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**TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES**

LSA Document #02-281(E)

DIGEST

Temporarily amends 405 IAC 6-2-3, 405 IAC 6-2-5, 405 IAC 6-2-9, 405 IAC 6-2-12, 405 IAC 6-2-14, 405 IAC 6-2-18, 405 IAC 6-2-20, 405 IAC 6-2-21, 405 IAC 6-3-2, 405 IAC 6-3-3, 405 IAC 6-4-2, 405 IAC 6-5-1, 405 IAC 6-5-2, 405 IAC 6-5-3, 405 IAC 6-5-4, 405 IAC 6-5-5, 405 IAC 6-5-6, 405 IAC 6-6-2, 405 IAC 6-6-4, provisions affecting applicants, enrollees, eligibility and enrollment requirements, benefits, and policy for the Indiana prescription drug program. Temporarily adds provisions that will set forth procedures for point of service processing and provider claims, payments, overpayments and appeals for the Indiana prescription drug program. Authority: IC 4-22-2-37.1; IC 12-10-16-5. The original emergency document, LSA Document #02-195(E), as printed at 25 IR 3780, effective July 1, 2002, expires September 26, 2002. Effective September 26, 2002.

SECTION 1. **"Benefit period" means a specified time frame during which an enrollee accrues or expends the cost of prescription drugs. The benefit periods are specified in 405 IAC 6-5-3.**

SECTION 2. **"Complete application" means an application which 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 had health insurance with a prescription drug benefit in the past year.**
**(7) Whether the applicant currently has insurance that includes a prescription drug benefit.**
**(8) Whether the applicant is on Medicaid, including Medicaid with a spend-down.**
**(9) Whether the applicant has resided in Indiana for at least ninety (90) days in the past twelve (12) months.**
**(10) Proof of income.**
**(11) Signature.**

SECTION 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) Corresponding National Drug Code (NDC) number.**
**(3) Identification of prescribing physician.**
**(4) Name and dosage of drug.**
**(5) Provider's retail price.**
**(6) Actual price enrollee paid for the drug.**

SECTION 4. **"Domicile" means the applicant's true, fixed, principal, and permanent home.**

SECTION 5. **"Family" means the applicant, spouse, and any child who reside in the same residence.**

SECTION 6. **"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 as long as the discount is deducted prior to the calculation of any enrollee benefit.**

SECTION 7. **"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 profit from financial investments.**

SECTION 8. **"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.**

SECTION 9. **"Point of service" means receiving the program benefit at the time of purchase of the prescription drugs.**

SECTION 10. **"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:**

**(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; and**
**(10) the amount paid by the enrollee, or any insurance plan.**

SECTION 11. **"Proof of income" means documentation of the income of an applicant and an applicant's family.**

SECTION 12. **(a) "Provider" means:**

**(1) an entity who 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) who complies with the same state enrollment requirements established for the Medicaid program at 405 IAC 5-4.**

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

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

SECTION 13. **"Refund certificate" means the claim document issued to an enrollee by the office which authorizes the enrollee, who has not received a benefit at point of service, to request a refund for prescription drugs purchased during a benefit period.**

SECTION 14. **"Reside" means the place where an applicant actually lives as distinguished from a domicile.**

SECTION 15. **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.**

SECTION 16. **(a) The program is available to an enrollee beginning with the benefit period prior to the one**

**in which the enrollee applied for enrollment in the program.**

**(b) After July 1, 2002, program availability will be no sooner than the date complete application is received and approved.**

**(c) 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 enrollee's 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.**

**(d) The program is not available for prescription drugs purchased prior to the month in which the enrollee turned sixty-five (65) years of age.**

SECTION 17. **(a) To be eligible for the program, an applicant's monthly family net income must not exceed the income limit listed below for the applicant's family size:**

| Family Size | Net Monthly Income Limit |
|---|---|
| 1 | $997 |
| 2 | $1,344 |
| 3 | $1,690 |

**(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.**

SECTION 18. **(a) The program shall issue a partial refund to an enrollee for the purchase of prescription drugs, as defined under this article, based upon the limitations set forth in this rule if an enrollee submits a refund certificate.**

**(b) Rather than submit a refund certificate, 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) That all prescription discounts are deducted from provider's retail price prior to calculating program benefits.**

**(5) The amount of the enrollee's copayment.**

SECTION 19. **(a) The refund or benefit at the time of purchase, which is issued to an enrollee per benefit period is limited by family monthly net income as follows:**

| Income Guideline | Individual's Monthly Net Income | Couple's Monthly Net Income | Annual Benefit |
|---|---|---|---|

| | | | |
|---|---|---|---|
| **Up to 135% of federal poverty guideline** | **Up to $997 per month** | **Up to $1,344 per month** | **50% benefit, up to $500 benefit/year** |
| **Up to 120% of federal poverty guideline** | **Up to $886 per month** | **Up to $1,194 per month** | **50% benefit, up to $750 benefit/year** |
| **Under 100% of federal poverty guideline** | **Up to $739 per month** | **Up to $995 per month** | **50% benefit, up to $1,000 benefit/year** |

**(b) An enrollee and spouse who are enrolled in the program will each receive the maximum refund, or benefit at the time of purchase, for prescription drug expenses up to the annual benefit in subsection (a) for which they qualify by family income level.**

