IC 12-15-12

Chapter 12. Managed Care

IC 12-15-12-0.3

"Emergency medical condition" defined

Sec. 0.3. As used in this chapter, "emergency medical condition" means a medical condition manifesting itself by acute symptoms, including severe pain, of sufficient severity that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

(1) serious jeopardy to the health of:

(A) the individual; or

(B) in the case of a pregnant woman, the woman or her unborn child;

(2) serious impairment to bodily functions; or

(3) serious dysfunction of any bodily organ or part.

As added by P.L.223-2001, SEC.4.

IC 12-15-12-0.5

"Emergency services" defined

Sec. 0.5. As used in this chapter, "emergency services" means covered inpatient and outpatient services that are:

(1) furnished by a provider qualified to furnish emergency services; and

(2) needed to evaluate or stabilize an emergency medical condition.

As added by P.L.223-2001, SEC.5.

IC 12-15-12-0.7

"Post-stabilization care services" defined

Sec. 0.7. As used in this chapter, "post-stabilization care services" means covered services related to an emergency medical condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or, under the circumstances described in IC 12-15-12-17(b)(3), to improve or resolve the enrollee's condition.

As added by P.L.223-2001, SEC.6.

IC 12-15-12-1

Providers from whom recipients may obtain services other than physician services; exceptions

Sec. 1. Except as provided in sections 6, 7, and 8 of this chapter, a Medicaid recipient may obtain any Medicaid services, with the exception of physician services, from a provider who has entered into a provider agreement under IC 12-15-11.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-2

Providers from whom recipients may receive physician services; exceptions

Sec. 2. Except as provided in sections 8 and 9 of this chapter, a Medicaid recipient may receive physician services from a managed

care provider selected by the recipient from a list of managed care providers furnished the recipient by the office.
As added by P.L.2-1992, SEC.9.

IC 12-15-12-3
List of managed care providers furnished recipient; providers included; exception

Sec. 3. Except as provided in section 9 of this chapter, the list of managed care providers furnished the recipient must include the names of all managed care providers who meet the following requirements:

(1) Have entered into a provider agreement with the office under IC 12-15-11 to provide physician services to Medicaid recipients.

(2) Provide physician services in the geographic area in which the recipient resides.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-4
Failure by recipient to select managed care provider within reasonable time; assignment by office; exception

Sec. 4. Except as provided in section 9 of this chapter, if a recipient fails to select a managed care provider within a reasonable time after the list is furnished the recipient, the office may assign a managed care provider to the recipient.
As added by P.L.2-1992, SEC.9.

IC 12-15-12-4.5
Managed care prescription drug program requirements

Sec. 4.5. A managed care provider's contract or provider agreement with the office may include a prescription drug program, subject to IC 12-15-5-5, IC 12-15-35, and IC 12-15-35.5.
As added by P.L.101-2005, SEC.2.

IC 12-15-12-5
Circumstances permitting recipient to receive physician services from provider other than managed care provider; exceptions

Sec. 5. Except as provided in sections 6 and 7 of this chapter, a Medicaid recipient may not receive physician services from a provider other than the managed care provider selected by the recipient under section 2 of this chapter, except as follows:

(1) In an emergency.

(2) Upon the written referral of the managed care provider.

(3) As provided in sections 6 through 9 of this chapter.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-6
Admission to hospital by physician other than managed care provider; notification of managed care provider; services for which payment made

Sec. 6. (a) A Medicaid recipient may be admitted to a hospital by

a physician other than the recipient's managed care provider if the recipient requires immediate medical treatment.

(b) The admitting physician shall notify the recipient's managed care provider of the recipient's admission not more than forty-eight (48) hours after the recipient's admission.

(c) Payment for services provided a recipient admitted to a hospital under this section shall be made only for services that the office or the contractor under IC 12-15-30 determines were medically reasonable and necessary.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-7

Providers from whom recipients may obtain eye care services other than surgical services

Sec. 7. A Medicaid recipient may obtain eye care services, except for surgical services, from any provider licensed under IC 25-22.5 or IC 25-24 who has entered into a provider agreement under IC 12-15-11.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-8

Providers from whom recipients may obtain foot care services

Sec. 8. A Medicaid recipient may obtain foot care services from any provider licensed under IC 25-22.5 or IC 25-29 who has entered into a provider agreement under IC 12-15-11.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-9

Providers from whom recipients may obtain psychiatric services

Sec. 9. A Medicaid recipient may obtain psychiatric services from any provider licensed under IC 25-22.5 who has entered into a provider agreement under IC 12-15-11.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-10

Selection or assignment of managed care provider; selection of new provider; exception

Sec. 10. (a) A Medicaid recipient who has selected or been assigned a managed care provider under this chapter may not select a new managed care provider for twelve (12) months after the managed care provider was selected or assigned.

(b) The office may make an exception to the requirement under subsection (a) if the office determines that circumstances warrant a change.

As added by P.L.2-1992, SEC.9.

IC 12-15-12-11

Waiver from Department of Health and Human Services; implementation of chapter

Sec. 11. The office shall seek the necessary waiver under 42 U.S.C. 1396n(b)(1) from the United States Department of Health and

Human Services to implement this chapter.
As added by P.L.2-1992, SEC.9.

