DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

APR 25 2013

Patricia Casanova, Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204

RE: Indiana State Plan Amendment (SPA) 12-007

Dear Ms. Casanova:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid State plan submitted under transmittal number (TN) 12-007. Effective for services on or after July 1, 2012, this amendment updates International Classification of Diseases (ICD) codes and also deletes reference to targeted case management (TCM) except for recipients with elevated blood lead levels. Additionally, this amendment revises coverage language for case management services, tuberculosis related services, and pregnancy-related and postpartum services.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(2), 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the regulations at 42 CFR 447 Subpart C. We hereby inform you that Medicaid State plan amendment 12-007 is approved effective July 1, 2012. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Todd McMillion at (312) 353-9860.

Sincerely,

[redacted]

Cindy Mann,
Director

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

ANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 12-007

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2012

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
45 CFR Section162.1002

7. FEDERAL BUDGET IMPACT:
a. FFY 2012 $0.00. (Thousands)
b. FFY 2013 $0.00 (Thousands)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A Addendum Page 12
Attachment 4.19-A Page 1C and Page 1E
Attachment 4.22-A Page 3
Attachment 4.39 Page 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 3.1-A Addendum Page 12
Attachment 4.19-A Page 1C and Page 1E
Attachment 4.22-A Page 3
Attachment 4.39 Page 1

10. SUBJECT OF AMENDMENT:
This amendment makes changes to the State Plan to update code references to the International Classification of Diseases (ICD), 10th Revision.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:

Indiana's Medicaid State Plan does not require the Governor's review. See Section 7.4 of the State Plan

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME: Patricia Casanova

14. TITLE: Director of Medicaid

15. DATE SUBMITTED:

16. RETURN TO:
Patricia Casanova
Director of Medicaid
Indiana Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204
ATTN: Audie Gilmer, State Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: APR 25 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME:

22. TITLE:

23. REMARKS:

FORM HCFA-179 (07-92)

19. Targeted Case Management for: Recipients with Elevated Blood Lead Levels	Reimbursement is available for targeted case management when provided in accordance with 42 CFR 440.169 and for individuals, who, through a blood lead screening conducted in accordance with the EPSDT periodicity schedule, are found with a confirmed elevated blood lead level, as defined by the Centers for Disease Control and Prevention. Reimbursement is limited to no more than 26, 15 minute units, per recipient, per twelve month period of time. Prior authorization is required for additional units of medically necessary targeted case management.
20. Extended Services for Pregnant Women	Reimbursement is available for extended services for pregnant women with limitations and include the following: - Pregnancy-related and postpartum services for 60 days after the pregnancy ends -Services for any other medical conditions that may complicate pregnancy Services must be medically necessary and reasonable and defined as a covered service required for the care or well being of the patient and provided in accordance with generally accepted standards of medical or professional practice.
20.a. Pregnancy-related and postpartum services for 60 days after the pregnancy ends	Coverage is limited to legend and non-legend drugs, prescribed for indications directly related to the pregnancy and routine prenatal, delivery and postpartum care, including family planning services. Additionally, transportation services, to and from the aforementioned services, will be provided. Payment for pregnancy-related services is subject to prior authorization.
20.b. Services for any other medical conditions that may complicate pregnancy	Reimbursement is available for services provided to a pregnant woman for the treatment of a chronic condition or other abnormal condition related to the pregnancy or complicates the medical management of the mother during pregnancy, childbirth and Puerperium including those conditions associated with fetal abnormalities and conditions. A condition that may complicate the pregnancy, is any condition manifesting itself by symptoms of sufficient severity that the absence of medical attention could reasonably be expected to result in a deterioration of the patient's condition or a need for a higher level of care. Reimbursement is available subject to prior authorization.

"Medical education costs" means that costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

"Office" means the Office of Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

"Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

"Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

"Principal diagnosis" means the diagnosis, as described by the International Classifications of Diseases, current version, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

"Readmission" means that a patent is admitted into the hospital following a previous hospital admission and discharge for a related condition as defined by the office.

"Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in the providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient form one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

PROSPECTIVE REIMBURSEMENT METHODOLOGY

The purpose of this section is to establish a prospective reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective.

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. The office shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

Level-of-Care cases are categorized as DRG numbers 424-428, 429 (excluding diagnosis codes 317.XX-319.XX, and when ICD 10 becomes effective, excluding diagnosis codes for Intellectual Disabilities-Mild, Moderate, Severe and Profound or not otherwise specified classifiable to F70-F79), 430-432, 456-459, 462, and 472, as defined and grouped using the all patient DRG grouper, version 14.1. These DRG numbers represent burn, psychiatric, and rehabilitative care. The office may assign a LOC DRG number for long term care hospital admissions.

In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must be designated by the state department of health as offering a burn intensive care unit.

The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

After January 1 2002, the office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of a long-term care hospital to be eligible for the separate level-of-care rate.

Add-On Payments

Capital payment rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

- Depreciation
- Interest
- Property Taxes
- Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital payment rates will be calculated using a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data.

qualified for Black Lung benefits. The contractor has the responsibility to do verification follow-up and then to bill the Board for reimbursement of claims already paid by Medicaid.

G. Defense Eligibility and Enrollment Reporting System (DEERS)

The Medicaid contractor conducts data matches with DEERS annually. A data exchange tape is created from the IV-D and Medicaid Eligibility files. In turn, a tape is received from DEERS of all those who qualify for Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) benefits. The contractor has the responsibility to do verification follow-up, add the information to the TPL data base for future cost avoidance, and then bill CHAMPUS for reimbursement of claims already paid by Medicaid.

H. Diagnosis and Trauma Code Edits (See 42 CFR 433.138(e).)

The Medicaid contractor conducts diagnosis and trauma code edits for all ICD diagnostic codes that identify an accident or injury.

All claims in the IMMIS weekly processing cycle are edited for trauma codes. Claims with these trauma codes are reported to the contractor's TPL unit via the MARS reporting system for potential recovery. Recipients who have claims with these edits are contacted by the contractor to determine the potential for recovery. If potential exists, the contractor opens a casualty case and tracks the proceedings. The time frames for follow-up depend on the particulars of the case.

Information regarding the potential recovery of trauma related expenditures is maintained in the contractor's third party recovery unit and includes all parties involved in the case as well as Medicaid expenditure information related to the injury. Since liability is not finally established for such cases until settlement, casualty liability information is not coded on the IMMIS. Therefore, recovery of casualty related expenditures is performed on a post-payment basis. However, if liability is established for future medical expenses, the information is then coded on the TPL file.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

DEFINITION OF SPECIALIZED SERVICES:

Specialized services are those services identified through the Level II Assessment that are required to address the identified needs related to the person's developmental disability and/or mental illness. These services are not typically provided within or by a nursing facility due to the duration and/or intensity of the services. Specialized services include, but are not limited to, short-term inpatient psychiatric care, long-term inpatient psychiatric care, supported employment, supported employment follow-along, sheltered work, vocational evaluation, work adjustment training, vocational skills training and job placement.

INDIANA'S DEFINITION OF DEVELOPMENTAL DISABILITY:

A person with a developmental disability has a severe, chronic disability attributable to mental retardation, cerebral palsy, epilepsy, autism, or a condition other than mental illness, closely related to mental retardation in that the impairment of general intellectual function or adaptive behavior is similar to that of mental retardation. The condition is manifested prior to age 22, is likely to continue indefinitely, and requires the person to have 24 hour supervision. As a result of the condition, the person has substantial functional limitations in three or more of the following major life areas: self care, understanding and use of language, learning, mobility, self direction and/or capacity for independent living.

INDIANA'S DEFINITION OF MENTAL ILLNESS:

An individual is considered to have a mental illness if he/she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders) limited to schizophrenic, schizoaffective disorders, psychotic disorder not otherwise specified (formerly atypical psychosis), delusional (formerly paranoid) disorder, and mood (formerly affective) disorders of the bipolar and major depressive type, and he/she does not have a diagnosis of senile or presenile dementia (including Alzheimer's disease of a related disorder).