TITLE 407 OFFICE OF THE CHILDREN'S HEALTH INSURANCE PROGRAM

ARTICLE 1. CHILDREN'S HEALTH INSURANCE PROGRAM GENERAL PROVISIONS; PROVIDERS

Rule 1. Definitions

407 IAC 1-1-1 Use of Medicaid definitions
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Unless otherwise specifically defined in this title, definitions for terminology used are the same as those used in the Medicaid program and defined in 405 IAC 5-2. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)*

407 IAC 1-1-2 Applicability
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 2. The definitions in this rule apply throughout this title unless the context clearly indicates another meaning. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)*

407 IAC 1-1-3 "Applicant" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 3. "Applicant" means the person for whom children's health insurance program coverage is requested. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)*

407 IAC 1-1-4 "Children's health insurance program" or "CHIP" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-2

Sec. 4. "Children's health insurance program" or "CHIP" means the program established by IC 12-17.6-2. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-4; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)*

407 IAC 1-1-5 "Division" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 5. "Division" means the division of family and children. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-5; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)*

407 IAC 1-1-6 "Emergency" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 6. "Emergency" means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:
(1) place an individual's health in serious jeopardy;
(2) result in serious impairment to the individual's bodily functions; or
(3) result in serious dysfunction of a bodily organ or part of the individual.
(Office of the Children's Health Insurance Program; 407 IAC 1-1-6; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)

407 IAC 1-1-7 "Hoosier Healthwise" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-15; IC 12-17.6

Sec. 7. "Hoosier Healthwise" means:
(1) the Medicaid program for:
(A) children under nineteen (19) years of age;
(B) pregnant women; and
(C) certain low income families established by IC 12-15; and
(2) the children's health insurance program established by IC 12-17.6.
(Office of the Children's Health Insurance Program; 407 IAC 1-1-7; filed May 3, 2000, 2:02 p.m.: 23 IR 2225)

407 IAC 1-1-8 "Income" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 8. "Income" means gross monthly income, including earned and unearned income. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-8; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-9 "Institution for mental diseases" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 9. "Institution for mental diseases" means a hospital, nursing facility, or other institution of more than sixteen (16) beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-9; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-10 "Local office" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 10. "Local office" means the local office of the division of family and children. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-10; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

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 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)*

407 IAC 1-1-12 "Member" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 12. "Member" means an individual eligible and enrolled in the children's health insurance program in either the PCCM or RBMC component. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-12; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-13 "Office" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-2-1

Sec. 13. "Office" means the office of the children's health insurance program established by IC 12-17.6-2-1. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-13; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-14 "Parent" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 14. "Parent" means the biological or adoptive parent living with an unmarried applicant or member. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-14; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-15 "Primary care case management" or "PCCM" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 15. "Primary care case management" or "PCCM" means a delivery system for health care in which members are linked to a PMP who contracts directly with the office. The PMP is responsible for coordinating designated covered services, and he or she, as well as all other providers rendering services in this delivery system, is reimbursed on a fee-for-service basis. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-15; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-16 "Primary medical provider" or "PMP" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 16. "Primary medical provider" or "PMP" means a physician who is responsible for providing primary and preventive care, and for authorizing other CHIP services as needed, and within the scope of his or her contract to authorize, for CHIP members. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-16; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-17 "Risk-based managed care" or "RBMC" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 17. "Risk-based managed care" or "RBMC" means a fully capitated prepayment plan where a managed care organization, under a contract with the office, is at risk to arrange for and administer the provision of a comprehensive set of covered services to CHIP members. Members are linked to a PMP who contracts directly with the MCO. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-17; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-18 "Secretary" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 18. "Secretary" means the secretary of the family and social services administration. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-18; filed May 3, 2000, 2:02 p.m.: 23 IR 2226)*

407 IAC 1-1-19 "Spouse" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 19. "Spouse" means the legal husband or wife of an applicant or member. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-19; filed May 3, 2000, 2:02 p.m.: 23 IR 2227)*

407 IAC 1-1-20 "Third party" defined
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 20. "Third party" means an insurer, individual, institution, corporation, or public or private agency who is or may be liable to pay all or part of the medical costs of injury, disease, or disability of a CHIP applicant or member. *(Office of the Children's Health Insurance Program; 407 IAC 1-1-20; filed May 3, 2000, 2:02 p.m.: 23 IR 2227)*

Rule 2. General Provisions

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 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)

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.

(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.

(c) 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) 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) 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.

