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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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; readopted filed May 22, 2006, 3:22 p.m.: 29 IR 3424)*

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