



590 Program Provider Manual

LIBRARY REFERENCE NUMBER: PRPE10003
PUBLISHED: FEBRUARY 23, 2012
POLICIES AND PROCEDURES AS OF JANUARY 1, 2012
VERSION 7.0

Library Reference Number: PRPE10003

Document Management System Reference: 590 Program Provider Manual (16636)

Address any comments concerning the contents of this manual to:

HP Provider Relations Unit
950 North Meridian Street, Suite 1150
Indianapolis, IN 46204
Fax: (317) 488-5169

© 2012 Hewlett-Packard Development Company, LP.

*Current Dental Terminology (CDT) is copyrighted by the American Dental Association. © 2009, 2010
American Dental Association.*

Current Procedural Terminology (CPT) is a registered trademark of the American Medical Association.

Other products and brand names are the trademarks of their respective owners.

Revision History

Version	Revision Date	Reason for Revisions	Revisions Completed By
1.0	April 2002	New format and rewrite	EDS Publications
2.0	March 2004	Complete rewrite	EDS Publications
2.1	February 2007 Policies and procedures current as of October 2006	Quarterly Update. Added missing forms and web links.	EDS Publications
4.0	August 2009	Semiannual Update	EDS Provider Relations and Publications
4.1	September 2009	Semiannual Update	EDS Provider Relations and Publications
5.0	March 2010	Semiannual Update	HP Provider Relations and Publications
5.1	September 14, 2010	Semiannual Update	HP Provider Relations and Publications
6.0	February 1, 2011	Semiannual Update	HP Provider Relations and Publications
6.1	August 11, 2011 Policies and procedures as of July 1, 2011	Semiannual Update	HP Provider Relations and Publications
7.0	Policies and Procedures as of January 1, 2012 Published: February 23, 2012	Semiannual Update <ul style="list-style-type: none"> • Updated Overview section <ul style="list-style-type: none"> – Added link to provider enrollment page • Updated 590 Program Provider Enrollment section • Updated FSSA OMPP 590 Program Facilities Agreement • Updated Provider Avenues of Resolution table <ul style="list-style-type: none"> – Updated claim status contact information 	HP Provider Relations and Publications

Table of Contents

Revision History	i
Table of Contents	iii
Section 1: Introduction	1-1
Overview	1-1
590 Program Facilities.....	1-2
590 Program Facility Enrollment.....	1-3
590 Program Provider Enrollment	1-3
Section 2: Contractor and Contact Information	2-1
Fiscal Agent Contractors	2-1
590 Program Avenues of Resolution.....	2-1
Section 3: Member Eligibility and Enrollment	3-1
Overview	3-1
590 Program Member Enrollment Eligibility.....	3-1
New Admissions with existing Medicaid/Hoosier Healthwise Coverage	3-1
Coordination between the 590 Program and Care Select.....	3-1
Length of Stay.....	3-3
590 Program Member Enrollment	3-5
590 Program Enrollment/Discharge/Transfer (EDT) Form State Form	
32696 (R __) / OMPP 0747 Entered in IndianaAIM	3-6
Transfers	3-7
Discharges and Deaths of 590 Program Members	3-7
Name Changes and Corrections for 590 Program Members.....	3-8
Eligibility Verification	3-8
How to Verify Member Eligibility.....	3-9
Department of Corrections.....	3-9
Section 4: 590 Program Services and Claim Processing	4-1
Services outside a 590 Program Facility	4-1
Covered Services.....	4-1
Prior Authorization.....	4-2
Claim Submission	4-2
Claim Payment	4-2
Third-Party Liability and Medicare.....	4-3
Appendix A: Indiana Code IC 12-16-1, Indiana Administrative Code 470	
IAC 12-1	A-1
Indiana Code IC 12-16-1	A-1
Indiana Administrative Code 470 IAC 12-1.....	A-2
Index	1

Section 1: Introduction

Overview

The 590 Program provides coverage for certain healthcare services provided to members who are residents of state-owned facilities. These facilities operate under the direction of the Family and Social Services Administration (FSSA), the Division of Mental Health and Addiction (DMHA), and the Indiana State Department of Health (ISDH). Incarcerated individuals residing in Department of Corrections (DOC) facilities are not covered by the 590 Program.

