IC 12-15-13

Chapter 13. Provider Payment; General

IC 12-15-13-0.1

Application of certain amendments to chapter

Sec. 0.1. The amendments made to this chapter apply as follows:

(1) The amendments made to section 1 of this chapter by P.L.257-1996 apply to provider claims for payment under the Medicaid program under this article after March 31, 1996.

(2) The addition of section 1.5 of this chapter by P.L.257-1996 applies to provider claims for payment under the Medicaid program under this article after March 31, 1996.

As added by P.L.220-2011, SEC.266.

IC 12-15-13-0.4

"Office"

Sec. 0.4. As used in this chapter, "office" includes the following:

(1) The office of the secretary of family and social services.

(2) A managed care organization that has contracted with the office of Medicaid policy and planning under this article.

(3) A person that has contracted with a managed care organization described in subdivision (2).

As added by P.L.117-2008, SEC.2. Amended by P.L.109-2014, SEC.19.

IC 12-15-13-0.5

"Clean claim"

Sec. 0.5. (a) Except as provided in section 0.6 of this chapter, as used in this chapter, "clean claim" means a claim submitted by a provider for payment under the Medicaid program that can be processed without obtaining additional information from:

(1) the provider of the service; or

(2) a third party.

(b) The definition under subsection (a):

(1) includes a claim with errors originating in the state's claims processing system; and

(2) does not include a claim:

(A) from a provider who is under investigation for fraud or abuse (as used in 42 CFR 447.45(b); or

(B) under review for medical necessity.

As added by P.L.107-1996, SEC.2 and P.L.257-1996, SEC.2.

IC 12-15-13-0.6

"Clean claim" for purposes of IC 12-15-14

Sec. 0.6. (a) "Clean claim", as the term applies to payments to nursing facilities under IC 12-15-14, means a claim submitted by a provider for payment that meets the following conditions:

(1) Contains the following locators:

(A) Type of bill.
(B) Coverage dates.
(C) Bill status.
(D) Revenue codes.
(E) Rate of payment.
(F) Service units.
(G) Total charges.
(H) Provider number.
(I) Third party prior payments.
(J) Estimated amount due.
(K) Recipient number.
(L) Provider signature.
(M) Provider name.
(N) Number of covered days of service.
(O) Date of admission.
(P) Condition codes.
(Q) Occurrence codes and dates.
(R) Value codes and amounts.
(S) Third party liability payor name.
(T) Recipient name.
(U) Admitting diagnosis.
(V) Attending physician ID number.

(2) Has correct and valid information for each of the locators required by subdivision (1).

(3) The recipient for whom the claim is submitted is eligible for Medicaid on the date for which the service is billed.

(4) The office has approved the level of care for:
(A) the recipient; and
(B) the facility;
for the dates for which the service is billed.

(5) The provider is eligible to render service on the date for which the service is billed.

(6) The claim does not duplicate a claim already paid.

(b) The definition under subsection (a):

(1) includes a claim with errors originating in the state's claims processing system; and

(2) does not include a claim:
(A) from a provider who is under investigation for fraud or abuse (as used in 42 CFR 447.45(b)); or
(B) under review for medical necessity.

As added by P.L.107-1996, SEC.3 and P.L.257-1996, SEC.3.

IC 12-15-13-0.7

Addition, deletion, or modification of locators

Sec. 0.7. The office may adopt rules under IC 4-22-2 that add, delete, or modify the locators contained in section 0.6(a)(1) of this chapter as necessary to conform with:

(1) changes in federal law or regulation; or

(2) directives from the United States Centers for Medicare and

Medicaid Services.

As added by P.L.107-1996, SEC.4 and P.L.257-1996, SEC.4. Amended by P.L.66-2002, SEC.3.

IC 12-15-13-1

Payment, denial, or suspension of claims submitted by nursing facilities; time; notice of suspension or denial

Sec. 1. (a) This section applies only to claims submitted for payment by nursing facilities.

(b) The office shall pay, deny, or suspend each claim submitted by a provider for payment under the Medicaid program not more than:

(1) twenty-one (21) days after the date a claim that is filed electronically; or

(2) thirty (30) days after the date a claim that is filed on paper;

is received by the office or, if IC 12-15-30 applies, by the contractor under IC 12-15-30.

(c) The office shall pay each clean claim.

(d) The office may deny or suspend a claim that is not a clean claim. If the office denies a provider's claim for payment, the office shall notify the provider of each reason the claim was denied.

(e) If the office suspends a provider's claim for payment under the Medicaid program, the office shall notify the provider of each reason the claim was suspended.

