

DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 79

HEALTHY MONTANA KIDS (HMK)

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Subchapter 1

General Provisions

37.79.101 HEALTHY MONTANA KIDS (HMK) PLAN (1) The rules in this subchapter implement the Healthy Montana Kids Plan to provide comprehensive health care coverage to Montana residents who are 18 years of age or younger residing in households with a combined family income at or below 250% of the 2009 federal poverty level (FPL). There is no resource test, as that term is used in 53-6-113 and 53-6-131, MCA, to qualify to participate in the Healthy Montana Kids Plan.

(2) The Healthy Montana Kids Plan has two health care coverage groups, Healthy Montana Kids (HMK) and Healthy Montana Kids Plus (HMK Plus). The coverage group an applicant is eligible for is determined by the combined family income.

(a) Qualified residents residing in households with income at or below 250% of the 2009 FPL but greater than 133% of the 2009 FPL qualify for the HMK coverage group. The HMK coverage group is a public benefit program administered by the department through a third party administrator. HMK enrollees have health care coverage to the extent described in this chapter. HMK providers are members of a provider network reimbursed at rates agreed to by contract. The provisions of this chapter apply to HMK enrollees.

(b) Qualified residents residing in households with income at or below 133% of the 2009 FPL qualify for the HMK Plus coverage group. The HMK Plus coverage group is the term used to identify the Montana Medicaid program for Montana residents 18 years of age or younger. HMK Plus enrollees have health care coverage to the extent provided by Montana Medicaid. HMK Plus providers are reimbursed at Montana Medicaid rates. The provisions of this chapter and Title 37, chapters 82, 83, 85, 86, and 88 apply to HMK Plus. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, 53-4-1110, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.102 DEFINITIONS Definitions as used in this subchapter, unless expressly provided otherwise, the following definitions apply:

(1) "Advanced practice registered nurse (APRN)" means a registered professional nurse who has completed educational requirements related to the nurse's specific practice role, in addition to basic nursing education, as specified by the Board of Nursing in ARM Title 8, chapter 32, subchapter 3.

(2) "Ambulance services" means all mileage, services, procedures, and supplies provided by a licensed ambulance provider.

(3) "Applicant" means an individual under the age of 19 years who applied for the HMK Plan benefits or whose parent or guardian applied for the HMK Plan benefits on the individual's behalf.

(4) "Benefits" means the services an enrollee is eligible for as outlined in this subchapter. All benefits are provided to an enrollee through the department.

(5) "Benefit year" means the period from October 1st through September 30th. If an individual is enrolled in the HMK coverage group after October 1st, the benefit year is the period from the date of enrollment through the following September 30th.

(6) "Children's Health Insurance Program (CHIP)" means the Children's Health Insurance Program described in this subchapter and administered by the department under Title 53, chapter 4, part 10, MCA and Title XXI of the Social Security Act.

(7) "Department" means the Montana Department of Public Health and Human Services.

(8) "Earned income" means payments received as compensation for work performed. Some examples are: bonus, wages, salaries, tips, commission, self-employment, military pay, and severance pay.

(9) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

(a) serious jeopardy to the health of the enrollee or the enrollee's unborn child;

(b) serious impairment of bodily function; or

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

(10) "Enrollee" means an individual who is eligible to receive HMK Plan benefits as determined by the department under this subchapter and is enrolled in the the HMK coverage group program. An individual is not an enrollee while on a waiting list or pending issuance of a hearing decision or during any period a hearing officer determines the individual was not eligible for the HMK coverage group benefits. The term "enrollee" and "member" are synonymous.

(11) "Enrollment partner" means an organization or individual approved by the department to assist in enrolling eligible children in the plan.

(12) "Eyeglasses" means corrective lens and/or frames prescribed by an ophthalmologist or by an optometrist to aid and improve vision.

(13) "Family span" means the 12 month period beginning the first day of the month after the department receives an application for HMK coverage group benefits and ending the last day of the 12th month. Although qualified for the HMK coverage group benefits, applicants placed on the waiting list may not be enrolled during the entire family span.

(14) "Federal poverty level (FPL)" means the poverty guidelines for 2009 for the 48 contiguous states and the District of Columbia as published under the "Annual Update on the HHS Poverty Guidelines" in the Federal Register each year on or about February 15.

(15) "Federally qualified health center (FQHC)" means an entity that is a federally qualified health center as defined in 42 USC 1396d(l)(2)(B) (2009 Supp.).

(16) "Guardian" means the custodial parent or a person granted legal guardianship of a child by court order, judgment, or decree.

(17) "Health coverage" means a program administered by the department or a disability insurance plan, referred to in 33-1-207(1)(b), MCA, that provides public health care coverage or private health insurance for children.

(18) "Healthy Montana Kids (HMK) Plan" means the two health care coverage groups, Healthy Montana Kids (HMK) and Healthy Montana Kids (HMK) Plus, which pay for covered health care services to qualified individuals until their 19th birthday. The HMK coverage group was formerly referred to as CHIP and the provisions of Title 53, chapter 4, part 10, MCA apply. The HMK Plus coverage group is also referred to as children's Medicaid and the provisions of Title 53, chapter 6, MCA apply.

(19) "Incarcerated" means living in a facility which would be termed a public institution under Medicaid regulations at 42 CFR 435.1009.

(20) "Income" or "family income" means the gross earned income, unearned income, and imputed income of the custodial parent. Regular, continuing, and intermittent sources of income will be annualized for purposes of determining the annual income level.

