

# TITLE 407 OFFICE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

## PROPOSED RULE LSA Document #10-420

### DIGEST

Amends 407 IAC 1-1-11 to amend the definition of "managed care organization". Amends 407 IAC 1-2-1 to provide that the office or its contractor shall assign a member to a PMP if the member fails to select a PMP within a reasonable time. Amends 407 IAC 1-2-2 to require claims for payment of services carved out of a CHIP MCO contract to be filed within twelve (12) months and to make various other technical changes. Amends 407 IAC 1-4-1 to apply the Medicaid reimbursement dispute resolution procedures to providers who do not have a contract with a CHIP MCO. Amends 407 IAC 1-6-2 regarding the primary care case management fee. Amends 407 IAC 2-3-1 to delete the identification of specific premium amounts per income level and, as an alternative, indicate that premium amounts will be established by the office in accordance with federal law. Amends 407 IAC 2-4-2 to make technical changes. Amends 407 IAC 3-3-2 to apply Medicaid prior authorization procedures to the CHIP program, to require publication of prior authorization policies by CHIP MCOs and to establish other guidelines for the prior authorization procedures of CHIP MCOs. Amends 407 IAC 3-10-1 to cover non-legend drugs in certain circumstances. Amends 407 IAC 3-10-2 to establish prior authorization procedures for brand name drugs. Amends 407 IAC 3-13-1 to remove over-the-counter drugs from the list of noncovered services. Statutory Authority: IC 12-17.6-2-11. Effective 30 days after filing with the Publisher.

**407 IAC 1-1-11**  
**407 IAC 1-2-1**  
**407 IAC 1-2-2**  
**407 IAC 1-4-1**  
**407 IAC 1-6-2**  
**407 IAC 2-3-1**  
**407 IAC 2-4-2**  
**407 IAC 3-3-2**  
**407 IAC 3-10-1**  
**407 IAC 3-10-2**  
**407 IAC 3-13-1**

SECTION 1. 407 IAC 1-1-11 IS AMENDED TO READ AS FOLLOWS:

#### **407 IAC 1-1-11 "Managed care organization" or "MCO" defined**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6; IC 27-13-2**

Sec. 11. "Managed care organization" or "MCO" means a health maintenance organization established under IC 27-13-2 **or a health insurer licensed by the Indiana department of**

**insurance** with whom the office has entered into a contract to provide services to CHIP members. (*Office of the Children's Health Insurance Program; 407 IAC 1-1-11; filed May 3, 2000, 2:02 p.m.: 23 IR 2226; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 2. 407 IAC 1-2-1 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 1-2-1 Choice of provider and use of healthcare card**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 1. (a) The member shall select a physician as PMP who is responsible for coordinating the member's health care needs. If a member fails to select a PMP within a reasonable time after being furnished a list of managed care providers by the office, or its contractor, the office **or its contractor** shall assign a PMP to the member. A CHIP member may not receive services from a provider other than the designated PMP, except in the following cases:

(1) Medical emergencies.

(2) Where the designated managed care provider has authorized referral services in writing.

(3) Where specific covered services can be accessed through self-referral by members.

(b) In the event that the office determines that a member has utilized any CHIP coverage service or supply at a frequency or amount not medically reasonable or necessary, the office may restrict the benefits available to such member in the same manner as such restrictions are imposed for Medicaid recipients under 405 IAC 1-1-2. Any member whose benefits have been restricted pursuant to this subsection may appeal such restriction. Member appeals are governed by the procedures and time limits for Medicaid recipients set out in 405 IAC 1.1.

(c) Before providing any service covered by the CHIP, each provider shall verify the eligibility of the individual for whom the provider is performing the service. Failure to do so can result in denial of the provider's claim if the individual is not eligible or the service is not authorized. In checking the healthcare card, the provider must determine all of the following:

(1) The healthcare card is valid at the time the service is being provided.

(2) The individual whose name appears on the healthcare card is the same individual for whom the service is being performed.