IC 12-15-12-12
Payments to providers

Sec. 12. For a managed care program or demonstration project established or authorized by the office, or established or authorized by another entity or agency working in conjunction with or under agreement with the office, the office must provide for payment to providers in the managed care program that the office finds is reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers in order to:

(1) provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards; and

(2) ensure that individuals eligible for medical assistance under the managed care program or demonstration project have reasonable access (taking into account geographic location and reasonable travel time) to the services provided by the managed care program.

As added by P.L.93-1995, SEC.3.

IC 12-15-12-13
Permitted forms

Sec. 13. (a) The office and an entity with which the office contracts for the payment of claims shall accept claims submitted on any of the following forms by an individual or organization that is a contractor or subcontractor of the office:

(1) HCFA-1500.

(2) HCFA-1450 (UB92).

(3) American Dental Association (ADA) claim form.

(4) Pharmacy and compound drug form.

(b) The office and an entity with which the office contracts for the payment of claims:

(1) may designate as acceptable claim forms other than a form listed in subsection (a); and

(2) may not mandate the use of a crossover claim form.

As added by P.L.256-2001, SEC.2.

IC 12-15-12-14
Repealed

(Repealed by P.L.145-2014, SEC.6.)

IC 12-15-12-15
Coverage for emergency services

Sec. 15. The office, for purposes of the primary care case management program, and a managed care contractor, for purposes of the risk-based managed care program, shall:

(1) cover and pay for all medically necessary screening services provided to an individual who presents to an emergency department with an emergency medical condition; and

(2) beginning July 1, 2001, not deny or fail to process a claim for reimbursement for emergency services on the basis that the enrollee's primary care provider's authorization code for the services was not obtained before or after the services were rendered.

As added by P.L.223-2001, SEC.7.

IC 12-15-12-17

Coverage for post-stabilization care services

Sec. 17. (a) This section applies to post-stabilization care services provided to an individual enrolled in:

(1) the Medicaid risk-based managed care program; or

(2) the Medicaid primary care case management program.

(b) The office, if the individual is enrolled in the primary care case management program, or the managed care organization, if the individual is enrolled in the risk-based managed care program, is financially responsible for the following services provided to an enrollee:

(1) Post-stabilization care services that are pre-approved by a representative of the office or the managed care organization, as applicable.

(2) Post-stabilization care services that are not pre-approved by a representative of the office or the managed care organization, as applicable, but that are administered to maintain the enrollee's stabilized condition within one (1) hour of a request to the office or the managed care organization for pre-approval of further post-stabilization care services.

(3) Post-stabilization care services provided after an enrollee is stabilized that are not pre-approved by a representative of the office or the managed care organization, as applicable, but that are administered to maintain, improve, or resolve the enrollee's stabilized condition if the office or the managed care organization:

(A) does not respond to a request for preapproval within one (1) hour;

(B) cannot be contacted; or

(C) cannot reach an agreement with the enrollee's treating physician concerning the enrollee's care, and a physician representing the office or the managed care organization, as applicable, is not available for consultation.

(c) If the conditions described in subsection (b)(3)(C) exist, the office or the managed care organization, as applicable, shall give the enrollee's treating physician an opportunity to consult with a physician representing the office or the managed care organization. The enrollee's treating physician may continue with care of the enrollee until a physician representing the office or the managed care organization, as applicable, is reached or until one (1) of the following criteria is met:

(1) A physician:

(A) representing the office or the managed care organization, as applicable; and

(B) who has privileges at the treating hospital;

assumes responsibility for the enrollee's care.

(2) A physician representing the office or the managed care organization, as applicable, assumes responsibility for the enrollee's care through transfer.

(3) A representative of the office or the managed care organization, as applicable, and the treating physician reach an agreement concerning the enrollee's care.

(4) The enrollee is discharged from the treating hospital.

(d) This subsection applies to post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) to an individual enrolled in the Medicaid risk-based managed care program by a provider who has not contracted with a Medicaid risk-based managed care organization to provide post-stabilization care services under subsection (b)(1), (b)(2), and (b)(3) to the individual. Payment for post-stabilization care services provided under subsection (b)(1), (b)(2), and (b)(3) must be in an amount equal to one hundred percent (100%) of the current Medicaid fee for service reimbursement rates for such services.

(e) This section does not prohibit a managed care organization from entering into a subcontract with another Medicaid risk-based managed care organization providing for the latter organization to assume financial responsibility for making the payments required under this section.

(f) This section does not limit the ability of the office or the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the post-stabilization care services provided to an enrollee for purposes of determining coverage for such services.

As added by P.L.223-2001, SEC.8.

IC 12-15-12-18

Payment for emergency services

Sec. 18. (a) Except as provided in subsection (b), this section applies to:

(1) emergency services provided to an individual enrolled in the Medicaid risk-based managed care program; and

(2) medically necessary screening services provided to an individual enrolled in the Medicaid risk-based managed care program;

who presents to an emergency department with an emergency medical condition.

