursed for providing a CMHW service to an eligible member, the service must be provided in the manner established by this section.

(b) In order to be eligible for reimbursement, a covered CMHW service shall meet the following criteria:

(1) Be documented on the member's office-approved plan of care.

(2) Be supported by the member's level of need, as documented in the most recent assessment of the member.

(3) Be provided by an office-certified CMHW service provider meeting all required service-specific qualifications and standards.

(4) Be provided within the scope and limitations for the service as approved by the office.

(c) A CMHW service shall be deemed noncovered and shall not be eligible for reimbursement if the service meets any of the following criteria:

(1) The service is provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source, including federal, state, local, and private entities.

(2) The service is provided as a diversionary, leisurely, or recreational activity that is not a component of respite care service.

(3) The service is provided in a manner that is not within the scope or limitations of the CMHW service.

(4) The service is not documented as a covered or authorized service on the participant's office-approved plan of care.

(5) Provision of the service is not supported by the office-approved documentation standards in the member's clinical record.

(6) The service is provided by a service provider other than the service provider documented on the member's plan of care.

(7) The service provided exceeds the limits approved by the office, including the quantity, limit, duration, or frequency of the service.

(8) The service is listed in this rule as a noncovered service or is otherwise excluded from coverage.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-9; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-10 Provider certification and application process

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

Sec. 10. (a) Only an office-certified individual or agency enrolled as a provider of CMHW services may be reimbursed for providing a CMHW service to an eligible member.

(b) A CMHW service provider must be authorized by the office according to the specific qualifications for and standards of the service that the provider or agency is eligible to provide, as further defined in section 11 of this rule.

(c) An office-authorized service provider must be classified as one (1) of the following types of CMHW service provider:

(1) An accredited agency provider, which is defined as a provider employed by an accredited agency meeting the following requirements:

(A) The provider is authorized by the office as a community mental health center (CMHC) or has been accredited by one (1) of the following nationally recognized accrediting bodies:

(i) The Accreditation Association for Ambulatory Health Care (AAAHC).

(ii) The American Council for Accredited Certification (ACAC).

(iii) The Commission on Accreditation of Rehabilitation Facilities (CARF).

(iv) The Council on Accreditation (COA).

(v) The Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

(vi) The National Committee for Quality Assurance (NCQA).

(vii) The Utilization Review Accreditation Commission (URAC).

(B) The agency participates in a local system of care, which includes both a governing coalition and a service delivery system that endorses the values and principles of wraparound services, or, if that area of the state does not have an organized system of care, the provider is a part of a office-approved access site for services.

(C) The agency has employed a provider or providers that qualify to provide one (1) or more CMHW service, as set out in section 11 of this rule.

(2) A nonaccredited agency provider is defined as a provider employed by an agency without accreditation from a nationally-recognized accrediting body that meets the following requirements:

(A) The agency is able to submit documentation proving that the agency has articles of incorporation.

(B) The agency has employed a provider or providers that qualify to provide one (1) or more CMHW services, as defined in section 11 of this rule.

(3) An individual service provider is defined as a licensed or unlicensed service provider that meets the following requirements:

(A) The individual provider is not employed by an accredited or nonaccredited agency as defined in this section.

(B) The individual provider qualifies to deliver one (1) or more CMHW services, as defined in section 11 of this rule.

(d) An agency or individual provider that requests enrollment as a CMHW service provider must complete the following application requirements:

(1) Complete and submit the CMHW service provider application to the office for review and consideration.

(2) Submit documentation demonstrating that the individual or agency meets all qualifications outlined in this subsection.

(3) Submit documentation demonstrating that an individual provider or a provider hired by an accredited or nonaccredited agency meets the qualifications for the CMHW service authorization that is being applied for, as defined in section 11 of this rule.

(4) Submit documentation demonstrating completion of the following screenings required of all providers:

(A) Fingerprinting based on national and state criminal history background screenings.

(B) Local law enforcement screening.

(C) State and local department of child services abuse registry screening.

(D) A five-panel drug screening or, in the alternative, the provider meets the requirements specified under the Federal Drug Free Workplace Act of 1988 (P.L.100-690, Title V, subtitle D).

(e) The office shall review the provider application and documentation to determine whether the agency or the individual meets the criteria for an office-authorized CMHW service provider.

(f) An individual or an agency meeting the criteria as a CMHW service provider and receiving an office authorization approval letter must also apply to the office for a Medicaid Indiana Health Coverage Programs (IHCP) provider number prior to providing and billing for CMHW services.

(g) If the office denies the request of an individual or an agency for an IHCP provider number, then the individual or the

agency will not be authorized to:

(1) provide;

(2) bill for; or

(3) be reimbursed for;

any CMHW service. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-10; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-21.7-11 Provider authorization and service provider qualifications

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-13-7-3; IC 12-17-12; IC 12-17.2-4; IC 12-17.2-5; IC 12-29; IC 25-23.6; IC 25-27.5-5; IC 25-33-1; IC 31-27-3; IC 31-27-4

Sec. 11. (a) In addition to meeting CMHW service standards required for the provider authorization process, as defined in section 10 of this rule, the service provider must also meet service-specific qualifications, based upon the specific CMHW service for which the provider is seeking office authorization to deliver.

(b) A wraparound facilitation service provider must meet the following qualifications and standards:

(1) The provider must be employed by an office-authorized accredited agency.

(2) The provider must qualify as an other behavioral health professional (OBHP), as defined in 405 IAC 5-21.5-1, who has one (1) of the following:

(A) A bachelor's degree with two (2) or more years of clinical experience.

(B) A master's degree in social work, psychology, counseling, nursing, or other mental health-related field, with two (2) or more years of clinical experience.

(3) The provider must complete the following office-required service provider training and certifications:

(A) CMHW services orientation.

(B) Child and adolescent needs and strengths assessment tool certification.

(C) Wraparound practitioner certification, provided, however, that the facilitator shall have eighteen (18) months after the starting date to complete the certification.

(D) Cardiopulmonary resuscitation (CPR) certification.

(c) A habilitation service provider must meet the following qualifications and standards:

(1) Be at least twenty-one (21) years of age.

(2) Possess a high school diploma or the equivalent.

(3) Demonstrate a minimum of three (3) years of qualifying SED work experience.

(4) Provide documentation of a safe driving record, as well as the following:

(A) A current driver's license.

(B) Proof of motor vehicle insurance coverage.

(C) Proof of current vehicle registration.

(5) For every thirty (30) hours of habilitation services provided, the provider must obtain one (1) hour of face-to-face supervision with an approved mental health service provider that meets one (1) of the following licensure requirements:

(A) Licensure in psychology (HSPP) as defined in IC 25-33-1.

(B) Licensed marriage and family therapist (LMFT) under IC 25-23.6-8.

(C) Licensed clinical social worker (LCSW) under IC 25-23.6-5.

(D) Licensed mental health counselor (LMHC) under IC 25-23.6-8.5.

(6) Complete the following office-required service provider training:

(A) CMHW services orientation.

(B) CPR certification.

(d) A CMHW respite care service provider must meet the following requirements and standards as applicable:

(1) All individuals providing respite care services must meet the following qualifications and standards:

(A) Be at least twenty-one (21) years of age.

(B) Possess a high school diploma or the equivalent.
(C) Demonstrate three (3) years of qualifying SED work experience.
(D) Provide documentation of a safe driving record, as well as:
(i) a current driver's license;
(ii) proof of motor vehicle insurance coverage; and
(iii) proof of current vehicle registration.
(E) Complete the following office-required service provider training:
(i) CMHW services orientation.
(ii) CPR certification.
(2) A member's relative, related by blood, marriage, or adoption, who is not the member's legal guardian or primary caregiver and who does not live in the member's home, may also provide respite care services, under the following conditions:
(A) The individual is selected by the member or the member's family to provide the service.
(B) The team has determined that provision of the service by a relative is in the best interests of the member.
(C) The individual providing the service must do the following:
(i) Apply for and be certified as a CMHW respite care service provider.
(ii) Meet all of the qualifications and standards required for an individual respite care service provider.
(3) Office-authorized respite care service providers may include the following agencies or facilities licensed by the office or the Indiana department of child services, and shall meet CMHW services accredited agency authorization standards defined in section 10 of this rule:
(A) Emergency shelters licensed under 465 IAC 2-10.
(B) Foster homes licensed under IC 31-27-4, including special needs and therapeutic foster homes only when the licensed child placing agency (LCPA) is an office-certified agency provider. The office is authorized to request a copy of the study of the home of the foster parent providing respite care services.
(C) Other child caring institutions licensed under IC 31-27-3.
(D) Child care centers licensed under IC 12-17.2-4.
(E) Child care homes licensed under IC 12-17.2-5.
(F) School age child care project licensed under IC 12-17-12.
(e) A CMHW services training and support for unpaid caregiver service provider must meet the following qualifications and standards:
(1) Be at least twenty-one (21) years of age.
(2) Possess a high school diploma or the equivalent.
(3) Demonstrate two (2) years of qualifying SED work experience with SED children.
(4) With regard to an individual service provider, live within a one-county area from the county of the member's residence.
(5) Complete the following office-required service provider training:
(A) CMHW service orientation.
(B) CPR certification.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-11; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-21.7-12 Provider training
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 12. (a) Each year an office-authorized CMHW service provider must complete ten (10) hours of ongoing training and continuing education in either child mental health or SED child-related topics.
(b) The provider must keep current all service-related trainings and certifications required for a CMHW service provider.
(c) The provider must submit verification of compliance with training and service-related certification requirements to the office at the time of provider reauthorization.

(d) A service provider's failure to comply with CMHW training and service-related certification requirements may result in the revocation of the provider's CMHW service provider authorization. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-12; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.7-13 Provider reauthorization

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

Sec. 13. (a) To ensure continued compliance with provider qualifications and standards for providing CMHW services, an office-approved CMHW service provider must reapply for authorization according to the following reauthorization schedule:

(1) An accredited agency provider must apply for reauthorization:

(A) at least every three (3) years following the initial office authorization; or

(B) at the time of the agency reaccreditation;

whichever date is earlier.

(2) A nonaccredited agency provider must apply for reauthorization at least every two (2) years following the initial office authorization.

(3) An individual service provider must apply for reauthorization at least every two (2) years following the initial office authorization.

(b) A provider must submit the application for reauthorization in writing to the office at least sixty (60) days prior to the due date for reauthorization.

(c) An agency or individual provider applying for reauthorization as a CMHW service provider must complete the following application requirements:

(1) Complete and submit the CMHW services provider reauthorization application to the office for review and consideration.

(2) Submit documentation demonstrating that the individual provider or agency provider continues to meet all qualifications contained in section 10 of this rule.

(3) Submit documentation demonstrating that the individual provider or agency provider continues to meet the qualifications for the CMHW service authorization being applied for, as defined in section 11 of this rule.

(4) Submit documentation demonstrating compliance with the following:

(A) Yearly provider continuing education training.

(B) Updated certification requirements.

(d) The office shall review the provider application and documentation to determine whether the agency or individual provider continues to meet the criteria for authorization as a CMHW service provider.

(e) Failure to comply with authorization requirements in a timely manner will result in the following corrective action:

(1) The agency or individual provider will be placed on suspended status as a CMHW services provider, pending the completion of the office reauthorization process.

(2) The agency or individual provider must continue to provide services to those members whom the provider is currently serving, but will be prohibited from accepting any new members.

(3) Upon the office's receipt and approval of the provider reauthorization paperwork, the status of the agency or individual provider will be updated to active status, thereby allowing the provider to accept new CMHW services members.

(4) A provider's continued failure to comply with reauthorization requirements will result in the office's revoking authorization for that provider to deliver CMHW services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-13; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

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 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 14. (a) Under 405 IAC 1-1-6, if a provider has violated any provision established under IC 12-15, the office 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 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 for noncompliance with CMHW services' policies and procedures.

(3) The provider's failure to maintain CMHW services provider qualifications, office-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)

405 IAC 5-21.7-15 Services: general provisions

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

Sec. 15. (a) All CMHW services provided to a member must meet the following requirements:

(1) Be supported by the member's level of need.

(2) Be documented in the member's plan of care.

(b) A provider shall maintain documentation for services provided to a CMHW services member in accordance with the requirements under 405 IAC 1-5-1.

(c) Provider reimbursement for CMHW services is subject to, but not limited to, the following:

(1) The member's eligibility for services.

(2) The provider's qualifications and certification.

(3) Prior authorization by the office.

(4) The scope, limitations, and exclusions of the services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-15; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-16 Wraparound facilitation services

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

Sec. 16. (a) Wraparound facilitation services are as follows:

(1) Comprehensive services comprised of a variety of specific tasks and activities designed to carry out the wraparound process.

(2) A required component of the CMHW services program.

(b) Wraparound facilitation is:

(1) a planning process that follows a series of steps; and

(2) provided through a child and family wraparound team.

(c) The team is responsible for assuring that a member's needs, and the entities responsible for addressing those needs, are identified in a written plan of care.

(d) The wraparound facilitator manages and supervises the wraparound process through the following activities:
(1) Completing a comprehensive evaluation of the member, including administration of the office-approved behavioral assessment tool.
(2) Guiding the family engagement process by exploring and assessing strengths and needs.
(3) Facilitating, coordinating, and attending team meetings.
(4) Working in full partnership with the member, family, and team members to ensure that the plan of care is developed, written, and approved by the office.
(5) Assisting the member and the member's family in gaining access to the full array of services, that is, medical, social, educational, or other needed services.
(6) Guiding the planning process for the plan of care by:
(A) informing the team of the family's vision; and
(B) ensuring that the family's vision is central to the planning and delivery of services.
(7) Ensuring the development, implementation, and monitoring of a crisis plan.
(8) Assuring that all work to be done to assist the member and the member's family in achieving goals on the plan of care is identified and assigned to a team member.
(9) Overseeing and monitoring all services authorized for a member's plan of care.
(10) Reevaluating and updating the plan of care as dictated by the member's needs and securing office approval of the plan of care.
(11) Assuring that care is delivered in a manner consistent with strength-based, family-driven, and culturally competent values.
(12) Offering consultation and education to all CMHW service providers regarding the values and principles of the wraparound services model.
(13) Monitoring a member's progress toward meeting treatment goals.
(14) Ensuring that necessary data for evaluation is gathered, recorded, and preserved.
(15) Ensuring that the CMHW services assessment and service-related documentation are gathered and reported to the office as required by the office.
(16) Completing an annual CMHW services level of need reevaluation, with active involvement of the member, the member's family, and the team.
(17) Guiding the transition of the member and the member's family from CMHW services to state plan services or other community-based services when indicated.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-16; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-17 Habilitation services

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

Sec. 17. (a) Habilitation services are provided with the following goals:
(1) Enhancing the member's level of functioning, quality of life, and use of social skills.
(2) Building the strengths, resilience, and positive outcomes of the member and the member's family.
(b) Habilitation services are provided face-to-face in either the member's home or other community-based setting, based upon the preferences of the member and the member's family.
(c) Habilitation services are provided to assist the member with the following:
(1) Identifying feelings.
(2) Managing anger and emotions.
(3) Giving and receiving feedback, criticism, or praise.
(4) Problem solving and decision making.
(5) Learning to resist negative peer pressure and develop pro-social peer interactions.
(6) Improving communication skills.

(7) Building and promoting positive coping skills.
(8) Learning how to have positive interactions with peers and adults.
(d) Service exclusions are the following:
(1) Services provided to a person other than the member, such as when an activity occurs in a group setting.
(2) Services provided to a family member or members.
(3) Services provided in order to give the family respite.
(4) Services that are strictly vocational or educational in nature, such as tutoring or any other activity available to the member through the local educational agency under the:
(A) Individuals with Disabilities Education Improvement Act of 2004; or
(B) Rehabilitation Act of 1973.
(5) Activities provided in the service provider's residence.
(6) Leisure activities that provide a diversion rather than a therapeutic objective.
(e) The provision of habilitation services is limited to the following:
(1) Up to three (3) hours of services daily.
(2) Up to thirty (30) hours of services per month.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-17; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-18 Respite care services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 18. (a) Respite care services are:
(1) provided to a member unable to care for himself or herself; and
(2) furnished on a short-term basis because of the absence, or need for relief, of a person or persons who normally provide care for the member.
(b) Respite care services may be provided in the following manner for planned or routine time frames when a caregiver is aware of needing relief or assistance through respite care:
(1) On an hourly basis, but billed for less than seven (7) hours in the same day.
(2) On a daily basis and billed for a service provided from seven (7) to twenty-four (24) hours in the same day.
(3) As a daily service not to exceed a period of fourteen (14) consecutive days at one (1) time.
(c) Crisis respite care services may be provided on an unplanned basis when the caregiver requires assistance in caring for a member as follows:
(1) In a crisis situation in which a child's health and welfare would be seriously impacted or harmed in the absence of crisis respite care.
(2) On a daily basis, and billed from eight (8) to twenty-four (24) hours in the same day.
(3) Not to exceed fourteen (14) consecutive days at one (1) time.
(d) Respite care services must be provided in the least restrictive environment available to ensure the health and welfare of the member.
(e) Respite care service may be provided in the following locations:
(1) The member's home or private place of residence in the community.
(2) Any office-certified state licensed facility.
(f) A member who needs consistent twenty-four (24) hour supervision, with regular monitoring of medications or behavioral symptoms, must be placed in a facility under the supervision of any of the following:
(1) A psychologist.
(2) A psychiatrist, physician, or nurse who meets licensing or certification requirements of his or her profession in the state of Indiana.
(g) Allowed respite care service activities include the following:
(1) Assistance with daily living skills, including assistance with accessing community activities and transporting the member

to or from community activities.
(2) Assistance with grooming and personal hygiene.
(3) Meal preparation, serving, and cleanup.
(4) The administration of medications.
(5) Supervision.
(h) Respite care service exclusions are the following:
(1) Respite care provided by the following:
(A) A parent or parents for a member who is a minor child.
(B) Any relative who is the primary caregiver of a member.
(C) Any individual living in a member's residence.
(2) Respite care services provided as a substitute for regular child care to allow the parent to attend school or to engage in employment or employment search-related activities.
(3) Respite care provided in the residence of a CMHW respite care service provider, unless the service is provided by an office-authorized relative of the member.
(4) Respite care used to provide services to the member while the member is attending school.
(5) Crisis respite care service scheduled to relieve the family when a member is in crisis.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-18; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-19 Training and support for unpaid caregiver services
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 19. (a) Training and support for unpaid caregivers is a service for an individual who is providing unpaid support, training, companionship, or supervision for a member.
(b) The intent of this service is to provide education and supports to assist the caregiver in preserving the member's family unit.
(c) Training and support activities must be:
(1) based on the unique needs of the family and caregiver; and
(2) identified in the plan of care.
(d) The providers of training and support activities must be identified in the plan of care.
(e) Allowed training and support activities for a caregiver may include, but are not limited to, the following:
(1) Practical living and decision making skills.
(2) Child development and parenting skills.
(3) Home management skills.
(4) Use of community resources and development of informal supports.
(5) Conflict resolution skills.
(6) Coping skills.
(7) Assistance in increasing understanding of a member's mental health needs.
(8) Teaching communication and crisis deescalation skills geared for working with member's mental health and behavioral needs.
(f) Nonhourly training and support service must be provided according to the following requirements:
(1) The service provides reimbursement to cover the costs for a training event or training resources, such as registration or conference fees, books, or supplies associated with the identified training and support need.
(2) A training support need must be as follows:
(A) Identified by the team as a member's need.
(B) Documented on the member's plan of care.
(3) An approved event identified by the team must be provided by one (1) of the following types of office-approved resources:
(A) A nonprofit, civic, faith-based, professional, commercial, or government agency or organization.

(B) A community college, vocational school, or university.
(C) A lecture series, workshop, conference, or seminar.
(D) An online training program.
(E) A community mental health center.
(F) Other qualified community service agency.
(4) The maximum annual limitation for a nonhourly service is five hundred dollars ($500).
(g) The hourly training and support service is provided in the following manner:
(1) The service is provided for the caregiver identified on the plan of care.
(2) The service is provided face-to-face in the home or a community-based setting.
(3) An hourly service is limited to a maximum of two (2) hours per day.
(4) There is no annual limit for the hourly service subject, however, to the limitation in subdivision (3).
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-19; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.7-20 Fair hearings and appeals
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 20. (a) CMHW services applicants, members, and their families shall have an opportunity to request a fair hearing to appeal a decision of the office regarding CMHW services eligibility or a request for services as described in this section.
(b) Information concerning a member's right to a fair hearing and appeal and how to request such an appeal's hearing shall be provided to an applicant, member, or the family of an applicant or member at the following times:
(1) Provided to the applicant and the applicant's family by the local access site following the office's determination of the applicant's eligibility for CMHW services.
(2) Provided to the member and family by the wraparound facilitator following the office review of a proposed CMHW services plan of care, or updated plan of care, to document the office authorization or denial of the requested CMHW services.
(3) Provided to the member and family by the wraparound facilitator following the member's reevaluation for CMHW services eligibility.
(c) Notices of adverse action and the opportunity for a fair hearing shall be maintained in the member's record by the local wraparound facilitation agency and by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-20; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.7-21 Complaints and grievances
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-13-7-3; IC 12-29; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 21. (a) An applicant, a member, and the family of an applicant or a member shall have the right to file a complaint or grievance in writing with the state regarding CMHW service providers or CMHW services. All complaints and grievances are accepted by the following means:
(1) Delivery to the family-consumer section on the DMHA website.
(2) Delivery in-person to a DMHA staff member.
(3) Delivery via written complaint or e-mail that is submitted to the DMHA.
(b) The receipt of a complaint or grievance shall be recorded in the office's data system with a copy attached to the provider's file. An investigation shall begin within seventy-two (72) hours of receipt of the complaint or grievance.
(c) When an investigation is complete, the following shall occur:
(1) The individual filing the complaint or grievance shall be informed of the office's investigative findings through a letter from an office staff member.
(2) The individual who filed a grievance or complaint must be informed that filing a grievance or complaint is neither a

prerequisite nor a substitute for a fair hearing.

(d) If indicated by the results of an investigation, a letter of findings shall be sent to the CMHW service provider who is the subject of the complaint or grievance. The CMHW service provider shall correct any identified deficiency within the timeline established by the office.