(21) "Initiative I-155" means the initiative passed by Montana voters in November, 2008, that enacted the HMK Plan Act.

(22) "Institution for mental disease (IMD)" means a facility which would be termed an institute for mental disease under Medicaid regulations at 42 CFR 435.1009.

(23) "Medically necessary" or "medically necessary covered services" means services and supplies which are necessary and appropriate for the diagnosis, prevention, or treatment of physical or mental conditions as described in this subchapter and that are not provided only as a convenience.

(24) "Member" means an individual who is eligible to receive HMK Plan benefits as determined by the department under this rule. An individual is not a member while on a waiting list or pending issuance of a hearing decision or during any period a hearing officer determines the individual was not eligible for the HMK coverage group benefits. The term "member" and "enrollee" are synonymous.

(25) "Mid-level practitioner" is defined at ARM 37.86.202.

(26) "Montana resident" means a U.S. citizen or qualified alien who declares himself or herself to be living in the state of Montana, including a migrant or other seasonal worker.

(27) "Outpatient prospective payment system (OPPS)" means the reimbursement method for federally qualified health centers (FQHCs) and Rural Health Centers (RHCs).

(28) "Outreach" means efforts which promote the Healthy Montana Kids Plan through a combination of traditional marketing methods, and social marketing. The department will develop and maintain an enrollment partner network to encourage, assist, and actively enroll children in the program.

(29) "Participating provider" means a health care professional or facility as defined at 33-36-103(19), MCA.

(30) "Qualified alien" means a person residing legally in the United States, as defined by federal immigration laws and regulations and in ARM 37.78.220.

(31) "Rural health clinic (RHC)" means a clinic determined by the secretary of the U.S. Department of Health and Human Service to meet the rural health clinic conditions of certification specified in 42 CFR, part 491, subpart A.

(32) "Serious emotional disturbance (SED)" means the criteria stated in ARM 37.87.303.

(33) "State employee" means a person, including the HMK applicant, employed on a permanent basis by the state of Montana.

(34) "Third party administrator (TPA)" means an entity with a certificate of registration to conduct business in Montana in accordance with 33-17-603, MCA, or an entity licensed as a health service corporation. The department may contract for TPA services including but not limited to claims processing, maintaining an adequate network of participating providers, coordination and continuation of care, health education, notices, quality assurance, reporting, case management services, and customer service.

(35) "Unearned income" means all payments received other than earned income. Some examples are: adoption subsidies, annuities, dividends, interest, social security benefits, disability, and unemployment insurance payments.

(36) "Waiting list" means a list of applicants who have been determined eligible for the HMK coverage group but who are not enrolled because funds are not available. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.103 through 37.79.105 reserved

37.79.106 ELECTRONIC APPLICATIONS AND SIGNATURES (1) The HMK Plan will accept electronic applications and signatures. Electronic signatures are allowed in compliance with the requirements of ARM Title 30, chapter 18, subchapters 106, 117, and 122 to the extent those provisions are not inconsistent with this subchapter. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.107 through 37.79.109 reserved

37.79.110 PROCESS FOR IDENTIFYING AND APPROVING ENROLLMENT PARTNERS (1) The following entities are qualified to be enrollment partners:

- (a) a licensed or certified health care provider;
- (b) a school district;
- (c) a community-based organization;
- (d) a government agency; and
- (e) provider associations.

(2) The department will consider requests to act as an enrollment partner from other entities and approve requests on a case-by-case basis.

(3) A qualified entity becomes an enrollment partner by contacting the department and indicating an interest in becoming an enrollment partner. The department will notify the entity if it is accepted as an enrollment partner.

(4) The department will recruit, train, provide program materials, and provide ongoing technical assistance to HMK enrollment partners.

(5) Enrollment partners must attend and complete department-sponsored training. The training will address HMK policies and procedures, confidentiality requirements, step-by-step instructions on how to complete the HMK application, and details regarding acceptable documents for citizenship, identity, and income verification.

(6) Enrollment partners will distribute program materials and applications. They will provide assistance to families to complete the application and obtain required documentation. Enrollment partners will submit the completed application and documentation to the department. The department will conduct the eligibility determination process and enroll eligible children in the appropriate coverage group of the HMK Plan.

(7) The department will maintain a list of the names, addresses, and telephone numbers of its enrollment partners and publish the list on its web site.

(8) The department has the option of denying or discontinuing enrollment partner status. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.111 through 37.79.114 reserved

37.79.115 ACTIVE ENROLLMENT PROCESS (1) The department will promote the HMK Plan through a combination of traditional marketing methods and social marketing. The department will develop and maintain an enrollment partner network to encourage, assist, and actively enroll children in the plan.

(2) An individual may apply for the HMK Plan coverage group, HMK, or HMK Plus at any time and, if qualified, will be enrolled in the appropriate program. The department will process applications based upon the date of receipt. The department will enroll eligible children in the appropriate HMK Plan group based upon the respective program guidelines. An application may be submitted to the HMK Plan office, or any county public assistance office, or an enrollment partner. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.116 through 37.79.119 reserved

37.79.120 MOVEMENT BETWEEN HMK AND HMK PLUS (1) The HMK Plan is available to all Montana residents who are 18 years of age or younger and live in households with a combined family income at or below 250% of the 2009 federal poverty level (FPL). The HMK Plan provides for two coverage groups, HMK and HMK Plus. The HMK coverage group is available to qualified residents who reside in households with a combined family income between 134% and 250% of the 2009 FPL. A waiting list may apply to this program. The HMK Plus coverage group is available to qualified residents who reside in households with a combined family income between 0 and 133% of the 2009 FPL.