(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)*

407 IAC 1-2-3 Denial of claim payment; basis; discretion of director

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

Sec. 3. The procedures set out in 405 IAC 1-1-4 for the denial of claims and the basis for denial for Medicaid providers shall apply to the denial of claims to providers under this title, except that any discretion exercised shall be that of the director of the children's health insurance program, or his or her duly authorized representative. *(Office of the Children's Health Insurance Program; 407 IAC 1-2-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2228)*

407 IAC 1-2-4 Overpayments to providers

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

Sec. 4. The procedures set out in 405 IAC 1-1-5 for recovery of overpayments from Medicaid providers shall apply to the recovery of overpayments made to providers under this title, except that any discretion exercised shall be that of the director of the office of the children's health insurance program, or his or her duly authorized representative. *(Office of the Children's Health Insurance Program; 407 IAC 1-2-4; filed May 3, 2000, 2:02 p.m.: 23 IR 2228)*

407 IAC 1-2-5 Sanctions against providers; determination after investigation

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

Sec. 5. The procedures set out in 405 IAC 1-1-6 for sanctions against Medicaid providers and determinations after investigation shall apply to providers under this title, except that any discretion exercised shall be that of the director of the office of the children's health insurance program, or his or her duly authorized representative. *(Office of the Children's Health Insurance Program; 407 IAC 1-2-5; filed May 3, 2000, 2:02 p.m.: 23 IR 2228)*

407 IAC 1-2-6 Subrogation of claims and third party liability
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 6. (a) By applying for and accepting benefits under the CHIP program, a CHIP applicant or member or one legally authorized to act on behalf of an applicant or member shall be considered to have assigned to the office the member's rights to medical payments from any responsible third party.

(b) The office shall be subrogated to all claims by CHIP members against third parties to the extent of CHIP benefits paid by the office.

(c) The office, acting on behalf of the CHIP member, may initiate an action against a third party that is or may be liable for the injury, illness, or disease of a CHIP member when:

(1) the member has not done so; and

(2) the time remaining under the statute of limitations for the action is six (6) months or less.

(d) The office may seek reimbursement from any money or fund payable by any third party who is or may be liable for the medical expenses of a CHIP member when CHIP provides benefits. Circumstances under which the office may seek reimbursement include, but are not limited to, cases where CHIP has made payment because:

(1) payment from a third party was not immediately available;

(2) there are disputes and delays in the coordination of benefits;

(3) the third party was not identified;

(4) the office erroneously made payment before the third party or all other parties had made payment;

(5) a court order has been issued; or

(6) the member asserts a claim against a third party who is or may be liable for the injury, illness, or disease of a CHIP applicant or member.

(e) The office may enforce its right to seek reimbursement by serving notice to third parties in the following manner:

(1) By sending a notice to the following persons or entities if the appropriate names and addresses are determined:

(A) The member.

(B) The member's attorney.

(C) The insurer or other third parties.

(2) The notice under this subsection shall include the following:

(A) The name and address of the member.

(B) That the individual is eligible for CHIP.

(C) The name of the person or third party alleged to be liable to the injured or ill member.

(f) Before submitting a claim to the office or its contractor, the provider shall make reasonable efforts to determine whether a third party is responsible for payment of the service. If a responsible third party is identified, the provider must seek payment from the third party prior to billing CHIP.

(g) If the office has established the probable existence of third party liability at the time the claim is filed, the office may deny the claim and return it to the provider for a determination of the amount of liability. The establishment of third party liability takes place when the office receives confirmation from the provider or a third party resource indicating the extent of third party liability. When the amount of liability is determined, the office may then pay the claim to the extent that payment allowed under CHIP exceeds the amount of the third party's payment.

(h) If the probable existence of third party liability cannot be established or third party benefits are not available to pay the recipient's medical expenses at the time the claim is filed, the office may pay the full amount allowed under CHIP program and seek recovery of reimbursement from the third party.

(i) The office may waive its right to seek reimbursement under this section, at its discretion. *(Office of the Children's Health Insurance Program; 407 IAC 1-2-6; filed May 3, 2000, 2:02 p.m.: 23 IR 2228; errata filed Aug 2, 2000, 3:21 p.m.: 23 IR 3091)*

407 IAC 1-2-7 Insurance information; release
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 7. (a) As used in this section, "insurer" means any insurance company, health maintenance organization, prepaid health

care delivery plan, self-funded employee benefit plan, pension fund, retirement system, group coverage plan, blanket coverage plan, franchise insurance coverage plan, individual coverage plan, family-type insurance coverage plan, Blue Cross/Blue Shield plan, group practice plan, individual practice plan, labor-management trusteed plan, union welfare plan, employer organization plan, employee benefit organization plan, governmental program plan, fraternal benefits society, Indiana Comprehensive Health Insurance Association plan, any plan or coverage required or provided by any statute, or similar entity that is:

(1) doing business in this state; and

(2) under an obligation to make payments for medical services as a result of an injury, illness, or disease suffered by a CHIP member.

