ARTICLE 6. INDIANA PRESCRIPTION DRUG PROGRAM

Rule 1. General Provisions

405 IAC 6-1-1 Intent and purpose

Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 1. Under IC 12-10-16-3, the office of the secretary of family and social services hereby adopts and promulgates this article to:

(1) interpret and implement the provisions of IC 12-10-16-3 to provide assistance with the expense of prescription drugs for low income seniors; and

(2) ensure the efficient, economical, and reasonable operations of the Indiana prescription drug program.

(Office of the Secretary of Family and Social Services; 405 IAC 6-1-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)

405 IAC 6-1-2 Annual report

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. On an annual basis, the office shall provide a report describing the program's activities, and such other information pertaining to the program as may be requested, to the state budget agency. *(Office of the Secretary of Family and Social Services; 405 IAC 6-1-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

Rule 2. Definitions

405 IAC 6-2-1 Applicability

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. The definitions in this rule apply throughout this article unless the context clearly indicates another meaning. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-2 "Applicant" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. "Applicant" means the person for whom Indiana prescription drug program enrollment is requested. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)*

405 IAC 6-2-3 "Benefit period" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. "Benefit period" means a specified time frame during which an enrollee expends the cost of prescription drugs. The benefit period is specified in 405 IAC 6-5-3. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456; filed Nov 4, 2002, 12:13 p.m.: 26 IR 697; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2486)*

405 IAC 6-2-4 "Child" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. "Child" means any child for whom the applicant or spouse has legal guardianship or legal custody, and who is either less than eighteen (18) years of age, or between eighteen (18) and twenty-one (21) years of age and a student. *(Office of the Secretary*

of Family and Social Services; 405 IAC 6-2-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2456)

405 IAC 6-2-5 "Complete application" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. "Complete application" means an application that includes the following information about the applicant and applicant's spouse, if applicable:

(1) Name.
(2) Address of domicile.
(3) Date of birth.
(4) Social Security number.
(5) Marital status.
(6) Whether the applicant currently has insurance that includes a prescription drug benefit, except for a Medicare Drug Discount Card.
(7) Whether the applicant is on Medicaid with prescription drug assistance.
(8) Whether the applicant intends to reside in Indiana permanently.
(9) Proof of income.
(10) Signature.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457; filed Nov 4, 2002, 12:13 p.m.: 26 IR 697; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2486; filed Sep 7, 2004, 5:05 p.m.: 28 IR 179)

405 IAC 6-2-5.3 "Complete claim" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5.3. "Complete claim" means a claim submitted by a provider for processing that contains the enrollee's name and for each drug listed all of the following information:

(1) The day the drug was dispensed.
(2) The corresponding National Drug Code (NDC) number.
(3) The identification of prescribing physician.
(4) The name and dosage of drug.
(5) The provider's selling price in accordance with 405 IAC 6-8-3.
(6) If discounts are given, the actual price enrollee paid for the drug.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5.3; filed Nov 4, 2002, 12:13 p.m.: 26 IR 697)

405 IAC 6-2-5.5 "Domicile" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5.5. "Domicile" means the applicant's true, fixed, principal, and permanent home. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-5.5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 697)*

405 IAC 6-2-6 "Earned income" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. "Earned income" means income the applicant earns through employment. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-7 "Eligible" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 7. "Eligible" means a person who meets all requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-7; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-8 "Enrollee" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 8. "Enrollee" means an applicant who has met all requirements and has been enrolled into the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-8; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-9 "Family" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. "Family" means the applicant, spouse, and any child who reside in the same residence. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-9; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-10 "Family member standard" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 10. "Family member standard" means the difference between the net monthly income limit for a family of two (2) and a family of three (3). *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-10; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-11 "Federal poverty guideline" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 11. "Federal poverty guideline" means the nonfarm income official poverty guideline as determined annually by the federal Office of Management and Budget. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-11; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-12 "Health insurance with a prescription drug benefit" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12. "Health insurance with a prescription drug benefit" means any contract with an insurance company or organization approved or recognized by the Indiana department of insurance, under which an individual receives health benefits, including a prescription drug benefit. This term includes Medicaid and veteran's benefits. A prescription discount offered by an insurance company, department, manufacturer, provider, or organization is not considered to be a prescription drug insurance benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-12; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-12.5 "Income" defined
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 12.5. "Income" means the amount of money or its equivalent received in exchange for or as a result of labor or services, from the sale of goods or property or as profits from financial investments. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-12.5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-13 "Indiana prescription drug program" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 13. "Indiana prescription drug program" means the program established by IC 12-10-16. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-13; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457)*

405 IAC 6-2-14 "Net income" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 14. "Net income" means the earned income minus tax deductions, tax exemptions, and other tax reductions, and unearned income minus Medicare premiums that an applicant and an applicant's family receives, calculated on a monthly basis. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-14; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2457; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-15 "Not eligible" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 15. "Not eligible" means a person who does not meet one (1) or more of the requirements for enrollment in the program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-15; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-16 "Office" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 16. "Office" means the office of the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-16; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-16.5 "Point of service" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 16.5. "Point of service" means receiving the program benefit at the time of purchase of the prescription drugs. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-16.5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-17 "Prescription drug" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 17. "Prescription drug" means any legend drug covered under the Medicaid fee-for-service program, as defined in 405 IAC 5-24-3, and insulin. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-17; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-18 "Prescription printout" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 18. "Prescription printout" means an itemized report prepared by a provider for an enrollee showing prescription data for the enrollee for a stated benefit period. Such prescription data must include, but is not limited to, the following:

(1) Enrollee name and address.
(2) Prescription number.
(3) NDC code.
(4) Drug name.
(5) Drug strength.
(6) Dosage form.
(7) Quantity dispensed.
(8) Date of dispense.
(9) The amount of any discount provided.
(10) The amount paid by the enrollee or any insurance plan.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-18; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)

405 IAC 6-2-19 "Program" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 19. "Program" means the Indiana prescription drug program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-19; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458)*

405 IAC 6-2-20 "Proof of income" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 20. "Proof of income" means documentation of the income of an applicant and an applicant's family. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-20; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; filed Nov 4, 2002, 12:13 p.m.: 26 IR 698)*

405 IAC 6-2-20.5 "Provider" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16; IC 25-26-13-17

Sec. 20.5. (a) "Provider" means an entity who:

(1) participates in the program;
(2) is licensed under IC 25-26-13;
(3) holds a proper permit under IC 25-26-13-17; and
(4) complies with the same state enrollment requirements established for the Medicaid program at 405 IAC 5-4.

