TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Proposed Rule
LSA Document #13-422

DIGEST

Amends 405 IAC 1-4.2-4 to modify Medicaid reimbursement formulas by reducing reimbursement for all covered home health services through June 30, 2015. Amends 405 IAC 1-8-3 to modify Medicaid reimbursement formulas by reducing reimbursement for all covered outpatient hospital services through June 30, 2015, and adding nonpayment provisions for provider-preventable conditions as noncovered Medicaid services. Amends 405 IAC 1-10.5-4 and 405 IAC 1-10.5-5 and adds 405 IAC 1-10.5-6 to modify the out-of-state hospital payment methodology, to add nonpayment provisions for health care-acquired and provider-preventable conditions, and to modify Medicaid reimbursement formulas by reducing reimbursement for all covered inpatient hospital services through June 30, 2015. Amends 405 IAC 1-11.5-2 to add nonpayment provisions for provider-preventable conditions. Adds 405 IAC 1-12-27 to modify Medicaid reimbursement formulas by reducing reimbursement for all services provided by privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) through June 30, 2015. Adds 405 IAC 1-14.6-26 to modify Medicaid reimbursement formulas by reducing reimbursement for all nursing facility services through June 30, 2015. Amends 405 IAC 5-19-1, 405 IAC 5-19-3, and 405 IAC 5-19-13 through 405 IAC 5-19-15 to modify the Medicaid rate setting methodology for medical supplies, medical equipment, and hearing aids, clarifying the prior authorization process for hearing aids and ear molds, and clarifying that hearing aids may be replaced more frequently in certain circumstances. Amends 405 IAC 5-24-6 to increase the Medicaid dispensing fee maximum to three dollars and ninety cents ($3.90) beginning on January 1, 2013, and continuing through June 30, 2015. Effective 30 days after filing with the Publisher.

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

405 IAC 1-4.2-4; 405 IAC 1-8-3; 405 IAC 1-10.5-4; 405 IAC 1-10.5-5; 405 IAC 1-10.5-6; 405 IAC 1-11.5-2; 405 IAC 1-12-27; 405 IAC 1-14.6-26; 405 IAC 5-19-1; 405 IAC 5-19-3; 405 IAC 5-19-13; 405 IAC 5-19-14; 405 IAC 5-19-15; 405 IAC 5-24-6

SECTION 1. 405 IAC 1-4.2-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-4.2-4 Home health care services; reimbursement methodology

Authority: IC 12-15
Affected: IC 12-15-13-2; IC 12-15-22-1

Sec. 4. (a) Home health agencies will be reimbursed for covered services provided to Medicaid recipients through standard, statewide rates, computed as:

(1) one (1) overhead cost rate per provider, per recipient, per day; plus

(2) the staffing cost rate multiplied by the number of hours spent in the performance of billable patient care activities;

to equal the total reimbursement per visit.

(b) The overhead cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median overhead cost per visit. The statewide median overhead cost per visit is derived in the following manner:

(1) Determine for each HHA total patient-related costs submitted by HHA providers on forms prescribed by the office, less direct staffing and benefit costs, divided by the total number of HHA visits during the Medicaid reporting period for that provider. The result of this calculation is an overhead cost per visit for each HHA.

(2) Array all HHA providers in the state in accordance with their overhead cost per visit, from the highest to the lowest cost.

(3) The statewide median overhead cost per visit is the cost of the agency at the point in the overhead cost array at which one-half (1/2) of the overhead cost observations are from higher-cost agencies and one-half (1/2) are from lower-cost agencies.

(c) The staffing cost rate is a flat, statewide rate based on ninety-five percent (95%) of the statewide median direct staffing and benefit costs per hour for each of the following disciplines:

(1) Registered nurse.

(2) Licensed practical nurse.
(3) Home health aide.
(4) Physical therapist.
(5) Occupational therapist.
(6) Speech pathologist.