As added by P.L.2-1992, SEC.9. Amended by P.L.10-1994, SEC.4; P.L.107-1996, SEC.5; P.L.257-1996, SEC.5.

IC 12-15-13-1.5

Payment of interest on claims submitted by nursing facilities

Sec. 1.5. (a) This section applies only to claims submitted for payment by nursing facilities.

(b) If the office:

(1) fails to pay a clean claim in the time required under section 1(b) of this chapter; or

(2) denies or suspends a claim that is subsequently determined to have been a clean claim when the claim was filed;

the office shall pay the provider interest on the Medicaid allowable amount of the claim.

(c) Interest paid under subsection (b):

(1) accrues beginning:

(A) twenty-two (22) days after the date the claim is filed under section 1(b)(1) of this chapter; or

(B) thirty-one (31) days after the date the claim is filed under section 1(b)(2) of this chapter; and

(2) stops accruing on the date the office pays the claim.

(d) The office shall pay interest under subsection (b) at the same rate as determined under IC 12-15-21-3(7)(A).

As added by P.L.107-1996, SEC.6 and P.L.257-1996, SEC.6. Amended by P.L.42-2011, SEC.29.

IC 12-15-13-1.6

Payment, denial, or suspension of claims; notice of suspension or denial

Sec. 1.6. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim in accordance with section 1.7 of this chapter.

(c) The office shall deny or suspend each claim that is not a clean claim in accordance with subsection (d).

(d) The office shall deny or suspend each claim that is:

(1) not a clean claim; and

(2) submitted by a provider for payment under the Medicaid program;

not more than thirty (30) days after the date the claim is received by the office or, if IC 12-15-30 applies, by the contractor under IC 12-15-30.

(e) If the office denies a provider's claim for payment under subsection (d) or section 1.7 of this chapter, the office shall notify the provider of each reason the claim was denied.

(f) If the office suspends a provider's claim for payment under subsection (d), the office shall notify the provider of each reason the claim was suspended.

As added by P.L.107-1996, SEC.7 and P.L.257-1996, SEC.7.

IC 12-15-13-1.7

Timing of payment or denial of claims; payment of interest

Sec. 1.7. (a) This section does not apply to claims submitted for payment by nursing facilities.

(b) The office shall pay or deny each clean claim as follows:

(1) If the claim is filed electronically, within twenty-one (21) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(2) If the claim is filed on paper, within thirty (30) days after the date the claim is received by:

(A) the office; or

(B) a contractor of the office under IC 12-15-30, if IC 12-15-30 applies.

(c) If:

(1) the office fails to pay or deny a clean claim in the time required under subsection (b); and

(2) the office or a contractor of the office under IC 12-15-30 subsequently pays the claim;

the office shall pay the provider that submitted the claim interest on the Medicaid allowable amount of the claim paid under this section.

(d) Interest paid under subsection (c) shall:

(1) begin accruing:

(A) twenty-two (22) days after the date the claim is filed

under subsection (b)(1); or

(B) thirty-one (31) days after the date the claim is filed under subsection (b)(2); and

(2) stop accruing on the date the claim is paid.

(e) In paying interest under subsection (c), the office shall use the same interest rate as provided in IC 12-15-21-3(7)(A).

As added by P.L.107-1996, SEC.8 and P.L.257-1996, SEC.8.

IC 12-15-13-2

Payments to providers; requirements; federal law or regulations specifying reimbursement criteria

Sec. 2. (a) Except as provided in IC 12-15-14 and IC 12-15-15, payments to Medicaid providers must be:

(1) consistent with efficiency, economy, and quality of care; and

(2) sufficient to enlist enough providers so that care and services are available under Medicaid, at least to the extent that such care and services are available to the general population in the geographic area.

(b) If federal law or regulations specify reimbursement criteria, payment shall be made in compliance with those criteria.

As added by P.L.2-1992, SEC.9. Amended by P.L.278-1993(ss), SEC.27.

IC 12-15-13-3

Repealed

(As added by P.L.152-1995, SEC.10. Amended by P.L.107-1996, SEC.9; P.L.257-1996, SEC.9; P.L.78-2004, SEC.3; P.L.8-2005, SEC.1. Repealed by P.L.229-2011, SEC.270.)

IC 12-15-13-3.5

Recovery of overpayment to noninstitutional provider; appeal

Sec. 3.5. (a) As used in this section, "noninstitutional provider" means any Medicaid provider other than the following:

(1) A health facility licensed under IC 16-28.

