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.

(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).

(24) Inpatient substance abuse detoxification services.

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; P.L.154-2015, SEC.2; P.L.210-2015, SEC.47.

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Repealed

(As added by P.L.46-1995, SEC.39. Repealed by P.L.161-2007, SEC.40.)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

(As added by P.L.107-2002, SEC.10. 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.

IC 12-15-5-13

Coverage for treatment of opioid or alcohol dependence; office requirements; report use of medications to committee

Sec. 13. (a) The office shall provide coverage for treatment of opioid or alcohol dependence that includes the following:

(1) Counseling services that address the psychological and behavioral aspects of addiction.

(2) When medically indicated, drug treatment involving agents approved by the federal Food and Drug Administration for the:

(A) treatment of opioid or alcohol dependence; or

(B) prevention of relapse to opioids or alcohol after detoxification.

(3) Inpatient detoxification:

(A) in accordance with:

(i) the most current edition of the American Society of Addiction Medicine Patient Placement Criteria; or

(ii) other clinical criteria that are determined by the office and are evidence based and peer reviewed; and

(B) when determined by the treatment plan to be medically necessary.

(b) The office shall:

(1) develop quality measures to ensure; and

(2) require a Medicaid managed care organization to report; compliance with the coverage required under subsection (a).

(c) The office may implement quality capitation withholding of reimbursement to ensure that a Medicaid managed care organization has provided the coverage required under subsection (a).

(d) The office shall report the clinical use of the medications covered under this section to the mental health Medicaid quality advisory committee established by IC 12-15-35-51. The mental health Medicaid quality advisory committee may make recommendations to the office concerning this section.

As added by P.L.209-2015, SEC.11. Amended by P.L.8-2016, SEC.1.

IC 12-15-5-14

Reimbursement for services provided by an advanced practice nurse; eligible provider

Sec. 14. (a) As used in this section, "advanced practice nurse" means:

(1) a nurse practitioner; or

(2) a clinical nurse specialist;

who is a registered nurse licensed under IC 25-23 and qualified to practice nursing in a specialty role based upon the additional knowledge and skill gained through a formal organized program of study and clinical experience, or the equivalent as determined by the Indiana state board of nursing.

(b) As used in this section, "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).

(c) The office shall reimburse eligible Medicaid claims for the following services provided by an advanced practice nurse employed by a community mental health center if the services are part of the advanced practice nurse's scope of practice:

(1) Mental health services.

(2) Behavioral health services.

(3) Substance use treatment.

(4) Primary care services.

(5) Evaluation and management services for inpatient or outpatient psychiatric treatment.

(6) Prescription drugs.

(d) The office shall include an advanced practice nurse as an eligible provider for the supervision of a plan of treatment for a patient's outpatient mental health or substance abuse treatment services, if the supervision is in the advanced practice nurse's scope of practice, education, and training.

(e) This section:

(1) may not be construed to expand an advanced practice nurse's scope of practice; and

(2) is subject to IC 25-23-1-19.4(c) and applies only if the service is included in the advance practice nurse's practice agreement with a collaborating physician.

As added by P.L.87-2016, SEC.4.

IC 12-15-5-15

Reimbursement for students; conditions; policies

Sec. 15. (a) This section is effective upon approval by the federal government of the office's Medicaid state plan amendment to implement the requirements of this section. The office shall submit the Medicaid state plan amendment not later than December 1, 2016.

(b) As used in this section, "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).

(c) The office shall authorize Medicaid reimbursement for eligible Medicaid services provided by a student who:

(1) is currently enrolled in a graduate or postgraduate degree level:

(A) medical;

(B) nursing;

(C) mental health;

(D) behavioral health; or

(E) addiction treatment;

accredited college or university program;

(2) has been approved by the college or university to work as an intern or practicum student at a community mental health center under the direct supervision of a licensed professional who holds a master's degree or doctoral level degree related to the area of study; and

(3) the services being provided by the student are within the scope of practice of the supervising practitioner.

(d) Medicaid claims for eligible Medicaid services provided under this section must be submitted by the supervising practitioner. Only one (1) Medicaid claim may be submitted per episode of care.

(e) A community mental health center that allows intern and practicum students to provide services under this section shall have a policy and procedure for the intern and practicum students to receive supervision and a method for documenting the supervision provided.

As added by P.L.87-2016, SEC.5.

IC 12-15-5-16

Reimbursement for clinical addiction counselors; clinical supervision requirement

Sec. 16. (a) This section is effective upon approval by the federal government of the office's Medicaid state plan amendment to implement the requirements of this section. The office shall submit the Medicaid state plan amendment not later than December 1, 2016.

(b) As used in this section, "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).

(c) The office shall reimburse a clinical addiction counselor licensed under IC 25-23.6 for an eligible Medicaid behavioral health or addictions service that is within the counselor's scope of practice if the clinical addiction counselor is under the clinical supervision of a physician or health service provider in psychology.

As added by P.L.87-2016, SEC.6.