(3) No restrictions have been imposed on the individual's benefits that would prohibit the provider from performing the requested service.

(*Office of the Children's Health Insurance Program; 407 IAC 1-2-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2227; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 3. 407 IAC 1-2-2 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 1-2-2 Filing of claims; filing date; waiver of limit; claim auditing; payment liability; third party payments**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 2. (a) ~~All provider claims for payment of services rendered to CHIP primary care case~~

~~management members must be originally filed with the fiscal agent contractor within twelve (12) months of the date of the provision of service.~~ **The following claims must be originally filed with the fiscal agent contractor within twelve (12) months of the date of the provision of service:**

**(1) All provider claims for payment of services rendered to CHIP primary care case management members; and**

**(2) All provider claims for payment of services rendered to CHIP risk-based managed care members if the service is carved-out of a CHIP risk-based MCO contract.**

~~(b) A provider who contracts with a CHIP risk-based (MCO) must file its claims with the risk-based MCO in accordance with the terms of that contract. Such a provider does not retain any independent right or duplicative right for reimbursement from the office in addition to or in lieu of the reimbursement that it would receive from the risk-based MCO. Any disputes about reimbursement shall be handled in accordance with the terms of the contract between the provider and the risk-based MCO.~~

~~(e)~~ **(b)** A provider who is dissatisfied with the disposition of his or her claim by the fiscal agent contractor may request a payment adjustment or administrative review from the fiscal agent contractor. Before filing an appeal, the provider must seek administrative review from the fiscal agent contractor.

~~(d)~~ **(c)** All provider requests for payment adjustments, administrative review, and waiver of filing limit shall be processed in the same way as such requests are processed for Medicaid providers under rules promulgated by the secretary at 405 IAC 1-1-3.

~~(e)~~ **(d)** All claims filed for reimbursement shall be reviewed prior to payment by the office or its fiscal contractor, for completeness, including required documentation, appropriateness of services and charges, prior authorization when required, and other areas of accuracy and appropriateness as indicated.

**(e) A provider who contracts with a CHIP risk-based MCO must file its claims with the risk-based MCO in accordance with the terms of that contract. Such a provider does not retain any independent right or duplicative right for reimbursement from the office in addition to or in lieu of the reimbursement that it would receive from the risk-based MCO. Any disputes about reimbursement shall be handled in accordance with the terms of the contract between the provider and the risk-based MCO.**

**(f) CHIP is only liable for the payment of claims filed by providers who were certified and enrolled providers at the time the service was rendered and for services provided to persons who were enrolled in CHIP at the time service was provided. Payment may be made for services rendered no earlier than the first day of the month of CHIP application, if the patient is found to be eligible. Noncertified and nonenrolled providers giving service during the first month of eligibility must file a provider application retroactive to the beginning date of eligible service and meet provider certification requirements during this period. A claim for services that requires prior authorization provided during the first month of eligibility will not be paid unless such services have been reviewed and approved prior to payment. The claim will not be paid if the services provided are outside the service parameters established by the office.**

**(g) No CHIP reimbursement shall be available for services provided to individuals who are not eligible CHIP members on the date the service is provided.**

**(h) No CHIP reimbursement shall be available for services provided outside the parameters of a restricted healthcare card as established in section 1 of this rule.**

(i) A CHIP provider shall not collect from a CHIP member or from the family of a CHIP member any portion of his or her charge for a CHIP covered service that is not reimbursed by CHIP, except for any copayment authorized by law. A provider may deny services if the CHIP member does not pay the copayment, except that a provider may not deny emergency transportation services.

(j) A CHIP provider may charge a member or the member's family for a missed appointment if doing so is consistent with the provider's policy for private pay patients. (*Office of the Children's Health Insurance Program; 407 IAC 1-2-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2227; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 4. 407 IAC 1-4-1 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 1-4-1 Provider appeal procedures**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 1. (a) All provider appeals from office action taken under this article shall be governed by the procedures and time limits for Medicaid providers set out in 405 IAC 1-1.5.