**(c) Upon such time as the enrollee exceeds the annual benefit, the enrollee may use the prescription identification card to access program benefit prescription drug rates as defined by SECTIONS 28 and 29 of this document until the enrollee benefit period expires.**

SECTION 20. **(a) The refund certificate program shall consist of four (4) benefit periods per year, defined as follows:**

**(1) Benefit period one: October 1 through December 31.**

**(2) Benefit period two: January 1 through March 31.**

**(3) Benefit period three: April 1 through June 30.**

**(4) Benefit period four: July 1 through September 30.**

**(b) The point of service benefit shall be one (1) year of continuous eligibility up to that which is proscribed in SECTION 19 of this document.**

SECTION 21. **(a) The refund certificate program is available to an enrollee for a maximum of four (4) consecutive benefit periods.**

**(b) The point of service benefit is available to an enrollee for one (1) year.**

**(c) If an enrollee is utilizing both the refund certificate program and the point of service program, the maximum benefit duration to an enrollee is one (1) year of continuous benefits.**

**(d) To reenroll in the refund certificate program, or for point of service benefits, a new application must be submitted to the office in accordance with this article** *[document]***.**

SECTION 22. **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.**

SECTION 23. **(a) Upon submission of a completed refund certificate, or at the point of service, benefits are available under this program on a first come, first served basis.**

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

**(c) The state budget director shall determine if appropriations are available to continue offering and paying benefits to enrollees.**

SECTION 24. **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.**

SECTION 25. **(a) If the enrollee is using refund certificates, during each refund period, the enrollee must submit the applicable refund certificate with the prescription printout for the corresponding benefit period to the office in the manner prescribed by the office.**

**(b) The refund period deadline is the date which corresponds to the later of thirty-five (35) days from the date on the letter of eligibility or the last day of the applicable refund period.**

**(c) An enrollee will be notified by mail if the enrollee submits an incomplete request for refund. An incomplete request for refund includes:**

**(1) an unsigned refund certificate;**

**(2) a refund certificate with no insurance verification;**

**(3) a prescription printout which fails to state all information in SECTION 10 of this document;**

**(4) the absence of a refund certificate for the applicable benefit period;**

**(5) the absence of a prescription printout for the applicable benefit period; or**

**(6) the absence of any other information that is necessary under this article** *[document]* **to process a refund request.**

**The enrollee must submit the information requested in the letter of notification by the deadline in the letter of notification.**

**(d) Refund certificates received by the office after the refund deadline date will not be processed and no refund will be issued. Any refund certificate or prescription printout requested in subsection (c) that is received by the office after the stated deadline date will not be processed and no refund will be issued.**

SECTION 26. **All provider appeals from office action taken under this 405 IAC 6 and this document shall be governed by the procedures and time limits for Medicaid providers set out in 405 IAC 1-1.5.**

SECTION 27. **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.**

SECTION 28. **The rates of reimbursement for the covered prescription drugs provided under this title shall be the same as those calculated for Medicaid prescription drugs under rules adopted by the secretary at 405 IAC 5-24.**

SECTION 29. **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.**

SECTION 30. **(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 reimbursement may appeal under the provisions of SECTION 26 of this document. However, prior to filing such an appeal, the provider must either:**

**(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 and/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:**

**(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 charge for a benefit as defined by SECTION 19 of this document which is not reimbursed by the Indiana prescription drug program and after all prescription discounts have been calculated as proscribed by this article** *[document]***.**

SECTION 31. **(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 SECTION 27 of this document.**

**(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 provider certification 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 405 IAC 6, this document, 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 of Indiana for participating in the program.**

**(J) Refusal to execute a new provider certification 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 and regulations 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 under SECTION 30 of this document.**

**(c) The decision as to claim payment suspension is at the discretion of the office, and may include any 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 SECTION 26 of this document.**

**(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 SECTION 26 of this document.**

SECTION 32. **(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 SECTION 27 of this document;**

**(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;**

**(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).**

**(g) Whenever the office determines, after an investigation or audit, that an overpayment to a provider should be recovered, the office shall assess an interest charge in addition to the amount of overpayment demanded. Such interest charge shall not exceed the rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c). Such interest charge shall be applied to the total amount of the overpayment, less any subsequent repayments. The interest shall accrue from the date of the overpayment to the provider and shall apply to the net outstanding overpayment during the periods in which such overpayment exists. When an overpayment is determined pursuant to the results of a random sample audit, the date the overpayment occurred shall be considered to be the last day of the audit period, and**

**interest will be calculated from the last day of the audit period. 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'' *[sic., state's]* previous fiscal year, excluding pension fund investments, as published in the auditor of state' *[sic., 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.**

**(h) 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.**

**(i) 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.**

SECTION 33. **(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 32 of this document. 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 32 of this document.**

**(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.**

SECTION 34. **(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 *[document]* 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:**

**(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 of Indiana law for participation;**

**(13) charged an enrollee copayment for covered services over and above that allowable under this article** *[document]***;**

**(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 SECTION 26 of this document.**

**(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 SECTION 26 of this document.**

**(e) The decision to impose a sanction shall be made at the discretion of the office.**

SECTION 35. **SECTIONS 1 through 34 of this document expire December 25, 2002.**

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