(e) If the CMHW service provider fails to correct the deficiency within the established timeline, the office may pursue sanctions up to, and including, revoking authorization for the provider to deliver CMHW services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.7-21; filed Dec 18, 2013, 11:13 a.m.: 20140115-IR-405130211FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

Rule 21.8. Behavioral and Primary Health Care Coordination Services

405 IAC 5-21.8-1 General provisions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 1. The intent of this rule is to provide BPHC services to individuals with serious mental illness who demonstrate impairment in self-management of health services. Eligibility for services and the provision of services are based upon an individual meeting specific BPHC needs-based and targeting criteria. BPHC services will be:

(1) provided through a state plan; and

(2) delivered by service provider agencies meeting specific state-defined criteria.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-1; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA)

405 IAC 5-21.8-2 Definitions

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Applicant" refers to an individual who is seeking enrollment in BPHC services.

(c) "Behavioral and primary health care coordination services" or "BPHC services" refers to coordination of health care services to manage the health care needs of the member including direct assistance in gaining access to health services, coordination of care within and across systems, oversight of the entire case, and linkage to appropriate services.

(d) "Certified community health worker" or "CHW" refers to an individual who meets all of the following:

(1) Has completed the CHW office and Indiana state department of health state-approved training program.

(2) Receives a passing score on the certification exam.

(3) Is supervised by a licensed professional or QBHP.

(4) Delivers services as defined at section 8(a) of this rule.

(e) "Certified recovery specialist" or "CRS" refers to an individual who meets all of the following:

(1) Is maintaining healthy recovery from mental illness.

(2) Has completed the CRS office state-approved training program.

(3) Receives a passing score on the certification exam.

(4) Is supervised by a licensed professional or QBHP.

(5) Delivers services as defined at section 8(a) of this rule.

(f) "DMHA" means the division of mental health and addiction.

(g) "Health" means physical and behavioral health.

(h) "Individualized integrated care plan" or "IICP" means a treatment plan that meets all of the following:

(1) Integrates all components and aspects of care that are:

(A) deemed medically necessary;

(B) needs-based;

(C) clinically indicated; and

(D) provided in the most appropriate setting to achieve the member's goals.

(2) Includes all indicated medical and support services needed by the member in order to:

(A) remain in the community;

(B) function at the highest level of independence possible; and

(C) achieve goals identified in the IICP.

(3) Reflects the member's desires and choices.

(i) "Level of need" means a recommended intensity of services based on a pattern of a member's needs, as determined using the office-approved behavioral health assessment tool.

(j) "Licensed professional" means any of the following persons:

(1) A licensed psychiatrist.

(2) A licensed physician.

(3) A licensed psychologist or a psychologist endorsed as a health service provider in psychology (HSPP).

(4) A licensed clinical social worker (LCSW).

(5) A licensed mental health counselor (LMHC).

(6) A licensed marriage and family therapist (LMFT).

(7) A licensed clinical addiction counselor (LCAC), as defined under IC 25-23.6-10.5.

(k) "Medicaid rehabilitation services" means any medical or remedial service recommended by a physician or other licensed practitioner of the healing arts, within the scope of that individual's practice under state law, for:

(1) maximum reduction of physical or mental health disability; and

(2) restoration to a member's best possible level of functioning.

(l) "Member" means a person receiving BPHC services.

(m) "Needs-based eligibility criteria" means factors used to determine an applicant's need for BPHC services. The applicant meets the BPHC needs-based eligibility criteria when the following are demonstrated:

(1) Needs related to management of the applicant's health.

(2) Impairment in self-management of the applicant's health services.

(3) A health need that requires assistance and support in coordinating health treatment.

(4) A recommendation for intensive community based care based on the uniform office-approved behavioral health assessment tool as indicated by a rating of three (3) or higher.

(n) "Office-approved behavioral health assessment tool" means the state designated assessment tool administered by a qualified individual who is trained and office-certified to administer the tool in order to assist in determining the level of need and functional impairment of an applicant or a member.

(o) "Other behavioral health professional" or "OBHP" means any of the following:

(1) An individual with an associate's or bachelor's degree, or equivalent behavioral health experience who:

(A) meets minimum competency standards set forth by a behavioral health service provider; and

(B) is supervised by either a licensed professional or a QBHP.

(2) A licensed addiction counselor, as defined under IC 25-23.6-10.5, who is supervised by either a licensed professional or a QBHP.

(p) "Provider agency" means any office-approved agency that meets the qualifications and criteria to become a BPHC provider agency, as required by this rule.

(q) "Provider staff" means any individual working for an office-approved BPHC provider agency who meets the qualifications and requirements mandated by the BPHC service being provided, as defined in this rule.

(r) "Qualified behavioral health professional" or "QBHP" means any of the following:

(1) An individual who has had at least two (2) years of clinical experience treating persons with mental illness under the supervision of a licensed professional, with such experience occurring after the completion of a master's degree or a doctoral degree, or both, in any of the following disciplines from an accredited university:

(A) Psychiatric or mental health nursing, including a license as a registered nurse in Indiana.

(B) Pastoral counseling.

(C) Rehabilitation counseling.

(2) An individual who:

(A) is supervised by a licensed professional;

(B) is eligible for and working toward professional licensure; and

(C) has completed a master's degree or a doctoral degree, or both, in any of the following disciplines from an accredited university:

(i) Social work from a university accredited by the Council on Social Work Education.

(ii) Psychology.

(iii) Mental health counseling.

(iv) Marital and family therapy.

(3) A licensed, independent practice school psychologist under the supervision of a licensed professional.

(4) An authorized health care professional (AHCP) who is either of the following:

(A) A physician assistant with the authority to prescribe, dispense, and administer drugs and medical devices or services under an agreement with a supervising physician and subject to the requirements of IC 25-27.5-5.

(B) A nurse practitioner or clinical nurse specialist, with prescriptive authority, performing duties within the scope of that person's license and under the supervision of, or under a supervisory agreement with, a licensed physician under IC 25-23-1.

(s) "State evaluation team" means the office independent evaluation team that will review and assess all evaluation information and supporting clinical documentation collected for BPHC applicants and members and will be responsible for making final determinations regarding the following:

(1) Needs-based and target group eligibility of applicants for BPHC services.

(2) Authorization for BPHC services for eligible members.

(3) Continued eligibility determination for BPHC members.

(4) Appropriate service delivery to BPHC members as a result of conducting quality improvement reviews of BPHC service provider agencies.

(t) "Target group eligibility criteria" means factors used to determine an applicant's eligibility for BPHC services. To meet the BPHC target group criteria, an applicant must:

(1) be nineteen (19) years of age or older; and

(2) have been diagnosed with an eligible primary mental health diagnosis as defined at section 4(3) of this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-2; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-3 Applicants and the application process

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 3. (a) In order for an individual to receive services under this rule, a BPHC eligible provider agency, in collaboration with the applicant, must submit an application in the manner required by the office.

(b) Each applicant for BPHC services must receive a face-to-face evaluation using both the:

(1) office-approved behavioral health assessment tool; and

(2) application form developed by the office.

(c) The application form and supporting documentation should include the following information about the applicant:

(1) Health status.

(2) Current living situation.

(3) Family functioning.

(4) Vocational or employment status.

(5) Social functioning.

(6) Living skills.

(7) Self-care skills.

(8) Capacity for decision making.

(9) Potential for self-injury or harm to others.
(10) Substance use or abuse.
(11) Need for assistance managing a medical condition.
(12) Medication adherence.
(d) An application must, at a minimum, include documentation demonstrating the following:
(1) The applicant is an active member in the planning and development of the IICP.
(2) The applicant is requesting the services listed on the proposed IICP submitted with the application.
(3) The applicant has chosen, from a randomized list of eligible BPHC service providers in the applicant's community, a provider to deliver the office authorized BPHC services under this rule.
(e) Upon receipt of the application and supporting clinical documentation, the state evaluation team will assess the submitted information and determine whether or not the applicant meets the needs-based and target group eligibility criteria for receiving BPHC services.
(f) For those applicants who are not Medicaid enrolled at the time of application for BPHC services, a Medicaid application must be submitted in the manner set forth in 405 IAC 2-1.1 for a Medicaid eligibility determination.
(g) The state evaluation team retains responsibility for the following:
(1) Determining whether an applicant meets the needs-based and target group eligibility criteria for BPHC services.
(2) Approving all proposed BPHC services included in the IICP.
(h) Any approval or denial of eligibility for services under this rule will be communicated to the:
(1) applicant or the applicant's authorized representative; and
(2) referring provider agency.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-3; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-4 Eligibility
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 4. To be eligible for services under this rule, an applicant must meet all of the following:
(1) All of the criteria set forth in 405 IAC 2-1.1-6.
(2) Be nineteen (19) years of age or older.
(3) The applicant has been diagnosed with a BPHC-eligible primary mental health diagnosis including, but not limited to:
(A) schizophrenic disorder;
(B) major depressive disorder;
(C) bipolar disorder;
(D) delusional disorder; or
(E) psychotic disorder.
(4) The applicant either:
(A) resides in a community-based setting that is not an institutional setting; or
(B) will be discharged from an institutional setting back to a community-based setting.
(5) The applicant meets all of the following needs-based eligibility criteria, as defined in section 2(m) of this rule, based on the following:
(A) Behavioral health clinical evaluation.
(B) Referral form.
(C) Supporting documentation.
(D) The office behavioral health assessment tool results.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-4; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-5 IICP authorization period; renewal

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 5. (a) A member approved to receive BPHC services under this rule shall be eligible for such services for up to a six (6) month period commencing from the date of service approval and authorization, as long as eligibility and needs-based eligibility criteria and other eligibility continue to be met.

(b) A reevaluation will be conducted at least every six (6) months and shall include the following:

(1) Conducting a face-to-face holistic clinical and biopsychosocial evaluation completed by an office-approved BPHC service provider.

(2) Administering the office-approved behavioral assessment tool to determine whether the member still meets the level of need for intensive community-based services, as demonstrated by a rating level of three (3) or higher.

(3) Assessing the member's progress toward meeting treatment goals set forth in the IICP.

(4) Documenting that the member continues to meet BPHC target group eligibility and needs-based eligibility criteria.

(5) Completing an updated application.

(6) Completing an updated IICP documenting the member's choice of BPHC service providers.

(c) The state evaluation team will review and assess the application and reevaluation results to determine whether the member continues to meet needs-based and target group eligibility criteria.

(d) Any approval or denial of eligibility and services under this rule will be communicated to the following:

(1) The applicant or the applicant's authorized representative.

(2) The referring provider agency.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-5; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-6 Clinical documentation requirements

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 6. (a) To be reimbursable under this rule, the BPHC service must be supported by clinical documentation that is maintained in the member's clinical record.

(b) The documentation required to support billing for BPHC services must meet the following standards:

(1) Reflect progress toward the goals reflected in the member's IICP.

(2) Be updated with every member encounter when billing is submitted for reimbursement.

(3) Be written and signed by the agency staff rendering services.

(c) The documentation to support billing for BPHC services should:

(1) focus on recovery and habilitation or rehabilitation;

(2) support coordination or management of identified health needs and services; and

(3) emphasize member strengths.

(d) Clinical documentation of services provided under this section must contain the following information:

(1) The type of service being provided.

(2) The names and qualifications of the staff providing the service.

(3) The location or setting where the service was provided.

(4) The focus of the session or service delivered to or on behalf of the member.

(5) The member's symptoms, needs, goals, or issues addressed during the session.

(6) The actual time spent rendering the service.

(7) The start and end time of the service.

(8) The member's IICP goal being addressed during the session.

(9) The progress made toward meeting goals noted on the IICP.

(10) The date of service rendered including month, day, and year.

(e) The content of the documentation must support the amount of time billed.

(f) For BPHC services provided on behalf of the member without the member present, documentation must be provided for each encounter and must include the following information:

(1) The names of all persons attending the session and each person's relationship to the member.

(2) How the service:

(A) benefits the member; and

(B) assists the member in reaching the IICP goals.

(g) A provider shall maintain documentation for services provided to a BPHC services member in accordance with the requirements under 405 IAC 1-5-1. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-6; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.8-7 BPHC services; general provisions

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 7. (a) All BPHC services provided to a member must meet the following requirements:

(1) Be supported by the member's level of need.

(2) Be documented in the member's IICP.

(b) Provider reimbursement for BPHC services is subject to, but not limited to, the following:

(1) The member's eligibility for services.

(2) The provider's qualifications and certification.

(3) The scope, limitations, and exclusions of the services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-7; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-8 BPHC activities

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 8. (a) BPHC reimbursable activities consist of coordination of health care services to manage the health care needs of the member. The BPHC services include the following reimbursable activities:

(1) Logistical support.

(2) Advocacy and education to assist individuals in navigating the health care system.

(3) Activities that help members:

(A) gain access to needed health services; and

(B) manage their health conditions, including, but not limited to:

(i) adhering to health regimens;

(ii) scheduling and keeping medical appointments;

(iii) obtaining and maintaining a primary medical provider; and

(iv) facilitating communication across medical providers.

(4) Needs assessment.

(5) IICP development.

(6) Referral and linkage.

(7) Coordination of health services across systems.

(8) Monitoring and follow-up.

(9) Evaluation.

(b) This subsection defines the activities identified at subsection (a)(4) through (a)(9) as follows:

(1) Needs assessment consists of identifying the member's needs for coordination of health services. Specific assessment activities necessary to form a complete needs assessment of the member may include the following:

(A) Taking the member's history.
(B) Identifying the member's needs.
(C) Completing related documentation.
(D) Gathering information from other sources, such as:
(i) family members; or
(ii) medical providers.

(2) IICP development activities include the development of a written IICP based upon the information collected during the needs assessment phase. An IICP shall include member-driven goals for health care or lifestyle changes and identify the health activities and assistance needed to accomplish the member's objectives. An IICP may include activities and goals such as:
(A) referrals to medical services;
(B) education on health conditions;
(C) activities to ensure compliance with health regimens and health care provider recommendations; or
(D) activities or contacts necessary to ensure that the IICP is effectively implemented and adequately address the health needs of the individual.

(3) Referral and linkage include activities that help link the member with medical providers and other programs and services that are capable of providing needed health services.

(4) Coordination of health services includes, but is not limited to, the following:
(A) Physician consults, defined as facilitating linkage and communication between medical providers.
(B) The BPHC provider serving as a communication conduit between the member and specialty medical and behavioral health providers.
(C) Notification, with the member's consent, of changes in medication regimens and health status.
(D) Coaching members to help them interact more effectively with providers.

(5) Monitoring and follow-up include the following:
(A) Face-to-face contact with the member at least every ninety (90) days.
(B) Contacts and activities necessary to ensure that the IICP is effectively implemented and adequately addresses the needs of the member.
(C) Contacts and activities with the following individuals:
(i) The member.
(ii) Family members or others who have a significant relationship with the member.
(iii) Nonprofessional caregivers.
(iv) Providers.
(v) Other entities.

(6) Evaluation includes periodic reevaluation of the member's progress in order to:
(A) ensure the IICP is effectively implemented and adequately addresses the member's needs;
(B) determine whether the services are consistent with the IICP and any changes to the IICP;
(C) make changes or adjustments to the IICP in order to meet the member's ongoing needs; and
(D) evaluate the member's progress toward achieving the IICP's objectives.

(c) The time devoted to formal supervision between the BPHC provider and the licensed supervisor to review the member's care and treatment shall be:
(1) an included BPHC activity;
(2) documented in the member's clinical record; and
(3) billed under only one (1) provider staff member.

(d) The BPHC activities under subsection (b)(1) through (b)(3) and b(4)(A) must be delivered by provider staff who are one (1) of the following:
(1) A licensed professional.
(2) A QBHP.
(3) An OBHP.

(e) With the exception of those activities described in subsection (d), provider staff delivering services under this section must

be one (1) of the following:

(1) A licensed professional.

(2) A QBHP.

(3) An OBHP.

(4) An office CRS.

(5) An office-certified community health worker.

(f) The following are not reimbursable under this section:

(1) Activities billed under behavioral health level of need redetermination.

(2) Activities billed under Medicaid rehabilitation option case management.

(3) Activities billed under adult mental health habilitation care coordination.

(4) Direct provision of medical services or treatment, including, but not limited to, the following:

(A) Medical screening such as blood pressure screenings or weight checks.

(B) Medication training and support.

(C) Individual, group, or family therapy services.

(D) Crisis intervention services.

(5) Services provided to the member at the same time as another service that is the same in nature and scope, regardless of funding source.

(6) Services provided while the member is in an institutional or noncommunity-based setting.

(7) Services provided in a manner that is not within the scope or limitations of a BPHC service.

(8) Services not documented as covered or approved on the member's office-approved IICP.

(9) Services not supported by documentation in the member's clinical record.

(10) Services provided that exceed the defined limits of the service, including service quantity, limits, duration, or frequency.

(11) Activities excluded from the service scope or definition.

(g) BPHC services are limited to a maximum of twelve (12) hours, or forty-eight (48) units, per six (6) months. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-8; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.8-9 BPHC provider agency requirements

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 9. (a) In order to deliver the BPHC program under this rule, a provider must be a state-certified community mental health center approved by the office as a BPHC provider agency.

(b) Any provider wishing to apply to become a BPHC provider agency must:

(1) submit a completed BPHC provider agency application to the office for review and consideration; and

(2) be enrolled as a provider.

(c) Provider agencies under this rule must attest that the staff members delivering BPHC allowable activities under this service meet the provider requirements and qualifications as defined in section 8(d) and 8(e) of this rule.

(d) Provider agencies approved to provide BPHC services under this rule are subject to the enforcement provisions in 405 IAC 1-1-6. *(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-9; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-21.8-10 Fair hearings and appeals

Authority: IC 12-8-6.5-5; IC 12-15

Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 10. (a) The following individuals may appeal an adverse agency action:

(1) An applicant.

(2) A member who receives services under this rule.

(3) A duly authorized representative of:
(A) an applicant; or
(B) a recipient.
(b) Administrative hearings and appeals by an applicant or recipient are governed by the procedures set forth in 405 IAC 1.1.
(c) The state evaluation team shall notify the following individuals of any such adverse agency action:
(1) The applicant or recipient.
(2) The duly authorized representative of the applicant or the recipient, if applicable.
(3) The BPHC provider agency.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-10; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-21.8-11 Complaints and grievances
Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-7-2-40.6; IC 12-13-7-3; IC 12-15-2-3.5; IC 12-29-2; IC 25-23-1-1; IC 25-23.6-10.5; IC 25-27.5-5

Sec. 11. (a) The following individuals may file a written complaint or a written grievance with the state or the office:
(1) An applicant.
(2) A member.
(3) A duly authorized representative of:
(A) an applicant; or
(B) a member.
(b) Upon receipt of a complaint or grievance, the office shall:
(1) log the complaint or grievance; and
(2) initiate an investigation.
(c) The office's decision with regard to a complaint or grievance is not appealable.
(d) The filing of a complaint or grievance is not a prerequisite to filing an appeal under section 10 of this rule.
(e) If the office issues findings regarding a complaint or a grievance of an applicant or a member, the office may require the provider agency to correct an identified deficiency within a timeline established by the office. A provider agency's failure to correct the deficiency within the established timeline may result in sanctions up to and including decertification of the provider agency.
(Office of the Secretary of Family and Social Services; 405 IAC 5-21.8-11; filed Apr 8, 2014, 12:41 p.m.: 20140507-IR-405130530FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 22. Nursing and Therapy Services

405 IAC 5-22-1 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. 1. The following definitions apply throughout this rule:
(1) "Acute medical condition" means a condition with an onset within the preceding fourteen (14) days, and sequelae of a temporary nature, including, but not limited to, sprains, spasms, infection, or joint inflammation.
(2) "Acute rehabilitation condition" means medical injury or insult, onset occurring within one (1) year, which results in impaired functioning. These conditions may include, but are not limited to, head injury, cerebrovascular accident (CVA), or fracture.
(3) "Applied behavioral analysis therapy services" or "ABA therapy services" means the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior.

(4) "Chronic medical condition or rehabilitation condition" means any injury or insult with onset and sequelae extending past one (1) year.
(5) "Educational in nature" means instruction or training that develops the general abilities of the mind and results in learning new material, as opposed to restoring or establishing a normal condition.
(6) "Habilitative therapy" means therapy addressing chronic medical conditions where further progress can no longer be expected to lessen the deterioration of function over time. Habilitative therapy includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology services, and audiology services provided to members for the purpose of maintaining a level of functionality, but not the improvement of functionality. Although the development of a habilitation plan is considered part of rehabilitation services, the services furnished under a habilitation plan are not skilled therapy.
(7) "Licensed or board certified behavior analyst" means a behavior analyst with credentialing as a:
(A) board certified behavior analyst - doctoral (BCBA-D);
(B) board certified behavior analyst (BCBA); or
(C) board certified assistant behavior analyst (BCaBA).
(8) "Medically necessary therapy" means therapy for the restoration of an impaired level of function caused by an acute change in medical condition.
(9) "Outpatient therapy services" means services provided to a member outside the member's primary place of residence.
(10) "Rehabilitative services" refers to the federal definition of rehabilitative services in 42 CFR 440.130(d) and includes physical therapy, occupational therapy, respiratory therapy, speech-language pathology, and audiology services provided to members.
(11) "Respiratory therapy" or "RT" means the adjunctive treatment, management, and preventive care of patients with acute and chronic cardiac pulmonary problems.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; 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 Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-2 Nursing services; prior authorization requirements

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Medicaid reimbursement is available for services rendered by registered nurses, licensed practical nurses, and home health agencies who are providers, subject to the following:
(1) Prior authorization is required for all nursing services, except services ordered in writing by a physician prior to the recipient's discharge from an inpatient hospital, which may continue for a period not to exceed one hundred twenty (120) units within thirty (30) days of discharge without prior authorization and except as noted in subsection (c). Prior authorization requests may be submitted by an authorized representative of the home health agency. The prior authorization form must contain the information specified in 405 IAC 5-3-5. In addition, the following information must be submitted with the prior authorization request form:
(A) A copy of the written plan of treatment, signed by the attending physician.
(B) An estimate of the costs for the requested services as ordered by the physician and as set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician.
(2) Prior authorization shall include consideration of the following:
(A) Written order of a physician.
(B) Services must be provided according to a plan of treatment developed in coordination with the attending physician.
(C) The attending physician must review the plan of treatment every sixty (60) days and reorder the service if medically necessary.
(D) 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 and effectiveness of nursing services, must be attached to the prior authorization request and available for postpayment audit purposes.