(2) The HMK and HMK Plus coverage groups provide 12 months continuous coverage. An eligible HMK coverage group enrollee's coverage begins on the first day of the month following the date the application is received. An eligible HMK Plus coverage group enrollee's coverage begins on the first day of the month in which the application is received. ARM 37.79.503 states eligibility determination procedures for the HMK coverage group. ARM 37.82.204 states eligibility determination procedures for the HMK Plus coverage group. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, 53-4-1110, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.121 through 37.79.124 reserved

37.79.125 POINT OF ACCESS (1) The department developed a combined Healthy Montana Kids Plan application for the HMK and HMK Plus coverage groups.

(2) The department will accept and determine eligibility for all applications for children's health coverage provided by the HMK Plan. Applications may be submitted directly to the Healthy Montana Kids Plan office or any county office of public assistance (OPA) , or to an enrollment partner who will forward it to the Healthy Montana Kids Plan office. Department staff will coordinate eligibility determination activities to enroll eligible children in the appropriate HMK Plan coverage group. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.126 through 37.79.129 reserved

37.79.130 TRANSITION (1) On October 1, 2009, all children currently enrolled in the CHIP and the Medicaid children's programs will transition from CHIP and Medicaid to the HMK Plan.

(2) The second transition will take place when current CHIP enrollees from families with income between 100% and 133% of the FPL transition to the CHIP-funded Medicaid expansion program. The transition will occur at the time of annual reapplication during federal fiscal year 2010 (October 1, 2009 to September 30, 2010). Approximately 10,000 current CHIP enrollees will be affected by this transition. The staggered transition will occur throughout the year. A parent or guardian of an enrollee in the HMK coverage group may apply for the HMK Plus coverage at any time.

(a) For an eligible child in the HMK coverage group there is a 12-month family span. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, 53-4-1110, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.131 through 37.79.134 reserved

37.79.135 PROSPECTIVE PAYMENT SYSTEM FOR FEDERALLY QUALIFIED HEALTH CENTER (FQHC) REIMBURSEMENT (1) The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires states with separate or combined CHIP programs to pay federally qualified health centers (FQHCs) and rural health centers (RHCs) using the Medicaid outpatient prospective payment system (OPPS) as described in ARM 37.86.4413. The department adopts the Medicaid OPPS rate for children enrolled in the HMK coverage group. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

Rules 37.79.136 through 37.79.139 reserved

37.79.140 OUTREACH EFFORTS (1) The department will promote the HMK Plan through a combination of traditional marketing methods, social marketing, the development and maintenance of an enrollment partner network and collaborative efforts with schools, advocacy groups, health care providers, and other community organizations to encourage, assist, and actively enroll children in the plan. All outreach will include the name HMK Plan on documents associated with the plan including, but not limited to advertising, brochures, applications, and membership cards. (History: 53-4-1105, MCA; IMP, 53-4-1104, 53-4-1105, MCA; NEW, 2009 MAR p. 1673, Eff. 10/1/09.)

Subchapter 2

Eligibility

37.79.201 ELIGIBILITY (1) An applicant may be eligible for covered services under the HMK coverage group if:

- (a) the applicant is under 19 years of age;
 - (b) the applicant's social security number is provided. Benefits will not be denied or delayed to an otherwise eligible applicant pending issuance of his or her social security number;
 - (c) the family of which the applicant is a member has annual family income, without regard to other family resources, at or below 250% of the federal poverty level (FPL);
 - (d) the applicant is a Montana resident;
 - (e) the applicant is a U.S. citizen or qualified alien as defined under federal statute;
 - (f) the applicant is not incarcerated;
 - (g) the applicant is not an inpatient in an institution for mental disease on the date of initial application or the date of any redetermination of eligibility; and
 - (h) the applicant does not have or has not had creditable health insurance coverage for three months prior to becoming eligible for the HMK coverage group. This three month period does not apply if the parent or guardian providing the insurance:
 - (i) dies;
 - (ii) is terminated or laid off;
 - (iii) can no longer work due to a disability;
 - (iv) has a lapse in insurance coverage due to new employment;
 - (v) had insurance coverage that ended because the stepparent, who provided the coverage, and the parent divorced;
 - (vi) had coverage through the Insure Montana Program;
 - (vii) had coverage through the Medicaid Health Insurance Premium Payment (HIPP) program;
 - (viii) paid more than 50% of the insurance premium;
 - (ix) has insurance coverage that is not accessible (e.g. coverage is through an HMO in another state); or
 - (x) loses Tricare military health insurance.
- (2) An applicant who is eligible for health benefits coverage under the Montana Employee's Health Insurance Plan or the Montana University System Employees Health Insurance Plan is not eligible for HMK coverage.
- (3) An applicant who is eligible or potentially eligible for the HMK Plus coverage group as determined by the department is not eligible for the HMK coverage group.
- (4) The department must verify an applicant's citizenship or qualified alien status.

(5) Family income must be verified to determine eligibility. The department will request documentation of income from the applicant and will access various electronic databases to verify income as needed.