(b) A CHIP applicant or member or one legally authorized to seek CHIP benefits on behalf of the applicant or member shall be considered to have authorized all insurers to release to the office all available information needed by the office to secure or enforce its rights pertaining to third party liability collection.

(c) Every insurer shall provide to the office, upon written request, information pertaining to coverage and benefits paid or available to an individual under an individual, group, or blanket policy or certificate of coverage when the office certifies that such individual is an applicant for or a member of CHIP. Information, to the extent available, regarding the insured may include, but need not be limited to, the following:

(1) Name, address, and Social Security number of the insured.

(2) Policy numbers, the terms of the policy, and the benefit code.

(3) Names of covered dependents whom the state certifies are applicants or members.

(4) Name and address of employer, other person, or organization that holds the group policy.

(5) Name and address of employer, other person, or organization through which the coverage was obtained.

(6) Benefits remaining available under the policy, including, but not limited to, coverage periods, lifetime days, and lifetime funds.

(7) The deductible and the amount of deductible outstanding for each benefit at the time of the request.

(8) Any additional coinsurance information that may be on file.

(9) Copies of claims when requested for legal proceedings.

(10) Copies of checks and their endorsements when these documents are needed as part of an investigation of a member and provider.

(11) Other policy information that the office certifies in writing is necessary to secure and enforce its rights pertaining to third party liability collection.

(12) Carrier information, including the following:

(A) Name and address of carrier.

(B) Adjuster's name and address.

(C) Policy number and claim number.

(13) Claims information, including the following:

(A) Identity of the individual to whom the service was rendered.

(B) Identity of the provider rendering services.

(C) Identity and position of provider's employee rendering the services, if necessary for claims processing.

(D) Date on which services were rendered.

(E) A detailed explanation of charges and benefits.

(Office of the Children's Health Insurance Program; 407 IAC 1-2-7; filed May 3, 2000, 2:02 p.m.: 23 IR 2229)

407 IAC 1-2-8 Severability; governing provisions; effect of provision inconsistent with or invalid under federal law

Authority: IC 12-17.6-2-11

Affected: IC 12-17.6

Sec. 8. (a) If any provision in this title is or becomes inconsistent with any subsequently enacted amendment to the federal Social Security Act or any regulation promulgated thereunder, the amendment to the Social Security Act or the regulation promulgated thereunder shall govern until such time as this title is amended.

(b) If any provision in this document is or becomes inconsistent with any subsequently enacted act of the Indiana general assembly, the act of the Indiana general assembly shall govern until such time as this document is amended.

(c) If any provision in this title, or its application to any person, entity, or circumstance is held invalid, the invalidity does not

affect other provisions or applications of this title that can be given effect without the invalid provision or application, and, to this end, the provisions in this title are severable. *(Office of the Children's Health Insurance Program; 407 IAC 1-2-8; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

Rule 3. Provider Enrollment

407 IAC 1-3-1 Provider enrollment

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

Sec. 1. The procedures set out in 405 IAC 5-4 for enrollment of providers in the Medicaid program shall apply to providers under this title who render services covered by CHIP. *(Office of the Children's Health Insurance Program; 407 IAC 1-3-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

407 IAC 1-3-2 Provider reciprocity

Authority: IC 12-17.6-2-11
Affected: IC 12-15; IC 12-17.6

Sec. 2. (a) Providers that are enrolled in the Medicaid program are enrolled in CHIP as long as they comply with the provider enrollment and eligibility requirements for Medicaid under IC 12-15 and rules adopted under that article.

(b) A PMP who has filed an addendum to his or her Medicaid provider agreement to participate in PCCM is considered a PMP for CHIP PCCM. *(Office of the Children's Health Insurance Program; 407 IAC 1-3-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

407 IAC 1-3-3 Risk-based managed care providers

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

Sec. 3. (a) Providers who have contracts with CHIP risk-based MCOs must also file provider agreements with the office.