(2) An ICF/MR (as defined in IC 16-29-4-2).

(b) If the office of the secretary or the office of the secretary's designee believes that an overpayment to a noninstitutional provider has occurred, the office of the secretary or the office of the secretary's designee may submit to the noninstitutional provider a preliminary review of draft audit findings.

(c) A noninstitutional provider that receives a preliminary review of draft audit findings under subsection (b) may request administrative reconsideration of the preliminary review of draft audit findings not later than forty-five (45) days after the issuance of the preliminary review of draft audit findings. The noninstitutional provider may submit comments along with the request for administrative reconsideration. The noninstitutional provider must request administrative reconsideration before filing an appeal.

(d) Following administrative reconsideration of the preliminary

review of draft audit findings and any comments submitted along with the noninstitutional provider's request for administrative consideration and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the noninstitutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final calculation of the overpayment.

(e) A noninstitutional provider who receives a notice under subsection (d) may elect to do one (1) of the following:

(1) Repay the amount of the final calculation not later than three hundred (300) days after the provider received the notice under subsection (d), including interest:

(A) due from the noninstitutional provider; and

(B) accruing from the date of overpayment.

(2) Request a hearing by filing an administrative appeal not later than sixty (60) days after receiving the notice under subsection (d) and repay the amount of the final calculation of the overpayment under subsection (d) not later than three hundred (300) days after receiving the notice under subsection (d).

(f) If:

(1) a noninstitutional provider elects to proceed under subsection (e)(2); and

(2) the office of the secretary or the office of the secretary's designee determines after the hearing and any subsequent appeal that the noninstitutional provider does not owe the money that the office of the secretary or the office of the secretary's designee believed the noninstitutional provider owed;

the office of the secretary or the office of the secretary's designee shall return the amount of the alleged overpayment, and any interest paid by the noninstitutional provider, and pay the noninstitutional provider interest on the money from the date of the noninstitutional provider's repayment.

(g) Interest that is due under this section shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) as follows:

(1) Interest due from a noninstitutional provider to the state shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(2) Interest due from the state to a noninstitutional provider shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(h) Interest on an overpayment to a noninstitutional provider is not due from the noninstitutional provider if the overpayment is the result of an error of:

(1) the office; or

(2) a contractor of the office;

as determined by the office of the secretary or the office of the

secretary's designee.

(i) If interest on an overpayment to a noninstitutional provider is due from the noninstitutional provider, the secretary or the secretary's designee may, in the course of negotiations with the noninstitutional provider regarding an appeal filed under subsection (e), reduce the amount of interest due from the noninstitutional provider.

(j) Proceedings under this section are subject to IC 4-21.5.

As added by P.L.229-2011, SEC.125.

IC 12-15-13-4

Recovery of overpayment to institutional provider; appeal

Sec. 4. (a) As used in this section, "institutional provider" means the following:

(1) A health facility that is licensed under IC 16-28.

(2) An ICF/MR (as defined in IC 16-29-4-2).

(b) If the office of the secretary or the office of the secretary's designee believes that an overpayment to an institutional provider has occurred, the office of the secretary or the office of the secretary's designee may do the following:

(1) Submit to the institutional provider a draft of the audit findings and accept comments from the institutional provider for consideration by the office of the secretary or the office of the secretary's designee before the audit findings are finalized.

(2) Finalize the audit findings and issue the preliminary recalculated Medicaid rate.

(c) An institutional provider that receives a preliminary recalculated Medicaid rate under subsection (b)(2) may request administrative reconsideration of the preliminary recalculated Medicaid rate not later than forty-five (45) days after the issuance of the preliminary recalculated rate. The institutional provider must request administrative reconsideration before filing an appeal.

(d) Following reconsideration of an institutional provider's comments, and if the office of the secretary or the office of the secretary's designee believes that an overpayment has occurred, the office of the secretary or the office of the secretary's designee shall notify the institutional provider in writing that the office of the secretary or the office of the secretary's designee:

(1) believes that the overpayment has occurred; and

(2) is issuing a final recalculated Medicaid rate.

(e) Upon the next payment cycle, the office of the secretary or the office of the secretary's designee shall retroactively implement the final recalculated Medicaid rate.

(f) If the institutional provider is dissatisfied with the reconsideration response issued by the office of the secretary or the office of the secretary's designee, the institutional provider may request a hearing by filing an appeal with the office of the secretary not later than sixty (60) days after the issuance of the reconsideration response.