The 590 Program's member data is solely entered and maintained in IndianaAIM rather than in the Indiana Client Eligibility System (ICES). The 590 Program eligibility process is outlined in [Section 3: Member Eligibility and Enrollment](#) of this manual. Members enrolled in the 590 Program are eligible for the full array of benefits covered by the Indiana Health Coverage Programs (IHCP) with the exception of transportation services. Transportation services are provided by the 590 facility where the member resides. Only 590-enrolled providers can render services to members enrolled in the 590 Program.

Services provided to members enrolled in the 590 Program are reimbursed per claim by the IHCP when the claim total is greater than \$150. If the claim total is less than \$150, the 590 facility is responsible for the cost of services. All services totaling \$500 or more require prior authorization (PA). The 590 Program does not reimburse for transportation.

A Hoosier Health Card is not issued to 590 Program members who are not eligible for Traditional Medicaid, Hoosier Healthwise, or *Care Select* at the time of admission. The facility where the member resides is responsible for contacting the provider to schedule appointments for medical services. Eligibility status for the 590 Program may be determined using the Eligibility Verification System (EVS). Information about EVS options can be found in [Chapter 3](#) of the *IHCP Provider Manual*.

To receive reimbursement, any provider rendering services to 590 Program members must be enrolled in the IHCP as a 590 provider. Providers must check the appropriate box on the Billing/Group and Rendering (if applicable) Provider Application and Maintenance Form to become a 590 Program provider. Providers may access the appropriate enrollment form on the [IHCP Provider Enrollment Options](#) page on indianamedicaid.com.

Claims for services rendered to 590 Program members under the jurisdiction of the DMHA or the ISDH must be billed to HP Enterprise Services. The billing address for 590 Program claims is located in [Chapter 1](#) of the *IHCP Provider Manual*.

The 590 Program differs from Traditional Medicaid, *Care Select*, and the Hoosier Healthwise Program in the following ways:

- If a member enrolled in the 590 Program receives services that have a total billed amount per claim of less than \$150, the 590 Program facility where the member resides is responsible for payment of the service. If the claim total is \$150 or more, the claim is submitted to HP for processing. Claims cannot report span dates, and multiple dates of service cannot be lumped together on one claim form to exceed \$150.
- PA is required for all services equal to or greater than \$500 per service per claim provided to members enrolled in the 590 Program. Because the billed amount of services is often unknown until after the services are provided, 590 Program services can be retroactively prior authorized. Information about the procedures for filing a PA request is located in [Chapter 6](#) of the *IHCP Provider Manual*. This manual is available on the [Manuals](#) page on indianamedicaid.com.

- The 590 Program covers only services rendered outside the 590 Program facilities.
- Transportation is not a covered service. Transportation must be provided by the facility where the member resides.
- The claim-filing limit is one year from the date of service. See [Section 4: 590 Program Services and Claim Processing, Claim Submission](#) for additional information.
- Identification cards are not issued to members enrolled only in the 590 Program. An IHCP member who resides in a State-owned facility may have a Hoosier Health Card if he or she was previously eligible for Traditional Medicaid, *Care Select*, or Hoosier Healthwise prior to admission to the 590 Program facility. IHCP eligibility, however, must be terminated upon entry into the facility unless the member is younger than 21 or older than 64 years. All providers must verify eligibility and verify residency before providing services, even if the member presents a Hoosier Health Card.
- All providers must verify the member enrolled in the 590 Program resides in a State-owned facility. All members enrolled in the 590 Program must be chaperoned to off-site providers.
- Individuals who are on probation or incarcerated are not eligible for the 590 Program.
- The 590 Program does not cover targeted case management (TCM) services.

590 Program Facilities

Table 1.1 lists the Indiana facilities currently enrolled in the IHCP as 590 Program facilities.

Table 1.1 – 590 Program Facilities

Facility Name	Address	Phone
Evansville State Hospital	3400 Lincoln Ave. Evansville, IN 47714	(812) 469-6800
Madison State Hospital	711 Green Rd. Madison, IN 47250	(812) 265-7374
Logansport State Hospital	1098 S. State Road 25 Logansport, IN 46947	(574) 722-4141
Richmond State Hospital	498 N.W. 18 th St. Richmond, IN 47374	(765) 966-0511
Indiana School for the Deaf	1200 E. 42 nd St. Indianapolis, IN 46205	(317) 924-8402
Indiana School for the Blind	7725 North College Ave. Indianapolis, IN 46240	(317) 253-1481
Indiana Veterans Home	3851 N. River Rd. West Lafayette, IN 47906	(765) 463-1502
Larue D. Carter Memorial Hospital	2601 Cold Spring Rd Indianapolis, IN 46222-2202	(317) 941-4000

Individuals in 590 Program facilities are considered residents of the facility. Residents eat meals, are educated, and receive mail at the facility. Most facilities provide on-site medical care.