(E) Additional hours of nursing service may be authorized for ventilator dependent patients who have a developed plan of home health care providing it is cost effective and prevents repeated or prolonged stays in an acute care facility.

(b) Reimbursement is not available for care provided by family members or other individuals residing with the recipient.

(c) Medicaid reimbursement is available for IEP nursing services when the services are medically necessary, consistent with the definition set forth in 405 IAC 5-2-13.2, and provided pursuant to a Medicaid enrolled student's IEP. The following apply to IEP nursing services:

(1) The IEP is the prior authorization for IEP nursing services, when provided by a Medicaid participating school corporation.

(2) The school corporation must bill for the appropriate start and stop time or times of IEP nursing services. Documentation of IEP nursing services must include:

(A) The start and stop time or times for each IEP nursing service provided per date of service.

(B) The place of service and a description of the beginning and ending date or dates and time or times if the IEP services provided off-site or during a school field trip.

(3) The Medicaid enrolled student's IEP must:

(A) specifically authorize the Medicaid covered IEP nursing service; and

(B) demonstrate there is a medical need for the IEP nursing service.

(4) The reimbursement rate will be set by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3338; filed Sep 27, 1999, 8:55 a.m.: 23 IR 317; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-3 Certified nurse midwife services

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. Medicaid reimbursement is available for services rendered by a certified nurse midwife. Coverage of certified nurse-midwife services is restricted to services that the nurse midwife is legally authorized to perform, including well-woman gynecological healthcare, family planning, and care to the normal and expanding family throughout pregnancy, labor, delivery, and post-delivery. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-22-4 Certified nurse practitioner services

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. 4. Medicaid reimbursement is available for medically necessary services or preventative health care services provided by a licensed, certified nurse practitioner within the scope of the applicable license and certification. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; 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)*

405 IAC 5-22-5 Audiology, occupational, and physical therapy and speech pathology; reimbursement

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. 5. Audiology, occupational and physical therapy, and speech pathology may be reimbursed directly to an individual provider by Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-22-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; 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)*

405 IAC 5-22-6 Occupational, physical, and respiratory therapy and speech pathology; criteria for prior authorization

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. 6. (a) Prior authorization is required for all therapy services with the following exceptions:

(1) Initial evaluations.

(2) Emergency respiratory therapy.

(3) Any combination of therapy ordered in writing prior to a member's discharge from an inpatient hospital that may continue for a period not to exceed thirty (30) units in thirty (30) calendar days.

(4) The deductible and copay for services covered by Medicare, Part B.

(5) Oxygen equipment and supplies necessary for the delivery of oxygen with the exception of concentrators.

(6) Therapy services provided by a nursing facility or large private or small intermediate care facility for individuals with intellectual disabilities (ICF/IID), which are included in the facility's per diem rate.

(7) Respiratory therapy ordered in writing by a physician to treat an acute medical condition, except as required in section 10 of this rule.

(b) Unless specifically indicated otherwise, the following criteria for prior authorization of therapy services apply to occupational therapy, physical therapy, respiratory therapy, and speech pathology:

(1) Written evidence of physician involvement and personal patient evaluation will be required to document the acute medical needs. Therapy must be ordered by a physician (doctor of medicine or doctor of osteopathy). A current plan of treatment and progress notes, as to the necessity and effectiveness of therapy, must be attached to the prior authorization request and available for audit purposes.

(2) Therapy must be provided by a qualified therapist or qualified assistant under the direct supervision of the therapist as appropriate.

(3) Therapy must be of such a level of complexity and sophistication and the condition of the member must be such that the judgment, knowledge, and skills of a qualified therapist are required.

(4) Medicaid reimbursement is available only for medically necessary therapy.

(5) Therapy rendered for a diversional, recreational, vocational, or avocational purpose, or for the remediation of learning disabilities or for developmental activities that can be conducted by nonmedical personnel, is not covered by Medicaid.

(6) This subdivision applies to services for recipients twenty-one (21) years of age and older. Therapy for rehabilitative services will be covered for a member twenty-one (21) years of age and older for no longer than two (2) years from the initiation of the therapy unless there is a significant change in the member's medical condition requiring longer therapy. Habilitative therapy is not a covered service for members twenty-one (21) years of age and older. Respiratory therapy services are covered for members twenty-one (21) years of age and older but for no longer than two (2) years from the date of initiation of the therapy. Respiratory therapy may be covered for a longer period of time on a case-by-case basis subject to prior authorization.

(7) This subdivision applies to services for members under twenty-one (21) years of age. Therapy for rehabilitative services will be covered for a member under twenty-one (21) years of age when determined to be medically necessary. Habilitative therapy services for members under twenty-one (21) years of age will be covered on a case-by-case basis and are subject to prior authorization. Educational services, including, but not limited to, the remediation of learning disabilities, are not covered by Medicaid.

(8) When a member is enrolled in therapy, ongoing evaluations to assess progress and redefine therapy goals are part of the therapy program. Ongoing evaluations are not separately reimbursed by Medicaid.

(9) One (1) hour of billed therapy service must include a minimum of forty-five (45) minutes of direct patient care with the balance of the hour spent in related patient services.

(10) Reimbursement for therapy services is limited to one (1) hour per day per type of therapy. Additional therapy services must be medically necessary and requires prior authorization.

(11) A request for therapy services, which would duplicate other services provided to a member, will not be prior authorized. Therapy services will not be authorized when such services duplicate nursing services required under 410 IAC 16.2-3.1-17.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3339; filed Sep 27, 1999, 8:55 a.m.: 23 IR 318; 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 Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-7 Audiology services

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. 7. (a) Audiology services are subject to the following restrictions:

(1) The physician must certify in writing the need for audiological assessment or evaluation.

(2) The audiology service must be rendered by a licensed audiologist or a person registered for his or her clinical fellowship year who is supervised by a licensed audiologist. A registered audiology aide can provide services under the direct on-site supervision of a licensed audiologist under 880 IAC 1-1.

(3) When a member is to be fitted with a hearing amplification device, by either the audiologist or a registered hearing aid specialist, a medical clearance and audiometric test form must be completed in accordance with instructions given below and submitted with the request for prior authorization. This form must be complete and must include the proper signatures, where indicated, before the prior authorization request will be reviewed by the department.

(4) Initial audiological assessments are limited to one (1) assessment every three (3) years per member. If more frequent audiological assessments are necessary, prior authorization is required.

(b) Provision of audiology services are subject to the following criteria:

(1) All requests for prior authorization will be reviewed on a case-by-case basis by the contractor.

(2) Member history must be completed by any involved professional.

(3) The referring physician must complete Part 2 of the Medical Clearance and Audiometric Test Form no earlier than six (6) months prior to the provision of the hearing aid. Children fourteen (14) years of age and under must be examined by an otolaryngologist; older members may be examined by a licensed physician if an otolaryngologist is not available.

(4) All testing must be conducted in a sound-free enclosure. If a member is institutionalized and his or her physical or medical condition precludes testing in a sound-free enclosure, the ordering physician must verify medical confinement in the initial order for audiological testing. The audiological assessment must be conducted by a licensed audiologist, clinical fellowship year audiologist, or otolaryngologist. Testing conducted by other professionals and cosigned by an audiologist or otolaryngologist will not be reimbursed by Medicaid. If the audiological evaluation reveals one (1) or more of the following conditions, the member must be referred to an otolaryngologist for further evaluation:

(A) Speech discrimination testing indicates a score of less than sixty percent (60%) in either ear.

(B) Pure tone testing indicates an air bone gap of fifteen (15) decibels or more for two (2) adjacent frequencies in the same ear.

(5) The hearing aid evaluation may be completed by the audiologist or registered hearing aid specialist. The results must be documented on the prior authorization request and indicate that significant benefit can be derived from amplification before prior authorization may be granted.

(6) The hearing aid contract portion of the audiometric test form must be signed by a registered hearing aid specialist.

(7) Audiological assessments rendered more frequently than every three (3) years will be assessed on a case-by-case basis, based upon documented otological disease.

(c) Audiologic procedures cannot be fragmented and billed separately. Hearing tests, such as whispered voice and tuning fork, are considered part of the general otorhinolaryngologic services and cannot be reported separately as follows:

(1) Basic comprehensive audiometry include pure tone, air and bone threshold and discrimination. The above descriptions refer to testing of both ears.

(2) All other audiometric testing procedures will be reimbursed on an individual basis, only for such medically necessary test procedures.
(d) The following audiological services do not require prior authorization:
(1) A screening test indicating the need for additional medical examination. Screenings are not reimbursed separately by Medicaid.
(2) The initial assessment of hearing.
(3) Determination of suitability of amplification and the recommendation regarding a hearing aid.
(4) The determination of functional benefit to be gained by the use of a hearing aid.
(5) Audiology services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3340; 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)

405 IAC 5-22-8 Physical therapy services

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. 8. Physical therapy services are subject to the following restrictions:
(1) The physical therapy service must be performed by a licensed physical therapist or certified physical therapist's assistant under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(g) for reimbursement. Only the activities in this subdivision related to the therapy can be performed by someone other than a licensed therapist or certified physical therapist's assistant who must be under the direct supervision of a licensed physical therapist. Payment for the following services is included in the Medicaid allowance for the modality provided by the licensed therapist and may not be billed separately to Medicaid:
(A) Assisting patients in preparation for and, as necessary, during and at the conclusion of treatment.
(B) Assembling and disassembling equipment.
(C) Assisting the physical therapist in the performance of appropriate activities related to the treatment of the individual patient.
(D) Following established procedures pertaining to the care of equipment and supplies.
(E) Preparing, maintaining, and cleaning treatment areas and maintaining supportive areas.
(F) Transporting:
(i) patients;
(ii) records;
(iii) equipment; and
(iv) supplies;
in accordance with established policies and procedures.
(G) Performing established clerical procedures.
(2) Certified physical therapists' assistants may provide services only under the direct supervision of a licensed physical therapist or physician as defined in 844 IAC 6-1-2(g).
(3) Evaluations and reevaluations are limited to three (3) hours of service per member evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include physical therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.
(4) Physical therapy services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3341; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1902; 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 Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-9 Speech pathology services

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. 9. Speech pathology services are subject to the following restrictions:

(1) The speech pathology service must be rendered by a licensed speech-language pathologist or a person registered for a clinical fellowship year who is supervised by a licensed speech-language pathologist. A registered speech-language pathology aide may provide services subject to 880 IAC 1-2.1.

(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include speech pathology orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the patient's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

(3) Group therapy is covered in conjunction with, not in addition to, regular individual treatment. Medicaid will not pay for group therapy as the only or primary means of treatment.

(4) Speech therapy services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; 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)

405 IAC 5-22-10 Respiratory therapy services

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. 10. Respiratory therapy services are subject to the following restrictions:

(1) Respiratory therapy services will be reimbursed only when performed by a licensed respiratory therapist or a certified respiratory therapy technician who is an employee or contractor of a hospital, medical agency, or clinic.

(2) The equipment necessary for rendering respiratory therapy will be considered part of the provider's capital equipment.

(3) Oxygen provided in a nursing facility does not require prior authorization if oxygen is ordered in writing by a physician.

(4) Respiratory therapy given on an emergency basis does not require prior authorization.

(5) Respiratory therapy services ordered in writing for the acute medical diagnosis of asthma, pneumonia, bronchitis, and upper respiratory infection may be provided without prior authorization for a period not to exceed fourteen (14) hours on fourteen (14) calendar days. If additional services are required after that date, prior authorization must be obtained.

(6) Respiratory therapy services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; 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 Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-11 Occupational therapy services

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. 11. Occupational therapy services are subject to the following restrictions:

(1) Occupational therapy services must be performed by a licensed occupational therapist or by a licensed occupational therapy assistant under the supervision of a licensed occupational therapist. An evaluation must be performed by a licensed occupational therapist in order for reimbursement to be made.

(2) Evaluations and reevaluations are limited to three (3) hours of service per evaluation. The initial evaluation does not require prior authorization. Any additional reevaluations require prior authorization unless they are conducted during the initial thirty (30) days after hospital discharge and the discharge orders include occupational therapy orders. Reevaluations will not be authorized more than one (1) time yearly unless documentation indicating significant change in the member's condition is submitted. It is the responsibility of the provider to determine if evaluation services have been previously provided.

(3) General strengthening exercise programs for recuperative purposes are not covered by Medicaid.

(4) Passive range of motion services are not covered by Medicaid as the only or primary modality of therapy.

(5) Medicaid reimbursement is not available for occupational therapy psychiatric services.

(6) Occupational therapy services provided by a nursing facility or large private or small ICF/IID, which are included in the facility's established per diem rate, do not require prior authorization.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3342; 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 Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-22-12 Applied behavioral analysis therapy services

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. 12. (a) ABA therapy services shall be available to an individual who:

(1) is eligible for Medicaid services;

(2) has been diagnosed as having autism spectrum disorder by a qualified provider; and

(3) has a completed diagnostic evaluation. A qualified provider, when completing such evaluation, shall:

(A) utilize a standardized assessment tool approved by the office; and

(B) include a recommended treatment referral for ABA therapy services, including projected length of treatment.

(b) Services shall be available from the time of initial diagnosis through twenty (20) years of age.

(c) The following providers may provide ABA therapy services:

(1) A health services provider in psychology (HSPP).

(2) A licensed or board certified behavior analyst.

(3) A credentialed registered behavior technician (RBT).

(d) Services shall be reimbursed subject to the following restrictions:

(1) Services performed by a bachelor-level board certified behavior analyst (BCaBA) or a credentialed RBT shall be supervised by a master's (BCBA) or doctoral level board certified behavior analyst (BCBA-D), or an HSPP.

(2) Services provided by a credentialed RBT shall be reimbursed at seventy-five percent (75%) of the rate on file.

(e) A provider described in subsection (c) shall develop a treatment plan for each recipient eligible for services under this section. The treatment plan shall be based on criteria such as the individual's:

(1) needs;

(2) age;

(3) school attendance; and

(4) other daily activities as documented in the treatment plan not otherwise excluded from coverage under subsection (i).

(f) All covered ABA therapy services shall be subject to prior authorization. A provider shall abide by the prior authorization requirements under 405 IAC 5-3, with the exception that a BCBA may also submit a prior authorization request to the office for review and approval. Each prior authorization request shall include, at a minimum, the following:

(1) The individual's treatment plan and supporting documentation.

(2) The number of therapy hours requested and supporting documentation.

(3) Other documentation as requested by the office.

(g) Prior approval for the initial course of treatment may be approved for up to six (6) months. In order to continue providing ABA therapy services, a provider shall submit a new prior authorization request and receive approval. The prior authorization request shall include an updated treatment plan along with the documentation specified in subsection (f)(2) and (f)(3).

(h) ABA therapy services shall only be available to a recipient for a period of three (3) years and shall not exceed a period of forty (40) hours per week. Additional ABA therapy services must be medically necessary and requires prior authorization. The office shall not approve any prior authorization request that provides ABA therapy services for a period longer than six (6) months.

(i) As follows, coverage under this section shall not be available for services that:

(1) Focus solely on recreational outcomes.

(2) Focus solely on educational outcomes.

(3) Are duplicative, such as services rendered under an individualized educational plan.

(4) Are provided by a registered behavior technician in the home or school setting.

(Office of the Secretary of Family and Social Services; 405 IAC 5-22-12; filed Jan 7, 2016, 8:00 a.m.: 20160203-IR-405140337FRA; errata filed May 4, 2016, 12:47 p.m.: 20160518-IR-405160170ACA)

Rule 23. Vision Care Services

405 IAC 5-23-1 Reimbursement limitations

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; IC 25-24-1-4

Sec. 1. Medicaid reimbursement is available for vision care services as defined in IC 25-24-1-4 rendered by a licensed provider within the scope of his or her license subject to the limitations set out in this rule. Optical supplies are covered when prescribed by an ophthalmologist or optometrist when dispensed within the limitations listed in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; 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)*

405 IAC 5-23-2 Initial examinations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-24-1-4

Sec. 2. (a) Reimbursement for the initial vision care examination will be limited to:

(1) one (1) examination per year for a member under twenty-one (21) years of age; and

(2) one (1) examination every two (2) years for a member twenty-one (21) years of age or older.

If more frequent examination or care is medically necessary, documentation supporting such medically necessary determinations must be maintained in the provider's office. The documentation shall be subject to postpayment review and audit.

(b) An initial examination is the initial vision care service performed for the determination of the need for additional vision care services. The type of initial exam given must be medically necessary. The frequency of vision care services is subject to the limitations listed in subsection (a). The initial examination may include the following:

(1) An eye examination, including history.

(2) Visual acuity determination.

(3) External eye examination.

(4) Biocular measure.

(5) Routine ophthalmoscopy.

(6) Tonometry and gross visual field testing, including:

(A) color vision;

(B) depth perception; or

(C) stereopsis.

(Office of the Secretary of Family and Social Services; 405 IAC 5-23-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:00 p.m.: 20110608-IR-405100794FRA; 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)

405 IAC 5-23-3 Covered vision care services

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; IC 25-24-1-4

Sec. 3. The following services, if medically necessary, may be provided in addition to the initial examination:

(1) Supplemental evaluation.
(2) Multiple pattern fields, including Roberts, Harrington, or Flods.
(3) Central field study.
(4) Peripheral field study.
(5) Tangent screen study.
(6) Color field study.
(7) Binocular ophthalmoscope.
(8) Other supplemental testing.
(9) Visual skills study.
(10) Clinical photography.
(11) Bifocal determination.
(12) Trifocal determination.
(13) Definitive fundus evaluation.
(14) Electrophysiology.
(15) Gonioscopy.
(16) Out-of-office visits.
(17) Neutralization of lens or lenses.
(18) Neutralization of contact lenses.
(19) Extended ophthalmoscopy.
(20) Serial tonometry.
(21) Refractions.
(22) Office visit.
(23) Consultation.
(24) Visual skills testing.

Screening services (excluding EPSDT) for members are not covered by Medicaid, and payment will not be made for such care. All services provided to recipients in long term care facilities must be documented in the recipient medical record that is maintained by the facility. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; filed Sep 27, 1999, 8:55 a.m.: 23 IR 318; 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)*

405 IAC 5-23-4 Frames and lenses; limitations

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 25-24-1-4

Sec. 4. The provision of frames and lenses are subject to the following limitations:

(1) Reimbursement will be made for frames, including, but not limited to, plastic or metal. The maximum amount reimbursed for frames is twenty dollars ($20) per pair except when a more expensive frame is medically necessary. Situations

where a more expensive frame may be indicated as medically necessary include, but are not limited to, the following:

(A) Frames to accommodate facial asymmetry or other anomalies of the:

(i) head;

(ii) neck;

(iii) face; or

(iv) nose.

(B) Allergy to standard frame materials.

(C) Specific lens prescription requirements.

(D) Frames with special modifications such as a ptosis crutch.

(E) Provision of frames to an infant where special size frames must be prescribed that are unavailable for twenty dollars ($20) or less.

All Medicaid claim forms submitted for a more expensive frame must be accompanied by documentation supporting a determination that said frames are medically necessary.

(2) Fashion tints, gradient tints, sunglasses, or photochromatic lenses are not covered. Tint numbers 1 and 2 are covered, for example, the following:

(A) Rose A.

(B) Pink 1.

(C) Soft lite.

(D) Cruxite.

(E) Velvet lite.

(3) Except when documented as medically necessary, lenses larger than size 61 millimeters are not covered.

(4) All Medicaid claim forms submitted for vision materials must be accompanied by a valid copy of the laboratory invoices.

(5) Reimbursement for eyeglasses provided to a member under twenty-one (21) years of age will be limited to a maximum of one (1) pair per year only if the criteria set out in subdivision (7) have been met. The office will provide reimbursement for repairs or replacements of eyeglasses only after receiving documentation that the repair or replacement is necessary due to extenuating circumstances beyond the member's control, for example, fire, theft, or automobile accident. The documentation of the extenuating circumstances:

(A) must be maintained in the provider's office; and

(B) shall be subject to postpayment review and audit.

(6) Reimbursement for eyeglasses provided to a member twenty-one (21) years of age or over is limited to a maximum of one (1) pair every five (5) years if the criteria set out in subdivision (7) have been met. Replacements will only be covered under subdivision (5).

(7) The office shall not provide reimbursement for an initial or subsequent pair of glasses unless the minimum prescription or change meets the following criteria:

(A) For one (1) eye, a minimum initial prescription or, for a subsequent pair of glasses, a change of seventy-five hundredths (.75) diopters for a patient six (6) to forty-two (42) years of age and fifty-hundredths (.50) diopters prescription or change for a patient over forty-two (42) years of age.

(B) An axis change of at least fifteen (15) degrees.

When provided in accordance with subdivisions (5) and (6), glasses that meet the criteria of this subdivision may be provided without prior authorization.

(8) Safety lenses are covered only for corneal lacerations or other severe intractable ocular or ocular adnexal disease.

(Office of the Secretary of Family and Social Services; 405 IAC 5-23-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3343; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 4:00 p.m.: 20110608-IR-405100794FRA; 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)

405 IAC 5-23-5 Contact lenses

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; IC 25-24-1-4

Sec. 5. Contact lenses are covered only when documented as medically necessary and are not covered for cosmetic purposes. Medically necessary documentation must be maintained in the provider's office and shall be subject to postpayment review and audit. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-23-6 Prior authorization

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; IC 25-24-1-4

Sec. 6. Prior authorization is not required for vision care services. *(Office of the Secretary of Family and Social Services; 405 IAC 5-23-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344; 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)*

Rule 24. Pharmacy Services

405 IAC 5-24-1 Reimbursement policy

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

Sec. 1. (a) This section represents the Medicaid medical policy and covered service limitations with respect to pharmacy services provided by a pharmacy provider. Medicaid reimbursement is available for pharmacy services rendered by pharmacy providers, when such services are:

(1) provided in accordance with all applicable laws, rules of the office, and Medicaid provider manual; and

(2) not specifically excluded from coverage by rules of the office.