(d) The statewide median direct staffing and benefit costs per hour is derived in the following manner:
(1) Determine for each HHA total patient-related direct staffing and benefit costs submitted by HHA providers on forms prescribed by the office, divided by the total number of HHA hours worked during the Medicaid reporting period for that provider for each discipline. The result of this calculation is a staffing cost rate per hour for each HHA and discipline.
(2) Array all HHA providers in the state in accordance with their staffing cost rate per hour for each discipline, from the highest to the lowest.
(3) The statewide median staffing cost rate per hour for each discipline is the cost of the agency at the point in the staffing cost array in which one-half (1/2) of the cost observations are from agencies with higher staffing rates per hour and one-half (1/2) are from agencies with lower staffing rates per hour.

(e) All HHAs must keep track of and make available for audit total hours paid and hours paid relating to vacation, holiday, and sick pay for all HHA personnel.

(f) Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the most recently filed Medicare cost report. Non-Medicare-certified HHA providers are required to submit a Medicaid cost report on forms prescribed by the office and the latest fiscal year end financial statements.

(g) Rate setting shall be prospective, based on the provider's initial or annual cost report for the most recent completed period. In determining prospective allowable costs, each provider's cost from the most recent completed year will be adjusted for inflation using the Center for Medicare & Medicaid Services Home Health Agency Market Basket index. The inflation adjustment shall apply from the midpoint of the initial or annual cost report period to the midpoint of the next expected rate period.

(h) The semivariable cost will be removed from the overhead cost calculated in accordance with subsection (b) and added to the staffing cost calculated in accordance with subsection (c), based on hours worked.

(i) Field audits will be conducted yearly on a selected number of home health agencies. Any audit adjustments shall be incorporated into the calculation of agency costs to be included in the rate arrays.

(j) Financial and statistical documentation may be requested by the office or its contractor. This documentation may include, but is not limited to, the following:
(1) Medicaid cost reports.
(2) Medicare cost reports.
(3) Statistical data.
(4) Financial statements.
(5) Other supporting documents deemed necessary by the office or the rate setting contractor.
Failure to submit requested documentation may result in the imposition of the sanctions described in section 3.1(c) and 3.1(d) of this rule and sanctions set forth in IC 12-15-22-1.

(k) Retroactive repayment will be required when any of the following occur:
(1) A field audit identifies overpayment by Medicaid.
(2) The provider knowingly receives overpayment of a Medicaid claim from the office. In this event, the provider must:
(A) complete appropriate Medicaid billing adjustment forms; and
(B) reimburse the office for the amount of the overpayment.

(l) Notwithstanding all other provisions of this rule, for the period beginning January 1, 2014, and continuing through June 30, 2015, reimbursement shall be reduced by three percent (3%) for home health services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-4.2-4; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3376; errata filed Sep 24, 1996, 3:20 p.m.: 20 IR 332; filed Jan 9, 1997, 4:00 p.m.: 20 IR 1117; filed Oct 8, 1998, 12:23 p.m.: 22 IR 434; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Jun 18, 2007, 11:38 a.m.: 20070718-IR-405070031FRA; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 2. 405 IAC 1-8-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-8-3 Reimbursement methodology

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

Sec. 3. (a) The reimbursement methodology for all covered outpatient hospital and ambulatory surgical center services shall be subject to the lower of the submitted charges for the procedure or the established fee schedule allowance for the procedure as provided in this section. Services shall be billed in accordance with provider manuals and update bulletins.

(b) Surgical procedures shall be:
(1) classified into a group corresponding to the Medicare ambulatory surgical center (ASC) methodology; and
(2) paid a rate established for each ASC payment group.
Outpatient surgeries that are not classified into the nine (9) groups designated by Medicare will be classified by the office into one (1) of those nine (9) groups or additional payment groups. Reimbursement will be based on the Indiana Medicaid statewide allowed amount for that service in effect during state fiscal year 2003.

(c) Payments for emergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(d) Payments for nonemergent care that:
(1) do not include surgery; and
(2) are provided in an emergency department, treatment room, observation room, or clinic;
will be based on the statewide fee schedule amount in effect during state fiscal year 2003.