590 Program Facility Enrollment

Facilities that wish to become 590 Program facilities must be State-owned facilities under the direction of the FSSA, DMHA, and ISDH. Facilities are required to complete the *FSSA OMPP 590 Program Facilities Agreement* (Figure 1.1). Enrolled 590 Program facilities are assigned an IHCP provider number to be used for eligibility verification of residents. The *FSSA OMPP 590 Program Facilities Agreement* is available on the [Forms](#) page on indianamedicaid.com.

590 Program Provider Enrollment

Providers that wish to participate in the 590 Program must complete the appropriate *IHCP Provider or Facility Application and Profile Maintenance Packet* to enroll in the IHCP and check **Yes** in the 590 Program box in *Schedule B* of the form. Enrolling providers are required to have obtained a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES) prior to completing the *IHCP Provider Application and Profile Maintenance Form*. Enrolled 590 Program providers are assigned an IHCP Legacy Provider Identifier (LPI). Enrollment forms are available on the [Provider Enrollment](#) section on indianamedicaid.com.

**FAMILY AND SOCIAL SERVICES ADMINISTRATION (FSSA)
OFFICE OF MEDICAID POLICY AND PLANNING (OMPP)**

AGREEMENT

BETWEEN 590 FACILITIES AND OMPP

Based on the execution of this agreement, the undersigned entity (State facility) is assigned an Indiana Health Coverage Programs (IHCP) provider number for the exclusive purpose of obtaining 590 Program eligibility information. Eligibility information is available using the Automated Voice Response system (AVR), Omni swipe card, Web interChange, or web solution, collectively referred to as the Eligibility Verification Systems (EVS). The EVS allows providers to verify member eligibility for members residing in State-operated facilities under the authority of the Indiana State Department of Health (ISDH) and the Department of Mental Health and Addiction (DMHA). As a condition to the assignment of an IHCP provider number, the facility agrees to the following:

To safeguard information about 590 Program members obtained through the EVS, including but not limited to:

1. Any information received about a member's 590 Program eligibility
2. Any information received to verify a member's amount of medical assistance payments and/or benefit limitation
3. Any information received about third-party liability
4. Any information received about prior authorization for medical services for a member provided under the 590 Program

Information about 590 Program members should be released only to the Indiana FSSA, an agent of the intended provider of service, and only when in connection with the following:

1. Providing services for members
2. Conducting or assisting an investigation prosecution, or civil or criminal proceeding related to the provision of 590 Program-covered services

THE UNDERSIGNED, HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE TO ABIDE BY AND COMPLY WITH ALL THE STIPULATIONS, CONDITIONS, AND TERMS SET FORTH ABOVE.

Facility Name

Name of Authorized Representative – Signature

Title

Date of Signature

Facility Address Phone Number

Figure 1.1 – FSSA OMPP 590 Program Facilities Agreement

Section 2: Contractor and Contact Information

Fiscal Agent Contractors

The Office of Medicaid Policy and Planning (OMPP) contracts with HP, a fiscal agent of the State, to perform the day-to-day program functions associated with administration of the Indiana Health Coverage Programs (IHCP). During State fiscal year (SFY) 2007, the OMPP reprocurved the IHCP fiscal agent contract pursuing a *multi-sourcing* approach that divided the fiscal agent contract into service packages.

The current fiscal agent service packages are as follows:

- HP
 - Claims Processing and Related Services
 - Customer Service
 - Long Term Care
 - Managed Care
 - Pharmacy Benefit Manager
 - Provider Relations
 - Third Party Liability
 - Waiver
- ADVANTAGE Health SolutionsSM (ADVANTAGE)
 - Prior Authorization
- Affiliated Computer Services (ACS)
 - Drug Rebate Services – Effective January 1, 2003, ACS assumed responsibility for drug rebate.
 - Prior authorization for prescribed drugs

In addition to the above services, medical policy functions are performed by the OMPP. Questions regarding medical policy should be directed to the HP Written Correspondence Unit (see [Table 2.1](#)).

