IC 12-15-5

Chapter 5. Services Provided

IC 12-15-5-1

Services and supplies provided; exceptions

Sec. 1. Except as provided in IC 12-15-2-12, IC 12-15-6, and IC 12-15-21, the following services and supplies are provided under Medicaid:

(1) Inpatient hospital services.

(2) Nursing facility services.

(3) Physician's services, including services provided under IC 25-10-1 and IC 25-22.5-1.

(4) Outpatient hospital or clinic services.

(5) Home health care services.

(6) Private duty nursing services.

(7) Physical therapy and related services.

(8) Dental services.

(9) Prescribed laboratory and x-ray services.

(10) Prescribed drugs and pharmacist services.

(11) Eyeglasses and prosthetic devices.

(12) Optometric services.

(13) Diagnostic, screening, preventive, and rehabilitative services.

(14) Podiatric medicine services.

(15) Hospice services.

(16) Services or supplies recognized under Indiana law and specified under rules adopted by the office.

(17) Family planning services except the performance of abortions.

(18) Nonmedical nursing care given in accordance with the tenets and practices of a recognized church or religious denomination to an individual qualified for Medicaid who depends upon healing by prayer and spiritual means alone in accordance with the tenets and practices of the individual's church or religious denomination.

(19) Services provided to individuals described in IC 12-15-2-8 and IC 12-15-2-9.

(20) Services provided under IC 12-15-34 and IC 12-15-32.

(21) Case management services provided to individuals described in IC 12-15-2-11 and IC 12-15-2-13.

(22) Any other type of remedial care recognized under Indiana law and specified by the United States Secretary of Health and Human Services.

(23) Examinations required under IC 16-41-17-2(a)(10).

As added by P.L.2-1992, SEC.9. Amended by P.L.24-1997, SEC.48; P.L.149-2001, SEC.1; P.L.274-2013, SEC.1.

IC 12-15-5-2

Necessity of federal financial participation

Sec. 2. Medicaid does not include a service or supply for which

federal financial participation is not available.
As added by P.L.2-1992, SEC.9.

IC 12-15-5-3
Repealed
(Repealed by P.L.161-2007, SEC.40.)

IC 12-15-5-5
Office may provide drug coverage; requirements for drug coverage in managed care
Sec. 5. (a) The office may provide a prescription drug benefit to a Medicaid recipient in the Medicaid risk based managed care program.
(b) If the office provides a prescription drug benefit to a Medicaid recipient in the Medicaid risk based managed care program:
(1) the office shall develop a procedure and provide the recipient's risk based managed care provider with information concerning the recipient's prescription drug utilization for the risk based managed care provider's case management program; and
(2) the provisions of IC 12-15-35.5 apply.
(c) If the office does not provide a prescription drug benefit to a Medicaid recipient in the Medicaid risk based managed care program, a Medicaid managed care organization shall provide coverage and reimbursement for outpatient single source legend drugs subject to IC 12-15-35-46, IC 12-15-35-47, and IC 12-15-35.5.
As added by P.L.231-1999, SEC.1. Amended by P.L.101-2005, SEC.1.

IC 12-15-5-6
Repealed
(Repealed by P.L.229-2011, SEC.272.)

IC 12-15-5-8
Maintenance drugs; prescriptions; Internet based pharmacies
Sec. 8. (a) As used in this section, "maintenance drug" means a medication that is dispensed under a single prescription for a period of not less than one hundred eighty (180) days, excluding authorized refills, for the ongoing treatment of a chronic medical condition or disease or congenital condition or disorder.
(b) The office may designate:
(1) a mail order pharmacy;
(2) an Internet based pharmacy (as defined in IC 25-26-18-1);
(3) a pharmacy that agrees to sell a maintenance drug at the same price as a mail order or an Internet based pharmacy; or
(4) all the pharmacies listed in subdivisions (1) through (3);
through which a recipient may obtain a maintenance drug.
(c) If the office makes a designation under subsection (b), a managed care organization that has a contract with the office under IC 12-15-12 is not required to use a pharmacy that is designated

under subsection (b).

(d) If a Medicaid recipient's physician prescribes a maintenance prescription drug, the Medicaid recipient may purchase the maintenance prescription drug from a pharmacy that is designated under subsection (b).

(e) The office shall apply to amend the state Medicaid plan if the office determines that an amendment is necessary to carry out this section.

(f) The office may require a recipient to pay the maximum copayment allowable under federal law if the recipient obtains a maintenance drug from a pharmacy other than a pharmacy described in subsection (b).

As added by P.L.246-2005, SEC.105.

IC 12-15-5-9

Provision of self-directed care options

Sec. 9. The office shall have self-directed care options and services available for an eligible individual who:

(1) is a Medicaid waiver recipient; and

(2) chooses self-directed care services.

As added by P.L.47-2009, SEC.3.

IC 12-15-5-9.2

Coverage for care related to cancer clinical trials

Sec. 9.2. (a) As used in this section, "care method" means the use of a particular drug or device in a particular manner.