(e) Reimbursement for laboratory procedures is based on the Medicare fee schedule amounts. Reimbursement for the technical component of radiology procedures shall be based on the Indiana Medicaid physician fee schedule rates for the radiology services technical component.

(f) Reimbursement allowances for all outpatient hospital procedures not addressed elsewhere in this section, for example, therapies, testing, etc., shall be equal to the Indiana Medicaid statewide fee schedule amounts in effect during state fiscal year 2003.

(g) Payments will not be made for outpatient hospital and ambulatory surgical center services occurring within three (3) calendar days preceding an inpatient admission for the same or related diagnosis. The office may exclude certain services or categories of service from this requirement. Such exclusions will be described in provider manuals and update bulletins.

(h) The established rates for hospital outpatient and ambulatory surgical center reimbursement shall be reviewed annually by the office and adjusted, as necessary, in accordance with this section.

(i) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(j) Notwithstanding all other provisions of this rule, for the period beginning January 1, 2014, and continuing through June 30, 2015, reimbursement shall be reduced by three percent (3%) for outpatient hospital services (excluding ambulatory surgical center reimbursement) that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-8-3; filed Dec 2, 1993, 2:00 p.m.: 17 IR 736; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 24, 2004, 11:15 a.m.: 27 IR 2247; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Aug 16, 2010, 3:35 p.m.: 20100915-IR-405100167FRA)

SECTION 3. 405 IAC 1-10.5-4 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-4 Reimbursement for new providers and out-of-state providers

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

Sec. 4. (a) The purpose of this section is to establish payment rates for inpatient hospital facilities that commenced participation in the state Medicaid program after fiscal year 1990 and for out-of-state hospital providers participating in the Indiana Medicaid program.

(b) Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate calculated using the statewide median capital rate, the medical education rate, and, if applicable, the outlier payment calculated using the statewide median cost-to-charge ratio.

(c) Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate calculated using the statewide median capital rate, and the medical education rate.

(d) Outlier payments for inpatient stays reimbursed under subsection (b) shall be determined according to the methodology described in section 3 of this rule. ~~however, for purposes of estimating costs,~~ **Each out-of-state hospital that submits an Indiana Medicaid hospital cost report will receive a cost-to-charge ratio. All other out-of-state facilities must use** the statewide **median** cost-to-charge ratio ~~shall be used~~ **to determine applicable cost outlier payments.**

(e) To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) ~~through~~ **and** 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement. **The facility-specific per diem medical education rate for an out-of-state provider shall not exceed the highest in-state medical education per diem rate.**

(f) To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) ~~through~~ **and** 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-4; filed Oct 5, 1994, 11:10 a.m.: 18 IR 246; filed Dec 19, 1995, 3:00 p.m.: 19 IR 1084; filed Dec 27, 1996, 12:00 p.m.: 20 IR 1517; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Aug 31, 2001, 9:53 a.m.: 25 IR 59; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA)

SECTION 4. 405 IAC 1-10.5-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-10.5-5 Health care-acquired conditions and other provider-preventable conditions

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

Sec. 5. (a) This section applies to the following:
(1) Payment for inpatient stays reimbursed according to the DRG ~~methodology.~~ **and level-of-care methodologies.**
(2) All inpatient hospital facility reimbursement provisions, including the following:

(A) Medicaid supplemental payments.
(B) Medicaid enhanced payments.
(C) Medicaid disproportionate share hospital payments.

(b) The DRG to be assigned for an inpatient stay shall be a DRG that does not result in higher payment based on the presence of a ~~hospital-acquired~~ **health care-acquired** condition that was not present on the date of admission. If a ~~hospital-acquired~~ **health care-acquired** condition is not present on the date of admission, the discharge will be assigned to a DRG as though the ~~hospital-acquired~~ **health care-acquired** condition was not present.