(b) Providers who have contracts with Medicaid risk-based MCOs and who have already filed provider agreements with the Medicaid contractor are not required to file an additional provider agreement to participate as a CHIP risk-based managed care provider. *(Office of the Children's Health Insurance Program; 407 IAC 1-3-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

Rule 4. Provider Appeals

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. *(Office of the Children's Health Insurance Program; 407 IAC 1-4-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

Rule 5. Provider Records

407 IAC 1-5-1 Provider records

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

Sec. 1. The provisions of 405 IAC 1-5-1 and 405 IAC 1-5-2 concerning contents, retention, and disclosure of records of

Medicaid providers shall apply to providers of covered services under this title. *(Office of the Children's Health Insurance Program; 407 IAC 1-5-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2230)*

Rule 6. Provider Reimbursement

407 IAC 1-6-1 Provider reimbursement; fee for service
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Except for reimbursement to providers who have contracts with a CHIP risk-based MCO, the rates of reimbursement for the services and supplies provided under this title shall be the same as those calculated for Medicaid services and supplies under the Medicaid state plan, state statute, and rules adopted by the secretary at 405 IAC 1. Reimbursement to providers who have contracts with a CHIP risk-based MCO is governed by the contract between the provider and the MCO as described in section 3 of this rule. *(Office of the Children's Health Insurance Program; 407 IAC 1-6-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)*

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 shall receive the same per member per month case management fee as is paid under the Medicaid primary care case management program. *(Office of the Children's Health Insurance Program; 407 IAC 1-6-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)*

407 IAC 1-6-3 Provider reimbursement; risk-based managed care
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 3. Reimbursement to providers who have contracts with a CHIP risk-based MCO is governed by the contract between the provider and the MCO. 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. *(Office of the Children's Health Insurance Program; 407 IAC 1-6-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)*

ARTICLE 2. APPLICANTS AND MEMBERS; ELIGIBILITY AND ENROLLMENT; APPEAL PROCEDURES

Rule 1. General Requirements; Eligibility

407 IAC 2-1-1 Application process
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-5

Sec. 1. (a) An application for CHIP shall be filed on the form prescribed by the family and social services administration.
(b) An application shall be made:
(1) at a local office in the county where the applicant resides;
(2) at an enrollment center that has entered into an agreement with the division to complete initial intake processing of Hoosier Healthwise applications; or
(3) by mail to the division.
(c) An application for CHIP may be filed on behalf of an applicant by any of the following:
(1) The applicant's parent, guardian, or caretaker.
(2) The applicant, if the applicant is either:
(A) eighteen (18) years of age and not living with a parent, guardian, or caretaker; or
(B) married and living with his or her spouse.

(d) The applicant may use an authorized representative to apply for CHIP. The authorization must be in writing and signed by a person authorized to file an application under subsection (c).

(e) The applicant, the applicant's parent or guardian, or the authorized representative must be interviewed by the local office or an enrollment center.

(f) An employee of an enrollment center who accepts an application or conducts an interview in conjunction with an application may not act as authorized representative for that applicant. *(Office of the Children's Health Insurance Program; 407 IAC 2-1-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)*

407 IAC 2-1-2 Date of application

Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-5

Sec. 2. For purposes of determining the effective date of coverage, the date of application is the date on which the signed application is received by the division or the enrollment center. *(Office of the Children's Health Insurance Program; 407 IAC 2-1-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)*

407 IAC 2-1-3 Date of coverage

Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-5

Sec. 3. CHIP reimbursement for covered services is available beginning on the first day of the month of application if both of the following requirements are met:

(1) The applicant is determined eligible for CHIP.

(2) The applicable premium has been paid.

(Office of the Children's Health Insurance Program; 407 IAC 2-1-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2231)

Rule 2. Eligibility Requirements

407 IAC 2-2-1 Age

Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-2

Sec. 1. To be eligible to enroll in the program, an applicant must be less than nineteen (19) years of age. *(Office of the Children's Health Insurance Program; 407 IAC 2-2-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2232)*

407 IAC 2-2-2 Income

Authority: IC 12-17.6-2-11
Affected: IC 12-15-2-14; IC 12-17.6-3-2

Sec. 2. (a) To be eligible to enroll in the program, an applicant must be a member of a family with an annual income of:

(1) more than one hundred fifty percent (150%); and

(2) not more than two hundred percent (200%);

of the federal income poverty level.

(b) All income of the following individuals is considered in determining the individual's eligibility, except for the exclusions listed in subsection (d):

(1) The applicant or member.

(2) The applicant or member's parents living in the home with the applicant or member unless the applicant or member is married.

(3) The applicant's or member's spouse.

(c) The amount of countable income shall be computed according to 405 IAC 2-5-1.