(b) Nothing in this rule prevents an enrolled provider from dispensing a prescription from an out-of-state branch location as long as the:

(1) provider has an Indiana presence and is enrolled under the provisions of this article; and
(2) branch location where the prescription is dispensed is located within the United States of America.

(Office of the Secretary of Family and Social Services; 405 IAC 6-2-20.5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 699)

405 IAC 6-2-21 "Refund certificate" defined (Repealed)

Sec. 21. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2489)*

405 IAC 6-2-22 "Refund period" defined (Repealed)

Sec. 22. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2489)*

405 IAC 6-2-22.5 "Reside" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 22.5. "Reside" means the place where an applicant actually lives as distinguished from a domicile. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-22.5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 699)*

405 IAC 6-2-23 "Secretary" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 23. "Secretary" means the secretary of family and social services. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-23; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-24 "Senior" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 24. "Senior" means a person sixty-five (65) years of age or older. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-24; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2458; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-25 "Spouse" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 25. "Spouse" means the legal husband or wife of an applicant. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-25; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

405 IAC 6-2-26 "Unearned income" defined

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 26. "Unearned income" means income the applicant receives from a source other than employment including, but not limited to, Social Security, Supplemental Security Income, pensions, or income from assets. *(Office of the Secretary of Family and Social Services; 405 IAC 6-2-26; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070)*

Rule 3. Application and Enrollment; General Requirements

405 IAC 6-3-1 Application process

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) An application for the program shall be filed on the form prescribed by the office and shall include proof of income.
(b) An application shall be made in a manner prescribed by the office and can be made at any time.

(c) An application for the program may be filed on behalf of an applicant by any of the following:
(1) The applicant.
(2) The applicant's spouse.
(3) A court-appointed guardian of the applicant. or
(4) By power of attorney.
(d) The applicant may use an authorized representative to apply for the program. The authorization must be in writing and signed by a person authorized to file an application under subsection (c). *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-3-2 Date of application
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. For purposes of determining the effective date of availability of the program to an applicant, the date of application is the date the complete application is received by the office. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; filed Nov 4, 2002, 12:13 p.m.: 26 IR 699)*

405 IAC 6-3-3 Date of availability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) After July 1, 2002, program availability will be no sooner than the date complete application is received and approved.
(b) Those enrollees applying on or before the tenth of a month will have point of service benefits available on the first day of the following month. Those enrollees applying after the tenth of a month will have point of service benefits available no later than the first day of the second following month.
(c) The program is not available for prescription drugs purchased prior to the month in which the enrollee turned sixty-five (65) years of age.
(d) All current enrollees shall be automatically enrolled in a new benefit period on June 1, 2004. *(Office of the Secretary of Family and Social Services; 405 IAC 6-3-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; filed Nov 4, 2002, 12:13 p.m.: 26 IR 699; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2487; filed Sep 7, 2004, 5:05 p.m.: 28 IR 180)*

Rule 4. Eligibility Requirements

405 IAC 6-4-1 Age
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. To be eligible for the program, an applicant must be sixty-five (65) years of age or older. *(Office of the Secretary of Family and Social Services; 405 IAC 6-4-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459)*

405 IAC 6-4-2 Income
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) To be eligible for the program, an applicant's monthly family net income must not exceed the income limit listed as follows for the applicant's family size:

Family Size	Net Monthly Income Limit
1	$1,048
2	$1,406

3	$1,764

(b) For each additional family member over three (3), the family member standard shall be added to the net monthly income limit for a family of three (3) in order to calculate the net monthly income limit. A child who earns more than the family member standard per month is not included in the calculation of monthly net income or in family size.

(c) The monthly net income limits are determined by multiplying the annual federal poverty guideline amounts for each family size by one hundred thirty-five percent (135%), dividing by twelve (12), and then rounding up to the next whole dollar.

(d) The income standards in subsection (a) shall increase annually in the same percentage amount that is applied to the federal poverty guideline. The increase shall be effective on the first day of the second month following the month of publication of the federal poverty guideline in the Federal Register.

(e) The Social Security cost of living adjustment (COLA) received annually in January is disregarded until subsection (d) occurs.

(f) A general income disregard of twenty dollars ($20) is allowed and applied per household. It is deducted from the total monthly net income. *(Office of the Secretary of Family and Social Services; 405 IAC 6-4-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2459; filed Nov 4, 2002, 12:13 p.m.: 26 IR 699; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2487; filed Sep 7, 2004, 5:05 p.m.: 28 IR 180)*

405 IAC 6-4-3 Ineligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. Notwithstanding any other provision of this article, an individual is not eligible for the program if any of the following apply:

(1) The applicant currently has insurance that includes a prescription drug benefit, except for a Medicare Drug Discount Card.

(2) The individual is not domiciled in Indiana.

(3) The individual does not intend to reside permanently in Indiana.

(4) The individual is an inmate of a correctional facility.

(Office of the Secretary of Family and Social Services; 405 IAC 6-4-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; errata filed May 30, 2001, 10:00 a.m.: 24 IR 3070; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2487; filed Sep 7, 2004, 5:05 p.m.: 28 IR 180)

Rule 5. Benefits

405 IAC 6-5-1 Prescription drug coverage

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. An eligible enrollee may go to any participating provider to purchase prescription drugs and present his or her prescription and program identification card at the point of service to receive immediate program benefits. At the point of service, the provider shall determine the following:

(1) Whether the enrollee is eligible.

(2) Whether the individual whose name appears on the identification card is the same as the individual for whom the prescription is written.

(3) Whether the enrollee has benefits available.

(4) The price of a prescription drug in accordance with 405 IAC 6-8-3.