(b) Providers who have contracts with CHIP risk-based MCOs right to appeal actions taken by the MCO is limited to that provided for in their contracts with the MCO. There is no state appeal right.

**(c) The reimbursement dispute resolution procedure set out in 405 IAC 1-1.6 shall apply to providers who do not have a contract with a CHIP risk-based MCO for services provided under CHIP.** (*Office of the Children's Health Insurance Program; 407 IAC 1-4-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2230; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 5. 407 IAC 1-6-2 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 1-6-2 Primary care case management fee**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 2 Primary medical providers **in the CHIP primary care case management program** shall receive ~~the same a~~ per member per month case management fee ~~as is paid under the Medicaid primary care case management program established by the office.~~ (*Office of the Children's Health Insurance Program; 407 IAC 1-6-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2231; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 6. 407 IAC 2-3-1 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 2-3-1 Responsibility for premium payment**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6-3-2; IC 12-17.6-4-3**

Sec. 1. (a) In order for an individual to receive benefits under CHIP, the individual's family

must pay ~~the monthly premiums as described as follows:~~ **premium established by the office in accordance with 42 U.S.C. 1397cc.**

Income (as a percentage of federal poverty level)	One child enrolled	Two or more children enrolled
<del>over 150% to 175%</del>	\$22	\$33
<del>over 175% to 200%</del>	\$33	\$50
<del>over 200% to 225%</del>	\$42	\$53
<del>over 225% to 250%</del>	\$53	\$70

~~For purposes of this section, the family's income includes the income considered in 407 IAC 2-2-2.~~

(b) Premiums must be paid monthly. Partial month payments will not be accepted. (*Office of the Children's Health Insurance Program; 407 IAC 2-3-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2233; filed Aug 7, 2002, 9:41 a.m.: 25 IR 4103; errata filed Sep 26, 2002, 11:42 a.m.: 26 IR 383; filed Nov 23, 2005, 11:30 a.m.: 29 IR 1213; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424; filed Dec 15, 2008, 11:27 a.m.: 20090114-IR-407080533FRA*)

SECTION 7. 407 IAC 2-4-2 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 2-4-2 Members of managed care organizations**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6-8; IC 27-13-10**

Sec. 2. A member complaining of an action of a managed care organization must exhaust the managed care organization's internal grievance procedure ~~under IC 27-13-10~~ prior to requesting a hearing by the office. (*Office of the Children's Health Insurance Program; 407 IAC 2-4-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2234; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)

SECTION 8. 407 IAC 3-3-2 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 3-3-2 Prior authorization; administrative review and appeals**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 2. (a) The procedures and requirements set forth in 405 IAC 5-3 and 405 IAC 5-7 for Medicaid prior authorization, administrative review, and appeals shall apply to ~~the children's health insurance program~~ **the following:**

- (1) Services rendered to CHIP primary care case management members; and**
- (2) Services rendered to CHIP risk-based managed care members if the service is carved-out of a CHIP risk-based MCO contract.**

(b) Except as provided in subsection (a) or as otherwise set forth in this article, the prior authorization procedures used by the Medicaid risk-based managed care program shall apply to services rendered to a CHIP risk-based managed care member.

- (1) Services furnished by a CHIP managed care organization must be sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services**

are furnished.

(2) CHIP managed care organizations shall publish their prior authorization procedures. The initial publication of prior authorization procedures and any updates to prior authorization procedures shall be made effective not earlier than forty-five (45) days after the date of publication. For purposes of this section, "publication" means, at minimum, making the prior authorization procedures available by posting the prior authorization procedures on the CHIP managed care organization's public website.

(3) A CHIP managed care organization's prior authorization procedures shall include all information necessary for a provider to submit a prior authorization request.

(4) A provider that:

(A) has an agreement with the office; and

(B) renders services to a CHIP managed care organization member;

must follow the procedures published under subsection (b) whether that provider has a contract with the CHIP managed care organization or not.