(b) As used in this section, "clinical trial" means a Phase I, II, III, or IV research study:

(1) that is conducted:

(A) using a particular care method to prevent, diagnose, or treat a cancer for which:

(i) there is no clearly superior, noninvestigational alternative care method; and

(ii) available clinical or preclinical data provides a reasonable basis from which to believe that the care method used in the research study is at least as effective as any noninvestigational alternative care method;

(B) in a facility where personnel providing the care method to be followed in the research study have:

(i) received training in providing the care method;

(ii) expertise in providing the type of care required for the research study; and

(iii) experience providing the type of care required for the research study to a sufficient volume of patients to maintain expertise; and

(C) to scientifically determine the best care method to prevent, diagnose, or treat the cancer; and

(2) that is approved or funded by one (1) of the following:

(A) A National Institutes of Health institute.

(B) A cooperative group of research facilities that has an

established peer review program that is approved by a National Institutes of Health institute or center.

(C) The federal Food and Drug Administration.

(D) The United States Department of Veterans Affairs.

(E) The United States Department of Defense.

(F) The institutional review board of an institution located in Indiana that has a multiple project assurance contract approved by the National Institutes of Health Office for Protection from Research Risks as provided in 45 CFR 46.103.

(G) A research entity that meets eligibility criteria for a support grant from a National Institutes of Health center.

(c) As used in this section, "routine care cost" means the cost of medically necessary services related to the care method that is under evaluation in a clinical trial. The term does not include the following:

(1) The drug or device that is under evaluation in a clinical trial.

(2) Items or services that are:

(A) provided solely for data collection and analysis and not in the direct clinical management of an individual enrolled in a clinical trial;

(B) customarily provided at no cost by a research sponsor to an individual enrolled in a clinical trial; or

(C) provided solely to determine eligibility of an individual for participation in a clinical trial.

(d) The Medicaid program must provide coverage for routine care costs that are incurred in the course of a clinical trial if the Medicaid program would provide coverage for the same routine care costs not incurred in a clinical trial.

(e) The coverage that must be provided under this section is subject to the terms, conditions, restrictions, exclusions, and limitations that apply generally under the Medicaid program, including terms, conditions, restrictions, exclusions, or limitations that apply to health care services rendered by participating providers and nonparticipating providers.

(f) This section does not do any of the following:

(1) Require the Medicaid program to provide coverage for clinical trial services rendered by a participating provider.

(2) Prohibit the Medicaid program from providing coverage for clinical trial services rendered by a participating provider.

(3) Require reimbursement for services that are rendered in a clinical trial by a nonparticipating provider at the same rate of reimbursement that would apply to the same services rendered by a participating provider.

As added by P.L.109-2009, SEC.2.

IC 12-15-5-10

Care available for individuals receiving Medicaid waiver services; eligibility not affected by receipt of services

Sec. 10. (a) An individual who receives Medicaid services through a Medicaid waiver shall receive the following:

(1) The development of a care plan addressing the individual's needs.

(2) Advocacy on behalf of the individual's interests.

(3) The monitoring of the quality of community and home care services provided to the individual.

(4) Information and referral services concerning community and home care services if the individual is eligible for these services.

(b) The use by or on behalf of an individual receiving Medicaid waiver services of any of the following services or devices does not make the individual ineligible for services under a Medicaid waiver:

(1) Skilled nursing assistance.

(2) Supervised community and home care services, including skilled nursing supervision.

(3) Adaptive medical equipment and devices.

(4) Adaptive nonmedical equipment and devices.

As added by P.L.47-2009, SEC.4.

IC 12-15-5-11

Reimbursement for telehealth services and telemedicine services for certain providers; implementation; rules

Sec. 11. (a) As used in this section, "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.

(b) As used in this section, "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.

(c) The office shall reimburse a Medicaid provider who is licensed as a home health agency under IC 16-27-1 for telehealth services.

(d) The office shall reimburse the following Medicaid providers for telemedicine services:

(1) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(2) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(e) The office shall reimburse the following Medicaid providers for telemedicine services regardless of the distance between the provider and the patient:

(1) A federally qualified health center (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(2) A rural health clinic (as defined in 42 U.S.C. 1396d(l)(1)).

(3) A community mental health center certified under IC 12-21-2-3(5)(C).

(4) A critical access hospital that meets the criteria under 42

CFR 485.601 et seq.

(f) The office shall, not later than December 1, 2013, file any Medicaid state plan amendment with the United States Department of Health and Human Services necessary to implement and administer this section, including an amendment to eliminate the current twenty (20) mile distance restriction.

(g) The office shall implement any part of this section that is approved by the United States Department of Health and Human Services.

(h) The office may adopt rules under IC 4-22-2 necessary to implement and administer this section.

As added by P.L.204-2013, SEC.3.

IC 12-15-5-12

"Child"; reimbursement for specialized or nonstandard wheelchairs; prior authorization

Sec. 12. (a) As used in this section, "child" includes any of the following:

(1) An individual who is less than eighteen (18) years of age.

(2) An individual who is at least eighteen (18) years of age and either:

(A) continues to be enrolled in a kindergarten through grade 12 school; or

(B) has a developmental disability.

(b) The office shall reimburse a nursing facility for a specialized or nonstandard wheelchair for a child recipient who resides in a nursing facility at a rate outside the nursing facility's per diem payment for nursing facility services, regardless of whether the child recipient is determined by the office to be rehabilitative.

(c) The office may require prior authorization for reimbursement under this section.

As added by P.L.108-2014, SEC.1.