(c) Secondary diagnoses that are present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for Medicaid reimbursement to be made. Secondary diagnoses that are not present on the date of admission must be designated as such as part of the claim information submitted by an inpatient hospital facility in order for the diagnoses to be excluded for purposes of assigning the claim to a DRG.

(d) For purposes of this section, a ~~"hospital~~ **"health care-**acquired condition" means a condition associated with a diagnosis code selected by the Secretary of the U.S. Department of Health and Human Services pursuant to 42 U.S.C. 1395ww(d)(4)(D) **and 42 CFR 447.26(b)** and in effect on the date of admission.

(e) The state shall not pay for other provider-preventable conditions, as defined at 42 CFR 447.26(b).

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-5; filed Aug 28, 2009, 3:38 p.m.: 20090923-IR-405090202FRA)

SECTION 5. 405 IAC 1-10.5-6 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-10.5-6 Rate reduction

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

Sec. 6. Notwithstanding all other provisions of this rule, for the period beginning January 1, 2014, and continuing through June 30, 2015, reimbursement shall be reduced by three percent (3%) for inpatient hospital services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-10.5-6)

SECTION 6. 405 IAC 1-11.5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-11.5-2 Reimbursement methodology

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

Sec. 2. (a) The office shall establish fee schedules with maximum allowable payment amounts for services and procedures:
(1) covered under the Medicaid program; and
(2) provided by eligible physicians, LLPs, and other NPPs.

(b) The reimbursement for services of physicians and LLPs shall be determined as follows:
(1) Reimbursement for services of physicians and LLPs, except services of the physicians in subdivisions (3) through (10), shall be equal to the lower of the following:
(A) The submitted charges for the procedure.
(B) The established fee schedule allowance for the procedure. The statewide established fee schedule allowance for the procedure is based on the Medicare relative value unit for an Indiana urban locality multiplied by the conversion factor for the procedure as established by the office of Medicaid policy and planning (office).

(2) If no Medicare relative value unit, as defined in this section, exists for a procedure, reimbursement will be established as follows:

(A) Relative value units may be:

(i) obtained from other state Medicaid programs; or

(ii) developed specifically for the Indiana Medicaid program, subject to review by the Medicaid director.

(B) For laboratory procedures not included in the Medicare Part B fee schedule for physician services, reimbursement will be made using the fee value in the national Medicare clinical laboratory fee schedule.

(3) The office may set reimbursement for specific procedure codes using a different methodology from that specified in subdivisions (1) and (2) in order to preserve access to the specific service.

(4) Reimbursement for services of anesthesiologists shall be based on a statewide fee schedule. The statewide fee schedule for anesthesiology services is based on the total base and time units for the procedure multiplied by the conversion factor as established by the office.

(5) Reimbursement for services of assistant surgeons shall be equal to twenty percent (20%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).

(6) Reimbursement for services of cosurgeons shall be paid at sixty-two and one-half percent (62.5%) of the statewide fee schedule for physician and LLP services as established under subdivision (1).

(7) Reimbursement for services of physicians and LLPs shall be subject to the global surgery policy as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services. The global surgery policy will not apply to the following codes:

(A) 59410–Vaginal delivery, including postpartum care.

(B) 59515–Caesarean delivery, including postpartum care.

(8) Reimbursement for services of physicians and LLPs shall be subject to the policy for supplies and services incident to other procedures as defined by the Health Care Financing Administration for the Medicare Part B fee schedule for physician services.

(9) Separate reimbursement will not be made for radiologic contrast material, except for low osmolar contrast material (LOCM) used in intrathecal, intravenous, and in intra-arterial injections, if it is used for patients who meet the criteria established by the office.

(10) Reimbursement for services of physicians and LLPs shall be subject to the site of service payment adjustment. Procedures performed in an outpatient setting that are normally provided in a physician's office will be paid at eighty percent (80%) of the statewide fee schedule for physician and LLP services as established under subdivision (1). These procedures are identified using the site of service indicator on the Medicare fee schedule database.