(5) That all prescription discounts, if applicable, are taken after the appropriate drug price has been determined.

(6) The amount of the enrollee's copayment.

(7) Whether the individual has a Medicare Drug Discount Card and has spent the six hundred dollar ($600) annual transitional assistance credit. The provider shall encourage the enrollee to use the Medicare Drug Discount Card benefit first.

(Office of the Secretary of Family and Social Services; 405 IAC 6-5-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 700; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2487; filed Sep 7, 2004, 5:05 p.m.: 28 IR 181)

405 IAC 6-5-2 Benefit defined by family income level

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (a) The amount of benefit will be limited to a maximum of one thousand two hundred dollars ($1,200) over a period of nineteen (19) months and prorated depending on time of enrollment.

$1,200 if enrolled June – September 2004	$1,000 if enrolled October – December 2004	$800 if enrolled January – March 2005	Prorate $200 per quarter after March 2005

(b) An enrollee and spouse who are enrolled in the program will each receive the maximum benefit at the time of purchase for prescription drug expenses for which amount in subsection (a) they qualify.

(c) The prescription drug program will pay seventy-five percent (75%) of the cost of prescription drugs up to the individual's maximum limit. Enrollee will pay twenty-five percent (25%) of the cost of prescription drugs up to the individual's maximum limit.

(d) Upon such time as the enrollee exceeds the maximum benefit, the enrollee may use the program identification card to access program benefit prescription drug rates as defined by 405 IAC 6-8-3 and 405 IAC 6-8-4 through December 31, 2005. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 700; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2488; filed Sep 7, 2004, 5:05 p.m.: 28 IR 181)*

405 IAC 6-5-3 Benefit period

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. The benefit shall be for a period of continuous eligibility up to the benefit limits delineated in section 2 of this rule. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 700; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2488; filed Sep 7, 2004, 5:05 p.m.: 28 IR 181)*

405 IAC 6-5-4 Benefit duration

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) The point of service benefit is available to an enrollee through December of 2005.

(b) Following the expiration of the enrollee's last benefit period, the individual must reenroll for the point of service benefit. A new application must be submitted to the office in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 701; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2488; filed Sep 7, 2004, 5:05 p.m.: 28 IR 181)*

405 IAC 6-5-5 Benefit period ineligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. An enrollee is ineligible for a program benefit for prescription drugs purchased during any benefit period in which the enrollee has health insurance or Medicaid with a prescription drug benefit. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 701)*

405 IAC 6-5-6 Benefits; program appropriations

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. (a) At the point of service, benefits are available under this program on a first come, first served basis.

(b) If eligible, enrollees are encouraged to enroll in the Medicare Drug Discount Card program and apply for the six hundred dollar ($600) annual transitional assistance available for low-income beneficiaries. Seniors are encouraged to use the six hundred

dollar ($600) annual Medicare benefit first before using the prescription drug program benefit.

(c) Benefits will exist under this program to the extent that appropriations are available for the program.

(d) The state budget director shall determine if appropriations are available to continue offering and paying benefits to enrollees. *(Office of the Secretary of Family and Social Services; 405 IAC 6-5-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2460; filed Nov 4, 2002, 12:13 p.m.: 26 IR 701; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2489; filed Sep 7, 2004, 5:05 p.m.: 28 IR 182)*

Rule 6. Program Procedure

405 IAC 6-6-1 Application process

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) A complete application will be processed by the office.

(b) An applicant who submits an incomplete application will be deemed ineligible for the program. Such an applicant may reapply for the program at any time or may file for written review of the determination in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

405 IAC 6-6-2 Letter of eligibility

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. Once the office has determined eligibility, the applicant will receive a letter of eligibility notifying the applicant of his or her status in the program. An applicant will either be eligible and enrolled in the program, or ineligible and not enrolled in the program. New applicants determined to be eligible after July 1, 2002, will receive an approved letter of eligibility and a program benefit card. *(Office of the Secretary of Family and Social Services; 405 IAC 6-6-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461; filed Nov 4, 2002, 12:13 p.m.: 26 IR 701)*

405 IAC 6-6-3 Refund certificates (Repealed)

Sec. 3. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2489)*

405 IAC 6-6-4 Refund certificate redemption (Repealed)

Sec. 4. *(Repealed by Office of the Secretary of Family and Social Services; filed Mar 22, 2004, 3:15 p.m.: 27 IR 2489)*

Rule 7. Administrative Review and Administrative Appeal Procedures for Applicants and Enrollees

405 IAC 6-7-1 Purpose

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) It is the purpose of this rule to establish a uniform method of administrative review and administrative adjudication for appeals concerning applicants and enrollees of the program, in order to determine whether or not any action for which there is a complaint was done in accordance with state statutes, regulations, rules, and policies. As used in this rule, “policies” includes program manuals, administrative directives, transmittals, and other official written pronouncements of state policy.

(b) This rule shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard in accordance with due process of law. As used in this rule, “party” means:

(1) a person to whom the agency action is specifically directed; or

(2) the office of the secretary of family and social services.

(c) In the event that any provision of this article is deemed to be in conflict with any other provision of state statute, regulation,

or rule that is specifically applicable to the program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-1; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2461)*

405 IAC 6-7-2 Standing

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. (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, then such person or entity may request an administrative review by the office as provided for in section 3 of this rule.

(b) Unless otherwise provided by law, only those persons or entities, or their respective attorneys at law, whose rights, duties, obligations, privileges, or other legal relations are alleged to have been adversely affected by any action or determination of the office, may request administrative review under this rule. Any alleged harm to an enrollee or applicant must be direct and immediate to the party and not indirect and general in character. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-2; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-3 Requests for administrative review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) Any party complaining of an action of the office in accordance with this article may file a request for administrative review as provided in this section.

(b) The enrollee or applicant is required to seek administrative review prior to filing an administrative appeal under section 5 of this rule.

(c) Unless otherwise provided for by statute, regulation, or rule, a request for administrative review by an enrollee or applicant shall be filed in writing with the office not later than thirty-five (35) days following the date of the action being reviewed. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-3; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-4 Conduct of administrative review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) Upon receipt of a request for administrative review, the office will conduct a review of the action.

