

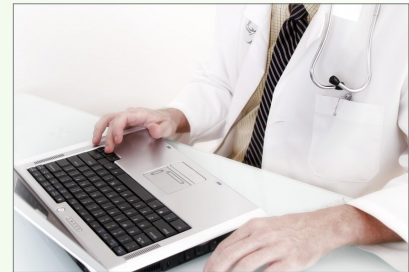
IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201835

AUGUST 28, 2018

IHCP eligibility verification systems return clearer messages regarding member copayments

The Indiana Health Coverage Programs (IHCP) Eligibility Verification System (EVS) methods – the Provider Healthcare Portal (Portal), 271 eligibility transactions, and the Interactive Voice Response (IVR) system – were enhanced to return clearer messages regarding member copayments due from IHCP members. These messages reflect whether members have or have not met their cost-sharing obligations for the quarter in which eligibility is being verified.



Copayments might apply for an IHCP-covered service when a member has coverage under one of the following benefit plans:

- Full Medicaid
- Package A Standard Plan
- Package C – Children’s Health Plan (SCHIP)
- Package E – Emergency Services Only
- HIP 2.0 Basic
- HIP 2.0 State Plan Plus Copay
- HIP 2.0 State Plan Basic
- Presumptive Eligibility - Adult

If copayments are required under a member’s benefit plan, and the member has not satisfied his or her cost-sharing obligation for the quarter, when verifying the member’s eligibility the type of copayment required and the amount due will be indicated (see Figure 1). In this example, the Portal message indicates the member is responsible for paying a \$3 copayment for hospital outpatient non-emergency services for the dates of service (DOS) verified.

Figure 1 – Portal copayment message if cost-sharing obligation has not yet been met for the quarter

Benefit Details			
Coverage	Description	Effective Date	End Date
Package A-Standard Plan	Package A-Standard Plan	01/01/2018	01/31/2018
Coverage	Description and Copayment Message	Copay Amount	
Package A-Standard Plan	Hospital - Outpatient - Copay applies to non-emergency services.	\$3.00	

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If a copayment is required under the member's benefit plan, but the member has satisfied his or her cost-sharing obligation for the quarter, the Portal message will indicate the type of copayments that apply but will indicate \$0 due for the DOS verified (see Figure 2).

Figure 2 – Portal copayment message if cost-sharing obligation has been met for the quarter

Benefit Details			
Coverage	Description	Effective Date	End Date
HIP 2.0 Plus	HIP 2.0 Regular Plus-No MRO services	01/20/2018	01/30/2018
Presumptive Eligibility Adult	Mirrors HIP 2.0 Regular Basic-No MRO services	01/03/2018	01/19/2018
Coverage	Description and Copayment Message	Copay Amount	
HIP 2.0 Plus	Medical care - Copay is not applicable to members in the HIP 2.0 Regular Plus benefit plan.	\$0.00	
Presumptive Eligibility Adult	Emergency Services - No copay for preventive services. Copay of \$4 on all outpatient services. Outpatient copays are assessed as one copayment per provider/per type of service/per day. Inpatient copay of \$75 per hospital stay.	\$0.00	
Presumptive Eligibility Adult	Urgent Care - No copay for preventive services. Copay of \$4 on all outpatient services. Outpatient copays are assessed as one copayment per provider/per type of service/per day. Inpatient copay of \$75 per hospital stay.	\$0.00	

If a member's benefit plan does not require copayments, such as *HIP 2.0 Plus*, the Portal message will indicate that copayments do not apply (see Figure 3).

Figure 3 – Portal message when copayments do not apply under the member's benefit plan

Coverage	Description and Copayment Message	Copay Amount
HIP 2.0 Plus	Hospital - Copay is not applicable to members in the HIP 2.0 Regular Plus benefit plan.	\$0.00
HIP 2.0 Plus	Chiropractic - Copay is not applicable to members in the HIP 2.0 Regular Plus benefit plan.	\$0.00
HIP 2.0 Plus	Hospital - Outpatient - Copay is not applicable to members in the HIP 2.0 Regular Plus benefit	\$0.00

The figures above relate to messages displayed in the Portal. Similar messages will be returned when the provider verifies a member's eligibility using 270/271 transactions or the IVR system.