(b) Reimbursement is not available for any costs associated with unit of use packaging or unit dose packaging when the pharmacy provider repackages medications or any drug. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344; 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)*

405 IAC 5-24-2 "Pharmacy services" and "usual and customary charge" defined

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

Sec. 2. (a) As used in this rule, "pharmacy services" means legend drugs, nonlegend drugs included on the Medicaid nonlegend drug formulary developed in coordination with the Indiana Medicaid Drug Utilization Review (DUR) board, insulin, nutritional supplements, food supplements, and infant formulas. Pharmacy services do not include the following:

(1) Nonlegend drugs (except insulin) not included on the Medicaid nonlegend drug formulary.

(2) Any other products offered for sale or rent by a pharmacy provider except legend drugs, nonlegend drugs included on the Medicaid nonlegend drug formulary, insulin, and nutritional supplements, food supplements, and infant formulas.

(b) As used in this rule, "usual and customary charge" means the amount a pharmacy provider offers to charge the general public for a pharmacy service as follows:

(1) For dispensed legend drugs, this shall include the provider's dispensing fee, if any.

(2) For dispensed nonlegend drugs, the price of the drug as it is presented for retail sale.

(3) Discounts shall be considered as follows:

(A) If a pharmacy provider offers a discount on the pharmacy service to the general public, the usual and customary charge shall be the amount that results from the application of the discount.

(B) If a pharmacy provider offers multiple discounts on the pharmacy service to the general public, the usual and

customary charge shall be the lowest amount of the multiple discounts.

This subdivision applies regardless of whether the individual takes the steps necessary to receive the discount or even receives the discount.

(4) For purposes of this subsection, the term "general public" means all individuals who are seeking pharmacy services at a given locality except for individuals who:

(A) are enrolled in or a member of an insurance plan that covers pharmacy services; or

(B) receive a discount of pharmacy services through a program with selective criteria that disqualify certain individuals from eligibility in the program.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3344; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA; filed Jan 4, 2017, 1:44 p.m.: 20170201-IR-405160172FRA)

405 IAC 5-24-3 Coverage of legend drugs

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

Sec. 3. (a) A legend drug is covered by Medicaid if the drug is:

(1) approved by the United States Food and Drug Administration;

(2) not designated by the Centers for Medicare and medicaid Services (CMS) as less than effective, or identical, related, or similar to a less than effective drug;

(3) subject to the terms of a rebate agreement between the drug's manufacturer and CMS; and

(4) not specifically excluded from coverage by Medicaid.

(b) The following are not covered by Medicaid:

(1) Anorectics or any agent used to promote weight loss.

(2) Topical minoxidil preparations.

(3) Fertility enhancement drugs.

(4) Drugs when prescribed solely or primarily for cosmetic purposes.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319; 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)

405 IAC 5-24-4 Reimbursement for legend drugs

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

Sec. 4. (a) The office shall reimburse pharmacy providers for covered legend drugs at the lowest of the following:

(1) The estimated acquisition cost (EAC) of the drug as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(2) The state maximum allowable cost (MAC) of the drug as determined by the office as of the date of dispensing, plus any applicable Medicaid dispensing fee.

(3) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(b) For purposes of this section and section 5(c) of this rule, the Medicaid EAC is:

(1) for brand name drugs, eighty-four percent (84%); or

(2) for generic drugs, eighty percent (80%);

of the average wholesale price for each National Drug Code according to the office's drug database file.

(c) The state MAC is equal to the average actual acquisition cost per drug adjusted by a multiplier of at least 1.0. The actual

acquisition cost will be determined using pharmacy invoices and other information that the office determines is necessary. The purpose of the multiplier is to ensure that the applicable state MAC rate is sufficient to allow reasonable access by providers to the drug at or below the established state MAC rate.

(d) The office will review state MAC rates on an ongoing basis and adjust the rates as necessary to:

(1) reflect prevailing market conditions; and

(2) ensure reasonable access by providers to drugs at or below the applicable state MAC rate.

(e) Pharmacy providers are required, as a condition of participation, to make available and submit to the office acquisition cost information, product availability information, or other information deemed necessary by the office for the efficient operation of the pharmacy benefit in the format requested by the office. Providers will:

(1) not be reimbursed for this information; and

(2) submit information to the office within thirty (30) days following a request for such information unless the office grants an extension upon written request of the pharmacy or provider.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; errata filed Aug 22, 2002, 3:11 p.m.: 26 IR 35; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Jan 23, 2008, 1:42 p.m.: 20080220-IR-405070547FRA; 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)

405 IAC 5-24-5 Reimbursement for nonlegend drugs

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. 5. (a) The office shall reimburse pharmacy providers for the cost and dispensation of nonlegend (over-the-counter or "OTC") drugs included on the Medicaid nonlegend drug formulary as provided for in this section.

(b) The office shall reimburse for nonlegend drugs, except insulin, at the lowest of the following rates:

(1) One hundred fifty percent (150%) of the state maximum allowable cost, as set out in the Medicaid Pharmacy Provider Manual and amendments thereto, for the drug in the quantity dispensed, as of the date dispensed.

(2) The provider's submitted charge, representing the provider's usual and customary charge for the drug, as of the date of dispensing.

(c) The office shall reimburse for insulin at the estimated acquisition cost (EAC) of the drug, plus any applicable Medicaid dispensing fee. For purposes of this subsection, EAC is defined in section 4(b) of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1212; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-24-6 Dispensing fee

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 6. (a) For purposes of this rule, through June 30, 2017, the Medicaid dispensing fee maximum is three dollars and ninety cents ($3.90) per legend drug.

(b) A maximum of one (1) dispensing fee per month is allowable per member per drug order for legend drugs provided to members residing in Medicaid certified long-term care facilities.

(c) The practice of split billing of legend drugs, defined as the dispensing of less than the prescribed amount of drug solely for the purpose of collecting more dispensing fees than would otherwise be allowed, is prohibited. In cases in which the

pharmacist's professional judgment dictates that a quantity less than the amount prescribed be dispensed, the pharmacist should contact the prescribing practitioner for authorization to dispense a lesser quantity. The pharmacist must document the result of the contact and the pharmacist's rationale for dispensing less than the amount prescribed on the prescription or in the pharmacist's records. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3345; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 29, 2001, 9:50 a.m.: 25 IR 60 [NOTE: On October 9, 2001, the Marion Superior Court issued an Order in Cause No. 49D05-0109-CP-1480, enjoining the Family and Social Services Administration from implementing LSA Document #01-22(F), published at 25 IR 60.]; filed Apr 30, 2002, 10:59 a.m.: 25 IR 2727; 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 Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-24-7 Copayment for legend and nonlegend drugs

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

Sec. 7. (a) Under IC 12-15-6, a copayment is required for legend and nonlegend drugs and insulin in accordance with the following:

(1) The copayment shall be paid by the member and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the member is liable.

(2) In accordance with 42 CFR 447.15, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under 42 CFR 447.15, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

(b) The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for individuals with intellectual disabilities, or other medical institutions.

(5) Family planning services and supplies furnished to individuals of child bearing age.

(6) Health maintenance organization (HMO) pharmacy services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-24-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Nov 4, 2002, 12:16 p.m.: 26 IR 732; filed Feb 24, 2004, 10:45 a.m.: 27 IR 2252; 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)

405 IAC 5-24-8 Prior authorization; brand name drugs

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

Sec. 8. (a) Prior authorization is required for a brand name drug that:

(1) is subject to generic substitution under Indiana law; and

(2) the prescriber has indicated is "brand medically necessary" either orally or in writing on the prescription or drug order.

(b) In order for prior authorization to be granted for a brand name drug in such instances, the prescriber must:

(1) indicate on the prescription or drug order, in the prescriber's own handwriting, the phrase "brand medically necessary"; and

(2) seek prior authorization by substantiating the brand name drug is medically necessary as opposed to the less costly

generic equivalent.

The prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. The office may exempt specific drugs or classes of drugs from the prior authorization requirement, based on cost or therapeutic considerations. Prior authorization will be determined in accordance with the provisions of 405 IAC 5-3 and 42 U.S.C. 1396r-8(d)(5). *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; filed Sep 27, 1999, 8:55 a.m.: 23 IR 319; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-24-8.5 Prior authorization; other drugs (Voided)

Sec. 8.5. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-8.6 Prior authorization limitations and other; antianxiety, antidepressant, or antipsychotic agents (Voided)

Sec. 8.6. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-9 Food supplements, nutritional supplements, and infant formulas

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

Sec. 9. (a) Food supplements, nutritional supplements, and infant formulas are covered only when no other means of nutrition is feasible or reasonable. Prior authorization for these items is required. Approval is subject to the following criteria:

(1) The feasibility or reasonableness of other means of nutrition, as documented by the requesting practitioner, and as determined by the office's contractor on a case-by-case basis.

(2) Authorization will not be granted when convenience of the member or the member's caretaker is the primary reason for the request for the service.

(3) Coverage is not available in cases of routine or ordinary nutritional needs.

(4) Coverage is not available in cases in which the item is to be used for other than nutritional purposes.

(5) In a long term care facility setting, costs for these products, when utilized either for nutritional supplementation or as the sole source of nutrition for the resident, are included in the facility's established per diem rate. When these products are furnished to a long term care facility resident, they are not separately reimbursable by Medicaid and are not to be billed separately to Medicaid by either the long term care facility or another provider furnishing the products.

(b) Hyperalimentation and total parenteral nutritional products do not require prior authorization. These products may be separately billed to Medicaid for residents of long term care facilities. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3346; 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)*

405 IAC 5-24-10 Medical and nonmedical supply items for long term care facility residents

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

Sec. 10. The cost of both medical and nonmedical supply items is included in the per diem rate for long term care facilities. Under no circumstances shall medical or nonmedical supplies and equipment be billed through a pharmacy or other provider. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; 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)*

405 IAC 5-24-11 Limitations on quantities dispensed and frequency of refills (Voided)

Sec. 11. *(Voided by P.L.101-2005, SECTION 9, effective July 1, 2005.)*

405 IAC 5-24-12 Risk-based managed care

Authority: IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15-13-6; IC 12-15-35-46; IC 12-15-35-47

Sec. 12. The use of prior authorization programs or formularies in risk-based managed care shall be subject to IC 12-15-35-46 and IC 12-15-35-47 and are not governed by this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-12; filed Jan 7, 2002, 10:11 a.m.: 25 IR 1614; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-24-13 Legend and nonlegend solutions for nursing facility residents

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

Sec. 13. The cost of legend and nonlegend water products used for irrigation or humidification are included in the per diem rate for nursing facilities. When water products used for irrigation or humidification are furnished to a nursing facility resident, they are not separately reimbursable by Medicaid and are not to be billed separately to Medicaid by either the nursing facility or another provider furnishing the products, as set forth in 405 IAC 5-31-4(7). Water agents used (or to be used) as a vehicle to deliver a drug therapy into the body must be reimbursed through the pharmacy benefit and not included in the nursing facility per diem reimbursement. *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-13; filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; 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 Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-24-14 Skin protectants, sealants, moisturizers, and ointments for nursing facility residents

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

Sec. 14. (a) The cost of skin protectants, sealants, moisturizers, and ointments for nursing facility residents are to be reimbursed as follows:

(1) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis, by the member, nursing facility care staff, or by prescriber's order, as a part of routine care, as defined in 405 IAC 1-14.6-2(ff), must be included in the per diem reimbursement and must not be reimbursed through the pharmacy benefit.

(2) If all of the following conditions are met, skin protectants, sealants, moisturizers, and ointments must be reimbursed through the pharmacy benefit:

(A) Legend or nonlegend (listed on the OTC drug formulary only).

(B) Prescribed for regular application or applications, or both, as a single agent or compounded with other drug agents.

(C) Used to treat or ameliorate a defect or physical or mental illness or condition.

(b) Non-drug skin protectants, sealants, moisturizers, and ointments must be reimbursed through the pharmacy benefit only when they are compounded with other drug agents, otherwise they are to be included in the per diem reimbursement, as set forth in 405 IAC 5-31-4(8). *(Office of the Secretary of Family and Social Services; 405 IAC 5-24-14; filed Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

Rule 25. Physician Services

405 IAC 5-25-1 Applicability

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. 1. Medicaid reimbursement is available for medically necessary services provided by a doctor of medicine or doctor of osteopathy for diagnostic, preventive, therapeutic, rehabilitative, or palliative services provided within the scope of the practice of medicine, as defined by Indiana law, when provided to members, except as provided in this rule. Medical services provided directly to a member by a doctor of medicine or doctor of osteopathy do not require prior authorization, except as specified in this article. *(Office of the Secretary of Family and Social Services; 405 IAC 5-25-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; 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)*

405 IAC 5-25-2 Reimbursement exclusions and limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 2. (a) Medicaid will not reimburse a physician for the following:
(1) Preparation of reports.
(2) Missed appointments.
(3) Writing or telephoning prescriptions to pharmacies.
(4) Telephone calls to laboratories.
(5) Any extra charge for after-hours services.
(6) Mileage.
(b) Medicaid reimbursement is available for a physician as an assistant surgeon with the following restrictions:
(1) If extenuating circumstances require an assistant surgeon when customarily one is not required:
(A) these circumstances must be well documented in the hospital record; and
(B) documentation must be attached to the claim form.
(2) Reimbursement is not available for a surgical assistant who assists in diagnostic surgical procedures or for minor surgical procedures.
(3) Reimbursement is limited to the procedures that generally require the skills and services of an assistant surgeon as set out in HCPCS.
(c) A physician visiting more than one (1) member in the same long-term care facility on the same day will be reimbursed for each patient seen in an amount equal to the physician's routine office service allowance.
(d) Office visits will be reimbursed up to thirty (30) per calendar year, per member, per provider. Prior authorization will be given for more frequent visits if medically necessary.
(e) Any physician services subject to prior authorization rendered during an office visit that were not prior authorized will not be reimbursed.
(f) Reimbursement for any physician service rendered during an office visit that is subsequently found not be medically necessary is subject to recoupment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-25-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 5, 2010, 2:10 p.m.: 20101201-IR-405090928FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-25-3 Physician's written order, plan of treatment; when required

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. 3. (a) All Medicaid covered services other than transportation and those services provided by chiropractors, dentists,

optometrists, podiatrists, and psychologists certified for private practice require a physician's written order or prescription.

(b) A plan of treatment developed by a physician, which must be renewed every sixty (60) days, is required in addition to a written order for the following services:

(1) Home health services.

(2) All therapy services, including:

(A) physical;

(B) speech pathology;

(C) audiology; and

(D) occupational, respiratory, and psychiatric or psychological.

(Office of the Secretary of Family and Social Services; 405 IAC 5-25-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3347; 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)

405 IAC 5-25-4 Injections administered by physicians

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. 4. Medicaid reimbursement is not available to a physician for injecting medications that can be self-administered unless justified by the patient's condition. Possible noncompliance by a member to oral medication is insufficient justification to administer injections. *(Office of the Secretary of Family and Social Services; 405 IAC 5-25-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; 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)*

405 IAC 5-25-5 Inpatient services; reimbursement limitations

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) Any physician services rendered during inpatient days that require prior authorization and paid under the level of care methodology defined in 405 IAC 1-10.5 that were not prior authorized will not be reimbursed.

(b) Reimbursement for any inpatient physician service rendered during a hospital stay that is subsequently found not to be medically necessary is subject to recoupment. *(Office of the Secretary of Family and Social Services; 405 IAC 5-25-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; 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)*

Rule 26. Podiatric Services

405 IAC 5-26-1 Scope

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. 1. Subject to the limitations set out in this rule, Medicaid reimbursement is available for podiatric services performed within the scope of the practice of the podiatric profession as defined by Indiana law. Services covered shall include diagnosis of foot disorders and mechanical, medical, or surgical treatment of these disorders, subject to the restrictions and limitations set out in this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; 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)*

405 IAC 5-26-2 General restrictions

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. Podiatric services are subject to the following restrictions:

(1) Except as set forth in 405 IAC 5-3-12(1), in an emergency situation, for services requiring prior authorization, the authorization must be obtained within forty-eight (48) hours, not including Saturdays, Sundays, and legal holidays.

(2) Any podiatrist services rendered during inpatient days that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed. Prior authorization is required for hospitals stays as outlined in 405 IAC 5-17.

(3) Any podiatrist services rendered during an outpatient visit that were not appropriately prior authorized or were subsequently found to be not medically necessary will not be reimbursed.

(4) Consultation services rendered by a podiatrist in a nursing facility are not covered when performed on patients on a routine basis for screening purposes, except in those cases where a specific foot ailment is involved.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-26-3 Routine foot care; restrictions

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. 3. (a) Routine foot care includes the following:

(1) Cutting or removal of corns, calluses, or warts (including plantar warts).

(2) Trimming of nails, including mycotic nails.

(3) Treatment of a fungal (mycotic) infection of the toenail is routine foot care only when:

(A) clinical evidence of infection of the toenail is present; and

(B) compelling medical evidence exists documenting that the patient either has a marked limitation of ambulation requiring active treatment of the foot or, in the case of a nonambulatory patient, has a condition that is likely to result in significant medical complications in the absence of such treatment.

(b) A maximum of six (6) routine foot care services per year are covered and only when a patient:

(1) has a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and

(2) the systemic condition has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet.

Prior authorization for routine foot care is not required. However, no more than six (6) visits per year are covered. The patient must have been seen by a medical doctor or doctor of osteopathy for treatment or evaluation of the systemic disease during the six (6) month period prior to the rendering of routine foot care services. Documentation that the treatment or evaluation occurred within six (6) months prior to routine foot care must be included with the claim, as well as documentation of the nature of the systemic condition and the foot condition being treated. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3348; 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)*

405 IAC 5-26-4 Laboratory or x-ray 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. 4. (a) Medicaid will reimburse a podiatrist for laboratory or x-ray services only if the services are rendered by or under the personal supervision of the podiatrist. Services ordered by a podiatrist, but performed by a laboratory or x-ray facility, shall be billed directly to Medicaid by the laboratory or x-ray facility. The podiatrist may be reimbursed for handling or conveyance of a specimen sent to an outside laboratory in accordance with 405 IAC 5-18.

(b) Medicaid reimbursement is not available for comparative foot x-rays, unless prior authorized.
(c) Medicaid reimbursement is available for the following lab and x-ray services billed by a podiatrist:
(1) Cultures for foot infections and mycotic (fungal) nails for diagnostic purposes.
(2) Sensitivity studies for treatment of infection processes.
(3) Medically necessary presurgical testing.
(Office of the Secretary of Family and Social Services; 405 IAC 5-26-4; 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)

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)*

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 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)*

405 IAC 5-26-7 Podiatric office visits
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. (a) Medicaid reimbursement is available for podiatric office visits, subject to the following restrictions:
(1) Reimbursement is limited to one (1) office visit per twelve (12) months, per member.
(2) New patient office visits are limited to one (1) per member, per provider, within the last three (3) years. As used in this subdivision, "new patient" is one who has not received professional services from the provider or another provider of the same specialty who belongs to the same group practice within the past three (3) years.

(3) A visit may be billed separately only on the initial visit. For subsequent visits, a visit may be billed only if a significant additional problem is addressed.

(b) Reimbursement is not available for the following types of extended or comprehensive office visits:

(1) New patient comprehensive.

(2) Established patient detailed.

(3) Established patient comprehensive.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-7; 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)

405 IAC 5-26-8 Doppler evaluations

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. 8. Medicaid reimbursement is available for ultrasonic measurement of blood flow (Doppler) provided that prior authorization has been obtained for the proposed medical procedure and subject to the following limitations:

(1) A preoperative diagnosis of diabetes mellitus peripheral vascular disease or peripheral neuropathy.

(2) The ultrasonic measurement is for preoperative podiatric evaluation.

(3) The ultrasonic measurement cannot be used for routine screening purposes.

(4) The ultrasonic measurement cannot be used as an evaluation of routine foot care procedures, including such services as removal or trimming of corns, calluses, and nails.

(5) The preoperative Doppler evaluation is limited to one (1) per year.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-8; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-26-9 Surgical procedures; reimbursement

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. 9. (a) All surgical procedures on one (1) foot or both feet performed on the same date will be paid at one hundred percent (100%) of the Medicaid allowance for the major procedure and fifty percent (50%) of the Medicaid allowance for subsequent procedures.

(b) If the surgery is performed on both feet, and if the surgery on the second foot is performed at least five (5) days following surgery on the first foot, one hundred percent (100%) allowance is payable for the second surgery.

(c) If the major surgical procedure is performed on one (1) foot, a time period of five (5) days must elapse before subsequent surgery on the same foot would again be paid at one hundred percent (100%) of Medicaid allowable reimbursement. Surgery performed sooner than five (5) days will be paid at fifty percent (50%) of Medicaid allowable reimbursement.

(d) If the major surgical procedure is performed on one (1) toe, a time period of thirty (30) days must elapse before subsequent surgery on the same toe would again be paid at one hundred percent (100%) of Medicaid allowable reimbursement. Surgery performed sooner than thirty (30) days will be reimbursed at fifty percent (50%) of Medicaid allowable reimbursement.

(e) Podiatric surgical procedures, including diagnostic surgical procedures, cannot be fragmented and billed separately. Such procedures generally are included in the major procedure. Such procedures may include, but are not limited to, the following:

(1) Scope procedures used for the surgical procedure approach.

(2) Arthroscopy or arthrotomy procedures in the same area as a major joint procedure unless claim documents a second incision was made.

(3) Local anesthesia administered to perform the surgical or diagnostic procedure.

(Office of the Secretary of Family and Social Services; 405 IAC 5-26-9; 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)

405 IAC 5-26-10 Surgical procedures; confirmatory consultations

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. 10. (a) Providers may be required, based upon the facts of the case, to obtain a confirmatory consultation in accordance with 405 IAC 5-8 substantiating the medically necessary service or approach for the following surgical procedures:

(1) Bunionectomy procedures.

(2) All surgical procedures involving the foot.