(b) This section does not apply to emergency services or screening services provided to an individual enrolled in the Medicaid risk-based managed care program by a provider who has contracted with a Medicaid risk-based managed care organization to provide emergency services to the individual.

(c) Payment for emergency services and medically necessary screening services in the emergency department of a hospital licensed under IC 16-21 must be in an amount equal to one hundred percent

(100%) of the current Medicaid fee for service reimbursement rates for such services.

(d) Payment under subsection (c) is the responsibility of the enrollee's risk-based managed care organization. This subsection does not prohibit the risk-based managed care organization from entering into a subcontract with another Medicaid risk-based managed care organization providing for the latter organization to assume financial responsibility for making the payments required under this section.

(e) This section does not limit the ability of the managed care organization to:

(1) review; and

(2) make a determination of;

the medical necessity of the services provided in a hospital's emergency department for purposes of determining coverage for such services.

As added by P.L.223-2001, SEC.9.

IC 12-15-12-19

Disease management program; case management program

Sec. 19. (a) This section applies to an individual who is a Medicaid recipient.

(b) Subject to subsection (c), the office shall develop the following programs regarding individuals described in subsection (a):

(1) A disease management program for recipients with any of the following chronic diseases:

(A) Asthma.

(B) Diabetes.

(C) Congestive heart failure or coronary heart disease.

(D) Hypertension.

(E) Kidney disease.

(2) A case management program for recipients described in subsection (a) who are at high risk of chronic disease, that is based on a combination of cost measures, clinical measures, and health outcomes identified and developed by the office with input and guidance from the state department of health and other experts in health care case management or disease management programs.

(c) The office shall implement:

(1) a pilot program for at least two (2) of the diseases listed in subsection (b) not later than July 1, 2003; and

(2) a statewide chronic disease program as soon as practicable after the office has done the following:

(A) Evaluated a pilot program described in subdivision (1).

(B) Made any necessary changes in the program based on the evaluation performed under clause (A).

(d) The office shall develop and implement a program required under this section in cooperation with the state department of health and shall use the following persons to the extent possible:

(1) Community health centers.

(2) Federally qualified health centers (as defined in 42 U.S.C. 1396d(l)(2)(B)).

(3) Rural health clinics (as defined in 42 U.S.C. 1396d(l)(1)).

(4) Local health departments.

(5) Hospitals.

(6) Public and private third party payers.

(e) The office may contract with an outside vendor or vendors to assist in the development and implementation of the programs required under this section.

(f) The office and the state department of health shall provide the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6 with an evaluation and recommendations on the costs, benefits, and health outcomes of the pilot programs required under this section. The evaluations required under this subsection must be provided not more than twelve (12) months after the implementation date of the pilot programs.

(g) The office and the state department of health shall report to the interim study committee on public health, behavioral health, and human services established by IC 2-5-1.3-4 in an electronic format under IC 5-14-6 not later than November 1 of each year regarding the programs developed under this section.

(h) The disease management program services for a recipient diagnosed with diabetes or hypertension must include education for the recipient on kidney disease and the benefits of having evaluations and treatment for chronic kidney disease according to accepted practice guidelines.

As added by P.L.291-2001, SEC.161. Amended by P.L.66-2002, SEC.2; P.L.212-2003, SEC.1; P.L.13-2004, SEC.1; P.L.48-2005, SEC.1; P.L.18-2007, SEC.1; P.L.205-2013, SEC.189; P.L.53-2014, SEC.104.

IC 12-15-12-20

Child lead poisoning screening

Sec. 20. The office shall develop the following:

(1) A measure to evaluate the performance of a Medicaid managed care organization in screening a child who is less than six (6) years of age for lead poisoning.

(2) A system to maintain the results of an evaluation under subdivision (1) in written form.

(3) A performance incentive program for Medicaid managed care organizations evaluated under subdivision (1).

As added by P.L.135-2005, SEC.1.

IC 12-15-12-21

Accreditation

Sec. 21. (a) Not later than January 1, 2011, the following must be accredited by the National Committee for Quality Assurance or its successor:

(1) A managed care organization that has contracted with the office before July 1, 2008, to provide Medicaid services under the risk based managed care program.

(2) A behavioral health managed care organization that has

contracted before July 1, 2008, with a managed care organization described in subdivision (1).

(b) A:

(1) managed care organization that has contracted with the office after June 30, 2008, to provide Medicaid services under the risk based managed care program; or

(2) behavioral health managed care organization that has contracted after June 30, 2008, with a managed care organization described in subdivision (1);

must begin the accreditation process and obtain accreditation by the National Committee for Quality Assurance or its successor at the earliest time that the National Committee for Quality Assurance allows a managed care organization to be accredited.

As added by P.L.113-2008, SEC.6.

IC 12-15-12-22

Accepting, receiving, and processing electronic claims

Sec. 22. A:

(1) managed care organization that has a contract with the office to provide Medicaid services under the risk based managed care program; or

(2) behavioral health managed care organization that has contracted with a managed care organization described in subdivision (1);

shall accept, receive, and process claims for payment that are filed electronically by a Medicaid provider.

As added by P.L.113-2008, SEC.7.