590 Program Avenues of Resolution

The following information is intended to assist providers with contacting the appropriate area to best meet the needs of an inquiry. When providers have questions about claims or the IHCP, or require clarification about a specific topic, the following avenues of resolution are available and listed in [Table 2.1](#) in the order of use.

Table 2.1 – Provider Avenues of Resolution

Area of Client Services	Contact Information	When to Contact
<i>Indiana Health Coverage Programs Provider Manual</i>	View or download from the Manuals page on indianamedicaid.com Send request in writing to: HP Written Correspondence P. O. Box 7263 Indianapolis, IN 46207-7263 Additional paper copies require a fee. Contact Customer Assistance for current pricing information.	Providers should always refer to the <i>Indiana Health Coverage Programs Provider Manual</i> as a primary reference for submitting and processing claims, prior authorization requests, and other related documents. This manual contains detailed instructions for claims submission and is the first referral source for answers to policy and procedural questions.
IHCP website	indianamedicaid.com	This website provides program information, such as banner pages, bulletins, newsletters, the <i>Indiana Health Coverage Programs Provider Manual</i> and all program supplemental manuals, program contact information, schedules of training events, forms, and general program updates.
Customer Assistance	(317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278	Customer Assistance represents the primary line of communication for the provider community and is responsible for telephone inquiries about IHCP claim processing, policy, and coverage services.
Provider Relations Field Consultants	Provider Relations field consultant contact information on indianamedicaid.com or call (317) 488-5000	The field consultants work closely with the provider community to explain program policies and objectives, assist with resolving issues, and conduct training seminars and on-site visits. Consultants can also provide additional information about electronic claims capture (ECC).

Area of Client Services	Contact Information	When to Contact
Written Correspondence	HP Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	The Written Correspondence Unit is available to research claims and denials for providers experiencing difficulty in receiving claim payment. Providers should not submit claims for processing to the Written Correspondence Unit unless specifically directed to do so. The Written Correspondence Unit performs specific claim research and determines the best resolution. The Written Correspondence Unit forwards medical policy inquiries to the OMPP.
Claim Status	Claim status is accessible using Web interChange at https://interchange.indianamedicaid.com . Providers can also obtain claim status through the Automated Voice Response (AVR) system at (317) 692-0819 in the Indianapolis area or toll-free at 1-800-738-6770. Both systems provide access 24 hours a day, seven days a week.	As needed

Section 3: Member Eligibility and Enrollment

Overview

All members of the 590 Program must be enrolled as such in IndianaAIM. To enroll members in the 590 Program, the 590 Program facility must send HP eligibility staff an enrollment request for a member identification number (RID) assignment. When a member's eligibility for the 590 Program is completed in IndianaAIM, the RID is forwarded to the facility for its records. The HP 590 Program eligibility analyst answers provider questions about the 590 Program and interacts with the Office of Medicaid Policy and Planning (OMPP) staff related to 590 Program issues.

590 Program Member Enrollment Eligibility

New Admissions with existing Medicaid/Hoosier Healthwise Coverage

When a member is admitted to a 590 Program facility and the member is enrolled in Traditional Medicaid or the Hoosier Healthwise Program, the facility must check with the family or placing agency to ensure that the Division of Family Resources (DFR) has been informed of the member's admission. In most cases, the member will retain original eligibility.

New admissions must be screened by the facility for potential Medicaid/Hoosier Healthwise eligibility. Those potentially eligible should be referred to the DFR office to file a Hoosier Healthwise application.

Contact information for the DFR is available at in.gov/fssa/dfc. On the home page, click the link entitled, "Where do I Apply," then scroll down to the member's county of residence to locate the contact telephone number.

Coordination between the 590 Program and Care Select

Member in 590 Program Facility Prior to Care Select Enrollment

If a *Care Select* member is a resident in a 590 Program facility, there can be healthcare coordination and payment issues, especially if the primary medical provider (PMP) is in a different county than the 590 Program facility. The OMPP excludes 590 Program facility residents from participation in *Care Select* during their 590 Program facility stay. It is critical to the success of the member's coordination of care that the 590 Program facility alerts the enrollment broker, Maximus Administrative Services (MAXIMUS), when a member leaves the facility. The 590 Program facility should also contact the *Care Select* care management organization (CMO) to which the member was assigned prior to being admitted to the 590 Program facility to advise the CMO of the member's discharge from the facility. This will help ensure that the member's medical home with the PMP can be established or resumed. All 590 Program facilities must maintain a tracking system to ensure adherence to this exit alert policy.