(b) Upon completion of the review, the office will issue a written decision. The decision will be final unless a party requests an administrative appeal in accordance with this rule.

(c) The written decision shall specify the reasons for the decision and identify the statutes, regulations, rules, and policies supporting the decision. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-4; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-5 Filing an administrative appeal; scheduling appeals

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) Any party who is not satisfied with the administrative review of the office as provided for in this rule may file a request for an administrative appeal as provided in this section. The person or entity requesting the administrative appeal shall be known as the appellant.

(b) Unless otherwise provided for by statute, regulation, or rule, appeal requests by appellant's *[sic., an appellant]* shall be filed in writing with the hearings and appeals section of the family and social services administration not later than thirty (30) days following the effective date of the administrative review being appealed. Appeal hearings shall be conducted at a reasonable time, place, and date.

(c) The hearings and appeals section of the family and social services administration, upon application of any party, or in its own discretion, may consolidate appeals to promote administrative efficiency. Hearings may only be consolidated in cases in which the sole issue involved is one of state law or policy.

(d) Any party filing an appeal under this rule is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review prior to the filing of an administrative appeal. Any issues not raised within the interim review procedures of the administrative review in a timely manner are waived and shall not be an issue during the evidentiary hearing of the administrative appeal.

(e) The hearings and appeals section of the family and social services administration will schedule evidentiary hearings and issue notices to the parties regarding the date, time, and location of the scheduled hearing.

(f) A continuance of a hearing will be granted only for good cause shown. An objection to a request for a continuance shall be considered before a continuance is granted or denied. Requests for a continuance shall be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes:

(1) inability to attend the hearing because of a serious physical or mental condition;

(2) incapacitating injury;

(3) death in the family;

(4) severe weather conditions making it impossible to travel to the hearing;

(5) unavailability of a witness and the evidence cannot be obtained otherwise; or

(6) other reasons similar to those listed in this section.

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-5; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2462)*

405 IAC 6-7-6 Conduct and authority of administrative law judge

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 6. (a) An administrative law judge's (ALJ) conduct shall be in a manner that promotes public confidence in the integrity and impartiality of the administrative hearing process. The ALJ who conducts a hearing is prohibited from:

(1) consulting any party or party's agent on any fact in issue unless upon notice and opportunity for all parties to participate;

(2) performing any of the investigative or prosecutorial functions of the family and social services administration in the administrative appeal heard or to be heard by him or her or in a factually related administrative or judicial action;

(3) being influenced by partisan interests, public clamor, or fear of criticism;

(4) conveying or permitting others to convey the impression that they are in a special position to influence the ALJ;

(5) commenting publicly, except as to hearing schedules or procedures, about pending or impending proceedings; or

(6) engaging in financial or business dealings that tend to:

(A) reflect adversely on his or her impartiality;

(B) interfere with the proper performance of his or her duties;

(C) exploit the ALJ's position; or

(D) involve the ALJ in frequent financial business dealings with attorneys or other persons who are likely to come before the ALJ.

(b) An ALJ shall disqualify himself or herself in a proceeding in which his or her impartiality might reasonably be questioned, or in which the ALJ's personal bias, prejudice, or knowledge of a disputed evidentiary fact might influence the decision. Nothing in this subsection prohibits a person who is an employee of the family and social services administration from serving as an ALJ.

(c) The ALJ shall be authorized to:

(1) administer oaths and affirmations;

(2) issue subpoenas;

(3) rule upon offers of proof;

(4) receive relevant evidence;

(5) facilitate discovery in accordance with the Indiana rules of trial procedure;

(6) regulate the course of the hearing and conduct of the parties;

(7) hold informal conferences for the settlement or simplification of the issues under appeal;

(8) dispose of procedural motions and similar matters; and

(9) exercise such other powers as may be given by the law relating to the particular program area under appeal.

(Office of the Secretary of Family and Social Services; 405 IAC 6-7-6; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)

405 IAC 6-7-7 Conduct of hearing; hearing decisions

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 7. (a) The administrative law judge (ALJ) shall conduct the hearing in an informal manner and without recourse to the technical common law rules of evidence.

(b) The ALJ shall exclude from consideration irrelevant, immaterial, or unduly repetitious evidence.

(c) Every party shall have the right to submit evidence. In the event that an objection to evidence is sustained, the party proffering the evidence may make an offer of proof. Each party shall have the right to cross-examine the witnesses and offer rebutting evidence. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-7; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)*

405 IAC 6-7-8 Hearing decision

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 8. (a) Following completion of the hearing, or after submission of briefs by the parties (if briefing is permitted by the ALJ), the ALJ shall issue his or her decision in the matter concurrently to the parties. The decision shall be final unless a party requests agency review of the decision in accordance with this rule.

(b) The ALJ's decision shall:

(1) include findings of fact;

(2) specify the reasons for the decision; and

(3) identify the evidence and statutes, regulations, rules and policies supporting the decision.

(c) The findings of fact need not include a recitation of every piece of evidence admitted in the evidentiary hearing. Rather, the findings should contain the basic facts that have formed the basis for the ALJ's ultimate decision. The ALJ's decision must also cite the relevant laws upon which the ultimate decision is based, and relate the facts to the law. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-8; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2463)*

405 IAC 6-7-9 Agency review

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 9. (a) Any party who is not satisfied with the decision of the administrative law judge (ALJ) may request agency review of the decision within ten (10) days of receipt thereof in accordance with instructions issued with the decision.

(b) After receiving a request for agency review of a hearing decision, the hearings and appeals section of the family and social services administration shall notify the parties when the decision will be reviewed. The agency review shall be completed by the secretary of the family and social services administration or the secretary's designee. All such reviews shall be conducted upon the record, as defined in section 7 of this rule, except that a transcript of the oral testimony shall not be necessary for review unless the party requests that one be transcribed at the party's expense.

(c) No new evidence will be considered during the agency review; however, any party wishing to submit a memorandum of law, citing evidence in the record, may do so pursuant to instructions issued by the hearings and appeals section of the family and social services administration.