(a) Family income may include one or more of the following:

(i) the income of both parents if the child resides with both parents;

(ii) the income of the parent with whom the child resides the majority of the year, including any child support received for the child, if the child resides with one parent in a single parent household:

(A) If the parent with whom the child resides the majority of the year has remarried, the stepparent's income is imputed to the parent with whom the child resides the majority of the year.

(B) The income of individuals under the age of 19 who live in the household but do not attend school is imputed to the parent with whom the child resides the majority of the year.

(b) Family income does not include:

(i) money received from assets drawn down such as withdrawals from a savings account, an annuity, or from the sale of a house or a car;

(ii) gifts, loans, one-time insurance payments, or lump sum compensation for an injury;

(iii) the first \$2,000 of an enrolled tribal member's per capita payment;

(iv) the first \$2,000 of an enrolled tribal member's tribal land income;

(v) the interest earned on (2)(b)(iii) and (iv);

(vi) earned income which is excluded and dependent care expenses which are deducted from income under the HMK Plus coverage group;

(vii) income excluded under federal Medicaid regulations;

(viii) foster care income for any children unless the only children in the family are in foster care; or

(ix) income of an individual with whom a child resides who has no legal obligation to support the child.

(c) Income information will be used by the department to project the family's income.

(d) The family's debts, medical expenses, or other financial circumstances will not be taken into consideration when determining family income.

(6) Applicants eligible to receive services from the Indian Health Services (IHS) program administered by the United States Department of Health and Human Services are eligible for the HMK coverage group if they meet the criteria specified in this subchapter.

(7) Applicants who are losing HMK Plus coverage or who were denied HMK Plus coverage for a reason other than the family withdrew their application or failed to comply with HMK Plus requirements will be referred to the HMK coverage group via an electronic report. The HMK coverage group eligibility will be determined and applicants will be enrolled in the HMK coverage group or placed on the HMK coverage group's waiting list.

(8) Applicants and their parents or guardians must comply with the procedures specified by the department as necessary to obtain or access benefits.

(9) The HMK coverage group benefits do not start until the applicant is enrolled even though the applicant may have been determined eligible for the HMK coverage group prior to the date of enrollment.

(10) The HMK coverage group eligibility is redetermined within one year after the initial eligibility period, and annually thereafter. A renewal application must be completed, signed, dated and returned by a specified date for purposes of eligibility redetermination. Prior eligibility for HMK does not guarantee continued eligibility or enrollment.

(11) The HMK coverage group eligibility and benefits are not an entitlement. If funding is insufficient, the department may reduce enrollment numbers or reduce eligibility to a lower percentage of the federal poverty level to limit the number of individuals who are eligible to participate.

(12) A determination of the HMK coverage group eligibility will be completed within 45 calendar days after receipt of a complete application. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

37.79.202 NONQUALIFYING APPLICANTS (1) Applicants determined by the department to be eligible for the HMK Plus coverage group are eligible to receive the HMK Plus coverage group benefits but not eligible to receive the HMK coverage group benefits.

(2) Applicants who are themselves eligible or who have a parent who is eligible for state employee or the Montana University System employee insurance benefits are not eligible for the HMK coverage group.

(3) Applicants who are patients in an institution for mental diseases on the date of initial application or any redetermination of eligibility are not eligible for the HMK coverage group (42 CFR 457.310).

(4) Applicants who are incarcerated cannot be enrolled in the HMK coverage group.

(5) Applicants who are not eligible for HMK coverage group benefits because their family income exceeds the HMK coverage group income guideline for the family size will be referred to other health care programs for children, as appropriate.

(History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.203 through 37.79.205 reserved

37.79.206 ELIGIBILITY REDETERMINATION, NOTICE OF CHANGES

(1) Eligibility determinations shall be effective for a period of 12 months unless one or more of the following changes occurs:

- (a) the enrollee moves from the state of Montana;
- (b) the enrollee moves, does not notify the department of the new address and the department is unable to locate the enrollee;
- (c) the enrollee is found to have other creditable health coverage;
- (d) the enrollee becomes an inmate of a public institution;
- (e) the enrollee attains the age of 19 years;
- (f) the enrollee or the enrollee's parent becomes eligible for state employee or the Montana University System employee benefits before the expiration of the 12 month eligibility period;
- (g) the enrollee dies; or
- (h) the enrollee becomes eligible for HMK Plus.

(2) Parents or guardians must give notice within 30 days when the family moves or another change specified in (1) occurs.

(3) A HMK renewal application must be completed and eligibility redetermined every 12 months. If the renewal application is not returned before the HMK coverage group enrollment is scheduled to end, benefits will terminate. A new application may be completed at a later date but, if the children are determined eligible, they may be placed on the waiting list if one exists. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.207 TERMINATION OF ELIGIBILITY AND GUARDIAN LIABILITY

(1) The HMK coverage group eligibility terminates immediately upon:

- (a) death of the enrollee; or
- (b) incarceration of the enrollee.

(2) The HMK coverage group eligibility terminates at the end of the month the department becomes aware:

- (a) the enrollee attains the age of 19 years;
- (b) the parent or guardian or enrollee becomes eligible for state employee or Montana University System employee insurance benefits;
- (c) the enrollee is a beneficiary of other creditable health insurance;
- (d) the enrollee is determined eligible for HMK Plus;
- (e) the enrollee wishes to disenroll;
- (f) the enrollee moves out of Montana;
- (g) the applicant has moved without providing a new address and the department is unable to locate the applicant; or
- (h) a completed renewal application has not been received by the department.