(c) Reimbursement for services of NPPs shall be in accordance with the following:

(1) Reimbursement for services of dentists in calendar year 1994 shall be based on a statewide fee schedule equal to a percentage of the fiscal year 1992 submitted charges. That percentage shall be not lower than the average percentage difference between physician and LLP submitted charges and the fee established for those services in accordance with subsection (b)(1). The office may set reimbursement for specific dental procedures using a different methodology from that specified in this subdivision in order to preserve access to the service. Beginning with the effective date of this revised rule, fees for covered dental services are priced at the levels in effect at the end of calendar year 1994, increased by a percentage determined by the office.

(2) Reimbursement for services of:

(A) social workers certified through the American Academy of Certified Social Workers (ACSW) or who have masters of social work (MSW) degrees;

(B) psychologists with basic certificates; and

(C) licensed psychologists;

providing outpatient mental health services in a physician-directed outpatient mental health facility in accordance with 405 IAC 5-20-8 shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must continue to be billed through a physician or a physician-directed outpatient mental health facility.

(3) Reimbursement for services provided by independently practicing respiratory therapists and advance practice nurses shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1).

(4) Reimbursement for services provided by certified physical therapists' assistants shall be equal to seventy-five percent (75%) of the physician and LLP fees for that service as established under subsection (b)(1). These services must be billed through the supervising licensed physical therapist or physician.

(5) Blood factor products used during an inpatient hospital stay shall be paid based on the state maximum allowable cost (state MAC) rate for the blood factor products. The state MAC rate for blood factor products 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 office will review the state MAC rates for blood factor products on an ongoing basis and adjust the rates as necessary to:

(A) reflect the prevailing market conditions; and

(B) ensure reasonable access by inpatient hospital providers to blood factor products at or below the applicable state MAC rate.

Inpatient hospitals shall submit claims for reimbursement in accordance with the instructions set forth in the provider manual or update bulletins.

(6) Reimbursement for services of all other NPPs shall be equal to the statewide fee schedule for physician and LLP services as established under subsection (b)(1).

(d) The established rates for physician, LLP, and NPP reimbursement shall be reviewed annually by the office and adjusted as necessary.

(e) The relative value units used for the Indiana resource-based relative value scale fee schedule will be reviewed annually, taking into account the Medicare fee schedule proposed by the Health Care Financing Administration to take effect January 1 of the following calendar year and adjusted as necessary.

(f) Reimbursement for physician-administered drugs shall be one hundred five percent (105%) of the published wholesale acquisition cost (WAC) of the benchmark National Drug Code (NDC). For benchmark NDCs without a published WAC, the reimbursement for physician-administered drugs shall be the Medicare payment amount as published by the Centers for Medicare and Medicaid Services (CMS). If no WAC or Medicare payment amount is available, other pricing metrics may be used as determined by the office. This provision shall not apply to parenteral nutrition and blood factor products.

(g) Notwithstanding all other provisions of this rule, for the period beginning upon the later of the effective date of LSA Document #10-793 or June 27, 2011, and continuing through June 30, 2013, reimbursement shall be reduced by five percent (5%) for chiropractic and podiatric services that have been calculated under this rule and for dental services that are billed using current dental terminology (CDT) codes that have been calculated under this rule.

(h) The state shall not pay for provider-preventable conditions, as defined at 42 CFR 447.26(b).

(Office of the Secretary of Family and Social Services; 405 IAC 1-11.5-2; filed Sep 6, 1994, 3:25 p.m.: 18 IR 88; errata filed Oct 18, 1994, 3:25 p.m.: 18 IR 532; filed Jun 21, 1995, 4:00 p.m.: 18 IR 2767; errata filed Sep 29, 1995, 1:30 p.m.: 19 IR 209; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; filed Feb 3, 2006, 2:00 p.m.: 29 IR 1901; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Sep 12, 2008, 12:34 p.m.: 20081008-IR-405080186FRA; filed Aug 19, 2010, 3:32 p.m.: 20100915-IR-405100250FRA; filed May 9, 2011, 3:59 p.m.: 20110608-IR-405100793FRA)