IHCP enhances Portal process for converting OPR and rendering provider classifications

Effective September 10, 2018, the Indiana Health Coverage Programs (IHCP) will enhance the Provider Healthcare Portal (Portal) so that an actively enrolled ordering, prescribing, or referring (OPR) provider can convert to a rendering provider, or an actively enrolled rendering provider can convert to an OPR provider, in a single transaction. This process applies to conversions between these two classifications only.

Providers will be able to access this new feature in the Portal by following these steps:

1. Log into the Portal as a registered OPR provider or as a registered rendering provider.



continued

2. On the *My Home* page, under the Provider section, select the **Converting OPR or Rendering** link (see Figure 4).
3. On the *Provider Enrollment Conversion* panel, select **OPR or Rendering Conversion** to begin a new request, or select **Resume Conversion** to resume a conversion request previously started but not yet completed and submitted. View the status of a conversion request already submitted by selecting **Conversion Status**. (See [Figure 5](#).)
4. When selecting the option to begin a new request or to resume a request, the *Provider Conversion: Request Information* page is displayed. Enter an effective date for the change. The effective date can be a retroactive date but not a future date. (See [Figure 6](#).)
5. Follow all prompts to enter the required enrollment data for the new classification (either OPR or rendering) and select **Confirm** on the *Summary* page to submit your request.

Note: There is no need to complete a deactivation to convert between these two provider classifications; the system will end date the old classification (either OPR or rendering) associated with the enrolled Provider Profile and activate the new classification. The provider's existing Medicaid ID will be automatically be assigned to the new Provider Profile.

Figure 4 – Link on the Portal My Home page for converting OPR or rendering provider classifications



continued

The Portal is the preferred method for converting between the OPR and rendering provider classifications. However, the IHCP will continue to accept paper transaction requests as follows:

- **OPR to Rendering** – Providers are required to submit **both** an [IHCP Provider Disenrollment Form](#) to request deactivation as an OPR, and an [IHCP Rendering Provider Enrollment and Profile Maintenance Packet](#) to request enrollment as a rendering provider, together in one submission.
- **Rendering to OPR** – Providers are required to submit **both** an [IHCP Provider Disenrollment Form](#) to request deactivation as a rendering provider, and an [IHCP Ordering, Prescribing, or Referring Provider Enrollment and Profile Maintenance Packet](#) to request enrollment as an OPR provider, together in one submission.

Figure 5 – Provider Enrollment Conversion panel on the Portal to choose a conversion option



continued

Figure 6 – Provider Conversion: Request Information page on the Portal to begin a conversion request

Provider Conversion: Request Information

Initial Enrollment Information

Provider Classification Ordering, Prescribing, Referring (OPR)

***Provider Type** 50 - Ordering/Prescribing/Referring

***Requested Enrollment Effective Date** 08/14/2018

Enrollment Request Type Rendering to OPR Conversion

Provider Identification

Enter SSN if you are enrolling as an Individual or FEIN if enrolling as a business. The Social Security number disclosed on this form is used to determine whether the person named in this enrollment application is a federally excluded party and to verify licensure.

Social Security Number *****3450

***Tax ID Type** ☐ EIN ☒ SSN

Contact Information

The contact person may be contacted to answer any questions regarding the information provided in this enrollment application. Email addresses will be used for IHCP business only.

***Last Name**

***First Name**

Title

***Telephone Number** **Telephone Number Extension**

Fax Number

***Contact Email**

***Confirm Email Address**

Preferred Method of Communication

Continue **Finish Later** **Cancel**

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