(3) Termination of eligibility, based on insufficient funding at the department may not be effective earlier than the end of the month notice of termination is given to the enrollee or the enrollee's parent or guardian.

(4) A parent or guardian is liable to the department and the department may collect from the parent or guardian the amount of actual payments to the TPA contractor or to providers for any benefits furnished to the enrollee because of an intentional misrepresentation or a failure to give notice of changes as required by this subchapter. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.208 PROVISIONAL BENEFITS, DETERMINATION OF ELIGIBILITY, AND APPLICATIONS FOR HMK (1) Provisional HMK coverage group benefits may be extended to enrollees who would otherwise lose health care coverage while awaiting an HMK Plus determination. Provisional coverage may be extended to enrollees who:

(a) complete the HMK Plan renewal application process before their HMK coverage group benefits are scheduled to end;

(b) have been determined potentially eligible for HMK Plus coverage; and

(c) are awaiting an HMK Plus eligibility determination.

(2) A determination of HMK Plan eligibility will be completed within 45 calendar days after receipt of a complete application. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.209 ELIGIBILITY VERIFICATION REVIEWS (REPEALED) (History:
53-4-1009, MCA; IMP, 53-4-1004, MCA; NEW, 2004 MAR p. 330, Eff. 2/13/04;
AMD, 2008 MAR p. 49, Eff. 1/18/08; REP, 2009 MAR p. 1673, Eff. 10/1/09.)

Subchapter 3

Benefits

37.79.301 COVERED BENEFITS (1) The following services, if medically necessary, are covered benefits:

- (a) inpatient hospital;
- (b) outpatient hospital;
- (c) physician;
- (d) advanced practice registered nursing;
- (e) prescription drugs;
- (f) laboratory and radiology;
- (g) mental health;
- (h) chemical dependency;
- (i) vision;
- (j) audiology; and
- (k) medical dental benefits as provided in this subchapter unless specific

limitations to benefit coverage are noted. A service may be subject to prior authorization requirements.

(2) Eyeglasses and dental benefits are paid by the department as specified in ARM 37.79.322 and 37.79.326.

(3) Emergency services, including urgent care and emergency room screening to determine if a medical emergency exists, shall be available 24 hours per day, seven days per week. In emergency situations, no prior authorization is required to provide necessary medical care and enrollees may seek care from nonparticipating providers. Prior authorization may be required for any needed follow-up care.

(4) Access to information through a 24-hour call-in service, commonly referred to as a "nurse advice line", is a covered benefit for HMK Plan members. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.302 COVERAGE LIMITATIONS (1) The lifetime maximum benefit coverage is one million dollars per enrollee.

(2) Pre-existing conditions of each enrollee are covered as of the effective date of enrollment if the condition would be otherwise covered.

(3) A newborn of an HMK coverage group enrollee shall have all medically necessary benefits covered by the HMK coverage group program for 31 days after the newborn's date of live birth. Coverage for the newborn shall begin the day of live birth, without regard to whether the newborn is hospitalized on the date of coverage.

(History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.303 BENEFITS NOT COVERED (1) In addition to any exclusions noted elsewhere in these rules, the following services are not covered benefits:

- (a) experimental services or services generally regarded by the medical profession as unacceptable treatment;
- (b) custodial care;
- (c) personal comfort, hygiene, and convenience items which are not primarily medical in nature;
- (d) whirlpools;
- (e) organ and tissue transplants;
- (f) treatment for obesity;
- (g) acupuncture;
- (h) biofeedback and neurofeedback;
- (i) chiropractic services;
- (j) cosmetic surgery;
- (k) radial keratotomy;
- (l) private duty nursing;
- (m) treatment for which other coverage such as workers' compensation is responsible;
- (n) routine foot care;
- (o) any medical transportation;
- (p) ambulance services;
- (q) abortions which are not performed to save the life of the mother or to terminate a pregnancy which is the result of an act of rape or incest;
- (r) in vitro fertilization, gamete or zygote intra fallopian transfer, artificial insemination, reversal of voluntary sterilization, transsexual surgery, or fertility enhancing treatment beyond diagnosis;
- (s) acupressure;
- (t) contraceptives, for the purpose of birth control;
- (u) temporomandibular joint (TMJ) treatment;
- (v) hypnosis;
- (w) cochlear implants and associated components;
- (x) durable medical equipment; and
- (y) any treatment which is not medically necessary. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

Rules 37.79.304 through 37.79.306 reserved

37.79.307 INPATIENT HOSPITAL BENEFITS (1) Inpatient hospital benefits are provided, including but not limited to:

- (a) a semi-private room;
- (b) intensive and coronary care units;
- (c) general nursing;
- (d) drugs;
- (e) oxygen;
- (f) blood transfusions;
- (g) laboratory;
- (h) imaging services;
- (i) physical, speech, occupational, heat, and inhalation therapy;
- (j) operating, recovery, birthing, and delivery rooms;
- (k) routine and intensive nursery care for newborns; and
- (l) other medically necessary benefits and prescribed supplies for treatment of injury or illness.

(2) Coverage of postpartum care for at least 48 hours for vaginal delivery and 96 hours for caesarean section is guaranteed. Any decision to shorten the length of inpatient stay to less than these stated amounts shall be made by the attending provider and the mother. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

37.79.308 OUTPATIENT HOSPITAL BENEFITS (1) Outpatient hospital benefits provided include all benefits described in the inpatient hospital rule, ARM 37.79.307, which are provided on an outpatient basis in a hospital or ambulatory surgical center, and also include:

- (a) chemotherapy;
- (b) emergency room benefits for surgery, pain, accident, or medical emergency; and
- (c) other services for diagnostic or outpatient treatment of a medical condition, accident or illness. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.309 PHYSICIAN AND ADVANCED PRACTICE REGISTERED NURSE BENEFITS, LIMITATIONS, AND EXCLUSIONS (1) The services of physicians and advanced practice registered nurses are covered benefits.

