ARTICLE 12. PRIOR REVIEW OF OFF-SITE MEDICAL SERVICES; DEPARTMENT OF CORRECTION, STATE BOARD OF HEALTH, AND DEPARTMENT OF MENTAL HEALTH

Rule 1. Prior Review and Authorization of Requests for Off-Site Medical Services

470 IAC 12-1-1 Definitions

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-15-30; IC 12-16-1

Sec. 1. (a) "Affected agency" means the department of correction, the state board of health or the department of mental health.

(b) "Eligible individual" means any person, other than a Medicaid recipient, who requires medical or dental services while in the custody or care of an affected agency.

(c) "Health facility" means hospital, dispensary, out-patient department, practitioner's office, dental clinic, or other appropriate treatment facility.

(d) "Medical services" means services requested by a physician (M.D. or D.O.) or dentist, including the provision of supplies and use of appropriate health facilities. The term includes medical services or supplies provided by such other licensed practitioners, institutions or suppliers as a physician may specifically prescribe. Transportation services are specifically exempted from this rule *[470 IAC 12]*.

(e) "Covered medical services" means medical services subject to review by the department, hereinabove defined, which are provided to an eligible individual in a health facility or place other than an institution, at a total cost of more than $150.00. Such services include any medical or dental procedure, or series of such procedures related to a specific diagnosis, illness, injury, condition or syndrome.

(f) "Department" means the state department of public welfare (SDPW).

(g) "Request" means written or telephonic request for approval of medical services in the form and manner specified by the department.

(h) "Institution" means a facility housing, or responsible for, eligible individuals and operating under the jurisdiction of an affected agency.

(i) "SDPW 590 element" means the licensed medical professional staff of the department charged with the responsibility to prior review requests for medical services.

(j) "Emergency services" means those covered medical services which, by their medical nature, do not allow time for formal prior review by SDPW (see section 6 *[470 IAC 12-1-6]*).

(k) "Off-site services" means medical services delivered by a provider who is outside the administrative jurisdiction of any of the institutions of the affected agencies.

(l) "Prior review" means the professional review by the licensed medical professional staff of the SDPW 590 element, in advance of delivery, of a request for specific covered medical services for eligible individuals.

(m) "590 contractor" means the same fiscal agent with which it contracts under IC 12-1-7-17 *[Repealed by Acts 1984, P.L.80, SECTION 10. See IC 12-1-7-17.1]*, as it provides administrative and fiscal services in support of this rule *[470 IAC 12]*.

(n) "Provider" means a licensed or certified practitioner or institution which provides any medical or dental service, and which is properly enrolled in this program. *(Division of Family Resources; 470 IAC 12-1-1; filed Oct 26, 1983, 10:22 am: 7 IR 42; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-2 Criteria for authorization; procedural manual; private services not precluded

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 2. (a) Pursuant to IC 12-5-7 *[IC 12-5 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*, this rule *[470 IAC 12]* establishes procedures for prior review, and approval, conditional approval or denial, of requests for authorization of covered medical services.

(b) When acting upon requests, the department will consider the diagnosis and clinical summary of the individual, and the nature, duration and cost of the requested services, and will authorize only those that are requested by a physician or dentist and an official of an agency or institution, and are determined by licensed medical personnel of the department to be medically necessary and reasonable. For the purposes of this rule *[470 IAC 12]*, medically necessary and reasonable services are those which medical staff personnel of the SDPW 590 element determine, under the circumstances of each case, to be essential to the restoration or maintenance of physical or mental health.

(c) Each affected agency will be responsible for developing and maintaining a procedures manual which prescribes their policies for processing the request for and delivery of medical services.

(d) This rule *[470 IAC 12]* does not preclude any medical service from being provided at the expense of persons or entities other than the state of Indiana. *(Division of Family Resources; 470 IAC 12-1-2; filed Oct 26, 1983, 10:22 am: 7 IR 43; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-3 Request forms

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 3. (a) Requests for medical services must be made on forms specified by the department, using procedures developed by the department.

(b) Request forms shall contain such information as the department deems necessary to implement the provisions of IC 12-5-7 *[IC 12-5 was repealed by P.L.2-1992, SECTION 897, effective February 14, 1992.]*.