(d) The secretary of family and social services administration or the secretary's designee shall review the ALJ's decision to determine if the decision is supported by the evidence in the record and is in accordance with statutes, regulations, rules and policies applicable to the issues under appeal.

(e) Following the review of the secretary or designee, the secretary or designee shall issue a written decision:

(1) affirming the decision of the ALJ;
(2) amending or modifying the decision of the ALJ;
(3) reversing the decision of the ALJ;
(4) remanding the matter to the ALJ for further specified action; or
(5) make *[sic., making]* such other order or determination as is proper on the record.

(f) The parties will be issued a written notice of the action taken as a result of the agency review. If the decision of the ALJ is reversed, amended, or modified, the secretary or designee shall state the reasons for the action in the written decision.

(g) The hearings and appeals section of the family and social services administration shall distribute the written notice on agency review to:
(1) all parties of record;
(2) the ALJ who rendered the decision following the evidentiary hearing; and
(3) any other person designated by the secretary or designee.

(Office of the Secretary of Family and Social Services; 405 IAC 6-7-9; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2464)

405 IAC 6-7-10 Agency record; judicial review

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-33; IC 4-21.5-5; IC 12-10-16

Sec. 10. (a) The record of the administrative proceedings shall be that as defined in IC 4-21.5-3-33.

(b) If the appellant is not satisfied with the secretary's final action after agency review, he or she may file for judicial review in accordance with IC 4-21.5-5.

(c) The appellant is required to seek agency review prior to filing a petition for judicial review. *(Office of the Secretary of Family and Social Services; 405 IAC 6-7-10; filed Mar 8, 2001, 11:19 a.m.: 24 IR 2464)*

Rule 8. Provider Appeal; Records; Drug Price; Dispensing Fee

405 IAC 6-8-1 Provider appeal procedures

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. 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 and 405 IAC 6-9-1, if applicable. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-1; filed Nov 4, 2002, 12:13 p.m.: 26 IR 702)*

405 IAC 6-8-2 Provider records

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 2. The provisions of 405 IAC 1-5 concerning contents, retention, and disclosure of records of Medicaid providers shall apply to providers of covered drugs under this title. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-2; filed Nov 4, 2002, 12:13 p.m.: 26 IR 702)*

405 IAC 6-8-3 Drug price methodology

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. Drug prices for purposes of determining provider reimbursement and enrollee copayment shall be calculated using the reimbursement methodology for Medicaid prescription drugs under rules adopted by the secretary at 405 IAC 5-24. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-3; filed Nov 4, 2002, 12:13 p.m.: 26 IR 702)*

405 IAC 6-8-4 Dispensing fee
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. The Indiana prescription drug dispensing fee maximum under this title shall be the same as that which is allowable under rules adopted by the secretary at 405 IAC 5-24-6. *(Office of the Secretary of Family and Social Services; 405 IAC 6-8-4; filed Nov 4, 2002, 12:13 p.m.: 26 IR 702)*

Rule 9. Provider Claims; Payments; Overpayments; Sanctions

405 IAC 6-9-1 Filing of claims; filing date; payment liability
Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 1. (a) All provider claims for payment for point of service benefits rendered to enrollees must be originally filed with the office's contractor within twelve (12) months of the date of the provision of the service. A provider who is dissatisfied with the amount of his or her reimbursement may appeal under the provisions of 405 IAC 6-8-1. However, prior to filing such an appeal, the provider must:

(1) resubmit the claim if the reason for denial of payment was due to incorrect or inaccurate billing by the provider;

(2) submit, if appropriate, an adjustment request to the office contractor's adjustment and resolution unit; or

(3) submit a written request to the office's contractor, stating why the provider disagrees with the denial or amount of reimbursement.

(b) All requests for payment adjustments or reconsideration of a claim that has been denied must be submitted to the office contractor within sixty (60) days of the date of notification that the claim was paid or denied. In order to be considered for payment, each subsequent claim resubmission or adjustment request must be submitted within sixty (60) days of the most recent notification that the claim was paid or denied. The date of notification shall be considered to be three (3) days following the date of mailing from the office's contractor. All claims filed after twelve (12) months of the date of the provision of the service, as well as claims filed after sixty (60) days of the date of notification that the claim was paid or denied shall be rejected for payment unless a waiver has been granted. In extenuating circumstances a waiver of the filing limit may be authorized by the contractor or the office when justification is provided to substantiate why the claim could not be filed or refiled within the filing limit. Some examples of situations considered to be extenuating circumstances are as follows:

(1) Contractor or state error or action that has delayed payment.

(2) Reasonable and continuous attempts on the part of the provider to resolve a claim problem.

(c) All claims filed for reimbursement shall be reviewed prior to payment by the office or its contractor, for completeness, including required documentation, appropriateness of services and charges, application of discounts, and other areas of accuracy and appropriateness as indicated.

(d) The office is only liable for the payment of claims filed by providers who were certified providers at the time the service was rendered and for services provided to persons who were enrolled in the Indiana prescription drug program as eligible enrollees at the time service was provided. The claim will not be paid if the services provided are outside the service parameters as established by the office.

(e) A provider shall collect from an enrollee or from the authorized representative of the enrollee that portion of his or her charge for a benefit as defined by 405 IAC 6-5-2, which is not reimbursed by the Indiana prescription drug program and after all prescription discounts have been calculated in accordance with this article. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-1; filed Nov 4, 2002, 12:13 p.m.: 26 IR 702)*

405 IAC 6-9-2 Denial of claim payment; basis
Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 2. (a) The office may deny payment, or instruct the contractor to deny payment, to any provider if, after investigation by the office, the office's designee, or other governmental authority, the office finds any of the following:

(1) The services claimed cannot be documented by the provider in accordance with 405 IAC 6-8-2.

(2) The services claimed were provided to a person other than a person in whose name the claim is made.

(3) The services claimed were provided to a person who was not eligible for benefits at the time of the provision of the service.

(4) The claim arises out of any of the following acts or practices:

(A) Presenting, or causing to be presented, for payment any false or fraudulent claim.

(B) Submitting, or causing to be submitted, information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

(C) Submitting, or causing to be submitted, any false information.