(2) Prenatal care is covered as described for other medical conditions in these rules.

(3) Well baby, well child, and immunization services as recommended by the American Academy of Pediatrics and the Advisory Committee on Immunizations Practices are covered.

(4) Routine physicals for sports, employment, or as required by a governmental authority are covered.

(5) Anesthesia services rendered by a physician-anesthesiologist (other than the attending physician or assistant) or by a nurse anesthetist are covered providing that surgical and/or hospital services are also covered.

(6) Hypnosis, local anesthesia, unless included in the procedure charge, and consultations prior to surgery are not covered.

(7) Surgical benefits are covered as described in ARM 37.79.307, 37.79.308, and this rule. In addition, professional services rendered by a physician, surgeon, or doctor of dental surgery for treatment of a fractured jaw or other accidental injury to sound natural teeth and gums are covered.

(8) Medical or surgical treatment to reverse surgically induced infertility, fertility enhancing procedures beyond diagnosis and sex change operations are excluded.

(9) Medically appropriate second opinions which may include major diagnoses or courses of treatment are a covered benefit. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

Rules 37.79.310 and 37.79.311 reserved

37.79.312 PRESCRIPTION DRUG BENEFITS (1) Prescription drug benefits include drugs prescribed by a health care provider acting within the scope of his practice.

(2) Chemotherapy drugs approved for use in humans by the U.S. Food and Drug Administration, vaccines, prenatal vitamins, and drugs needed after an organ or tissue transplant are covered.

(3) Prescribed diabetic supplies including insulin, test tape, syringes, needles, and lancets are covered as a prescription drug.

(4) Food supplements and vitamins are not covered except prenatal vitamins and medical foods for treatment of inborn errors of metabolism as provided in 33-22-131, MCA. The need for a prescription to obtain food supplements or vitamins shall not affect the application of this rule.

(5) The HMK coverage group program shall use the Medicaid formulary if the program chooses to employ a formulary. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.313 LABORATORY AND RADIOLOGY BENEFITS (1) Laboratory and radiological benefits include imaging and laboratory services for diagnostic or therapeutic purposes due to accident, illness, or medical condition that are not described elsewhere in these rules.

(2) X-ray, radium, or radioactive isotope therapy are covered. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00.)

Rules 37.79.314 and 37.79.315 reserved

37.79.316 MENTAL HEALTH BENEFITS (1) Mental health benefits include:

(a) inpatient services furnished by public or private licensed and qualified practitioners in a hospital, including a state-operated mental hospital, a residential service, or a partial hospitalization program; and

(b) outpatient services furnished by public or private licensed and qualified practitioners in a community based setting or in a mental hospital.

(2) Additional mental health benefits are available for children with a serious emotional disturbance. These additional services are limited and may include:

(a) additional therapeutic group home care, including room and board;

(b) additional office visits for enrollee and/or family;

(c) therapeutic family care (moderate level);

(d) day treatment;

(e) community based psychiatric rehabilitation and support; and

(f) respite care.

(3) Mental health benefits shall be provided at least to the extent required by state law. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

37.79.317 SUBSTANCE USE DISORDER BENEFITS (1) Inpatient chemical dependency treatment benefits include treatment in an inpatient hospital or residential chemical dependency treatment center.

(2) Benefits for medical detoxification treatment will be paid the same as any illness.

(3) Chemical dependency benefits shall be provided at least to the extent required by state law. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2009 MAR p. 1673, Eff. 10/1/09; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

Rules 37.79.318 through 37.79.320 reserved

37.79.321 VISION BENEFITS (1) Vision benefits and medical eye care include:

- (a) services for the medical treatment of diseases or injury to the eye;
- (b) vision exams; and
- (c) a dispensing fee for eyeglasses which are ordered from the department's contractor and provided by a licensed physician, ophthalmologist, optometrist, or optician working within the scope of the profession. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04.)

37.79.322 EYEGLOSS BENEFITS (1) Eyeglasses shall be paid by the department through a single volume purchase contract.

(2) An enrollee is limited to one pair of eyeglasses per 365 day period unless additional pairs are necessary due to any of the following circumstances:

- (a) cataract surgery;
- (b) .50 diopter change in correction in sphere;
- (c) .75 diopter change in cylinder;
- (d) .5 prism diopter change in vertical prism;
- (e) .50 diopter change in the near reading power;
- (f) a minimum of a 5 degree change in axis of any cylinder less than or equal to 3.00 diopters;
- (g) a minimum of 3 degree change in axis of any cylinder greater than 3.00 diopters;
- (h) any 1 prism diopter or more change in lateral prism; or
- (i) the inability of the enrollee to wear bifocals because of a diagnosed medical condition.

(3) When the enrollee meets one or more of the conditions in (2)(a) through (2)(i), the enrollee may be allowed two pairs of single vision eyeglasses per 365 day period.

(4) Contact lenses are not a covered benefit. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04.)