(c) The department is not required to review any request form which is not properly signed and co-signed, and which has not been completed in its entirety. Request forms shall be returned without action if they are incomplete, illegible, or if they bear rubber-stamp; facsimile; machine-drawn, or any other substitute signature. *(Division of Family Resources; 470 IAC 12-1-3; filed Oct 26, 1983, 10:22 am: 7 IR 43; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-4 Provider agreements

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 4. A licensed provider of medical services may participate under this rule *[470 IAC 12]* upon signing a provider agreement. This agreement will not obligate the provider to participate in Title XIX of the Social Security Act. Said agreement shall include, among other provisions, assignment of a provider number, standards of provider performance, sanctions for provider abuses, and grounds for cancellation of the provider agreement. *(Division of Family Resources; 470 IAC 12-1-4; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-5 Review of requests

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 5. The department will review each request, and approve, conditionally approve, or deny same, without unnecessary delay. The department's decision will be made within ten (10) working days after it has received necessary documentation. If the original request is incomplete, or if additional information is required to clarify or supplement the request, the ten (10) day period shall begin upon receipt of such additional information. *(Division of Family Resources; 470 IAC 12-1-5; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA;*

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470 IAC 12-1-6 Emergency services

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 6. (a) The provider shall be compensated for emergency services if:

(1) The services are provided to an eligible individual requiring the treatment of a medical or surgical emergency, the nature of which precludes submission of a request to the SDPW 590 element.

(2) The services are provided to an eligible individual whose condition which, though not a bonafide medical or surgical emergency, is such that delay of immediate medical attention would cause deterioration of the patient's condition. This provision does not authorize any service which safely can be delayed pending SDPW 590 element approval of a request.

(b) Claims for emergency medical services described in section 6(a)(1) above are exempted from the prior approval provisions of this rule *[470 IAC 12]*, but must be appropriately and clearly identified and certified as such on billing forms.

(c) During the normal work week, telephonic requests may be made for services mentioned in section 6(a)(2) of this rule *[470 IAC 12]*, where delay of such services would cause deterioration of the patient's condition or result in unnecessary confinement or expense. For such services required during other than the normal work week, such telephonic requests shall be made on the first state working day following delivery of the service. The procedure for making telephonic requests will be specified by the department, and will include the requirement for follow-up with a formal request. Telephone approval of a service shall not serve as the basis for billing. All telephone approvals must be documented through the formal request process, and the approved documentation used to support any claims resulting from the services. *(Division of Family Resources; 470 IAC 12-1-6; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-7 Authorization, denial, or conditional approval; notice

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 7. (a) A request may be approved, denied, or conditionally approved. Conditional approval authorizes a service subject to the SDPW 590 element limitations on the nature, extent, duration or cost of the service.

(b) The department shall give prompt notice of any approval, denial or conditional approval to the affected agency having jurisdiction over the eligible individual, and it shall be the responsibility of such affected agency to promptly notify the eligible individual of the department's action. *(Division of Family Resources; 470 IAC 12-1-7; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

470 IAC 12-1-8 Appeals

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-16-1

Sec. 8. (a) The department's action in denying a request for covered medical services, or in granting conditional approval of such request, may be appealed by the individual in whose behalf the request was made.

(b) A person or entity who has provided any covered medical service may appeal the department's denial of compensation for same.

(c) All appeals from department action under 470 IAC 12 shall be governed by the provisions of 470 IAC 1-4. *(Division of Family Resources; 470 IAC 12-1-8; filed Oct 26, 1983, 10:22 am: 7 IR 44; filed May 22, 1987, 12:45 pm: 10 IR 2284, eff Jul 1,*

1987; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)

470 IAC 12-1-9 Payment for services

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3
Affected: IC 12-15-30; IC 12-16-1

Sec. 9. (a) The rate of payment for the services and materials provided under this rule *[470 IAC 12]* shall be the same as that applied to Title XIX services and materials pursuant to IC 12-1-7-17 *[Repealed by Acts 1984, P.L.80, SECTION 10. See IC 12-1-7-17.1]*, except that, when an estimate has been provided, and the estimate is lower than either the submitted charge or the Title XIX reimbursement rate (where available), the reimbursement will be in the amount of the estimate. Payment made under this rule *[470 IAC 12]* shall be considered payment in full.

(b) Claims for payment shall be submitted on forms specified by the department. Claims shall be denied if they do not include all the information required by the department, or if they cover services which have not been approved by the department.

(c) A provider shall not bill this program more than the usual and customary charge to the provider's private pay customers.

(d) The procedure provided in 470 IAC 5-1-3.6 *[405 IAC 1-1-5]* for recovery of overpayments shall apply to the recovery of overpayments made to providers under this rule *[470 IAC 12]*.

(e) The provisions of 470 IAC 5-5-1 *[405 IAC 1-5-1]* respecting maintenance of records shall apply to providers of covered medical services under this rule *[470 IAC 12]*. *(Division of Family Resources; 470 IAC 12-1-9; filed Oct 26, 1983, 10:22 am: 7 IR 45; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235; readopted filed Oct 24, 2007, 11:25 a.m.: 20071121-IR-470070448RFA; readopted filed Aug 23, 2013, 3:36 p.m.: 20130918-IR-470130306RFA; readopted filed Nov 13, 2019, 11:56 a.m.: 20191211-IR-470190490RFA)*

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