(b) The confirmatory consultation is required regardless of the surgical setting in which the surgery is to be performed, including ambulatory surgical treatment center, hospital, clinic, or office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-26-10; 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)*

Rule 27. Radiology Services

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 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 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)

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) Medicaid reimbursement is not available for radiology examinations of any body part taken as a routine study not necessary to 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)

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 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. *(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)*

405 IAC 5-27-4 Nuclear medicine

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. 4. Medicaid reimbursement is available for radionuclide bone scans when performed for the detection and evaluation of suspected or documented bone disease. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-4; 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)*

405 IAC 5-27-5 Upper gastrointestinal studies

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. 5. (a) Medicaid reimbursement is available for upper gastrointestinal (GI) studies when performed for the detection and evaluation of diseases of the esophagus, stomach, and duodenum.

(b) An upper GI study is not a covered service for a patient with a history of duodenal or gastric ulcer disease unless recently symptomatic.

(c) An upper GI study is not a covered service in the preoperative cholecystectomy patient unless symptoms indicate an upper GI abnormality in addition to the cholelithiasism or if the etiology of the abdominal pain is uncertain. *(Office of the Secretary of Family and Social Services; 405 IAC 5-27-5; 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)*

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 sonography performed during pregnancy when warranted by one (1) or more of the following conditions:

(1) Early diagnosis of ectopic or molar pregnancy.
(2) Placental localization associated with abnormal bleeding.
(3) Fetal postmaturity syndrome.
(4) Suspected multiple births.
(5) Suspected congenital anomaly.
(6) Polyhydramnios or oligohydramnios.
(7) Fetal age determination if necessitated by:
    (A) discrepancy in size versus fetal age; or
    (B) lack of fetal growth or suspected fetal death.
(8) Guide for amniocentesis.

(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)*

Rule 28. Medical and Surgical Services

405 IAC 5-28-1 Reimbursement limitations

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. 1. (a) All levels of medical care, prior to surgical procedures, will be reimbursed on an individual basis based on documentation of the member's medical condition. All levels of preoperative and postoperative care will be based on criteria set out in this rule.

(b) If the surgeon is doing the surgery only, and not the routine preoperative and postoperative care, this information must be indicated on the surgeon's claim form.

(c) If the primary care physician is rendering the preoperative or postoperative care only, this information must be indicated on the claim form and the name and address of the operating surgeon.

(d) If the member's condition requires additional medical or surgical care outside the scope of the operating surgeon, then reimbursement for medical components will be considered on an individual basis.

(e) Medical visits made for surgical complications may be reimbursed only if medically indicated and no other physician has billed for the same or related diagnosis. The claim must indicate the specific complications. These medical visits are billed

separately from the surgical fee.

(f) If visits are made for treatment of a condition other than the surgery related diagnosis and no other physician has billed for the same or related diagnosis, then these visits are billed separately from the surgical fee. Associated medical care for denied surgical procedures will also be denied.

(g) When two (2) or more covered surgical procedures are done during the same operative session, multiple surgery reductions shall apply to the procedures based on the following adjustments:

(1) One hundred percent (100%) of the global fee for the most expensive procedure.

(2) Fifty percent (50%) of the global fee for the second most expensive procedure.

(3) Twenty-five percent (25%) of the global fee for the remaining procedures.

(h) Surgical procedures, including diagnostic surgical procedures, may not be fragmented and billed separately. Such procedures are generally included in the major procedure. Such procedures may include, but are not limited to, the following:

(1) Exploratory laparotomy when done with an intra-abdominal procedure.

(2) Scope procedures used for the surgical procedure approach.

(3) Arthroscopy/arthrotomy procedures in the same area as a major joint procedure unless claim documents a second incision was made.

(4) Local anesthesia administered to perform the surgical/diagnostic procedure.

(5) Pelvic exam under anesthesia when performed during the same operative session as vaginal procedure, dilation and curettage (D&C), and laparoscopy procedures.

(i) A surgical procedure generally includes the preoperative visits performed on the same day or the day prior to the surgery for major surgical procedures, and the day of the surgical procedure for minor surgical procedures. Separate reimbursement is available for preoperative care when the member has never been seen by the provider performing the surgery, or the decision to perform surgery was made during the preoperative visit. The postoperative care days for a surgical procedure include ninety (90) days following a major surgical procedure and ten (10) days following a minor surgical procedure. Separate reimbursement is available for care provided during the global postoperative period that is unrelated to the surgical procedure, or for care rendered that is not considered routine postoperative care for the surgical condition, such as complications.

(j) Prior authorization is required for all procedures as listed in 405 IAC 5-17-2. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-1; 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; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-28-2 Medical diagnostic procedures

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. Medical diagnostic services may not be fragmented and billed separately. Such procedures include, but are not limited to, electromyography, electrocardiography, and muscle testing procedures. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3353; 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)*

405 IAC 5-28-3 Cardiac pacemaker

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. 3. (a) Medicaid reimbursement is available for single-chamber cardiac pacemaker implantations. Medicaid reimbursement is subject to the restrictions in this section.

(b) Reimbursement is available for implantation of a single-chamber cardiac pacemaker provided that the conditions are:

(1) chronic or recurrent; and

(2) not due to transient causes, such as acute myocardial infarction, drug toxicity, or electrolyte imbalance.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3353; 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)

405 IAC 5-28-4 Single-chamber cardiac pacemaker implantation

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. 4. (a) Reimbursement for single-chamber pacemaker implantation, in the absence of special medical circumstances documented in the medical record that the procedure is medically beneficial, is not available for the following:

(1) Syncope of undetermined cause.

(2) Sinus bradycardia without significant symptoms.

(3) Sinoatrial block or sinus arrest without significant symptoms.

(4) Prolonged PR intervals (slow ventricular response) with atrial fibrillation without third degree atrial ventricular (AV) block.

(5) Bradycardia during sleep.

(6) Right bundle branch block with left axis deviation and other forms of fascicular or bundle branch blocks without significant signs or symptoms.

(7) Asymptomatic second degree AV block of Mobitz Type I (Wenckebach).

(b) Reimbursement is available when the medical record documents that the member has any of the following:

(1) Acquired complete (also referred to as third degree) AV heart block.

(2) Congenital complete heart block with severe bradycardia in relation to age or significant physiological deficits or significant symptoms due to the bradycardia.

(3) Second degree AV heart block of Type II.

(4) Second degree AV heart block of Type I.

(5) Sinus bradycardia associated with major symptoms or substantial sinus bradycardia with heart rate less than fifty (50) associated with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.

(6) Sinus bradycardia of lesser severity (heart rate fifty (50) to fifty-nine (59)) with dizziness or confusion. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.

(7) Sinus bradycardia, which is the consequence of long term necessary drug treatment for which there is no acceptable alternative, when accompanied by significant symptoms. The correlation between symptoms and bradycardia must be documented, or the symptoms must be clearly attributable to the bradycardia rather than to some other cause.

(8) Sinus node dysfunction, with or without tachyarrhythmias or AV conduction block, when accompanied by significant symptoms.

(9) Sinus node dysfunction, with or without symptoms, when there are potentially life-threatening ventricular arrhythmias or tachycardia secondary to the bradycardia.

(10) Bradycardia associated with supraventricular tachycardia with high degree AV block, which is unresponsive to appropriate pharmacological management and when the bradycardia is associated with significant symptoms.

(11) Hypersensitive carotid sinus syndrome with syncope due to bradycardia and unresponsive to prophylactic medical measures.

(12) Bifascicular or trifascicular block accompanied by syncope, which is attributed to transient complete heart block after other plausible causes of syncope have been reasonably excluded.

(13) Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Mobitz Type II second degree AV block in association with bundle branch block.

(14) Recurrent and refractory ventricular tachycardia, overdrive pacing (pacing above the basal rate) to prevent ventricular tachycardia.

(15) Second degree AV heart block of Type I with the QRS complexes prolonged.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3353; 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)

405 IAC 5-28-5 Dual-chamber cardiac pacemaker implantation

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) Medicaid reimbursement is available for dual-chamber cardiac pacemaker implantations. Medicaid reimbursement is subject to the restrictions set forth in this rule.

(b) Reimbursement is available for implantation of a dual-chamber cardiac pacemaker provided that the conditions are as follows:

(1) Chronic or recurrent.

(2) Not due to transient causes such as acute myocardial infarction, drug toxicity, or electrolyte imbalance.

(c) Reimbursement for a dual-chamber pacemaker implantation is not available when the member has the following:

(1) Ineffective atrial contractions.

(2) Frequent or persistent supraventricular tachycardias, except where the pacemaker is specifically for the control of the tachycardia.

(3) A clinical condition in which pacing takes place only intermittently and briefly and is not associated with a reasonable likelihood that pacing needs will become prolonged.

(4) Prophylactic pacemaker use following recovery from acute myocardial infarction during which there was temporary complete (third degree) or Type II second degree AV block in association with bundle branch block.

(d) Reimbursement is available when the medical record documents that the member has any of the following:

(1) A definite drop in blood pressure, retrograde conduction, or discomfort during insertion of a single-chamber (ventricular) pacemaker.

(2) Pacemaker syndrome (atrial ventricular asynchrony) with significant symptoms with a pacemaker that is being replaced.

(3) A condition in which even a relatively small increase in cardiac efficiency will importantly improve the quality of life.

(4) A condition in which the pacemaker syndrome can be anticipated.

(e) Dual-chamber pacemakers shall also be covered for the conditions, as listed in section 4 of this rule, for single-chamber cardiac pacemakers, if medically necessary. The physician's judgment that such a pacemaker is warranted in the member, meeting requirements of section 4 of this rule, must be based upon the individual needs and characteristics of that member weighing the magnitude and likelihood of anticipated benefits against the magnitude and likelihood of disadvantages of the member. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3354; 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)*

405 IAC 5-28-6 Monitoring of pacemakers

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. (a) Medicaid reimbursement is available for clinic and telephone monitoring of cardiac pacemakers based upon the restrictions in this section.

(b) Frequency of monitoring, unless sufficiently documented by the physician on the Medicaid medical claim form, shall not exceed the following:

(1) For clinic monitoring of lithium battery pacemakers with single-chamber pacemakers, twice in the first six (6) months following implant, then once every twelve (12) months.

(2) For clinic monitoring of lithium battery pacemakers with dual-chamber pacemakers, twice in the first six (6) months following implant, then once every six (6) months.

(3) For telephone monitoring with single-chamber pacemaker following the first month of the implant, once every two (2) weeks.

(4) For telephone monitoring with single-chamber pacemaker following the second month of the implant through the thirty-sixth month, once every eight (8) weeks.
(5) For telephone monitoring with single-chamber pacemaker following the thirty-seventh month of the implant through failure, once every four (4) weeks.
(6) For telephone monitoring with dual-chamber pacemaker following the first month of the implant, once every two (2) weeks.
(7) For telephone monitoring with dual-chamber pacemaker following the second through the sixth month of the implant, once every four (4) weeks.
(8) For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-sixth month of the implant, once every eight (8) weeks.
(9) For telephone monitoring with dual-chamber pacemaker following the seventh through the thirty-seventh month through failure of the implant, once every four (4) weeks.

(c) The claim form must state the date of the pacemaker insertion and the type of pacemaker monitored. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3354; 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)*

405 IAC 5-28-7 Abortion

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. Medicaid reimbursement is available for abortions only if performed to preserve the life of the pregnant woman or in other circumstances if the abortion is required to be covered by Medicaid under federal law. Termination of an ectopic pregnancy is not considered an abortion. All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; 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)*

405 IAC 5-28-8 Sterilization

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. 8. Medicaid reimbursement is available for sterilization with the following restrictions:
(1) Sterilization procedures must comply with the mandates of federal rules.
(2) The member must be twenty-one (21) years of age or older at the time the informed consent form is signed.
(3) The member must be neither mentally incompetent nor institutionalized.
(4) The member must have voluntarily given informed consent on forms prescribed for such purposes by the federal Department of Health and Human Services.
(5) All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement shall be made.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; 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)

405 IAC 5-28-9 Hysterectomy

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. 9. Medicaid reimbursement is available for the performance of hysterectomies with the following restrictions:

(1) Hysterectomy procedures must comply with federal regulations.
(2) A hysterectomy performed solely for the purpose of rendering a woman permanently incapable of reproducing, whether performed as a primary or secondary procedure, is not reimbursable by Medicaid.
(3) The acknowledgement of the hysterectomy information statement must be signed by the member, or member's representative, but is not required where the member is already sterile or where a life-threatening emergency situation exists. Where the hysterectomy is performed on an already sterile member, the physician who performs the hysterectomy must certify in writing that the member was already sterile at the time the hysterectomy was performed and state the cause of the sterility.
(4) Where the hysterectomy is performed under a life-threatening emergency situation, the physician who performed the hysterectomy must certify in writing that the hysterectomy was performed under a life-threatening emergency situation and that prior acknowledgement was not possible. The physician must include a description of the nature of the life-threatening emergency.
(5) The individual must be informed orally and in writing that this procedure will render her permanently incapable of reproducing, and she must sign a written acknowledgement of receipt of this information.
(6) Hysterectomy is subject to prior authorization. Where the hysterectomy is performed under a life-threatening emergency situation, the physician shall notify the office within forty-eight (48) hours of the procedure, not including Saturday, Sunday, and legal holidays, to obtain prior authorization.
(7) All appropriate documentation must be attached to the claim and to claims for directly related services before reimbursement may be made.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; 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)

405 IAC 5-28-10 Chemotherapy

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. 10. (a) Outpatient administration of chemotherapy and costs related to this therapy, including catheterization, physician's visit, cost of drug and solutions, pump regulators, and servicing, will be covered and do not require prior authorization.
(b) Chemotherapy services provided by a home health agency are subject to the prior authorization criteria at 405 IAC 5-16-3.

(Office of the Secretary of Family and Social Services; 405 IAC 5-28-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3355; 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; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

405 IAC 5-28-11 Hyperbaric oxygen therapy

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. 11. (a) Medicaid reimbursement is available for hyperbaric oxygen (HBO) therapy for the following conditions:
(1) Acute carbon monoxide intoxication.
(2) Decompression illness.
(3) Gas embolism.
(4) Gas gangrene.
(5) Acute traumatic peripheral ischemia.
(6) Crush injuries and suturing of severed limbs; as in the previous conditions, HBO therapy would be an adjunctive treatment when loss of function, limb, or life is threatened.
(7) Meleney ulcers; the use of hyperbaric oxygen in any other type of cutaneous ulcer is not covered.
(8) Acute peripheral arterial insufficiency.
(9) Preparation and preservation of compromised skin grafts.

(10) Chronic refractory osteomyelitis, unresponsive to conventional medical and surgical management.
(11) Osteoradionecrosis as an adjunct to conventional treatment.
(12) Soft tissue radionecrosis as an adjunct to conventional treatment.
(13) Cyanide poisoning.
(14) Actinomycosis, only as an adjunct to conventional therapy when the disease process is refractory to antibiotics and surgical treatment.
(15) Acute cerebral edema.
(b) Medicaid reimbursement is not available for therapy by HBO for the following conditions or services:
(1) Topical application of oxygen.
(2) Cutaneous, decubitus, and stasis ulcers.
(3) Chronic peripheral vascular insufficiency.
(4) Anaerobic septicemia and infection other than clostridial.
(5) Skin burns (thermal).
(6) Senility.
(7) Myocardial infarction.
(8) Cardiogenic shock.
(9) Sickle cell crisis.
(10) Acute thermal and chemical pulmonary damage, including smoke inhalation with pulmonary insufficiency.
(11) Acute or chronic cerebral vascular insufficiency.
(12) Hepatic necrosis.
(13) Aerobic septicemia.
(14) Nonvascular causes of chronic brain syndrome, including Pick's disease, Alzheimer's disease, and Korsakoff's disease.
(15) Tetanus.
(16) Systemic aerobic infection.
(17) Organ transplantation.
(18) Organ storage.
(19) Pulmonary emphysema.
(20) Exceptional blood loss anemia.
(21) Multiple sclerosis.
(22) Arthritic diseases.
(c) Hyperbaric oxygen therapy shall be clinically practical and shall not be a replacement for other standard successful therapeutic measures. *(Office of the Secretary of Family and Social Services; 405 IAC 5-28-11; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356; 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)*

Rule 29. Services Not Covered by Medicaid

405 IAC 5-29-1 Noncovered services

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 1. The following services are not covered by Medicaid:
(1) Services that are not medically necessary.
(2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
(3) Experimental drugs, treatments, or procedures, and all related services.
(4) Any new product, service, or technology not specifically covered in this article. The product, service, or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.

(5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
(6) Services for the remediation of learning disabilities.
(7) Treatments or therapies of an educational nature.
(8) Experimental radiological or surgical or other modalities and procedures, including, but not limited to, the following:
(A) Acupuncture.
(B) Biofeedback therapy.
(C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.
(D) Hyperthermia.
(E) Hypnotherapy.
(9) Hair transplants.
(10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas deferens. This procedure is covered only in conjunction with disease.
(11) Augmentation mammoplasties for cosmetic purposes.
(12) Dermabrasion surgery for acne pitting or marsupialization.
(13) Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.
(14) Otoplasty for protruding ears unless one (1) of the following applies to the case:
(A) Multifaceted craniofacial abnormalities due to congenital malformation or maldevelopment, for example, Pierre Robin syndrome.
(B) A member has pending or actual employment where protruding ears would interfere with the wearing of required protective devices.
(15) Scar removals or tattoo removals by excision or abrasion.
(16) Ear lobe reconstruction.
(17) Removal of keloids caused from pierced ears unless one (1) of the following is present:
(A) Keloids are larger than three (3) centimeters.
(B) Obstruction of the ear canal is fifty percent (50%) or more.
(18) Rhytidectomy.
(19) Penile implants.
(20) Perineoplasty for sexual dysfunction.
(21) Reconstructive or plastic surgery unless related to disease or trauma deformity.
(22) Sliding mandibular osteotomies unless related to prognathism or micrognathism.
(23) Blepharoplasties when not related to a significant obstructive vision problem.
(24) Radial keratotomy.
(25) Miscellaneous procedures or modalities, including, but not limited to, the following:
(A) Autopsy.
(B) Cryosurgery for chloasma.
(C) Conray dye injection supervision.
(D) Day care or partial day care or partial hospitalization except when provided pursuant to 405 IAC 5-20.
(E) Formalized and predesigned rehabilitation programs, including, but not limited to, the following:
(i) Pulmonary.
(ii) Cardiovascular.
(iii) Work-hardening or strengthening.
(F) Telephone transmitter used for transtelephonic monitor.
(G) Telephone, or any other means of communication, consultation from one (1) doctor to another.
(H) Artificial insemination.
(I) Cognitive rehabilitation, except for treatment of traumatic brain injury.
(26) Ear piercing.
(27) Cybex evaluation or testing or treatment.
(28) High colonic irrigation.
(29) Services that are not prior authorized under the level-of-care methodology as required by 405 IAC 5-21.5.

(30) Amphetamines when prescribed for weight control or treatment of obesity.
(31) Under federal law, drug efficacy study implementation drugs not covered by Medicaid.
(32) All anorectics, except amphetamines, both legend and nonlegend.
(33) Physician samples.

(Office of the Secretary of Family and Social Services; 405 IAC 5-29-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3356, filed Sep 27, 1999, 8:55 a.m.: 23 IR 320; filed Sep 1, 2000, 2:16 p.m.: 24 IR 15; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 380; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 27, 2010, 9:15 a.m.: 20100623-IR-405100045FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 30. Transportation Services

405 IAC 5-30-1 Reimbursement restrictions

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 1. Medicaid reimbursement is available for emergency and nonemergency transportation, subject to the following restrictions:

(1) Except when additional trips are medically necessary and the same is demonstrated and documented through the prior authorization process, reimbursement is available for a maximum of twenty (20) one-way trips per member, per rolling twelve (12) month period of time. The following services are exempt from the numeric cap and do not require prior authorization, except as specified in subdivision (2):

(A) Emergency ambulance services.
(B) Transportation to or from a hospital for the purpose of an inpatient admission or discharge. This includes interhospital transfers when the member has been discharged from one (1) hospital for the purpose of admission to another hospital.
(C) Transportation for members on renal dialysis or those residing in nursing homes.
(D) Accompanying parent or member attendant, or both.
(E) Return trip from the emergency room in an ambulance, if use of ambulance is medically necessary for the transport.

(2) Prior authorization is required for all trips of fifty (50) miles or more one (1) way.

(3) Service must be for transportation to or from an Indiana Medicaid covered service, or both. The member being transported for treatment must be present in the vehicle in order for Medicaid reimbursement to be available. Providers must comply with all applicable Medicaid documentation requirements, as set forth in provider manuals or bulletins, in effect on the date of service.

(4) Transportation must be unavailable from a non-Medicaid reimbursed source, with the exception of Medicaid payments for family member mileage. This source may include, but is not limited to, the following:

(A) A member owned vehicle.
(B) A volunteer organization.
(C) Willing family or friends.

(5) Transportation must be the least expensive type of transportation available that meets the medical needs of the member.

(6) The office must authorize all in-state train, bus, or family member transportation services. The member or a party acting on the member's behalf must make the request for any required authorization to the office. For purposes of this rule, in-state includes out-of-state designated areas.

(7) When a member needs airline, air ambulance, interstate transportation, or transportation services from a provider located out-of-state in a nondesignated area, the office or the physician must forward the request for authorization by telephone or in writing to the contractor. Telephone requests must be followed up in writing. The request must include a description of the anticipated care and a brief description of the clinical circumstances necessitating the need for transportation by air or to another state, or both. The contractor will review the request. If authorized, the transportation provider will receive the

authorization to arrange the transportation. Copies of the prior authorization decision are sent to the member and the rendering provider.

