IC 12-15-21

Chapter 21. Rules

IC 12-15-21-1

Acceptance by provider of Medicaid claim payment; agreement to comply with statutes and rules

Sec. 1. A provider who accepts payment of a claim submitted under the Medicaid program is considered to have agreed to comply with the statutes and rules governing the program.

As added by P.L.2-1992, SEC.9.

IC 12-15-21-2

Secretary to adopt rules; consistency with Title XIX of Social Security Act

Sec. 2. The secretary shall, with the advice of the office's medical staff, adopt rules under IC 4-22-2 and consistent with Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) and regulations promulgated under the federal Social Security Act.

As added by P.L.2-1992, SEC.9.

IC 12-15-21-3

Required rules

Sec. 3. The rules adopted under section 2 of this chapter must include the following:

(1) Providing for prior review and approval of medical services.

(2) Specifying the method of determining the amount of reimbursement for services.

(3) Establishing limitations that are consistent with medical necessity concerning the amount, scope, and duration of the services and supplies to be provided. The rules may contain limitations on services that are more restrictive than allowed under a provider's scope of practice (as defined in Indiana law).

(4) Denying payment or instructing the contractor under IC 12-15-30 to deny payment to a provider for services provided to an individual or claimed to be provided to an individual if the office after investigation finds any of the following:

(A) The services claimed cannot be documented by the provider.

(B) The claims were made for services or materials determined by licensed medical staff of the office as not medically reasonable and necessary.

(C) The amount claimed for the services has been or can be paid from other sources.

(D) The services claimed were provided to a person other than the person in whose name the claim is made.

(E) The services claimed were provided to a person who was not eligible for Medicaid.

(F) The claim rises out of an act or practice prohibited by law or by rules of the secretary.

(5) Recovering payment or instructing the contractor under IC 12-15-30-3 to recover payment from a provider for services rendered to an individual or claimed to be rendered to an individual if the office after investigation finds any of the following:

(A) The services paid for cannot be documented by the provider.

(B) The amount paid for such services has been or can be paid from other sources.

(C) The services were provided to a person other than the person in whose name the claim was made and paid.

(D) The services paid for were provided to a person who was not eligible for Medicaid.

(E) The paid claim rises out of an act or practice prohibited by law or by rules of the secretary.

(6) Recovering interest due from a provider:

(A) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state general fund money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(B) accruing from the date of overpayment;

on amounts paid to the provider that are in excess of the amount subsequently determined to be due the provider as a result of an audit, a reimbursement cost settlement, or a judicial or an administrative proceeding.

(7) Paying interest to providers:

(A) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state general fund money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(B) accruing from the date that an overpayment is erroneously recovered by the office until the office restores the overpayment to the provider.

(8) Establishing a system with the following conditions:

(A) Audits may be conducted by the office after service has been provided and before reimbursement for the service has been made.

(B) Reimbursement for services may be denied if an audit conducted under clause (A) concludes that reimbursement should be denied.

(C) Audits may be conducted by the office after service has been provided and after reimbursement has been made.

(D) Reimbursement for services may be recovered if an audit conducted under clause (C) concludes that the money reimbursed should be recovered.

As added by P.L.2-1992, SEC.9. Amended by P.L.278-1993(ss), SEC.28; P.L.42-1995, SEC.23; P.L.107-1996, SEC.10; P.L.8-2005, SEC.2; P.L.113-2014, SEC.35.

IC 12-15-21-4

Rules not to eliminate type of provider licensed to provide services

Sec. 4. The rules adopted by the secretary may not eliminate a type of provider licensed to provide Medicaid services.

As added by P.L.2-1992, SEC.9.

IC 12-15-21-5

Rules not to be more restrictive than federal Medicaid reimbursement requirements

Sec. 5. (a) As used in this section, "facility" refers to an intermediate care facility for the mentally retarded (ICF/MR) not operated by a state agency.

(b) The rules adopted by the secretary may not establish eligibility criteria for Medicaid reimbursement for placement or services in a facility, including services provided under a Medicaid waiver, that are more restrictive than federal requirements for Medicaid reimbursement in a facility or under a Medicaid waiver.

(c) The office may not implement a policy that may not be adopted as a rule under subsection (b).

As added by P.L.78-1994, SEC.2. Amended by P.L.272-1999, SEC.41.

IC 12-15-21-6

Amendment of prior authorization rule

Sec. 6. (a) IC 4-22-2 does not apply to a rulemaking procedure under this section.

(b) The office may amend a rule regarding prior authorization (as defined in 405 IAC 1-6-2) that appears in the Indiana Administrative Code on January 1, 1996, to make the prior authorization rule less restrictive.

(c) If the office amends a prior authorization rule under this section, the office may later amend the prior authorization rule to restore, in whole or in part, the prior authorization rule as it was in effect on January 1, 1996.

(d) An amendment to a prior authorization rule under this section must comply with the notice requirements set forth in IC 12-15-13-6.

As added by P.L.107-1996, SEC.11.

IC 12-15-21-6.5

Family practice residency program

Sec. 6.5. A family practice residency program may choose to have the name of the residency program, the primary medical provider, or both, appear on the Medicaid identification card of a recipient who is enrolled in a Medicaid managed care program instead of just the name of the individual primary medical provider in the residency program to whom the recipient has been assigned.

As added by P.L.107-1996, SEC.12 and P.L.257-1996, SEC.11.

IC 12-15-21-7

Rules not to be more stringent than prior authorization rule

effective January 1, 1996

Sec. 7. The office may not amend a prior authorization rule to make it more stringent than the prior authorization rule as it was in effect on January 1, 1996, unless the office changes the rule through the rulemaking process.

As added by P.L.107-1996, SEC.13.