(D) Failure to disclose, or make available to the office, or its authorized agent, records of services provided to enrollees and records of payments made therefor.

(E) Engaging in a course of conduct or performing an act deemed by the office to be improper or abusive of the program or continuing such conduct following notification that the conduct should cease.

(F) Breach of the terms of the Indiana prescription drug pharmacy provider agreement or failure to comply with the terms of the provider certification on the claim form.

(G) Violating any provision of state law or any rule or regulation promulgated pursuant to this article or any provider bulletin published thereto.

(H) Submission of a false or fraudulent application for provider status.

(I) Failure to meet standards required by the state for participating in the program.

(J) Refusal to execute a new Indiana prescription drug Pharmacy Provider agreement when requested by the office or its contractor to do so.

(K) Failure to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.

(L) Failure to repay within sixty (60) days or make acceptable arrangements for the repayment of identified overpayments or otherwise erroneous payments, except as provided in this rule.

(M) Presenting claims for which benefits are not available.

(5) The claim arises out of any act or practice prohibited by rules of the office.

(b) The decision as to denial of payment for a particular claim or claims is at the discretion of the office. This decision shall be final and:

(1) will be mailed to the provider by United States mail at the address contained in the office records and on the claims or transmitted electronically if the provider has elected to receive electronic remittance advices;

(2) will be effective upon receipt; and

(3) may be administratively appealed in accordance with this article.

(c) The decision as to claim payment suspension is at the discretion of the office and may include either of the following:

(1) The denial of payment for all claims that have been submitted by the provider pending further investigation by the office, the office's designee, or other governmental authority.

(2) The suspension or withholding of payment on any or all claims of the provider pending an audit or further investigation by the office, the office's designee, or other governmental authority.

(d) The decision of the office under subsection (c) shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) contain a brief description of the decision;

(3) become final fifteen (15) days after its receipt; and

(4) contain a statement that any appeal from the decision shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(e) If an emergency exists, as determined by the office, the office may issue an emergency directive suspending or withholding payment on any or all claims of the provider pending further investigation by the office, the office's designee, or other governmental authority under IC 4-21.5-4. Any order issued under this subsection shall:

(1) be served upon the provider by certified mail, return receipt requested;

(2) become effective upon receipt;

(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and

(4) contain a statement that any appeal from the decision of the assistant secretary made under this subsection shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.

(Office of the Secretary of Family and Social Services; 405 IAC 6-9-2; filed Nov 4, 2002, 12:13 p.m.: 26 IR 703)

405 IAC 6-9-3 Overpayments made to providers; recovery

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3; IC 6-8.1-10-1; IC 12-10-16

Sec. 3. (a) The office may recover payment, or instruct its contractor to recover payment, from any provider for services rendered to an individual, or claimed to be rendered to an individual, if the office, after investigation or audit, finds that:

(1) the services paid for cannot be documented by the provider as required by 405 IAC 6-8-2;

(2) the services were provided to a person other than the person in whose name the claim was made and paid;

(3) the service reimbursed was provided to a person who was not eligible for benefits at the time of the provision of the service;

(4) the paid claim arises out of any act or practice prohibited by law or by rules of the office;

(5) overpayment resulted from an inaccurate description of prescription data;

(6) overpayment resulted from duplicate billing; and

(7) overpayment to the provider resulted from any other reason not specified in this subsection.

(b) The office may determine the amount of overpayments made to a provider by means of a random sample audit. The random sample audit shall be conducted in accordance with generally accepted statistical methods, and the selection criteria shall be based on a table of random numbers derived from any book of random sampling generally accepted by the statistical profession.

(c) The office or its designee may conduct random sample audits for the purpose of determining overcharges to the Indiana prescription drug program. The following criteria apply to random sample audits:

(1) In the event that the provider wishes to appeal the accuracy of the random sample methodology under IC 4-21.5-3, the provider may present evidence to show that the sample used by the office was invalid and therefore cannot be used to project the overpayments identified in the sample to total billings for the audit period.

(2) The provider may also conduct an audit, at the provider's expense, of either a valid random sample audit, using the same random sampling methodology as used by the office, or an audit of one hundred percent (100%) of medical records of payments received during the audit period. Any such audit must be completed within one hundred eighty (180) days of the date of appeal and must demonstrate that the provider's records for the unaudited services provided during the audit period were in compliance with state and federal law. The provider must submit supporting documentation to demonstrate this compliance.

(d) If the office determines that an overcharge has occurred, the office shall notify the provider by certified mail. The notice shall include a demand that the provider reimburse the office, within sixty (60) days of the provider's receipt of the notification, for any overcharges determined by the office. Except as provided in subsection (f), a provider who receives a notice and request for repayment may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office and not repay the alleged overpayment, except as provided in subsection (e).

(e) If:

(1) a provider elects to proceed under subsection (d)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;

the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

(f) The office may enter into an agreement with the provider regarding the repayment of any overpayment made to the provider. Such agreement shall state that the amount of overpayment shall be deducted from subsequent payments to the provider. Such subsequent payment deduction shall not exceed a period of six (6) months from the date of the agreement. The repayment agreement shall include provisions for the collection of interest on the amount of the overpayment. Such interest shall not exceed the percentage rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c). Recovering interest:

(1) at a rate that is the percentage rounded to the nearest whole number that equals the average investment yield on state

money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive annual financial report; and

(2) accruing from the date of overpayment on amounts paid to a provider that are in excess of the amount subsequently determined to be due the provider as a result of an audit, a reimbursement cost settlement or a judicial or an administrative proceeding.

(g) If the office recovers an overpayment to a provider that is subsequently found not to have been owing to the office, either in whole or in part, then the office will pay to the provider interest on the amount erroneously recovered from the provider. Such interest will accrue from the date that the overpayment was recovered by the office until the date the overpayment is restored to the provider. Such interest will accrue at the rate of interest set by the commissioner for interest payments from the department of state revenue to a taxpayer. The office will not pay interest to a provider under any other circumstances.