(8) A provider is not entitled to Medicaid reimbursement in any amount that exceeds what the provider accepts as payment in full (including any coupon, cash discount, or other type of discount) for the same or equivalent services provided to any non-Medicaid customer.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3357; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; 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)

405 IAC 5-30-1.5 Reimbursement rates for transportation services

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-6; IC 12-15-13-6

Sec. 1.5. (a) Reimbursement rates for ambulance transportation services shall be the rates listed in this subsection. Updates to covered procedure codes and rates shall be published as a provider bulletin by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). The reimbursement rates for ambulance transportation services are as follows:

Procedure Code	Rate
A0140	Ticket Price
A0225	$160.84
A0420 U1	$20.00
A0420 U2	$20.00
A0422	$15.00
A0424	$5.00
A0425 U1	$4.41
A0425 U2	$3.31
A0426	$95.84
A0427	$160.84
A0428	$95.84
A0429	$110.84
A0430	$2,788.24
A0431	$3,172.27
A0431 QL	$3,172.27
A0433	$160.84
A0435	$8.07
A0436	$21.53
A0999	Manual Pricing

(b) Reimbursement rates for nonemergency (nonambulance) transportation services shall be the rates listed in this subsection. Updates to covered procedure codes and rates shall be published as a provider bulletin by the office as needed. Any such updates shall be made effective no earlier than permitted under IC 12-15-13-6(a). The reimbursement rates for nonemergency (nonambulance) transportation services are as follows:

Procedure Code	Rate
A0100 UA	$6.00
A0100 UB	$10.00
A0100 UC	$15.00

A0100 U4	$15.00
A0100 TK UA	$3.00
A0100 TK UB	$5.00
A0100 TK UC	$7.50
A0100 TT UA	$3.00
A0100 TT UB	$5.00
A0100 TT UC	$7.50
A0110	Ticket Price
A0130	$20.00
A0130 TK	$10.00
A0130 TT	$10.00
A0130 U6	$5.00
A0425 U3	$1.25
A0425 U5	$1.25
T2001	$5.00
T2003	$10.00
T2004	$5.00
T2007 U3	$4.25
T2007 U5	$4.25

(c) Notwithstanding all other provisions of this rule, the fee schedule rates listed in this section will be reduced by five percent (5%) for emergency transportation services (ambulance services) and by ten percent (10%) for nonemergency transportation services (nonambulance services). These rate reductions will be in effect for the period beginning upon the later of the effective date of LSA Document #10-792 or June 27, 2011, and continuing through June 30, 2013. *(Office of the Secretary of Family and Social Services; 405 IAC 5-30-1.5; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100792FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-30-2 Copayments for transportation services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 2. In accordance with IC 12-15-6, a copayment will be required for transportation services as follows:

(1) The copayment shall be made by the member and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the member is liable.

(2) In accordance with 42 CFR 447.15, effective October 1, 1991, not including tertiary citations therein, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under this federal requirement, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The provider shall collect from the member a copayment amount equal to the following:

(A) Fifty cents ($0.50) for services for which Medicaid pays ten dollars ($10) or less.

(B) One dollar ($1) for services for which Medicaid pays ten dollars and one cent ($10.01) to fifty dollars ($50).

(C) Two dollars ($2) for services for which Medicaid pays fifty dollars and one cent ($50.01) or more.

(D) No copayment will be required for an accompanying adult traveling with a minor member or for an attendant.

(4) The following transportation services are exempt from the copayment requirement:

(A) Emergency ambulance services.

(B) Services furnished to individuals less than eighteen (18) years of age.

(C) Services furnished to pregnant women.

(D) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for

individuals with intellectual disabilities, or other medical institutions.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3358; 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)

405 IAC 5-30-3 Noncovered transportation services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 3. Medicaid reimbursement is not available for the following transportation services:

(1) One-way trips exceeding twenty (20) per member, per rolling twelve (12) month period of time, except when additional trips are medically necessary and the same is demonstrated and documented through the prior authorization process. The services identified in section 1(1) of this rule are exempt from the numeric cap and do not require prior authorization, except as specified in section 1(2) of this rule.

(2) Trips of fifty (50) miles or more one (1) way unless prior authorization is obtained.

(3) The first thirty (30) minutes of waiting time for any type of Medicaid covered conveyance, including ambulance.

(4) Nonemergency transportation provided by any of the following:

(A) A volunteer with no vested or personal interest in the member.

(B) An interested individual or neighbor of the member.

(C) A case worker or social worker.

(5) Ancillary nonemergency transportation charges, including, but not limited to, the following:

(A) Parking fees.

(B) Tolls.

(C) Member meals or lodging.

(D) Escort meals or lodging.

(6) Disposable medical supplies, other than oxygen, when provided by a transportation provider.

(7) Transfer of durable medical equipment, either from the member's residence to place of storage, or from the place of storage to the member's residence.

(8) Charges for use of red lights and siren in emergency ambulance call.

(9) All interhospital transportation services, except when the member has been discharged from one (1) hospital for the purpose of admission to another hospital.

(10) Delivery services for prescribed drugs, including transportation of a member to or from a pharmacy to pick up a prescribed drug.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3358; 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)

405 IAC 5-30-4 Prior authorization

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 4. Prior authorization is required for the following transportation services:

(1) Train or bus services.

(2) Family member services.

(3) Airline or air ambulance and transportation services rendered by a provider located out-of-state in a nondesignated area.

(4) Transportation rendered by any provider to or from an out-of-state nondesignated area.

(5) Trips exceeding twenty (20) one-way trips per member, per rolling twelve (12) month period of time, except as specified in section 1 of this rule.

(6) Trips of fifty (50) miles or more one (1) way.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; 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)

405 IAC 5-30-5 Ambulance services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 5. Medicaid reimbursement is available for medically necessary emergency and nonemergency ambulance services subject to the following:

(1) Medicaid will reimburse both basic and advanced life support emergency ambulance services; however, advanced life support ambulance services are covered only when such level of service is medically necessary, and a basic emergency ambulance is not appropriate due to the medical condition of the member being transported.

(2) Medicaid reimbursement is available for specialized neonatal ambulance services used exclusively for interhospital transfers of high risk and premature infants only when the member has been discharged from one (1) hospital for the purpose of admission to another hospital and only when such neonatal ambulances are recognized by emergency medical services.

(3) Ambulance services are subject to maximum allowable fees. Medicaid reimbursement is available for the following ambulance services:

(A) Loading fee.

(B) Loaded mileage, which shall be paid for each mile of the trip.

(C) Oxygen.

(D) Waiting time, except for the first thirty (30) minutes, and only when the trip exceeds fifty (50) miles one (1) way and prior authorization has been obtained from the Medicaid contractor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; 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)

405 IAC 5-30-6 Intrastate wheelchair/nonambulatory services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 6. Intrastate wheelchair/nonambulatory services are reimbursable when a member must travel in a wheelchair to or from an Indiana Medicaid covered service. Wheelchair/nonambulatory services are subject to maximum allowable fees. Reimbursement is available as follows:

(1) Base rate means the flat fee paid by Medicaid for all trips, regardless of trip length.

(2) In addition to the base rate, mileage payments are available for loaded miles in excess of a specified number of miles as determined by the state.

(3) Waiting time is reimbursable only when the member must travel fifty (50) miles or more one (1) way and prior authorization has been obtained from the Medicaid contractor. Waiting time is reimbursable only for those cases in which the vehicle is parked outside the provider of medical service awaiting the return of the member to the vehicle. The first thirty (30) minutes of waiting time are not covered by Medicaid.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; 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)

405 IAC 5-30-7 Intrastate commercial ambulatory services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 7. Intrastate commercial ambulatory services are reimbursable when an ambulatory member must travel to or from an Indiana Medicaid covered service. Commercial ambulatory services are those services provided to ambulatory members by any means other than the services described in sections 8 through 10 of this rule. This classification includes profit and not-for-profit entities using van, taxi, or bus type vehicles. Commercial ambulatory services are subject to maximum allowable fees. Reimbursement is available as follows:

(1) Taxi providers operating within their legal boundaries in accordance with state law whose rates are regulated by local ordinance must bill the lower of their metered or zoned rate, as established by local ordinance, or the maximum allowed rate.

(2) Taxi providers operating within their legal boundaries in accordance with state law whose rates are not regulated by local ordinance are reimbursed the lower of their submitted charge or a maximum allowable fee based on trip length.

(3) No additional mileage payments above the maximum rate are available for taxi services.

(4) Nontaxi commercial ambulatory service providers are reimbursed a base rate for all trips regardless of trip length, plus mileage payments for loaded miles in excess of a specified number of miles as determined by the state.

(5) The first thirty (30) minutes of waiting time is not covered by Medicaid. Waiting time is covered only when the member must travel fifty (50) miles or more one (1) way and prior authorization has been obtained from the Medicaid contractor. Waiting time is reimbursable only for those cases in which the vehicle is parked outside the provider of medical service awaiting the return of the member to the vehicle.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3359; 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)

405 IAC 5-30-8 Reimbursement for additional passengers

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 8. Medicaid reimbursement is available for second or subsequent passengers in a single vehicle at one-half (1/2) the base rate allowance for wheelchair/nonambulatory services and commercial ambulatory services when provided in such vehicles. No additional payment will be made for mileage or waiting time for second or subsequent passengers. Additional Medicaid reimbursement is not available for multiple passengers when the provider involved does not bill non-Medicaid customers for like services. Medicaid will not make additional payment for multiple passengers in ambulance or family member vehicles. The following are the circumstances under which providers may bill for multiple passengers in a single vehicle:

(1) When a minor member is in need of medical services and an adult must accompany him or her, payment will be made under the commercial ambulatory services or nonambulatory services base code for the member and under the appropriate multiple passenger code for the accompanying adult. Payment will not be made for the transportation of an individual to accompany a competent adult to obtain medical services.

(2) When an adult member is in need of medical services and because of his or her condition must have an assistant to travel with him or her and/or stay with him or her in the place of medical service, the commercial ambulatory services or the nonambulatory services base code will be reimbursed for the member and the accompanying multiple passenger code will be reimbursed for the assistant.

(3) When more than one (1) member is transported simultaneously from the same county to the same vicinity for medical services, the full base code (commercial ambulatory services or nonambulatory services) will be reimbursed for the first member, plus mileage and waiting codes, where appropriate. Payment for the second and subsequent members is available for one-half (1/2) the base rate allowance. Mileage and waiting codes may not be billed.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-8; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; 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)

405 IAC 5-30-9 Reimbursement for family member transportation services

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 9. Family members enrolled as transportation providers under 405 IAC 5-4-3 are eligible for reimbursement for mileage only. Reimbursement is determined by the actual loaded mileage multiplied by the rate per mile established by the Indiana legislature for state employees. The office must authorize all family member transportation. Notwithstanding all other provisions of this rule, beginning upon the later of the effective date of LSA Document #10-792 or June 27, 2011, and continuing through June 30, 2013, rates calculated under this section shall be reduced by ten percent (10%). *(Office of the Secretary of Family and Social Services; 405 IAC 5-30-9; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100792FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)*

405 IAC 5-30-10 Reimbursement for other transportation services

Authority: IC 12-15-1-10; IC 12-15-6-5; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-13-7-3; IC 12-15-6

Sec. 10. Medicaid reimbursement is available for other transportation services, including, but not limited to, intrastate bus or train transportation. Medicaid payment for other transportation services will be that fee usually and customarily charged the general public, subject to federal, state, or local law, rule, or ordinance. Intrastate bus or train services (including services provided in designated areas) require authorization by the office, and interstate bus or train services require authorization from the contractor. Authorization may be given for use of monthly bus passes in situations where a member has an ongoing medical need so that purchase of the bus pass is cost effective when compared to the cost of other modes of transportation. Such authorization shall be given only if the member has agreed to the use of this mode of transportation. To be reimbursed, the bus or train company providing services must be enrolled as a provider. *(Office of the Secretary of Family and Social Services; 405 IAC 5-30-10; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3360; 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)*

405 IAC 5-30-11 IEP transportation services

Authority: IC 12-15
Affected: IC 12-13-7-3; IC 20-27

Sec. 11. Medicaid reimbursement is available for IEP transportation services subject to the following limitations:

(1) Services are consistent with the definition set forth in 405 IAC 5-2-13.3.

(2) IEP transportation services must be listed in a Medicaid enrolled student's IEP and must be necessary to enable the student to receive other Medicaid covered services listed in the student's IEP.

(3) IEP transportation services:

(A) must be rendered by school corporation personnel or their contractor; and

(B) are not covered when provided by a member of the student's family if the person is not an employee of the school corporation.

(4) IEP transportation service must be provided using a type of vehicle that is appropriate for the student's disability and meets the specifications established in:

(A) 575 IAC 1-1-1(a) through 575 IAC 1-1-1(h);

(B) 575 IAC 1-5; or

(C) 575 IAC 1-5.5.

(5) Additional reimbursement is available for an attendant, subject to the limitations in 405 IAC 5-30-8(1) and 405 IAC 5-30-8(2), provided the student's IEP includes the need for an attendant and all other Medicaid requirements are met.

(6) Documentation for IEP transportation service claims, such as an ongoing trip log maintained by the provider of the transportation, must be maintained for audit purposes.

(7) Reimbursement is available for IEP transportation services subject to the requirements set forth in this rule and when provided in accordance with provider communications, including banners, bulletins, provider manuals, and the provider

agreement.

(8) School corporations are exempt from the transportation provider requirements set out in 405 IAC 5-4-2, when transportation services provided are in conformance with this rule and IC 20-27.

(Office of the Secretary of Family and Social Services; 405 IAC 5-30-11; filed Apr 22, 2013, 9:47 a.m.: 20130522-IR-405120550FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

Rule 31. Nursing Facility Services

405 IAC 5-31-1 Reimbursement

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

Sec. 1. Medicaid reimbursement is available for nursing facility services provided by a licensed and certified nursing facility in accordance with 405 IAC 1-14.6 or 405 IAC 1-17 when rendered to a member whose level of care has been approved by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; 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)*

405 IAC 5-31-1.1 "Nursing facility services" defined

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. 1.1. As used in this rule, "nursing facility services" means services ordered by and under the direction of a physician, which can only be provided on an inpatient basis in a certified nursing facility that meets conditions of participation in 42 CFR 440.150, 42 CFR 440.155, and 42 CFR 483. Members requiring nursing facility level of care are those who do not require the degree of care and treatment that a hospital provides, but who, because of their mental or physical condition, require care and services above the level of room and board. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-1.1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 321; 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)*

405 IAC 5-31-2 "Skilled care services" defined (Repealed)

Sec. 2. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-31-3 "Intermediate care services" defined (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324)*

405 IAC 5-31-4 Per diem services

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. 4. Those services and products furnished by the facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with 405 IAC 1-14.6. The per diem rate for nursing facilities includes the following services:

(1) Room and board (room accommodations, all dietary services, and laundry services). The per diem rate includes accommodations for semiprivate rooms. Medicaid reimbursement is available for medically necessary private rooms. Private rooms will be considered medically necessary only under one (1) or both of the following circumstances:

(A) The member's condition requires isolation for health reasons, such as communicable disease.
(B) The member exhibits behavior that is or may be physically harmful to self or others in the facility.
(2) Nursing care.
(3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure adequate medical care and personal hygiene of patients.
(4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:
(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs;
(G) traction equipment; and
(H) oxygen and equipment and supplies for its delivery;
are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require members to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the office. The office must be notified when the member no longer needs the equipment.
(5) Medically necessary and reasonable therapy services, which include physical, occupational, respiratory, and speech pathology services.
(6) Transportation to vocational/habilitation service programs.
(7) The cost of both legend and nonlegend water products used for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit. Water agents used alone (not intended to deliver a drug) for irrigation or humidification must be included in per diem reimbursement and must not be reimbursed through the pharmacy benefit.
(8) Skin protectants, sealants, moisturizers, and ointments that are applied on an as needed basis, by the member, nursing facility care staff, or by prescriber's order, as a part of routine care, as defined in 405 IAC 1-14.6-2(ff), must be included in the per diem reimbursement and must not be reimbursed by the pharmacy benefit.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-4; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:35 a.m.: 26 IR 3633, eff on the first day of the calendar quarter following the thirtieth day after filing with the secretary of state; 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 Apr 29, 2015, 3:38 p.m.: 20150527-IR-405150034FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-31-4.5 Per diem services, state nursing facility

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

Sec. 4.5. (a) Those services and products furnished by a state nursing facility for the usual care and treatment of patients are reimbursed in the per diem rate in accordance with 405 IAC 1-17. The per diem rate for state nursing facilities includes the following services:
(1) Room and board:
(A) room accommodations;
(B) all dietary services; and
(C) laundry services.
(2) Nursing care.
(3) The cost of all medical and nonmedical supplies and equipment, which includes those items generally required to assure

adequate medical care and personal hygiene of patients, is included in the nursing facility per diem.

(4) Durable medical equipment (DME), and associated repair costs, routinely required for the care of patients, including, but not limited to:

(A) ice bags;
(B) bed rails;
(C) canes;
(D) walkers;
(E) crutches;
(F) standard wheelchairs;
(G) traction equipment; and
(H) oxygen and equipment and supplies for its delivery;

are covered in the per diem rate and may not be billed to Medicaid by the facility, an outside pharmacy, or any other provider. Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to Medicaid directly by the DME provider. Facilities may not require members to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the office. The office must be notified when the member no longer needs the equipment.

(5) Medically necessary therapy services, which include:

(A) physical;
(B) occupational;
(C) respiratory; and
(D) speech pathology;

services.

(6) Dental services.

(7) Optometric services.

(8) Transportation services, except for emergency medical transportation services.

(9) Pharmaceutical products.

(10) The cost of both legend and nonlegend water products in all forms and for all uses.

(b) The services set out in subsection (a) provided to a Medicaid resident residing in a state nursing facility are reimbursed through the per diem rate except as follows:

(1) Hospital services rendered due to an acute illness or injury may be billed to Medicaid directly by the hospital. Individual exceptions to other medical care that must be rendered by practitioners outside the facility require prior authorization from the office.

(2) Dental services provided in the facility shall be included in the per diem rate. Necessary dental services that cannot be provided on-site by the dental staff require prior authorization by the office. Dental services prior authorized by the office must be billed to Medicaid directly by the outside dental provider. Admission of a member to a hospital for the purpose of performing dental services requires prior authorization by the office.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-4.5; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; 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)

405 IAC 5-31-5 Legend and prescription items

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. 5. (a) All covered legend and nonlegend drugs must be prescribed by a physician. Facilities cannot require members to purchase covered legend and nonlegend drug items with their personal funds.

(b) Anorectics (except amphetamines), both legend and nonlegend, are not covered by Medicaid. Amphetamines are not covered services for weight control or treatment of obesity. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-5; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3361; filed Sep 27, 1999, 8:55 a.m.: 23 IR 322; 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)

405 IAC 5-31-6 Personal care items

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. 6. Personal care or comfort items as defined in 42 CFR 483.10(c)(8)(ii) and 42 CFR 483.10(c)(8)(iii) are not covered under Medicaid. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-6; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)*

405 IAC 5-31-7 Limitations on nursing services

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. 7. Routine nursing services are reimbursed by Medicaid within the per diem rate. Such services must be provided by a registered nurse, a licensed practical nurse, or a nurse's aide. *(Office of the Secretary of Family and Social Services; 405 IAC 5-31-7; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)*

405 IAC 5-31-8 Reservation of nursing facility beds (Voided)

Sec. 8. *(Voided by P.L.229-2011, SECTION 293, effective July 1, 2011.)*

405 IAC 5-31-9 Prior authorization for services rendered outside the state nursing facility

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. 9. (a) Medical care rendered by practitioners outside the state nursing facility requires prior authorization.

(b) Prior authorization will not be given for medical services included in the per diem rate.

(c) Written evidence of physician involvement and personal patient evaluation in the progress notes and attached to the prior authorization form is required to document that the service is medically necessary.

(d) Prior authorization will include consideration of the following:

(1) Review of the properly completed Medicaid prior authorization request form substantiating both of the following:

(A) The service is medically necessary.

(B) Explanation of why the service cannot be rendered at the facility.

(2) Review of criteria for the specific medical service requested as set forth in this article.