SECTION 7. 405 IAC 1-12-27 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-12-27 Rate reduction

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

Sec. 27. Notwithstanding all other provisions of this rule, for the period beginning January 1, 2014, and continuing through June 30, 2015, reimbursement shall be reduced by one percent (1%) for services provided by all privately (nonstate) owned intermediate care facilities for the mentally retarded (ICFs/MR) and community residential facilities for the developmentally disabled (CRFs/DD) that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-12-27)

SECTION 8. 405 IAC 1-14.6-26 IS ADDED TO READ AS FOLLOWS:

405 IAC 1-14.6-26 Rate reduction

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

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

Sec. 26. Notwithstanding all other provisions of this rule, for the period beginning January 1, 2014, and continuing through June 30, 2015, reimbursement shall be reduced by three percent (3%) per resident day for nursing facility services that have been calculated under this rule.

(Office of the Secretary of Family and Social Services; 405 IAC 1-14.6-26)

SECTION 9. 405 IAC 5-19-1 IS AMENDED TO READ AS FOLLOWS:

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 of documented necessity, at a rate determined by the office; and
(2) for recipients 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 recipient is a Medicare beneficiary 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 ~~to be effective on the effective date of this rule is the base statewide fee schedule amount equal to the lower of~~ **is** the Medicaid fee schedule amount in effect ~~during state fiscal year (SFY) 2001 or the~~ **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).

~~(1)~~ **(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 ~~(2).~~ **(3).**

~~(2) The Indiana Medicare fee schedule amount adjusted by a multiplier of not less than eight-tenths (.8), if available. If this amount is not available, then subdivision (3).~~

~~(3) The weighted median of providers' usual and customary charges adjusted by a multiplier of not less than eight-tenths (.8), if available. If this amount is not available, then subdivision (4).~~

~~(4) The Medicaid fee schedule amount in effect during SFY 2001, if available. If this amount is not available, then subdivision (5).~~

~~(5) The average Indiana Medicaid payment amount per item during SFY 2001.~~

(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, ~~using the:~~
~~(1) Medicare fee schedule; and~~
~~(2) providers':~~
~~(A) usual and customary charges; and~~
~~(B) acquisition cost information;~~
subject to ~~subsection~~ **subsections** (k)(1) through ~~(k)(5).~~ **(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)

SECTION 10. 405 IAC 5-19-3 IS AMENDED TO READ AS FOLLOWS:

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

Authority: IC 12-15
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 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 following six (6) classes:~~ **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) 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.~~

(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.

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

~~(e)~~ **(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.

~~(f)~~ **(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)

SECTION 11. 405 IAC 5-19-13 IS AMENDED TO READ AS FOLLOWS:

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 recipient 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. ~~All hearing aids purchased by the office, which are no longer needed by a recipient, must be returned to the county office of family and children.~~

(4) Hearing aids are not covered for recipients 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 recipient 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)

SECTION 12. 405 IAC 5-19-14 IS AMENDED TO READ AS FOLLOWS:

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 recipients under ~~eighteen (18)~~ **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 under the Medicaid program.

(5) No payment shall be made for repair or replacement of hearing aids necessitated by recipient 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)

SECTION 13. 405 IAC 5-19-15 IS AMENDED TO READ AS FOLLOWS:

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 recipient's hearing status; and ~~must~~

(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 recipients under ~~eighteen (18)~~ **twenty-one (21)** years of age if circumstances are documented justifying medical necessity.

(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)

SECTION 14. 405 IAC 5-24-6 IS AMENDED TO READ AS FOLLOWS:

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, the Indiana Medicaid dispensing fee maximum is four dollars and ninety cents ($4.90) per legend drug. **For the period beginning upon the later of the effective date of this rule or January 1, 2014, and continuing through June 30, 2015, the Indiana 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 recipient per drug order for legend drugs provided to Medicaid recipients 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)

Notice of Public Hearing

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