Rules 37.79.323 and 37.79.324 reserved

37.79.325 AUDIOLOGY BENEFITS (1) Audiological benefits include hearing exams for assessment and diagnosis.

(2) Newborn hearing screens in a hospital or outpatient setting are covered.

(3) Hearing aids and specified supplies are covered benefits. Prior authorization is required for hearing aids. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2009 MAR p. 1673, Eff. 10/1/09; AMD, 2010 MAR p. 1539, Eff. 7/1/10.)

37.79.326 DENTAL BENEFITS (1) The maximum dental benefits paid will be 85% of the billed services received up to \$350 paid per benefit year for each enrollee. For example, \$412 in services received would result in \$350 paid.

(a) Providers may not balance bill the enrollee, parent, or guardian for the remaining 15% of the billed charges.

(b) Providers may bill the enrollee, parent, or guardian for services received in excess of \$412 per benefit year.

(2) Providers must bill for services using the procedure codes and modifiers set forth, and according to the definitions contained in the American Dental Association Manual of Current Dental Terminology Third Edition (CDT-3).

(3) The following procedures are not a benefit of the HMK coverage group Dental Program:

(a) D5900 through D5999 maxillofacial prosthetics;

(b) D6000 through D6199 implant services;

(c) D7610 through D7780 treatment of fractures;

(d) D7940 through D7999 other repair procedures; and

(e) D8000 through D8999 orthodontics.

(4) Providers must comply with all applicable state and federal statutes, rules and regulations, including the United States Code governing the HMK Plan and all applicable Montana statutes and rules governing licensure and certification.

(5) Enrollees with significant dental needs beyond those covered in the basic dental plan may, with prior authorization, receive additional services through the HMK coverage group Extended Dental Plan (EDP). The EDP program is dependent on legislative appropriation for the program.

(a) A HMK coverage group enrollee determined eligible for extended dental benefits may receive additional services in the benefit year. The maximum EDP payment to all dental providers for an enrollee's additional dental services is \$1000 per benefit year.

(b) The type of services covered by the EDP are the same type of services covered under the basic dental plan.

(c) The maximum basic and EDP payments combined is \$1350 (\$350 basic plan and \$1000 EDP) for a benefit year.

(6) Providers must also comply with the requirements of ARM Title 37, chapter 85, subchapters 4 and 5 to the extent those provisions are not inconsistent with this subchapter.

(7) For purposes of applying the provisions of any Medicaid rule as required by this subchapter, references in the Medicaid rule to "Medicaid" or the "Montana Medicaid program" or similar references shall be deemed to apply to the HMK coverage group or the HMK Plus coverage group as the context permits. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Subchapter 4 reserved

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9/30/09

ADMINISTRATIVE RULES OF MONTANA
HEALTHY MONTANA KIDS

37.79.501

Subchapter 5

Enrollment Provisions

37.79.501 COST SHARING PROVISIONS (1) Except as provided in (2) and (3), the parent or guardian of each HMK coverage group enrollee whose family income is greater than 100% of the federal poverty level must pay to the provider of service the following copayments not to exceed the cost of service:

(a) \$25 per admission for inpatient hospital services including hospitalization for physical, mental, and substance abuse reasons;

(b) \$5 per visit for emergency room services;

(c) \$5 per visit for outpatient hospital visits including outpatient treatment for physical, mental, and substance abuse reasons;

(d) \$3 per visit for physician, APRN, PA, optometrist, audiologist, mental health professional, substance abuse counselor, or other covered health care provider services;

(e) \$3 per prescription or refill of an outpatient generic drug;

(f) \$5 per prescription or refill for an outpatient brand-name drug;

(g) \$6 per mail order prescription or refill of an outpatient generic drug (90 day supply); and

(h) \$10 per mail order prescription or refill of an outpatient brand name drug (90 day supply).

(2) No copayment shall apply to:

(a) well baby or well child care, including age-appropriate immunizations;

(b) outpatient hospital visits for x-ray and laboratory services;

(c) dental, pathology, radiology, or anesthesiology services;

(d) families with at least one enrollee who is a Native American Indian or Native Alaskan; or

(e) extended mental health services for children with a serious emotional disturbance as stated in ARM 37.79.316(4).

(3) The total copayment for each family shall not exceed \$215 per family per benefit year. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Rule 37.79.502 reserved

NEXT PAGE IS 37-17685

37.79.503 ENROLLMENT (1) The HMK coverage group will accept without restriction eligible applicants in the order in which they are received for enrollment until the maximum enrollment, at which time eligible applicants will be put on a waiting list and will be enrolled when spaces become available. Applicants come off the waiting list and are enrolled based on the date they were determined eligible.

(2) The enrollment date will always be the first day of the enrollment month. An eligible child will be enrolled:

(a) the first of the month following the month the application is received if the family is determined eligible; or

(b) the month funding is sufficient to enroll the applicant from the waiting list.

(3) The HMK coverage group will:

(a) provide each enrollee with a handbook of information about the program including a summary of benefits; and

(b) issue an appropriate identification card to each enrollee. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1007, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.504 RIGHT TO CHOOSE PRIMARY CARE PROVIDER (REPEALED)
(History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; REP, 2008 MAR p. 49, Eff. 1/18/08.)

NEXT PAGE IS 37-17687

37.79.505 DISENROLLMENT (1) Participation in the HMK coverage group is voluntary and an enrollee may withdraw from the program at any time.

(a) HMK coverage group benefits may be terminated for good cause if the enrollee, parent, or guardian has violated rules adopted by the Montana Commissioner of Insurance for enrollment with an insurer.