(Office of the Secretary of Family and Social Services; 405 IAC 5-31-9; filed May 30, 2007, 8:22 a.m.: 20070627-IR-405060158FRA; 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)

Rule 32. Rehabilitation Unit

405 IAC 5-32-1 Severity of illness criteria

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. 1. The following criteria shall demonstrate the inability to function independently with demonstrated impairment:
(1) Cognitive function (attention span, memory, or intelligence).
(2) Communication (aphasia with major receptive or expressive dysfunction).
(3) Continence (bladder or bowel).
(4) Mobility (transfer, walk, climb stairs, or wheelchair).
(5) Pain management (pain behavior limits functional performance).
(6) Perceptual motor function (spatial orientation or depth or distance perception).
(7) Self-care activities (drink or feed, dress, maintain personal hygiene, brace or prosthesis).
(Office of the Secretary of Family and Social Services; 405 IAC 5-32-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)

405 IAC 5-32-2 Intensity of service criteria
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. Intensity of service criteria shall be as follows:
(1) Multidisciplinary team evaluation at least every two (2) weeks.
(2) Physical therapy and at least one (1) of the following therapies (totaling a minimum of three (3) hours daily):
(A) Occupational therapy.
(B) Speech therapy.
(3) Participation in a rehabilitation program under the direction of a qualified physician.
(4) Skilled rehabilitative nursing care or supervision required at least daily.
(Office of the Secretary of Family and Social Services; 405 IAC 5-32-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)

405 IAC 5-32-3 Discharge criteria
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. Discharge criteria for consideration may include the following:
(1) Evidence in record that patient has achieved stated goals.
(2) Medical complications preclude intensive rehabilitative effort.
(3) Multidisciplinary therapy no longer needed.
(4) No additional functional improvement is anticipated.
(5) Patient's functional status has remained unchanged for fourteen (14) days.
(Office of the Secretary of Family and Social Services; 405 IAC 5-32-3; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)

Rule 33. Acute Care Hospital Admission

405 IAC 5-33-1 Adult medical surgical criteria
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. 1. Day of admission appropriateness shall be as follows:
(1) Severity of illness criteria:

(A) sudden onset of unconsciousness or disorientation (coma or unresponsiveness);
(B) pulse rate:
(i) less than fifty (50) per minute; or
(ii) greater than one hundred forty (140) per minute;
(C) blood pressure:
(i) systolic less than ninety (90) or greater than two hundred (200) millimeters mercury; or
(ii) diastolic less than sixty (60) or greater than one hundred twenty (120) millimeters mercury;
(D) acute loss of sight or hearing;
(E) acute loss of ability to move body part;
(F) persistent fever equal to or greater than one hundred (100) (p.o) or greater than one hundred one (101) (R) for more than five (5) days;
(G) active bleeding;
(H) severe electrolyte/blood gas abnormality, including any of the following:
(i) Na < 123 mEq/L
Na > 156 mEq/L
(ii) K < 2.5 mEq/L
K > 6.0 mEq/L
(iii) CO_2 combining power (unless chronically abnormal) < 20 mEq/L
CO_2 combining power (unless chronically abnormal) > 36 mEq/L
(iv) Blood pH < 7.30
Blood pH > 7.45;
(I) acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, or breathe); must also meet intensity of service criterion simultaneously in order to certify; do not use for back pain;
(J) EKG evidence of acute ischemia; must be suspicion of a new MI; or
(K) wound dehiscence of evisceration.
(2) Intensity of service:
(A) intravenous medications and/or fluid replacement (does not include tube feedings);
(B) surgery or procedure scheduled within twenty-four (24) hours requiring:
(i) general or regional anesthesia; or
(ii) use of equipment, facilities, or procedure available only in a hospital;
(C) vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);
(D) chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;
(E) treatment in an intensive care unit;
(F) intramuscular antibiotics at least every eight (8) hours; and
(G) intermittent or continuous respirator use at least every eight (8) hours.
(3) Criteria of appropriateness of day of care shall include the following:
(A) Medical services:
(i) procedure in operating room that day;
(ii) scheduled for procedure in operating room the next day, requiring preoperative consultation or evaluation;
(iii) cardiac catheterization that day;
(iv) angiography that day;
(v) biopsy of internal organ that day;
(vi) thoracentesis or paracentesis that day;
(vii) invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day;
(viii) any test requiring strict dietary control for the duration of the diet;
(ix) new or experimental treatment requiring frequent dose adjustments under direct medical supervision;
(x) close medical monitoring by a doctor at least three (3) times daily (observations must be documented in

record); or
(xi) postoperative day for any procedure covered in item (i) or (iii) through (vii).
(B) Nursing/life support services:
(i) respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB) at least three (3) times daily;
(ii) parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications);
(iii) continuous vital sign monitoring, at least every thirty (30) minutes, for at least four (4) hours;
(iv) IM and/or SC injections at least twice daily;
(v) intake and output measurement;
(vi) major surgical wound and drainage care (chest tubes, T-tubes, hemovacs, Penrose drains); or
(vii) close medical monitoring by nurse at least three (3) times daily, under doctor's orders.
(C) Patient condition:
(i) within twenty-four (24) hours before day of review inability to void or move bowels (past twenty-four (24) hours) not attributable to neurologic disorder;
(ii) within forty-eight (48) hours before day of review:
(AA) transfusion due to blood loss;
(BB) ventricular fibrillation or ECG evidence of acute ischemia, as stated in progress note or in ECG report;
(CC) fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally), if patient was admitted for reasons other than fever;
(DD) coma–unresponsiveness for at least one (1) hour;
(EE) acute confusional state, not due to alcohol withdrawal;
(FF) acute hematologic disorders, significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis yielding signs or symptoms; or
(GG) progressive acute neurologic difficulties; and
(iii) within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

(Office of the Secretary of Family and Social Services; 405 IAC 5-33-1; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3362; 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)

405 IAC 5-33-2 Pediatric AEP admission criteria

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. Day of admission appropriateness shall be as follows:
(1) Severity of illness criteria:
(A) sudden onset of unconsciousness (coma or unresponsiveness) or disorientation;
(B) acute or progressive sensory, motor, circulatory, or respiratory embarrassment sufficient to incapacitate the patient (inability to move, feed, breathe, or urinate);
(C) acute loss of sight or hearing;
(D) acute loss of ability to move body part;
(E) persistent fever (> one hundred (100) degrees orally or > one hundred one (101) degrees rectally) for more than ten (10) days;
(F) active bleeding;
(G) wound dehiscence or evisceration;
(H) severe electrolyte/acid-base abnormality, including any of the following:
(i) Na < 123 mEq/L

Na > 156 mEq/L
(ii) K < 2.5 mEq/L
K > 6.0 mEq/L
(iii) CO_2 combining power (unless chronically abnormal) <20 mEq/L
CO_2 combining power (unless chronically abnormal) > 36 mEq/L
(iv) Arterial pH < 7.30
Arterial pH > 7.45;

(I) hematocrit < thirty percent (30%);

(J) pulse rate outside following ranges (optimally a sleeping pulse for < twelve (12) years old):

2–6 years old	70–200/minute
7–11 years old	60–180/minute
> 12 years old	50–140/minute

(K) blood pressure outside following ranges:

	Systolic	Diastolic
2–6 years old	75–125 mm Hg	40–90 mm Hg
7–11 years old	80–130 mm Hg	45–90 mm Hg
< 12 years old	90–200 mm Hg	60–120 mm Hg

(L) need for lumbar puncture, where this procedure is not done routinely on an outpatient basis;

(M) any conditions not responding to outpatient, including emergency room:
(i) seizures;
(ii) cardiac arrhythmia;
(iii) bronchial asthma or croup;
(iv) dehydration;
(v) encopresis (for clean-out); or
(vi) other physiologic problem (specify);

(N) special pediatric problems:
(i) child abuse;
(ii) noncompliance with necessary therapeutic regimen; or
(iii) need for special observation or close monitoring of behavior, including calorie intake in cases of failure to thrive.

(2) Intensity of service:

(A) surgery or procedure scheduled within twenty-four (24) hours requiring:
(i) general or regional anesthesia; or
(ii) use of equipment, facilities, or procedure available only in a hospital;

(B) treatment in an intensive care unit;

(C) vital sign monitoring every two (2) hours or more often (may include telemetry or bedside cardiac monitor);

(D) intravenous medications and/or fluid replacement (does not include tube feedings);

(E) chemotherapeutic agents that require continuous observation for life-threatening toxic reaction;

(F) intramuscular antibiotics at least every eight (8) hours; and

(G) intermittent or continuous respirator use at least eight (8) hours.

(3) Criteria of appropriateness of day of care shall be as follows:

(A) For medical services, the following documented criteria will be used for continued stay reviews; at least one (1) of the criteria must be met for the continued stay to be recertified:
(i) Procedure in operating room that day.
(ii) Procedure scheduled in operating room the next day, requiring preoperative consultation or evaluation.
(iii) If day being reviewed is the day of admission, any procedure among subdivisions *[sic., items]* (iv) through (ix) scheduled for the day after admission unless that procedure is usually done at that facility on a same-day basis.

(iv) Cardiac catheterization that day.
(v) Angiography that day.
(vi) Biopsy of internal organ that day.
(vii) Thoracentesis or paracentesis that day.
(viii) Invasive CNS diagnostic procedure, for example, lumbar puncture, cisternal tap, ventricular tap, or pneumoencephalography, that day.
(ix) Gastrointestinal endoscopy that day.
(x) Any test requiring strict dietary control for the duration of the diet.
(xi) New or experimental treatment requiring frequent dose adjustments under direct medical supervision.
(xii) Close medical monitoring by a doctor at least three (3) times daily (observations must be documented in record).

Postoperative day for any procedure covered in item (i) or (iv) through (ix).

(B) Nursing/life support services shall be as follows:

(i) Respiratory care–intermittent or continuous respirator use and/or inhalation therapy (with chest PT, IPPB), at least three (3) times daily, Bronkosol with oxygen, oxyhoods, or oxygen tents.
(ii) Parenteral therapy–intermittent or continuous intravenous fluid with any supplementation (electrolytes, protein, or medications).
(iii) Continuous vital sign monitoring, at least every thirty (30) minutes for at least four (4) hours.
(iv) IM and/or SC injections at least twice daily.
(v) Intake and/or output measurement.
(vi) Major surgical wound and drainage care, for example, chest tubes, T-tubes, hemovacs, or Penrose drains.
(vii) Traction for fractures, dislocations, or congenital deformities.
(viii) Close medical monitoring by nurse at least three (3) times daily, under doctor's orders.

(C) Patient condition:

(i) within twenty-four (24) hours on or before day of review, inability to void or move bowels, not attributable to neurologic disorder–usually a post-op;
(ii) within forty-eight (48) hours on or before day of review:
(AA) transfusion due to blood loss;
(BB) ventricular fibrillation or ECG evidence of acute ischemia as stated in progress note or in ECG report;
(CC) fever at least one hundred one (101) degrees rectally (at least one hundred (100) degrees orally) if patient was admitted for reason other than fever;
(DD) coma–unresponsiveness for at least one (1) hour;
(EE) acute confusional state, including withdrawal from drugs and alcohol;
(FF) acute hematologic disorders–significant neutropenia, anemia, thrombocytopenia, leukocytosis, erythrocytosis, or thrombocytosis–yielding signs of symptoms; or
(GG) progressive acute neurologic difficulties; and
(iii) within fourteen (14) days before day of review, occurrence of a documented, new acute myocardial infarction or cerebrovascular accident (stroke).

(Office of the Secretary of Family and Social Services; 405 IAC 5-33-2; filed Jul 25, 1997, 4:00 p.m.: 20 IR 3364; 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)

Rule 34. Hospice Services

405 IAC 5-34-1 Policy

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 1. (a) Medicaid reimbursement is available for hospice services subject to the limitations in this rule and 405 IAC 1-16. Hospice services consist of the following:

(1) Palliative care for the physical, psychological, social, spiritual, and other special needs of a hospice program patient during the final stages of the patient's terminal illness.

(2) Care for the psychological, social, spiritual, and other needs of the hospice program patient's family before and after the patient's death.

(b) In order to receive Medicaid reimbursement for hospice services, a hospice provider must meet the requirements of section 2 of this rule.

(c) Notwithstanding any prior authorization by the office, the provision of all services shall comply with the Medicaid provider agreement, the appropriate provider manual applicable at the time such services were provided, all other Medicaid policy documents issued to providers, and any applicable state or federal statute or regulation. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-1; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2379; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; 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)*

405 IAC 5-34-2 Provider enrollment

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15; IC 16-25-3

Sec. 2. (a) In order to enroll as a hospice provider in Medicaid a provider must submit a provider enrollment agreement as specified in 405 IAC 5-4. A separate provider agreement for hospice services must be completed even if the provider currently participates in Medicaid as a provider of another service.

(b) A hospice provider must be certified as a hospice provider in the Medicare program. A copy of the provider's Medicare Certification Letter from the Centers for Medicare and Medicaid Services (CMS), formerly the Health Care Financing Administration, must be submitted with the Medicaid provider enrollment agreement. The hospice provider who operates at more than one (1) location must provide a copy of the Medicare Certification Letter from CMS that demonstrates that the regional office has approved each additional office location to be Medicare-certified as a either a satellite office of the home office location or as a separate hospice with its unique Medicare provider number.

(c) The provider must comply with all state and federal requirements for Medicaid and Medicare providers in addition to the requirements in this section. The hospice and all hospice employees must be licensed in accordance with applicable federal, state, and local laws and regulations as required under federal regulations at 42 CFR 418.72 and Indiana state hospice licensure at IC 16-25-3.

(d) The hospice provider must designate an interdisciplinary group composed of individuals who are employees of the hospice and who provide or supervise care and services offered by the hospice provider. At a minimum, this group must include all of the following persons:

(1) A medical director, who must be a doctor of medicine or osteopathy.

(2) A registered nurse.

(3) A social worker.

(4) A pastoral or other counselor.

(e) The interdisciplinary group is responsible for the following:

(1) Participation in the establishment of the plan of care.

(2) Provision or supervision of hospice care and services.

(3) Review and updating of the plan of care.

(4) Establishment of policies governing the day-to-day provision of care and services.

(f) A hospice provider may not discontinue or diminish care provided to the Indiana member because of the member's source of payment.

(g) The provider must demonstrate respect for a member's rights by ensuring that the election of hospice services is based on the informed, voluntary consent of the member or the member's representative.

(h) A hospice provider may discharge a member from hospice services only if one (1) or more of the following occurs:

(1) The member dies.
(2) The member is determined to have a prognosis greater than six (6) months.
(3) The member moves out of the hospice's service area.
(4) The safety of the member, other patients, or hospice staff is compromised.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-2; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3635; 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)

405 IAC 5-34-3 Out-of-state providers

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 3. (a) Subject to the conditions in this section and section 2 of this rule, and any applicable state or federal licensing laws or regulations, an Indiana resident may receive hospice services from an out-of-state hospice provider if the provider is:
(1) located in a designated out-of-state city listed in 405 IAC 5-5-2(a); and
(2) enrolled in Medicaid.
(b) Prior authorization may be granted for an Indiana resident to receive hospice services from an out-of-state hospice provider not located in a designated out-of-state city if any one (1) of the criteria listed at 405 IAC 5-5-2(c) is met.
(c) Routine home care and continuous home care hospice services may be provided by out-of-state hospice providers to Indiana residents in their own home or in a nursing facility located in Indiana.
(d) Inpatient respite care and general inpatient care hospice services may be provided in an out-of-state hospice provider's facility.
(e) Routine home care and continuous home care hospice services cannot be provided to an Indiana resident in a nursing facility outside of Indiana, even if the nursing facility is located in an out-of-state designated city listed in 405 IAC 5-5-2(a). *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-3; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636; 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)*

405 IAC 5-34-4 Hospice authorization and benefit periods

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 4. (a) Hospice services require Medicaid hospice authorization by the office or its contractor. Medicaid reimbursement is not available for hospice services furnished without authorization.
(b) To request hospice authorization for Medicaid-only eligible members for each hospice benefit period, the provider must submit all of the following documentation on forms approved by the office:
(1) Member election statement.
(2) Medicaid physician certification.
(3) Medicaid plan of care.
(c) Dually-eligible Medicare/Medicaid members residing in nursing facilities who elect hospice benefits must enroll simultaneously in the Medicare and Medicaid hospice benefits. To obtain hospice authorization, the hospice provider must submit the following forms as approved by the office for a one (1) time enrollment in the Medicaid hospice benefit:
(1) Medicaid Hospice Authorization Notice for Dually-Eligible Medicare/Medicaid Nursing Facility Residents.
(2) A copy of the hospice agency form reflecting the member's election of the Medicare hospice benefit. The form must reflect the signature of the member or the member's representative and the date on which the form was signed.

The hospice provider is required to resubmit the forms described in this subsection when a dually-eligible Medicare/Medicaid hospice member residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice

revocation or hospice discharge.

(d) Hospice authorization is not required for the dually-eligible Medicare/Medicaid hospice member residing at home as Medicare is reimbursing for the hospice care.

(e) Hospice authorization for the Medicaid-only hospice member is available in the following consecutive benefit periods:

(1) One (1) period of ninety (90) days.

(2) A second period of ninety (90) days.

(3) An unlimited number of periods of sixty (60) days.

(f) Hospice authorization must be granted separately for each benefit period for the Medicaid-only hospice member. If benefit periods beyond the first ninety (90) days are necessary, then recertification on the physician certification form and an updated plan of care are required for authorization of the second and subsequent benefit periods. For the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility, hospice authorization is granted one (1) time at the time of enrollment in the Medicaid hospice benefit. Hospice authorization is not required for each hospice benefit period. Hospice authorization is required when the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility reelects the Medicare and the Medicaid hospice benefit following a previous hospice revocation or hospice discharge.

(g) In order to obtain authorization and reimbursement for hospice services, the provider must submit the documentation listed in this section to the office or its contractor within ten (10) business days of the effective date of the member's election, and within ten (10) business days of the beginning of the second and subsequent benefit periods if required under this section.

(h) When there is insufficient information submitted to render a hospice authorization decision or the documentation contains errors, a hospice authorization request will be suspended for thirty (30) days and the office or its contractor will request additional information from the provider. The provider must make the corrections and resubmit the proper documentation to the office or its contractor within thirty (30) calendar days after the additional information or correction is requested. If the provider fails to resubmit the documentation with the appropriate corrections within the thirty (30) day time period, the request for hospice authorization will be denied. If the provider submits additional documentation within thirty (30) days, but the documentation submitted does not provide sufficient information to render a decision, the office or its contractor may request additional information. The provider must submit the additional information within thirty (30) days after the additional information is requested. If the provider fails to submit the requested information within the additional thirty (30) days, or if the additional documentation does not provide sufficient information to render a decision, the request for hospice authorization will be denied.

(i) If a request for hospice authorization or supporting documentation are submitted after the time limits in this section, authorization may be granted only for services provided on or after the date that the request is received. Authorization for services furnished prior to the date of a request that does not comply with the time limits in this section may be granted only under the following circumstances:

(1) Pending or retroactive member eligibility. The hospice authorization request must be submitted within twelve (12) months of the date of the issuance of the member's Medicaid card.

(2) The provider was unaware that the member was eligible for services at the time services were rendered. Hospice authorization will be granted in this situation only if the following conditions are met:

(A) The provider's records document that the member refused or was physically unable to provide the member identification (RID or Medicaid) number.

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

(C) The provider submitted the request for prior authorization within sixty (60) days of the date Medicaid eligibility was discovered.

(3) Pending or retroactive approval of nursing facility level of care. The hospice authorization request must be submitted within one (1) year of the date nursing facility level of care is approved by the office.

(j) The office will rely on current professional guidelines, including the local Medicare medical review policies for hospice services, in making the hospice authorization determination.

(k) When approval for a benefit period has been granted, a hospice provider may manage a patient's care at the four (4) levels of care according to the medical needs determined by the interdisciplinary team and the requirements of the patient and the patient's family or primary caregivers. Changes in levels of care do not require prior authorization as long as these levels are rendered within a prior approved hospice benefit period. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4; filed Mar 9, 1998,*

9:30 a.m.: 21 IR 2380; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3636; 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)

405 IAC 5-34-4.1 Appeals of hospice authorization determinations

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8
Affected: IC 12-15

Sec. 4.1. (a) Members may appeal the denial or modification of hospice authorization under 405 IAC 1.1.

(b) Any provider submitting a request for hospice authorization under this rule, which has been denied either in whole or in part, may appeal the decision under 405 IAC 1.1 after first submitting a request for reconsideration of the hospice authorization in accordance with the procedures set out in 405 IAC 5-7-2 and 405 IAC 5-7-3 for administrative reconsideration of prior authorization decisions.

(c) When there is insufficient information submitted to render a decision, or the documentation contains errors, a hospice authorization request will be suspended pursuant to section 4 of this rule, and the office or its contractor will request additional information from the provider. Suspension is not a final decision on the merits of the request and is not appealable. If the provider does not submit sufficient information within the time frames set out in section 4(h) of this rule, the request shall be denied. Denial is a final decision and may be appealed pursuant to subsections (a) and (b). *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.1; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; 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)*

405 IAC 5-34-4.2 Audit

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40-8
Affected: IC 12-15

Sec. 4.2. (a) The office may conduct audits of hospice services, including services for which hospice authorization has been granted. Audit of hospice services shall include review of the medical record to determine the services are medically necessary based upon applicable current professional guidelines, including the local Medicare medical review policies for hospice services.

(b) If the office determines that hospice services for a member are not medically necessary, hospice authorization will be revoked for the dates during which hospice services did not meet medically necessary criteria for hospice care. Medicaid payment for hospice services is not available for services that the office determines are not medically necessary. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-4.2; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; 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)*

405 IAC 5-34-5 Physician certification

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 5. (a) In order for an individual to receive Medicaid-covered hospice services, a physician must certify in writing that the individual is terminally ill and expected to die from that illness within six (6) months. For a dually-eligible Medicaid/Medicare member, the hospice provider must comply with Medicare physician certification requirements, but the provider is not required to complete the Medicaid physician certification form or to submit the physician certification to the office. For a Medicaid-only hospice member, the Medicaid physician certification form must be completed and submitted to office as set out in this section.

(b) As required by federal regulations, the certification in subsection (a) must:

(1) be completed for the first period of ninety (90) days by the:

(A) medical director of the hospice program or the physician member of the hospice interdisciplinary group; and

(B) member's attending physician if the member has an attending physician;

(2) be completed by one (1) of the physicians listed in subdivision (1)(A) for the second and subsequent periods;
(3) be signed and dated;
(4) identify the diagnosis that prompted the individual to elect hospice services;
(5) include a statement that the prognosis for life expectancy is six (6) months or less; and
(6) be submitted to the office within the time frames in subsection (c).

(c) The Medicaid physician certification must be submitted for the first period within ten (10) business days of the effective date of the Medicaid-only member's election. For the second and subsequent periods, the Medicaid physician certification must be submitted within ten (10) business days of the beginning of the benefit period.

(d) For the Medicaid-only hospice member, the Medicaid physician certification form must be included in the member's medical chart in the hospice agency and the member's medical chart in the nursing facility.

(e) Prior to the beginning of the member's third benefit period or one hundred eightieth day of hospice service and prior to each subsequent benefit period, a hospice physician or hospice nurse practitioner (NP) must have a face-to-face encounter with the member to gather clinical findings to determine continued eligibility for hospice care and must attest in writing that such a visit took place. The face-to-face encounter must occur not more than thirty (30) calendar days prior to:
(1) the third benefit period recertification; and
(2) every subsequent recertification thereafter.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-5; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381;readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3638; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-34-6 Election of hospice services

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 6. (a) In order to receive hospice services, a member must elect hospice services by filing an election statement with the hospice provider on forms specified by the office.

(b) For members at least twenty-one (21) years of age, election of the hospice benefit requires the member to waive Medicaid coverage for the following services:
(1) Other forms of health care for the treatment of the terminal illness for which hospice care was elected, or for treatment of a condition related to the terminal illness.
(2) Services provided by another provider that are equivalent to the care provided by the elected hospice provider.
(3) Hospice services other than those provided by the elected hospice provider or its contractors.

(c) For members less than twenty-one (21) years of age who elect the hospice benefit, the member may receive concurrent curative care services in conjunction with hospice services for the terminal illness. This allows the member or the member's representative to elect the hospice benefit, without forgoing any curative service the member is entitled to under Medicaid for treatment of the terminal illness.

(d) The member or member's representative may designate an effective date for the election that begins with the first day of hospice care or any other subsequent day of hospice care. The individual may not designate an effective date that is earlier than the date of election.