(h) If, after receiving a notice and request for repayment, the provider fails to elect one (1) of the options listed in subsection (d) within sixty (60) days and the administrator determines that reasonable grounds exist to suspect that the provider has acted in a fraudulent manner, then the office shall immediately certify the facts of the case to the appropriate county prosecutor. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-3; filed Nov 4, 2002, 12:13 p.m.: 26 IR 704)*

405 IAC 6-9-4 Repayment of overpayment to office

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) The office may require the repayment of any amount determined by the office to have been paid to the provider in error, prior to an evidentiary hearing or summary review, unless an appeal is pending and the provider has elected not to repay an alleged overpayment pursuant to section 3(d)(3) of this rule. The office may, in its discretion, recoup any overpayment to the provider by the following means:

(1) Offset the amount of the overpayment against current payments to a provider.

(2) Require that the provider satisfy the overpayment by refunding the entire amount of the overpayment to the office directly.

(3) Enter into an agreement with the provider in accordance with section 3 of this rule.

(b) Interest from the date of the overpayment will be assessed even if the provider repays the overpayment to the office within thirty (30) days after receipt of the notice of the overpayment. This subsection applies to any of the methods of recoupment set out in this section. *(Office of Family and Social Services; 405 IAC 6-9-4; filed Nov 4, 2002, 12:13 p.m.: 26 IR 705)*

405 IAC 6-9-5 Sanctions against providers; determination after investigation

Authority: IC 12-10-16-5
Affected: IC 4-21.5-3-6; IC 4-21.5-3-7; IC 4-21.5-4; IC 12-10-16

Sec. 5. (a) If, after investigation by the office, the office's designee, or other governmental authority, the office determines that a provider has violated any provision of IC 12-10-16, or has violated any rule established under one (1) of those sections, the office may impose one (1) or more of the following sanctions:

(1) Deny payment to the provider for services rendered during a specified period of time.

(2) Reject a prospective provider's application for participation in the program.

(3) Remove a provider's certification for participation in the program (decertify the provider).

(4) Assess a fine against the provider in an amount not to exceed three (3) times the amounts paid to the provider in excess of the amounts that were legally due.

(5) Assess an interest charge, at a rate not to exceed the rate established within this article on the amounts paid to the provider in excess of the amounts that were legally due. The interest charge shall accrue from the date of the overpayment to the provider.

(b) Specifically, the office may impose the sanctions in subsection (a) if, after investigation by the office, the office's designee, or other governmental authority, the office determines that the provider did any of the following:

(1) Submitted, or caused to be submitted, claims for services which cannot be documented by the provider.

(2) Submitted, or caused to be submitted, claims for services provided to a person other than a person in whose name the claim is made.

(3) Submitted, or caused to be submitted, any false or fraudulent claims for services.

(4) Submitted, or caused to be submitted, information with the intent of obtaining greater compensation than that which the provider is legally entitled.
(5) Engaged in a course of conduct or performed an act deemed by the office to be abusive of the program or continuing such conduct following notification that the conduct should cease.
(6) Breached, or caused to be breached, the terms of the provider certification agreement.
(7) Failed to comply with the terms of the provider certification on the claim form.
(8) Overutilized, or caused to be overutilized, the program.
(9) Submitted, or caused to be submitted, a false or fraudulent provider certification agreement.
(10) Submitted, or caused to be submitted, any claims for services arising out of any act or practice prohibited by the criminal provisions of the Indiana Code or by the rules of the office.
(11) Failed to disclose or make available to the office, the office's designee, or other governmental authority, after reasonable request and notice to do so, documentation of services provided to enrollees and office records of payments made therefor.
(12) Failed to meet standards required by the state law for participation.
(13) Charged an enrollee copayment for covered services over and above that allowable under this article.
(14) Refused to execute a new provider certification agreement when requested to do so.
(15) Failed to correct deficiencies to provider operations after receiving written notice of these deficiencies from the office.
(16) Failed to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments, unless an appeal is pending and the provider has elected not to repay an alleged overpayment.
(c) The office may enter a directive imposing a sanction under IC 4-21.5-3-6. Any directive issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) contain a brief description of the order;
(3) become final fifteen (15) days after its receipt; and
(4) contain a statement that any appeal from the decision of the office made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.
(d) If an emergency exists, as determined by the office, the office may issue an emergency directive imposing a sanction under IC 4-21.5-4. Any order issued under this subsection shall:
(1) be served upon the provider by certified mail, return receipt requested;
(2) become effective upon receipt;
(3) include a brief statement of the facts and law that justifies the office's decision to issue an emergency directive; and
(4) contain a statement that any appeal from the decision made under this section shall be taken in accordance with IC 4-21.5-3-7 and 405 IAC 6-8-1.
(e) The decision to impose a sanction shall be made at the discretion of the office. *(Office of the Secretary of Family and Social Services; 405 IAC 6-9-5; filed Nov 4, 2002, 12:13 p.m.: 26 IR 705)*

Rule 10. Discontinuance of the Indiana Prescription Drug Program Point of Service Drug Card

405 IAC 6-10-1 General provisions

Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 1. Under IC 12-10-16-3, the office hereby adopts and promulgates this article to phase-out the IPDP discount card program and transition members to the federal Medicare Part D program. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-1; filed Mar 29, 2006, 2:19 p.m.: 29 IR 2524)*

405 IAC 6-10-2 Definitions

Authority: IC 12-10-16-5
Affected: IC 12-10-16-3

Sec. 2. (a) The definitions in this section apply throughout this rule unless the context clearly indicates another meaning.
(b) "Centers for Medicare and Medicaid Services" means the federal administrator of the Medicare prescription drug benefit.
(c) "Enhanced Medicare Part D plan" means a Medicare Part D plan that is not considered standard or basic actuarially

equivalent standard coverage by the Centers for Medicare and Medicaid Services.

(d) "Full low-income subsidy" means the Centers for Medicare and Medicaid Services benefit provided to eligible low-income individuals enrolled in the Medicare prescription drug benefit. Full low-income subsidy eligible individuals:

(1) are not required to pay monthly premiums or annual deductible;

(2) have small copayments; and

(3) have no gap in coverage.