If a resident of a 590 Program facility receives a letter from the member's previously assigned CMO notifying the member of his or her auto-assigned PMP, the facility must fax the *State Psychiatric Hospital Care Select Disenrollment/Enrollment Form* (Figure 3.1) to MAXIMUS at (317) 238-3120 as soon as possible. MAXIMUS then places a temporary hold on the member to prevent the member from being placed in managed care during the facility stay.

A 590 Program facility can verify *Care Select* eligibility when verifying the resident’s eligibility upon admission.

Indiana Care Select

State Psychiatric Hospital Care Select Disenrollment/Enrollment Form

Facility Name _____

Facility Address _____ City _____ ZIP Code _____

Member Name _____ Member ID # _____

Date of Admission _____

We are requesting that the member below be disenrolled from *Care Select* due to admission to our facility.

Anticipated Length of Stay _____

We are requesting that the member below be re-enrolled into *Care Select* due to discharge from our facility.

Discharge Date _____

Person completing this form _____ Phone _____

Date _____

Fax: 317-238-3120

Care Select
P.O. Box 441410
Indianapolis, IN 46244-1410

January 2008

Figure 3.1 – State Psychiatric Hospital *Care Select* Disenrollment/Enrollment Form

Member Enters 590 Program Facility with Medicaid/Care Select/Hoosier Healthwise Coverage

Members between 21 and 64 Years Old

If the member is between 21 and 64 years old, the facility's social worker must notify the DFR, which will discontinue benefits due to the law that prohibits federal Medicaid reimbursement on behalf of this age group in a psychiatric facility. It is at this point that the process to start the 590 Program enrollment is to be initiated. Once the DFR has completed the process to discontinue Hoosier Healthwise benefits, the 590 Program facility faxes a copy of the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) to MAXIMUS at (317) 238-3120. Once MAXIMUS has received this fax, it places a temporary hold on the member, which prevents the member from being placed in managed care while in the 590 Program facility. The normal 590 Program enrollment process is then followed to enroll the member in the 590 Program for the duration of the member's stay.

Members Younger than 21 or Older than 65 Years

If the member is younger than 21 or older than 65 years, the member is normally eligible to remain on Traditional Medicaid. However, if the member is a *Care Select* member, the facility must fax the *State Psychiatric Hospital Care Select Disenrollment/Enrollment Form* (Figure 3.1) to MAXIMUS at (317) 238-3120. If the member is ineligible for Hoosier Healthwise, the 590 Program facility should contact the DFR to discontinue Hoosier Healthwise benefits. The normal 590 Program enrollment process is then followed to enroll the member in the 590 Program for the duration of the member's stay.

Care Select or Hoosier Healthwise Member Leaves 590 Program Facility

When a member who had *Care Select* or Hoosier Healthwise before admission is ready to be discharged from the 590 Program facility, the social worker at the 590 Program facility must ensure that the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) is submitted to the HP eligibility analyst with the expected date of release to disenroll the member from the 590 Program. The facility's social worker also must contact MAXIMUS at 1-866-963-7383 as soon as a discharge date is set. The facility coordinates with the member and/or the member's family and the *Care Select* CMO to select an appropriate PMP for the member in his or her county.

If the member had previous *Care Select* coverage, the CMO enters the PMP selection. If the member had previous Hoosier Healthwise coverage, the member's managed care entity (MCE) enters the PMP selection. If the member did not have previous IHCP coverage, the social worker at the 590 Program facility contacts the DFR to enroll the member in the IHCP. Once the member is enrolled in the IHCP, the CMO/MCE then places the PMP selection in the database within 30 days of the approval for *Care Select* or Hoosier Healthwise. Contact information for the DFR is available at in.gov/fssa/dfr.

Length of Stay

If an individual will be a resident of a 590 Program facility for **more than 30 days** and is enrolled in the IHCP, IHCP eligibility is end-dated (except for members younger than 21 or over 64 years) and the member is enrolled in the 590 Program.

If a member will be a resident of a 590 Program facility for **30 days or less** and is an IHCP member, the member **should not** be enrolled in the 590 Program, but should keep original IHCP coverage. Attending providers outside the facility must bill IHCP-covered services totaling \$150 or more to the IHCP.