(e) For Medicaid-only hospice member, the Medicaid election form must be submitted to the office along with the Medicaid physician's certification required by section 5 of this rule when hospice services are initiated. It is not necessary to submit the Medicaid election form for the second and subsequent benefit periods unless the member has revoked the election and wishes to reelect hospice care.

(f) For the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility, the hospice agency election form reflecting the Medicare hospice election date and the member's signature must be submitted with the Medicaid hospice authorization form for dually-eligible Medicare/Medicaid nursing facility residents. It is not necessary to submit the Medicare election form for the second and subsequent benefit periods unless the member has revoked the election and wishes to reelect hospice care under the Medicare and Medicaid hospice benefits.

(g) In the event that a member or the member's representative wishes to revoke the election of hospice services, the following apply:

(1) The individual must file a hospice revocation statement on a form approved by the office. The form includes a signed statement that the individual revokes the election of Medicaid hospice services for the remaining days in the benefit period. The form must specify the date that the revocation is to be effective, if later than the date the form is signed by the individual or representative. An individual or representative may not designate an effective date earlier than the date that the revocation is made.

(2) A member may elect to receive hospice care intermittently rather than consecutively over the benefit periods.

(3) If a member revokes hospice services during any benefit period, time remaining on that benefit period is forfeited.

(4) The revocation form must be completed for Medicaid-only hospice members as well as dually-eligible Medicare/Medicaid hospice members residing in nursing facilities. The hospice provider must submit this form to the office.

(5) The Medicaid hospice revocation form must be included in the member's medical chart in the hospice agency. If the Medicaid hospice member resides in a nursing facility, the Medicaid hospice revocation form must be included in the member's nursing facility medical chart as well.

(h) A member or a member's representative may change hospice providers once during any benefit period. This change does not constitute a revocation of services. The following apply when a member changes hospice providers:

(1) To change the designation of hospice programs, the individual or the individual's representative must complete the Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form or other form designated by the office for this purpose. This form is required for the Medicaid-only hospice member and the dually-eligible Medicare/Medicaid hospice member residing in the nursing facility. The original provider must submit this form to the office.

(2) The Medicaid Hospice Provider Change Request Between Indiana Hospice Providers Form, or other form designated by the office for this purpose, must be included in the member's medical chart in the hospice agency. If the Medicaid hospice member resides in a nursing facility, this form must be included in the member's nursing facility chart. This documentation requirement is for the Medicaid-only hospice member as well as the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-6; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2381;readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3639; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-34-7 Plan of care

Authority: IC 12-8-6.5-5; IC 12-15
Affected: IC 12-15

Sec. 7. (a) When an eligible member elects to receive services from a certified hospice provider, the provider shall develop a plan of care. For the Medicaid-only hospice members, the provider must submit the Medicaid plan of care form to the office or the office's contractor with the Medicaid physician certification and the Medicaid election statement. For members less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the providers rendering those services must submit an updated coordinated plan of care, including delineation of hospice and curative care services, to the office or the office's contractor.

(b) In developing the plan of care, the provider must comply with the following procedures:

(1) The interdisciplinary team member who drafts the plan must confer with at least one (1) other member of the interdisciplinary team.

(2) One (1) of the conferees must be a physician or nurse, and all other team members must review the plan of care.

(3) All services stipulated within the plan of care must be reasonable and necessary for the palliation or management of the terminal illness and related conditions.

(4) For the Medicaid-only hospice member, the Medicaid hospice plan of care must be included in the member's medical chart at the hospice agency. If the Medicaid-only member resides in a nursing facility, the Medicaid plan of care must also be included in the member's nursing facility medical chart.

(5) For the dually-eligible Medicare/Medicaid hospice member residing in a nursing facility, a coordinated plan of care prepared and agreed upon by the hospice and nursing facility must be included in the member's nursing facility medical chart.

(6) For members less than twenty-one (21) years of age concurrently receiving hospice and curative care services, the Medicaid plan of care must include the information identified previously in this section, and a coordinated plan of care must be prepared and agreed upon by the hospice interdisciplinary team and the provider or providers rendering the curative care services. The plan of care must include the following:

(A) An assessment of the member's needs.

(B) The curative care and hospice services the member is receiving along with the scope and frequency of these services and the manner in which the services and assessments are coordinated.

The plan of care must be included in the member's medical charts of both the hospice and curative care providers. The advanced directive, if applicable, must be included in the member's medical charts of both the hospice and curative care providers.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-7; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 5, 2003, 8:30 a.m.: 26 IR 3640; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 14, 2013, 9:48 a.m.: 20130313-IR-405120451FRA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

405 IAC 5-34-8 Covered services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 8. Services covered within the hospice per diem reimbursement rates include the following:

(1) Nursing care provided by or under the supervision of a registered nurse.

(2) Medical social services provided by a social worker who has at least a bachelor's degree and who is working under the supervision of a physician.

(3) Physicians' services provided by the medical director or physician member of the interdisciplinary team that may be characterized as follows:

(A) General supervisory services.

(B) Participation in the establishment of the plan of care.

(C) Supervision of the plan of care.

(D) Periodic review.

(E) Establishment of governing policies.

(4) Counseling services provided to the member and the member's family or other person caring for the member.

(5) Short term inpatient care provided in a hospice inpatient unit, participating hospital, or nursing home, subject to the limits in 405 IAC 1-16-3.

(6) Medical appliances and supplies, including palliative drugs, that are related to the palliation or management of the member's terminal illness.

(7) Home health services furnished by qualified aides.

(8) Homemaker services that assist in providing a safe and healthy environment.

(9) Physical, occupational therapy, and speech-language pathology services provided for purposes of symptom control.

(10) Inpatient respite care, subject to the limitations in 405 IAC 1-16-2.

(11) Room and board for members who reside in long term care facilities, as set out in 405 IAC 1-16-4.

(12) Any other item or service specified in the member's plan of care, if the item or service is a covered service under the Medicare program.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-8; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; 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)

405 IAC 5-34-9 Levels of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 9. (a) Covered hospice services will be delivered and reimbursed at one (1) of four (4) levels, the utilization of which shall be determined by the hospice provider within the context of the overall utilization and reimbursement limitations contained in this rule and 405 IAC 1-16.

(b) The levels of care are as follows:

(1) Routine home hospice care.

(2) Continuous home hospice care.

(3) Inpatient respite care.

(4) General inpatient hospice care.

(c) When routine home care and continuous home care are furnished to a member who resides in a nursing facility, the nursing facility is considered the member's home. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-9; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; 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)*

405 IAC 5-34-10 Location of care

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 10. (a) The usual home of the hospice member determines the location of care for that member. For purposes of this rule and 405 IAC 1-16, hospice location of care will be categorized according to one (1) of two (2) locations.

(b) Private home location of care applies if the member usually lives in his or her private home.

(c) Nursing facility location of care applies if the member usually lives in a nursing facility.

(d) The additional room and board amount available for nursing facility residents under 405 IAC 1-16-4 is available only if the hospice member meets the criteria for nursing facility level of care under 405 IAC 1-3. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-10; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2382; 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)*

405 IAC 5-34-11 Prior authorization for nonhospice services

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 11. (a) Except as provided in subsection (b), prior authorization is required for any Medicaid-covered service not related to the hospice member's terminal condition if prior authorization is otherwise required under this article.

(b) Notwithstanding any other provision of this article, prior authorization is not required for the following services when provided to hospice patients:

(1) Pharmacy services, for conditions not related to the patient's terminal condition. Pharmacy services related to the patient's terminal condition do not require prior authorization because they are included in the hospice per diem.

(2) Dental services.

(3) Vision care services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-34-11; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383; 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)

405 IAC 5-34-12 Reservation of beds for hospice members in nursing facilities

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-40
Affected: IC 12-15

Sec. 12. (a) Although it is not mandatory for providers to reserve beds, Medicaid will reimburse for reserving nursing facility beds for hospice members at one-half (1/2) the room and board payment provided that the criteria as set out in this section are met.

(b) Hospitalization must be ordered by the hospice physician for treatment of an acute condition that cannot be treated in the nursing facility by the hospice provider. The maximum length of time allowed for payment of a reserved bed for a single hospital stay is fifteen (15) days.

(c) A leave of absence must be for therapeutic reasons, as prescribed by the hospice attending physician and as indicated in the hospice member's plan of care. The maximum length of time allotted for therapeutic leave in any calendar year is limited to eighteen (18) days, which need not be consecutive.

(d) Although prior authorization by the office is not required to reserve a bed, the hospice member's physician's order for the hospitalization or therapeutic leave must be on file in the nursing facility.

(e) In no instance will Medicaid reimburse a nursing facility for reserving nursing facility beds for hospice members when the nursing facility has an occupancy rate of less than ninety percent (90%). For purposes of this rule, the occupancy rate shall be determined by dividing the total number of residents in licensed beds, excluding residential beds, in the nursing facility taken from the midnight census as of the day that a Medicaid hospice member takes a leave of absence, by the total number of licensed nursing facility beds, excluding residential beds. *(Office of the Secretary of Family and Social Services; 405 IAC 5-34-12; filed Mar 9, 1998, 9:30 a.m.: 21 IR 2383; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Mar 18, 2002, 3:34 p.m.: 25 IR 2476; 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)*

Rule 35. Case Management Services for Infants and Toddlers with Disabilities

405 IAC 5-35-1 Definitions

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

Sec. 1. (a) The definitions in this section apply throughout this rule.

(b) "IFSP" means the individualized family service plan, a written plan for providing early intervention services to a child eligible for early intervention services and the child's family.

(c) "Service coordination services" means targeted case management services. Providers of targeted case management services are referred to as "service coordinators" in this rule.

(d) "Targeted case management services for infants and toddlers with disabilities" means an active, ongoing process of assisting the infant or toddler and his or her family to identify, access, and utilize early intervention services to benefit the development of the child and to coordinate the services to meet the individual needs of the infant or toddler and his or her family. The term includes the following services:

(1) Coordinating the evaluation activities related to eligibility redetermination.
(2) Assisting families in identifying available services.
(3) Coordinating and monitoring the authorization, scheduling, and performance of assessments and services.
(4) Participating and facilitating in the development, review, and evaluation of the IFSP.
(5) Assisting in the identification and access to available financial support.
(6) Informing families of the availability of advocacy services.
(7) Coordinating and participating in the development of a transition plan for infants and toddlers into, within, and from the early intervention system to preschool, or other appropriate services at or prior to three (3) years of age, or when the child is no longer eligible for early intervention services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-1; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2527; 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)

405 IAC 5-35-2 Providers eligible for reimbursement; certification

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

Sec. 2. Medicaid reimbursement is available for service coordination services provided to eligible children by either of the following, after he or she has been certified by and has successfully completed orientation to the First Steps Early Intervention system:

(1) Service coordinator specialist.
(2) Service coordinator associate.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-2; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; 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)

405 IAC 5-35-3 Covered services

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

Sec. 3. The following are service coordination services that may be reimbursed by Medicaid:

(1) Development of the IFSP based on fifteen (15) minute increments of face-to-face contact of up to two and one-half (2½) hours per meeting and with a maximum time limit of seven and one-half (7½) hours annually, per eligible child.
(2) Ongoing service coordination services, based on a minimum of fifteen (15) minutes of contact, with a maximum of four (4) contacts per month, that consist of the following:
    (A) Assessment of the eligible child's needs.
    (B) Coordination and advocacy.
    (C) Monitoring the IFSP.
    (D) Evaluation of the IFSP.

Direct face-to-face service coordination with the family of the eligible child must occur and be documented at least four (4) times per year.

(Office of the Secretary of Family and Social Services; 405 IAC 5-35-3; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; 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)

405 IAC 5-35-4 Prior authorization

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

Sec. 4. Service coordination services are exempt from prior authorization requirements. *(Office of the Secretary of Family and Social Services; 405 IAC 5-35-4; filed Mar 11, 1999, 5:00 p.m.: 22 IR 2528; 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)*

Rule 36. Diabetes Self Management Training

405 IAC 5-36-1 DSMT policy; definitions

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5-6

Sec. 1. (a) Reimbursement is available for diabetes self management training, as defined in this rule and when provided in accordance with all applicable provisions of this rule, provider bulletins, provider manuals, and the provider agreement.

(b) As used in this rule, "DSMT" means diabetes self management training and is comprised of those services provided in accordance with IC 27-8-14.5-6. These services are intended to enable the member to, or enhance the member's ability to, properly manage the member's diabetic condition, thereby optimizing the member's own therapeutic regimen. Examples of DSMT include, but are not limited to, the following:

(1) Instruction regarding the diabetic disease state, nutrition, exercise, and activity.
(2) Medications counseling.
(3) Blood glucose self-monitoring training.
(4) Foot, skin, and dental care.
(5) Behavior change strategies and risk factor reduction.
(6) Preconception care, pregnancy, and gestational diabetes.
(7) Accessing community health care systems and resources.

(c) As used in this rule, "health care professionals" means the following:

(1) Chiropractors.
(2) Dentists.
(3) Health facility administrators.
(4) Physicians.
(5) Nurses.
(6) Optometrists.
(7) Pharmacists.
(8) Podiatrists.
(9) Environmental health specialists.
(10) Audiologists.
(11) Speech-language pathologists.
(12) Psychologists.
(13) Hearing aid dealers.
(14) Physical therapists.
(15) Respiratory therapists.
(16) Occupational therapists.
(17) Social workers.
(18) Marriage and family therapists.
(19) Physician assistants.
(20) Athletic trainers.
(21) Dietitians.

(d) As used in this rule, a "unit" of DSMT service means a time period of fifteen (15) minutes. *(Office of the Secretary of Family and Social Services; 405 IAC 5-36-1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; errata filed Dec 9, 1999, 1:17 p.m.: 23 IR 814; 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)*

405 IAC 5-36-2 Requirements for the provision of DSMT

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5

Sec. 2. (a) DSMT must be medically necessary for the patient.

(b) DSMT must be ordered in writing by a physician or podiatrist licensed under applicable Indiana law.

(c) DSMT must be provided by a health care professional licensed under applicable Indiana law.

(d) The health care professional that provides DSMT must have specialized training in the management of diabetes. *(Office*

of the Secretary of Family and Social Services; 405 IAC 5-36-2; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; 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)

405 IAC 5-36-3 Limitations on coverage of DSMT

Authority: IC 12-15-1-10; IC 12-15-21-2; IC 12-15-21-3
Affected: IC 12-15; IC 27-8-14.5

Sec. 3. (a) Coverage of DSMT is limited to sixteen (16) units of DSMT per member, per rolling calendar year without prior authorization. Additional units of DSMT may be authorized via the prior authorization process as set forth in 405 IAC 5-3.

(b) Coverage of DSMT is limited to the following clinical circumstances:

(1) Receipt of a diagnosis of diabetes.

(2) Receipt of a diagnosis that represents a significant change in the patient's symptoms or condition.

(3) Re-education or refresher training.

(Office of the Secretary of Family and Social Services; 405 IAC 5-36-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 323; 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)

Rule 37. Tobacco Dependence Treatment Policy

405 IAC 5-37-0.5 Definitions

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

Sec. 0.5. The following definitions apply throughout this rule:

(1) "Tobacco dependence treatment" means the provision of products and services intended to reduce a person's dependence on tobacco products. The term includes the provision of the following:

(A) Covered legend or nonlegend drugs intended to reduce an individual's dependence on tobacco products.

(B) Tobacco dependence counseling services offered in conjunction with the delivery of a drug defined in clause (A) or by an individual identified under section 3 of this rule.

(2) "Tobacco products" means, but is not limited to, the following:

(A) Cigarettes.

(B) Pipes.

(C) Cigars.

(D) Inhaled tobacco products.

(E) Ingestible tobacco products.

(F) Chewing tobacco.

(Office of the Secretary of Family and Social Services; 405 IAC 5-37-0.5; filed May 27, 2016, 12:05 p.m.: 20160622-IR-405140338FRA)

405 IAC 5-37-1 Reimbursement and prior authorization

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

Sec. 1. (a) Reimbursement is available for tobacco dependence treatment subject to the requirements set forth in this rule and when provided in accordance with provider bulletins, provider manuals, and the provider agreement.

(b) Tobacco dependence products may be subject to prior authorization as defined in 405 IAC 5-2-20. A provider seeking prior authorization shall follow the process outlined in 405 IAC 5-3. *(Office of the Secretary of Family and Social Services; 405*

IAC 5-37-1; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; 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 May 27, 2016, 12:05 p.m.: 20160622-IR-405140338FRA)

405 IAC 5-37-2 Tobacco dependence products

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

Sec. 2. (a) Reimbursement is available to pharmacy providers for tobacco dependence products when prescribed by a practitioner within the scope of his or her license under Indiana law.

(b) In order for a pharmacy provider to receive reimbursement under this section for tobacco dependence products, the tobacco dependence product must be covered by Indiana Medicaid in accordance with 405 IAC 5-24-3 or 405 IAC 5-24-5.

(c) A member prescribed a legend or nonlegend drug intended to reduce an individual's dependence on tobacco products must engage in tobacco dependence counseling in conjunction with the receipt of said legend or nonlegend drug therapy. *(Office of the Secretary of Family and Social Services; 405 IAC 5-37-2; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; 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 May 27, 2016, 12:05 p.m.: 20160622-IR-405140338FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)*

405 IAC 5-37-3 Tobacco dependence counseling

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

Sec. 3. (a) Reimbursement is available for tobacco dependence counseling services rendered by licensed practitioners under applicable Indiana law participating in Medicaid and listed in subsection (c).

(b) A prescription for tobacco dependence products serves as documentation that the prescribing practitioner has prescribed or obtained assurance from the patient that counseling occurs corresponding to the receipt of tobacco dependence products.

(c) The following may provide tobacco dependence counseling services when prescribed by a practitioner within the scope of his or her license under Indiana law and within the limitations of this rule:

(1) A physician.
(2) A physician's assistant.
(3) A nurse practitioner.
(4) A registered nurse.
(5) A psychologist.
(6) A pharmacist.
(7) A dentist.
(8) An optometrist
(9) A clinical social worker.
(10) A marital and family counselor.
(11) A mental health counselor.
(12) A licensed clinical addictions counselor.

(Office of the Secretary of Family and Social Services; 405 IAC 5-37-3; filed Sep 27, 1999, 8:55 a.m.: 23 IR 324; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Oct 3, 2001, 9:47 a.m.: 25 IR 380; 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 May 27, 2016, 12:05 p.m.: 20160622-IR-405140338FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA)

Rule 38. Telemedicine Services

405 IAC 5-38-1 General provisions (Repealed)

Sec. 1. *(Repealed by Office of the Secretary of Family and Social Services; filed Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA)*

405 IAC 5-38-2 Definitions

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. The following definitions apply throughout this rule:

(1) "Hub site" means the location of the physician or provider rendering consultation services.

(2) "Interactive television" or "IATV" means the videoconferencing equipment at the hub and spoke site that allows real time, face-to-face consultation.

(3) "Spoke site" means the location where the patient is physically located when services are provided.

(4) "Store and forward" means the electronic transmission of medical information for subsequent review by a health care provider at the hub site. Restrictions placed on store and forward reimbursement in this rule shall not disallow the permissible use of store and forward technology to facilitate reimbursable services.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-2; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)

405 IAC 5-38-3 Description of service

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. 3. (a) In any telemedicine encounter, there will be the following:

(1) A hub site.

(2) A spoke site.

(3) An attendant to connect the patient to the specialist at the hub site.

(4) A computer or television monitor to allow the patient to have:

(A) real-time;

(B) interactive; and

(C) face-to-face;

communication with the hub specialist/consultant via IATV technology.

(b) Services may be rendered in an inpatient, outpatient, or office setting. *(Office of the Secretary of Family and Social Services; 405 IAC 5-38-3; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; readopted filed Oct 28, 2013, 3:18 p.m.: 20131127-IR-405130241RFA)*

405 IAC 5-38-4 Limitations

Authority: IC 12-15
Affected: IC 12-13-7-3

Sec. 4. Telemedicine shall be limited by the following conditions:

(1) The patient must:

(A) be physically present at the spoke site; and

(B) participate in the visit.

(2) The physician or practitioner who will be examining the patient from the hub site must determine if it is medically necessary for a medical professional to be at the spoke site. Separate reimbursement for a provider at the spoke site is payable only if that provider's presence is medically necessary. Adequate documentation must be maintained in the patient's medical record to support the need for the provider's presence at the spoke site during the visit. Such documentation is subject to postpayment review. If a health care provider's presence at the spoke site is medically necessary, billing of the appropriate

evaluation and management code is permitted.

(3) Reimbursement for telemedicine services is available to the following providers regardless of the distance between the provider and member:

(A) Federally qualified health centers.

(B) Rural health clinics.

(C) Community mental health centers.

(D) Critical access hospitals.

(4) Reimbursement for telemedicine services for all other eligible providers is available only when the distance between the hub and spoke sites are greater than twenty (20) miles. Adequate documentation must be maintained as service is subject to postpayment review.

(5) Store and forward technology is not reimbursable by Medicaid. The use of store and forward technology is permissible as defined under section 2(4) of this rule.

(6) The following service or provider types may not be reimbursed for telemedicine:

(A) Ambulatory surgical centers.

(B) Outpatient surgical services.

(C) Home health agencies or services.

(D) Radiological services.

(E) Laboratory services.

(F) Long term care facilities, including nursing facilities, intermediate care facilities, or community residential facilities for the developmentally disabled.

(G) Anesthesia services or nurse anesthetist services.

(H) Audiological services.

(I) Chiropractic services.

(J) Care coordination services.

(K) DME, medical supplies, hearing aids, or oxygen.

(L) Optical or optometric services.

(M) Podiatric services.

(N) Services billed by school corporations.

(O) Physical or speech therapy services.

(P) Transportation services.

(Q) Services provided under a Medicaid waiver.

(Office of the Secretary of Family and Social Services; 405 IAC 5-38-4; filed Feb 28, 2007, 2:42 p.m.: 20070328-IR-405060029FRA; 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 Sep 19, 2014, 3:22 p.m.: 20141015-IR-405140194FRA; filed Aug 1, 2016, 3:44 p.m.: 20160831-IR-405150418FRA; errata filed Nov 1, 2016, 9:36 a.m.: 20161109-IR-405160493ACA)

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