(d) Any income that would be excluded under the Medicaid program for a child under nineteen (19) years of age described

in IC 12-15-2-14 is excluded in determining eligibility for the program. *(Office of the Children's Health Insurance Program; 407 IAC 2-2-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2232)*

407 IAC 2-2-3 Agreement to pay cost sharing
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-2

Sec. 3. (a) As a condition of eligibility for CHIP, at least one (1) of the following individuals must agree to pay the cost-sharing required by the office under this title:
(1) The parent, guardian, or caretaker of an applicant.
(2) The applicant, if the applicant is either:
(A) eighteen (18) years of age and not living with a parent, guardian, or caretaker; or
(B) married and living with his or her spouse.
(b) If the individual who agrees to pay cost-sharing for an applicant under this section has failed to pay the required premiums due for any member at any time within the two (2) years preceding the date of application, the individual must pay all premiums due within the past two (2) years before an applicant for whom that individual has cost-sharing responsibility may enroll in the program. An applicant living with an individual who has not failed to pay any past due premiums may be enrolled even though his or her prior parent, guardian, or caretaker failed to pay. *(Office of the Children's Health Insurance Program; 407 IAC 2-2-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2232; errata filed Aug 2, 2000, 3:21 p.m.: 23 IR 3091)*

407 IAC 2-2-4 Waiting periods for certain members
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-4-4

Sec. 4. (a) Except as provided in subsection (b), an individual who was covered under a group health plan or under health insurance coverage as such terms are defined in 42 U.S.C. §300gg-91 is ineligible for CHIP for three (3) months from the effective date of termination of that coverage.
(b) This section does not apply if the individual's coverage under a group health plan or other health insurance coverage was terminated involuntarily, including, but not limited to, loss of coverage for the following reasons:
(1) The employer of the individual, parent, guardian, or other family member terminated the health plan coverage.
(2) The individual, parent, guardian, or other family member is no longer eligible for the plan due to termination of employment or a reduction in working hours.
(3) The individual is no longer covered under the plan due to the death or divorce of the parent, guardian, or other family member.
(4) The individual has reached the lifetime limit of benefits under the plan.
(Office of the Children's Health Insurance Program; 407 IAC 2-2-4; filed May 3, 2000, 2:02 p.m.: 23 IR 2232)

407 IAC 2-2-5 Eligibility
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-3

Sec. 5. (a) Subject to subsection (b), an individual who is eligible for CHIP shall remain covered under the program until the earlier of the following:
(1) The child becomes financially ineligible.
(2) The end of the month in which child becomes nineteen (19) years of age.
(b) Subsection (a) applies only if the individual:
(1) and the individual's parent, guardian, or caretaker comply with enrollment requirements, including, but not limited to, paying required premiums; and
(2) does not become ineligible under section 6(a) of this rule.
(Office of the Children's Health Insurance Program; 407 IAC 2-2-5; filed May 3, 2000, 2:02 p.m.: 23 IR 2232; filed Aug 7, 2002, 9:41 a.m.: 25 IR 4103)

407 IAC 2-2-6 Ineligibility
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-2

Sec. 6. (a) Notwithstanding any other provision of this article, an individual is not eligible for CHIP if any of the following apply:

(1) The individual is eligible for Medicaid, except for an individual who is subject to a spenddown under 405 IAC 2-3-10. An individual who is eligible for Medicaid with a spenddown may be eligible for CHIP if all other CHIP eligibility requirements are met.

(2) The individual is covered under a group health plan or under health insurance coverage as such terms are defined in 42 U.S.C. §300gg-91.

(3) The individual is eligible for health benefits coverage under a state health benefits plan on the basis of a family member's employment with a public agency in the state.

(4) The individual is an inmate of a public institution as defined in 42 CFR 435.1009.

(5) The individual is not a resident of Indiana.

(6) The individual is an undocumented alien.

(b) If any of the conditions in subsection (a) apply to a member, the member or the member's parent, guardian, or authorized representative must report the change to the local office.

(c) An individual who is a patient in an institution for mental diseases at the time of application or redetermination is not eligible for the program. A member who has been determined eligible under the program and becomes a patient in an institution for mental diseases after eligibility determination may remain eligible for covered services under the program until the end of the one (1) year period in section 5 of this rule if the individual:

(1) and the individual's parent or guardian comply with enrollment requirements, including, but not limited to, paying required premiums; and

(2) does not become ineligible under subsection (a).

