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TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #03-207

DIGEST

Amends 405 IAC 5-19-3 to modify the reimbursement methodology for durable medical equipment (DME); to permit the office to establish reimbursement rates for used DME; to require providers to bill for services using their usual and customary charges defined as the amount charged to the general public for services; to establish reimbursement as the lower of the provider's usual and customary charges or the maximum allowable fee schedule amount; to establish a new maximum allowable fee schedule for DME; to permit the office to establish a manual fee when information is not available to determine a fee schedule amount; to require providers to submit acquisition cost information; and to permit the office to update the maximum allowable fee schedule in accordance with the provisions therein. Effective 30 days after filing with the secretary of state.

405 IAC 5-19-3

SECTION 1. 405 IAC 5-19-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 5-19-3 Reimbursement parameters for durable medical equipment
Authority: IC 12-8-6-5; 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 the rental or purchase of **new or used** 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 recipients 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 recipients to purchase or rent such equipment with their personal funds.

(c) Reimbursement of DME is ~~based upon Medicare's fee schedule for fiscal year 1993 and classes of DME. The established Medicaid rates will be reviewed annually and adjusted as necessary. A separate fee schedule will be established for each of~~ **the lower of the provider's usual and customary charges, defined as the amount charged to the general public for services, or the maximum allowable fee schedule amount subject to subsections (g) through (j) and includes** the following six (6) classes:
(1) Capped rental items.
(2) Inexpensive and other routinely purchased DME.
(3) Items requiring frequent and substantial servicing.

(4) Customized items.
(5) Prosthetic and orthotic devices.
(6) Oxygen and oxygen equipment.

(d) DME reimbursed at less than one hundred fifty dollars ($150) or other amount as defined by the office will not be subject to the capped rental payment, but rather be reimbursed on a rental or lump sum purchase with prior authorization. The total payment for the rental period may not exceed the purchase price.

(e) 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.

(f) All DME must be ordered in writing by a physician. The written order must be kept on file for audit purposes.

(g) For DME items that comprise eighty percent (80%) of annual Medicaid payments for DME from the state fiscal year ended June 30, 2003, the maximum allowable fee schedule amount is based on the lowest of the following:
(1) The average acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).
(2) The Medicare rate of reimbursement for Indiana in effect as of July 1, 2003.
(3) The Medicaid rate of reimbursement in effect as of July 1, 2003.

(h) For items that comprise twenty percent (20%) of annual Medicaid payments for DME from the state fiscal year ended June 30, 2003, the maximum allowable fee schedule amount is based on the lowest of the following:
(1) The providers' average usual and customary charges of the item adjusted by a multiplier of no less than eight-tenths (.8).
(2) The Medicare rate of reimbursement for Indiana in effect as of July 1, 2003.
(3) The Medicaid rate of reimbursement in effect as of July 1, 2003.

(i) When information is not available to determine a maximum allowable fee for Healthcare Common Procedure Coding System (HCPCS) codes, the office may establish a fee under manual pricing. As used in this section, manual pricing equals the provider's acquisition cost of the item multiplied by one and two-tenths (1.2). Providers are required to submit acquisition cost information in order to receive manual pricing.

(j) For new HCPCS codes, as determined by the American Medical Association, the Centers for Medicare and Medicaid Services, or the HIPAA code maintenance committee, the office will establish a fee equal to the lowest of the following:
(1) Acquisition cost of the item adjusted by a multiplier of one and two-tenths (1.2).
(2) The Medicare rate of reimbursement for Indiana in effect at that time.
(3) The providers' usual and customary charge of the item adjusted by a multiplier of no less than eight-tenths (.8).
When items listed in this subsection are not available, the office may use manual pricing under subsection (i).

(k) Providers must bill using their usual and customary charge, subject to subsection (c), for each DME 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.

(l) Providers that are reimbursed under this section are required, as a condition of participation, to make available and submit to the OMPP or its designee acquisition cost information, product availability information, or other information deemed necessary by the OMPP to determine and maintain the fees determined and in the format requested by the OMPP or its designee. Providers will not be reimbursed for this information and will submit information to the OMPP or its designee within thirty (30) days following a request for such information unless the OMPP or its designee grants an extension upon written request of the provider.

(m) The office may update the maximum allowable fee schedule as necessary subject to subsections (g) through

(j) using the Medicare fee schedule for Indiana in effect at that time and most recently available Medicaid utilization to determine codes established by acquisition cost or usual and customary charges. *(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)*

Notice of Public Hearing

Under IC 4-22-2-24, notice is hereby given that on October 29, 2003 at 9:00 a.m., at the Indiana Government Center-South, 402 West Washington Street, Conference Room A, Indianapolis, Indiana the Office of the Secretary of Family and Social Services will hold a public hearing on proposed amendments to the Indiana Health Coverage Program's ("Indiana Medicaid") reimbursement of durable medical equipment.

In accordance with the public notice requirements of 42 CFR 447.205, the Indiana Family and Social Services Administration publishes this notice of proposed amendments to the Medicaid reimbursement of durable medical equipment. The amendments to 405 IAC 5-19-3 modify the reimbursement methodology for durable medical equipment (DME), permit the office to establish reimbursement rates for used DME; require providers to bill for services using their usual and customary charges defined as the amount charged to the general public for services; establish reimbursement as the lower of the provider's usual and customary charges or the maximum allowable fee schedule amount; establish a new maximum allowable fee schedule for DME; permit the office to use manual pricing when information is not available to determine a maximum allowable fee; permit the office to establish fees for new codes using acquisition cost information, usual and customary charges, or the Medicare fee schedule; require providers to submit acquisition cost information to the office; and permit the office to update the maximum allowable fee schedule in accordance with the provisions of the regulation. The amendments are being made to provide reimbursement for durable medical equipment items that is consistent with providers' cost of DME items; to update the fee schedule amounts; and to update the source of information used to establish fee schedule amounts; The proposed amendments are expected to generate fiscal savings to the state of approximately $370,000 and aggregate savings of approximately $1.0 million annually. The amendments will be effective upon approval from the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) of the state plan amendments and upon the effective date of this rule.

Copies of this notice and the proposed rule will be available for public review by contacting the Director of the local office of the Division of Family and Children, except in Marion County. The inspection material will be available for public viewing in Marion County at the Office of Medicaid Policy and Planning, 402 West Washington Street, Room W382, and will be available from 8:30 a.m. to 4:30 p.m., Monday through Friday. Written comments concerning these proposed amendments should be directed to: Kate Bowen, Office of Medicaid Policy and Planning, MS07 402 West Washington Street, Indianapolis, Indiana 46204. Written comments may be viewed by contacting Kate Bowen at (317) 233-1662. Copies of these rules are now on file at the Indiana Government Center-South, 402 West Washington Street, Room W382 and Legislative Services Agency, One North Capitol, Suite 325, Indianapolis, Indiana and are open for public inspection.

Pat Rios
Secretary
Office of the Secretary of Family and Social Services