Eligibility is determined by the Social Security Administration.

(e) "Low-income subsidy" means either a:

(1) full low-income subsidy; or

(2) partial low-income subsidy;

as determined by the Social Security Administration.

(f) "Low-income subsidy application" means the Application for Help with Medicare Prescription Drug Plan Costs, which is processed and administered through the Social Security Administration.

(g) "Low-income subsidy premium" means the maximum amount the low-income subsidy will pay towards a Medicare Part D beneficiary's monthly premium in the state of Indiana, as determined by the Centers for Medicare and Medicaid Services and adjusted annually.

(h) "Medicare-advantage prescription drug plan" means an entity authorized by the Centers for Medicare and Medicaid Services to provide prescription drug coverage to Medicare Advantage beneficiaries.

(i) "Medicare Part D plan" means a:

(1) Medicare prescription drug plan; or

(2) a Medicare-Advantage prescription drug plan.

(j) "Member" means a person who has:

(1) met all eligibility requirements; and

(2) has been enrolled in the Indiana prescription drug program.

(k) "Partial low-income subsidy" means the Centers for Medicare and Medicaid Services benefit provided to eligible low-income individuals enrolled in the Medicare prescription drug benefit. Partial low-income subsidy eligible individuals are eligible for the following:

(1) reduced premiums on a sliding-scale;

(2) a maximum annual deductible of fifty dollars;

(3) fifteen percent (15%) copayments; and

(4) no gap in coverage.

Eligibility is determined by the Social Security Administration.

(l) "Premium" means the monthly cost of being enrolled in a Medicare Part D plan.

(m) "Standard" means a Medicare Part D plan that is considered standard or basic actuarially equivalent standard coverage by the Centers for Medicare and Medicaid Services. Does not include enhanced Medicare Part D plans. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-2; filed Mar 29, 2006, 2:19 p.m.: 29 IR 2524)*

405 IAC 6-10-3 Benefits

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 3. (a) The IPDP drug card program will end on December 31, 2005.

(b) Any benefit dollars remaining on IPDP member drug cards will no longer be available to the member after December 31, 2005.

(c) December 31, 2005, will be the last date of service that pharmacy providers will be able to submit a claim to the IPDP.

(d) The IPDP shall accept reversals and rebills electronically ninety (90) days after December 31, 2005. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-3; filed Mar 29, 2006, 2:19 p.m.: 29 IR 2525)*

405 IAC 6-10-4 Transition to Medicare Part D plan; auto-assignment for full low-income subsidy beneficiaries

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 4. (a) The program may, to the extent it can identify IPDP members that have been determined eligible for full low-income subsidy from the Centers for Medicare and Medicaid Services, randomly assign members to Medicare prescription drug plans offering standard coverage with a monthly premium below the low-income subsidy premium amount in compliance with subsection (b). In the event the same entity offers more than one (1) such Medicare prescription drug plan in the state, the program will assign members randomly among the entity's eligible Medicare prescription drug plans.

(b) The program shall only auto-assign members to Medicare prescription drug plans that have agreed to accept electronic auto-assignment from the program in a manner defined by the program.

(c) Married couples auto-assigned by the office shall be assigned to the same Medicare prescription drug plan whenever possible.

(d) The program will send the member a letter notifying them that they will have at least twenty-five (25) calendar days to select a Medicare Part D plan. If no selection has been made within the period of not less than twenty-five (25) calendar days, the office may auto-assign the member to a Medicare prescription drug plan that has contracted with the IPDP to receive auto-assignment.

(e) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the twenty-five (25) calendar day period.

(f) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period, that is otherwise eligible for the program, may be auto-assigned to a Medicare Part D plan before the end of the twenty-five (25) calendar day opt-out period.

(g) If a member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug plan. *(Office of the Secretary of Family and Social Services; 405 IAC 6-10-4; filed Mar 29, 2006, 2:19 p.m.: 29 IR 2525)*

405 IAC 6-10-5 Transition to Medicare Part D plan; auto-assignment for partial low-income subsidy beneficiaries

Authority: IC 12-10-16-5
Affected: IC 12-10-16

Sec. 5. (a) The program may, to the extent it can identify IPDP members that have been determined eligible for partial low-income subsidy from the Centers for Medicare and Medicaid Services, randomly assign members to Medicare prescription drug plans offering standard coverage, with a monthly premium below the low income subsidy premium amount for the region, that have contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs. In the event the same entity offers more than one (1) such Medicare prescription drug plan in the state, the program will assign members randomly among the entity's eligible Medicare prescription drug plans.

(b) The program shall only auto-assign members to Medicare Part D plans that have agreed to accept electronic auto-assignment from the program in a manner defined by the program.

(c) Married couples auto-assigned by the office shall be assigned to the same Medicare Part D plan whenever possible.

(d) The program will send the member a letter notifying them that they will have at least twenty-five (25) calendar days to select a Medicare Part D plan. If no selection has been made within the period of not less than twenty-five (25) calendar days, the office may auto-assign the member to a Medicare prescription drug plan that has contracted with the IPDP to receive auto-assignment.

(e) A member may not receive IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs if he or she enrolls in a Medicare Part D plan that has not contracted with the program to administer such benefits.

(f) A member may opt out of the auto-assignment by calling or writing the IPDP before the end of the twenty-five (25) calendar day period.

(g) Any member that has not selected a Medicare Part D plan before the end of the initial enrollment period, that is otherwise eligible for the program, may be auto-assigned to a Medicare Part D plan that has contracted with the program to administer IPDP assistance with Medicare Part D premiums and other Medicare Part D plan costs before the end of the member's twenty-five (25) calendar day opt-out period.

(h) If member is enrolled in a Medicare-Advantage organization, the office may assign the member to the Medicare-Advantage prescription drug plan being offered by the same entity. If the Medicare-Advantage organization in which the member is enrolled does not offer Medicare prescription drug benefits, the office may randomly assign the member to a Medicare prescription drug

plan.*(Office of the Secretary of Family and Social Services; 405 IAC 6-10-5; filed Mar 29, 2006, 2:19 p.m.: 29 IR 2526)*

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