IMD services are not covered under CHIP. However, the individual remains eligible for services that are covered. *(Office of the Children's Health Insurance Program; 407 IAC 2-2-6; filed May 3, 2000, 2:02 p.m.: 23 IR 2233)*

Rule 3. Premiums

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 monthly premiums as described in *[sic.]* below:

Income (as a percentage of federal poverty level)	One child enrolled	Two or more children enrolled
over 150% to 175%	$11.00	$16.50
over 175% to 200%	$16.50	$24.75

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)*

407 IAC 2-3-2 Nonpayment of premium
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-3-2; IC 12-17.6-4-3

Sec. 2. (a) When an applicant is determined eligible for CHIP, the applicant will be conditionally approved for CHIP pending payment of the premium. Coverage begins when the first premium is received by the office or its designated contractor. After the premium is received, coverage will be retroactive to the first day of the month of application.

(b) The parent or guardian must pay the first premium in order for the applicant to receive coverage under CHIP. If payment

is not received by the due date specified in the second premium notice, the CHIP application will be denied.

(c) If any premium after the first premium is not paid by the due date, a maximum of sixty (60) days coverage without premium payment will be permitted before coverage is discontinued. When a member has been discontinued from the program due to non-payment of premiums, the family may reapply, but must pay all past due premiums and the premium for the current month in order to begin coverage. The member is not required to pay premiums for the time period between the date of discontinuance and the date that coverage resumes. Any services received by the member during the time period between the date of discontinuance and the date that coverage resumes are not covered by CHIP.

(d) A payment of less than the full amount due will not be accepted and will be considered nonpayment. *(Office of the Children's Health Insurance Program; 407 IAC 2-3-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2233; filed Aug 7, 2002, 9:41 a.m.: 25 IR 4103)*

407 IAC 2-3-3 Maximum total annual aggregate cost-sharing

Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-4-3

Sec. 3. (a) The total annual aggregate cost-sharing for a family may not exceed five percent (5%) of the family's income for the twelve (12) month period beginning on the date that the child's eligibility is determined. As used in this section, "total aggregate cost-sharing" means premiums and copayments paid by the member or the member's parent or guardian. For purposes of this section, the family's income includes the income considered in 407 IAC 2-2-2.

(b) The member's family is responsible for informing the local office when the total aggregate cost-sharing for the family has reached five percent (5%) of the family's income and for maintaining documentation to substantiate the amount of cost-sharing paid by the family. When the member provides the local office with documentary verification that the total aggregate cost-sharing for a family has reached five percent (5%) of the family's income for the twelve (12) month period:

(1) the member's parent or guardian will not be required to pay any premiums for the remainder of the twelve (12) month period; and

(2) the office will refund any copayments paid during the remainder of the twelve (12) month period.

(Office of the Children's Health Insurance Program; 407 IAC 2-3-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2234)

Rule 4. Appeals and Hearings

407 IAC 2-4-1 Appeals by applicants and members of CHIP

Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-8

Sec. 1. (a) In the event that the rights, duties, obligations, privileges, or other legal relations of any person or entity are required or authorized by law to be determined by the office of CHIP or any local office of family and children, then such person or entity may request an administrative hearing under this rule.

(b) Appeals by CHIP members and applicants are governed by the procedures and time limits for Medicaid applicants and recipients set out in 405 IAC 1.1. *(Office of the Children's Health Insurance Program; 407 IAC 2-4-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2234)*

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)*

407 IAC 2-4-3 Maintaining services
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-8

Sec. 3. (a) Except as provided in subsection (c), if a member requests a hearing prior to the effective date of a notice of discontinuance of coverage, the member may elect to continue CHIP coverage until the administrative law judge issues a decision after the hearing pursuant to 405 IAC 1.1-1-6. The member's parent or guardian must continue to pay premiums in order to continue coverage.

(b) If the office's action is sustained by the administrative law judge, the member or the member's parent or guardian is responsible for repaying the cost of any services furnished by reason of this section, minus any premiums paid for coverage during the pendency of the appeal.

(c) If the member is notified that coverage is to be discontinued due to nonpayment of the premium, CHIP coverage will not be maintained after the effective date of the discontinuance. *(Office of the Children's Health Insurance Program; 407 IAC 2-4-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2234)*

ARTICLE 3. BENEFITS AND MEDICAL POLICY

Rule 1. General Provisions

407 IAC 3-1-1 Intent and purpose
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6-4

Sec. 1. (a) Under IC 12-17.6, Title XXI of the federal Social Security Act, the office of the children's health insurance program hereby adopts and promulgates this article to:

(1) interpret and implement the provisions of IC 12-17.6-4;

(2) ensure the efficient, economical, and medically reasonable operations of a children's health insurance program (referred to as CHIP) in Indiana; and

(3) safeguard against overutilization, fraud, abuse, and utilization and provision of services and supplies that are not medically reasonable or medically necessary and are not covered by the CHIP benefits package.