(g) If an institutional provider requests a hearing under subsection

(f) and the office of the secretary or the office of the secretary's designee determines after the hearing and any subsequent appeal that the institutional provider does not owe the money that the office of the secretary or the office of the secretary's designee believed the institutional provider owed, the office of the secretary or the office of the secretary's designee shall repay the following to the institutional provider not later than thirty (30) days after the completion of the hearing:

(1) The amount of the alleged overpayment.

(2) Any interest paid by the institutional provider.

(3) Interest on the money described in subdivisions (1) and (2) from the date of the institutional provider's repayment.

(h) Interest due under this section by either the institutional provider or the office of the secretary shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(i) Interest on an overpayment to an institutional provider is not due from the institutional provider if the office of the secretary or the office of the secretary's designee determines that the overpayment is the result of an error by the following:

(1) The office of the secretary.

(2) A contractor of the office of the secretary.

(j) If interest on an overpayment to an institutional provider is due from the institutional provider, the office of the secretary or the office of the secretary's designee may, in the course of negotiations with the institutional provider concerning an appeal filed under this section, reduce the amount of interest due from the institutional provider.

As added by P.L.229-2011, SEC.126.

IC 12-15-13-5

Reimbursement for services provided by an ICF/MR

Sec. 5. The office shall reimburse at a reimbursement rate for services provided by an ICF/MR (as defined in IC 16-29-4-2) that is three percent (3%) greater than the Medicaid reimbursement rate for the services calculated using the methodology in effect on December 31, 2013.

As added by P.L.213-2015, SEC.128.

IC 12-15-13-6

Notices or bulletins; timing; noncompliance

Sec. 6. (a) Except as provided by IC 12-15-35-50, a notice or bulletin that is issued by:

(1) the office;

(2) a contractor of the office; or

(3) a managed care plan under the office;

concerning a change to the Medicaid program, including a change to prior authorization, claims processing, payment rates, and medical policies, that does not require use of the rulemaking process under

IC 4-22-2 may not become effective until thirty (30) days after the date the notice or bulletin is communicated to the parties affected by the notice or bulletin.

(b) The office must provide a written notice or bulletin described in subsection (a) within five (5) business days after the date on the notice or bulletin.

(c) If the office, a contractor of the office, or a managed care plan under the office does not comply with the requirements in subsections (a) and (b):

(1) the notice or bulletin is void;

(2) a claim may not be denied because the claim does not comply with the void notice or bulletin; and

(3) the office, a contractor of the office, or a managed care plan under the office may not reissue the bulletin or notice for thirty (30) days unless the change is required by the federal government to be implemented earlier.

As added by P.L.42-1995, SEC.22. Amended by P.L.187-2007, SEC.2; P.L.15-2009, SEC.1; P.L.153-2011, SEC.17.

IC 12-15-13-7

Permitted forms

Sec. 7. (a) The office and an entity with which the office contracts for the payment of claims shall accept claims submitted on any of the following forms by an individual or organization that is a contractor or subcontractor of the office:

(1) CMS-1500 or its subsequent form.

(2) CMS-1450 (UB04) or its subsequent form.

(3) American Dental Association (ADA) claim form.

(4) Pharmacy and compound drug form.

(b) The office and an entity with which the office contracts for the payment of claims:

(1) may designate as acceptable claim forms other than a form listed in subsection (a); and

(2) may not mandate the use of a crossover claim form.

As added by P.L.256-2001, SEC.3. Amended by P.L.27-2011, SEC.2.

IC 12-15-13-7.2

Use of diagnostic or procedure codes

Sec. 7.2. (a) As used in this section, "provider" has the meaning set forth in IC 27-8-11-1.

(b) Not more than ninety (90) days after the effective date of a diagnostic or procedure code described in this subsection:

(1) the office shall for all purposes begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the office processes claims for services provided under the Medicaid program; and

(2) a provider shall begin using the most current version of the:

(A) current procedural terminology (CPT);

(B) international classification of diseases (ICD);

(C) American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM);

(D) current dental terminology (CDT);

(E) Healthcare common procedure coding system (HCPCS); and

(F) third party administrator (TPA);

codes under which the provider submits claims for payment for services provided under the Medicaid program.

(c) If a provider provides services that are covered under the Medicaid program:

(1) after the effective date of the most current version of a diagnostic or procedure code described in subsection (b); and

(2) before the office begins using the most current version of the diagnostic or procedure code;

the office shall reimburse the provider under the version of the diagnostic or procedure code that was in effect on the date that the services were provided.

As added by P.L.161-2001, SEC.2. Amended by P.L.66-2002, SEC.4; P.L.27-2011, SEC.3.