(b) Good cause shall be defined as provided in Montana insurance law and rules and does not include an adverse change in health status.

(2) Disenrollment takes effect, at the earliest, the first day of the month after the department receives the request for disenrollment, but no later than the first day of the second calendar month after the request for disenrollment is received. The enrollee remains enrolled in the HMK coverage group and the HMK coverage group program is responsible for benefits covered under the contract until the effective date of disenrollment, which is always the first day of a month.

(3) The department will disenroll an enrollee if the enrollee becomes ineligible. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Subchapter 6

Services and Provider Requirements

37.79.601 CONTRACT FOR SERVICES (1) The department may contract as it determines appropriate and in conformity with state and federal procurement law for services to administer the HMK coverage group. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.602 PROVISION OF BENEFITS (1) The department may impose the following requirements in the provision of benefits:

- (a) the use of certain types of providers to the extent allowed by law;
- (b) prior authorization for benefits other than emergency services;
- (c) directing an enrollee to the appropriate level of care for receipt of covered benefits; and
- (d) denial of payment to a provider for benefits provided to an enrollee if the participation requirements in this rule are not met by the enrollee or the enrollee's parent, or guardian.

(2) An enrollee must use the HMK coverage group's TPA participating providers unless:

- (a) the department authorizes a nonparticipating provider to provide a service; or
- (b) the enrollee receives emergency services or emergency room screen.

(3) The TPA and participating providers must provide covered benefits as listed in this subchapter to enrollees in the same manner as those benefits are provided to any child who is not enrolled in the HMK Plan. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 48, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

Rules 37.79.603 and 37.79.604 reserved

37.79.605 PARTICIPATING PROVIDERS (1) The third party administrator must offer to federally qualified health centers (FQHCs), rural health clinics (RHCs), Title X family planning providers, Indian health services providers, tribal health providers, urban Indian centers, migrant health centers, and county public health departments terms and conditions that are at least as favorable as those offered to other providers.

(2) The department and the third party administrator will deny payment to a provider who is currently suspended or terminated by the Medicaid or the Medicare program in any state.

(3) Participating providers shall be licensed or certified in Montana or in the case of out-of-state providers, in the state in which they practice.

(4) Physicians, advanced practice registered nurses, and physician assistants shall either have admitting privileges to at least one general or critical shortage area hospital or shall have a mechanism in place to ensure hospitalization when appropriate.

(5) In addition to the cost sharing provisions outlined in ARM 37.79.501, participating providers may bill the enrollee, parent, or guardian for services provided to a HMK coverage group enrollee, which are not covered benefits.

(6) A third party administrator may not prohibit a participating provider from:

(a) discussing a treatment option with an enrollee, parent, or guardian; or

(b) advocating on behalf of an enrollee within the utilization review or grievance processes established by the third party administrator. (History: 53-4-1004, 53-4-1009, 53-4-1105, MCA; IMP, 53-4-1003, 53-4-1004, 53-4-1009, 53-4-1104, 53-4-1105, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 1027, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)

37.79.606 REIMBURSEMENT OF THE THIRD PARTY ADMINISTRATOR

(1) In consideration for all services rendered by a third party administrator under a contract with the department, the third party administrator will receive payment for services provided as agreed in the contract. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08.)

37.79.607 UTILIZATION REVIEW AND QUALITY ASSURANCE (1) The third party administrator shall have adequate staff and procedures to assure that health care provided to enrollees is medically necessary and appropriate.

(2) The third party administrator shall comply with and cooperate in any external quality review that may be implemented by the department or its designee. An external quality review may include participation in the design of the review, collection of data, and making data available to the department or its designee. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08.)

Subchapter 7 reserved

Subchapter 8

Hearing and Appeal Procedures

37.79.801 GRIEVANCE AND APPEAL PROCEDURES (1) A third party administrator must have a written procedure, approved in writing by the department before implementation, for resolution of grievances or complaints brought by enrollees or their parents or guardians either individually or as a class. In a situation requiring urgent care or emergency care, the department may require the third party administrator to expedite resolution of a grievance within a time line established by the department.

(2) Except when the HMK coverage group eligibility has been denied, an enrollee, parent, or guardian must exhaust the third party administrator's grievance procedure before appeal of the matter may be made to the department.

(3) An applicant, parent, or guardian aggrieved by a denial, suspension, or termination of the HMK coverage group eligibility or an enrollee, parent, or guardian aggrieved by a final grievance decision of a third party administrator, including but not limited to a reduction or denial of benefits, may request a fair hearing in accordance with ARM 37.5.304, 37.5.313, 37.5.322, 37.5.325, 37.5.328, 37.5.334, and 37.5.337.

(4) If a written request for hearing is not received by the department within 90 days after the date a notice of adverse action is mailed by the department or a final grievance decision is mailed by a third party administrator, the hearing officer may deny a hearing as provided in ARM 37.5.313.

(5) A proposal for decision by the hearing officer is a final agency decision for purposes of 2-4-702, MCA and is subject to judicial review as provided in Title 2, chapter 4, part 7, MCA. (History: 53-4-1009, MCA; IMP, 53-4-1003, MCA; NEW, 2000 MAR p. 1221, Eff. 5/12/00; AMD, 2004 MAR p. 330, Eff. 2/13/04; AMD, 2008 MAR p. 49, Eff. 1/18/08; AMD, 2009 MAR p. 1673, Eff. 10/1/09.)