(b) The purposes for this article are accomplished in this article by using, to the extent possible, the same coverage criteria as that used by the Medicaid managed care program, for those services included in the CHIP benefit package, except as otherwise set forth in this article. *(Office of the Children's Health Insurance Program; 407 IAC 3-1-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2234)*

Rule 2. Mental Health Parity

407 IAC 3-2-1 Mental health parity
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. (a) Coverage of services for mental illness shall be subject to the same treatment limitations and financial requirements as coverage of services for physical illness.

(b) For purposes achieving parity in the CHIP benefit package, outpatient services for mental health and substance abuse services shall be subject to the same maximum limits as those imposed for physical, occupational, respiratory, and speech therapies. *(Office of the Children's Health Insurance Program; 407 IAC 3-2-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2235)*

Rule 3. CHIP; Coverage; Use of Medicaid Rules

407 IAC 3-3-1 Covered services
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. (a) The following services will be covered by CHIP using the same coverage criteria, limitations, and procedures, including prior authorization, as Medicaid under rules adopted by the secretary at 405 IAC 5 unless a service is listed as noncovered in 407 IAC 3-13:

(1) Physician services, except that office visits shall be reimbursed in accordance with 407 IAC 3-5-1.
(2) Inpatient hospital, except that inpatient rehabilitation services are limited to fifty (50) days per calendar year.
(3) Outpatient hospital.
(4) Laboratory and radiology.
(5) Certified nurse practitioner.
(6) Family planning services and supplies.
(7) Certified nurse-midwife.
(8) Vision.
(9) Home health and clinic services.
(10) Dental.
(11) Hospice.
(12) Diabetes self-management training.
(13) Food supplements, nutritional supplements, and infant formulas.
(14) Restricted utilization.
(15) Consultations and second opinions.
(16) Anesthesia.

(b) The following services will be covered by CHIP using the coverage criteria, limitations, and procedures described in 407 IAC 3-4 through 407 IAC 3-12:

(1) Early intervention services.
(2) Evaluation and management services.
(3) Medical supplies and equipment.
(4) Mental health and substance abuse services.
(5) Therapy services.
(6) Transportation.
(7) Pharmacy services.
(8) Podiatry services.
(9) Chiropractic services.

(Office of the Children's Health Insurance Program; 407 IAC 3-3-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2235)

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

407 IAC 3-3-3 Out-of-state services

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

Sec. 3. Those services otherwise covered in this article are covered when provided out-of-state, subject to the same requirements applicable to out-of-state services provided under the Medicaid program. *(Office of the Children's Health Insurance Program; 407 IAC 3-3-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2235)*

Rule 4. Early Intervention Services

407 IAC 3-4-1 Immunizations; screening; diagnosis
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Age-appropriate immunizations and periodic screening and diagnosis services shall be covered by CHIP in the same manner and at the same intervals as they are in the Medicaid program. *(Office of the Children's Health Insurance Program; 407 IAC 3-4-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2235)*

407 IAC 3-4-2 Treatment
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 2. Treatment found necessary as a result of a diagnosis pursuant to an initial or periodic screening may be provided subject to any prior authorization requirements and coverage limitations set out in this article. If a service is not covered under the state plan, it is not a reimbursable service by CHIP. *(Office of the Children's Health Insurance Program; 407 IAC 3-4-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2235)*

Rule 5. Evaluation and Management Services

407 IAC 3-5-1 Limitations
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Reimbursement is available for office visits limited to a maximum of thirty (30) per recipient per rolling twelve (12) month period without prior authorization and subject to the restrictions applicable to the Medicaid program set forth in 405 IAC 5-9. *(Office of the Children's Health Insurance Program; 407 IAC 3-5-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

Rule 6. Medical Supplies and Equipment

407 IAC 3-6-1 Coverage and limitations
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. (a) Subject to the limitation in subsection (b), durable medical equipment, repairs to durable medical equipment, and medical supplies are covered using the same coverage criteria and prior authorization procedures applicable to the Medicaid program and set forth in 405 IAC 5-19.

(b) Durable medical equipment is subject to a maximum benefit of two thousand dollars ($2,000) per calendar year per member and five thousand dollars ($5,000) per member per lifetime. *(Office of the Children's Health Insurance Program; 407 IAC 3-6-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

Rule 7. Mental Health and Substance Abuse Services

407 IAC 3-7-1 Reimbursement limitations
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. (a) Reimbursement is available for mental health services subject to the limitations set out in the Medicaid program as well as additional limitations set forth in this rule.

(b) Inpatient mental health and substance abuse services are not covered when provided in an institution for mental diseases with more than sixteen (16) beds.