(5) Decisions by CHIP managed care organizations regarding prior authorization shall be made as expeditiously as possible considering the circumstances of each request. If no decision is made within seven (7) calendar days of receipt of all documentation required, authorization is deemed to be granted.

*(Office of the Children's Health Insurance Program; 407 IAC 3-3-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2235; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

SECTION 9. 407 IAC 3-10-1 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 3-10-1 Nonlegend drugs**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

~~Sec. 1. Reimbursement is not available for any nonlegend drug, except insulin when prescribed.~~ (a) A non-legend drug, with the exception of non-legend insulin, is covered to the extent such drug is:

(1) included on the Indiana Medicaid non-legend drug formulary;

(2) included on the Indiana Medicaid preferred drug list; and

(3) not specifically excluded from coverage.

(b) Non-legend insulin is covered to the extent it is subject to the terms of a rebate agreement between the drug's manufacturer and the Centers for Medicare and Medicaid Services (CMS).

*(Office of the Children's Health Insurance Program; 407 IAC 3-10-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2237; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

SECTION 10. 407 IAC 3-10-2 IS AMENDED TO READ AS FOLLOWS:

**407 IAC 3-10-2 Generic drugs**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 2. A provider filling a prescription under the CHIP program shall:

- (1) ~~substitute a generically equivalent drug product if one is available; and~~
- (2) ~~inform the customer of the substitution;~~

~~if the substitution would result in a lower price unless the practitioner prescribing the drug signs on the line under which the words "dispense as written" appear or indicates that the brand name drug is medically necessary. Brand name drugs, where generic substitution is possible, are covered in accordance with applicable law.~~

**(1) Brand name drugs are covered if the brand name drug is:**

- (A) medically necessary; or**
- (B) less costly than the generic.**

**(2) A brand name drug is medically necessary if the prescriber:**

- (A) indicates in the prescriber's own handwriting "brand medically necessary" on the prescription or drug order; and**
- (B) obtains prior authorization by substantiating the medical necessity of the brand name drug as opposed to the less costly generic equivalent. For brand name drugs reimbursable by the office, the prior authorization number assigned to the approved request must be included on the prescription or drug order issued by the prescriber or relayed to the dispensing pharmacist by the prescriber if the prescription is orally transmitted. The office may exempt specific brand name drugs or classes of brand name drugs from the prior authorization requirement. (*Office of the Children's Health Insurance Program; 407 IAC 3-10-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2237; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424*)**

SECTION 11. 407 IAC 3-13-1 IS AMENDED TO READ AS FOLLOWS:

#### **407 IAC 3-13-1 Noncovered services**

**Authority: IC 12-17.6-2-11**

**Affected: IC 12-17.6**

Sec. 1. The following services are not covered by CHIP:

- (1) Services that are not covered by the Medicaid program.
- (2) Services provided in a nursing facility.
- (3) Services provided in an intermediate care facility for the mentally retarded (ICF/MR).
- (4) Private duty nursing.
- (5) Case management services for the following:
  - (A) Persons with HIV/AIDS.
  - (B) Pregnant women.
- (6) Nonambulance transportation.
- (7) Services provided by Christian Science nurses.
- (8) Services provided in Christian Science sanatoriums.
- (9) Organ transplants.
- (10) ~~Over the counter drugs (except insulin).~~

~~(11)~~ **(10)** Reserved beds in psychiatric hospitals.

~~(12)~~ **(11)** Any other service or supply listed in this article as noncovered.

*(Office of the Children's Health Insurance Program; 407 IAC 3-13-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2237; filed Jul 21, 2004, 5:01 p.m.: 27 IR 3987; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424; filed Oct 6, 2009, 4:14 p.m.: 20091104-IR-407080932FRA)*

SECTION 12. This document takes effect January 1, 2011 or 30 days after filing with the Publisher, whichever comes later.