(c) Outpatient mental health and substance abuse services are limited to a maximum of thirty (30) office visits per rolling

twelve (12) month period without prior approval. Up to twenty (20) additional visits up to a maximum of fifty (50) visits per rolling twelve (12) month period may be prior authorized subject to Medicaid prior authorization criteria.

(d) Reimbursement is not available for reservation of beds in psychiatric hospitals.

(e) Community mental health rehabilitation services (Medicaid rehabilitation option) are not covered by the children's health insurance program. *(Office of the Children's Health Insurance Program; 407 IAC 3-7-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

Rule 8. Therapy Services

407 IAC 3-8-1 Reimbursement limitations

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

Sec. 1. Reimbursement is available for physical, speech, occupational, and respiratory therapy subject to the limitations set forth in the Medicaid program as well as the limitations set forth in this rule. *(Office of the Children's Health Insurance Program; 407 IAC 3-8-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

407 IAC 3-8-2 Maximum visits

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

Sec. 2. Physical, speech, occupational, and respiratory therapy is limited to a maximum of fifty (50) visits per member per rolling twelve (12) month period for each type of therapy. *(Office of the Children's Health Insurance Program; 407 IAC 3-8-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2236; errata filed Aug 2, 2000, 3:21 p.m.: 23 IR 3091)*

Rule 9. Transportation

407 IAC 3-9-1 Reimbursement limitations

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

Sec. 1. Emergency ambulance transportation is a covered service, subject to the prudent layperson definition of emergency in 407 IAC 1-1-6. *(Office of the Children's Health Insurance Program; 407 IAC 3-9-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

407 IAC 3-9-2 Nonemergency ambulance transportation

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

Sec. 2. Nonemergency ambulance transportation between medical facilities is a covered service when ordered by the treating physician. *(Office of the Children's Health Insurance Program; 407 IAC 3-9-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2236)*

407 IAC 3-9-3 Copayment

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

Sec. 3. (a) A ten dollar ($10) copayment is required for ambulance transportation.

(b) The copayment shall be paid by the member and collected by the provider. Reimbursement shall be adjusted to reflect the copayment amount for which the member is liable. *(Office of the Children's Health Insurance Program; 407 IAC 3-9-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)*

Rule 10. Pharmacy Services

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

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

407 IAC 3-10-3 Copayments
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 3. (a) A three dollar ($3) copayment is required for generic, compound, and sole source drugs.
(b) A ten dollar ($10) copayment is required for brand name drugs.
(c) The copayment shall be paid by the member and collected by the provider. Reimbursement shall be adjusted to reflect the copayment amount for which the member is liable.
(d) A provider may deny services if the member does not pay the required copayment. *(Office of the Children's Health Insurance Program; 407 IAC 3-10-3; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)*

Rule 11. Podiatry Services

407 IAC 3-11-1 Covered services
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Reimbursement is available for the following podiatry services when performed within the scope of practice of the podiatry profession as defined by Indiana law, subject to the limitations set forth in the Medicaid program as well as the limitations set forth in this rule:
(1) Surgical procedures involving the foot.
(2) Laboratory services.
(3) X-ray services.
(Office of the Children's Health Insurance Program; 407 IAC 3-11-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)

407 IAC 3-11-2 Noncovered services
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 2. Routine foot care as defined in 405 IAC 3-26-3 *[sic.]* is not covered. *(Office of the Children's Health Insurance Program; 407 IAC 3-11-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)*

Rule 12. Chiropractic Services

407 IAC 3-12-1 Reimbursement
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 1. Reimbursement is available for chiropractic services subject to the limitations set forth in the Medicaid program as well as the limitations set forth in this rule. *(Office of the Children's Health Insurance Program; 407 IAC 3-12-1; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)*

407 IAC 3-12-2 Limitations
Authority: IC 12-17.6-2-11
Affected: IC 12-17.6

Sec. 2. (a) Chiropractic services are limited to:
(1) five (5) visits; and
(2) fourteen (14) procedures;
per rolling twelve (12) month period.
(b) Reimbursement is available for medically necessary additional procedures subject to prior authorization. *(Office of the Children's Health Insurance Program; 407 IAC 3-12-2; filed May 3, 2000, 2:02 p.m.: 23 IR 2237)*

Rule 13. Services Not Covered by CHIP

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.
(C) Mentally ill or emotionally disturbed individuals.
(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) Reserved beds in psychiatric hospitals.
(12) Services provided in inpatient mental health facilities (other than acute care hospitals) with more than sixteen (16) beds.
(13) 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)

*