Any IHCP-enrolled 590 Program provider can render services to a 590 Program member and send the claim to HP for charges totaling \$150 or more. If an individual is not enrolled in the IHCP, will be a resident of the facility for more than 30 days, and has no medical coverage, he or she can be enrolled in the 590 Program.

590 Program Enrollment/Discharge/Transfer (EDT)				
State Form 32696 (R _____) / OMPP 0747				
Please check one: New enrollment _____ Update _____		Is individual currently on Medicaid? Yes _____ No _____ If Yes, enter RID number: _____		
<i>Sections I, II, & III are to be completed by institutional facility</i>				
I. New Enrollment Information (only for first-time enrollments, updates should be entered in section III below)				
1 Entrance date	2 Last name	3 First name	4 Middle initial	
5 Name of institutional facility				
6 Street				
7 City	8 State	9 ZIP code	10 Date of birth	
11 Race: White _____ Black _____ Asian _____ American Indian _____ Multiracial _____ Other _____			12 Sex: Male _____ Female _____	
13 DOC or DMH/DDARS number	14 Social Security number (required)	15 Medicare number	16 Medicare effective date	
II. Other Health Insurance				
17 Name of policy holder		18 Relationship		
19 Name of policy	20 Policy number	21 Type of insurance	22 Start date	23 Stop date
19 Name of policy	20 Policy number	21 Type of insurance	22 Start date	23 Stop date
III. Enrollment Update Information				
24 Date of death	25 Date of release	26 Date of parole	27 (intentionally left blank for future use)	
28 Date of transfer	29 Name of institution being transferred from		30. Name of institution being transferred to	
<i>To be completed by Indiana Medicaid</i>				
Original enrollment	RID	Start date	Stop date	
Update	RID	Start date	Stop date	

590 ProgramEDT.FRM

Figure 3.2 – 590 Program Enrollment/Discharge/Transfer (EDT) Form

If the individual is not enrolled in the IHCP and has other health insurance or third-party liability (TPL), he or she can be enrolled in the 590 Program, as long as the other health insurance or TPL information is provided on the member enrollment form (590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747).

Whenever a member is enrolled in the 590 Program, HP must be informed of all TPL coverage including private insurance, TRICARE, and Medicare. Providers **must** bill liable third parties before billing the IHCP.

Note: The 30-day enrollment limitations are due to federal regulations programmed in the design of Indiana Client Eligibility System (ICES), the eligibility determination system used at the Division of Family Resources to determine a person's coverage in the IHCP.

590 Program Member Enrollment

Only 590 Program facilities can initiate 590 Program member enrollment. The following is a step-by-step process of how enrollment requests are submitted and processed:

1. The 590 Program facility verifies any existing healthcare coverage for the incoming resident, including Traditional Medicaid. If the new admission has current IHCP coverage and does not meet the criteria to remain on Traditional Medicaid, the facility's social worker must contact the DFR to request the coverage be closed to initiate coverage under the 590 Program. After any existing open IHCP coverage has been closed, the facility's social worker must advise the proper staff member to begin the process to enroll the resident in the 590 Program.
2. The 590 Program facility completes a *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) and may mail or fax the form to the HP 590 Program eligibility analyst for processing. The completed form must be faxed to (317) 488-5217 or mailed to the following address:

**HP 590 Program
P.O. Box 7262
Indianapolis, IN 46207-7262**

Any EDT form that is faxed to HP is confirmed by return fax to the facility.

3. The 590 Program eligibility analyst searches IndianaAIM to ensure any enrollment in the IHCP has been closed. The analyst verifies other health insurance and ensures the member's spend-down, Level of Care, and dual eligibility segments are closed, if any exist.
4. If the 590 Program eligibility analyst receives an EDT form and the applicant is currently enrolled in the IHCP, the 590 Program eligibility analyst sends a letter to the 590 Program facility to request that the facility's social worker contact the DFR to end-date the member's eligibility in the IHCP before coverage under the 590 Program can begin. Only a caseworker at the DFR can end-date eligibility in the IHCP. The HP 590 Program eligibility analyst notes on the EDT form that the request has been sent to the facility. The 590 Program eligibility analyst processes the eligibility for the 590 Program after the IHCP coverage is end-dated by the DFR.

Note: Traditional Medicaid eligibility end-dating becomes effective at the end of the month in which it was entered, unless a caseworker completes the update during the last 13 days of the month, in which case, the end date is the last day of the following month. Per federal regulations 42 CFR 431.211 and 42 CFR 431.213 and the Social Security Act, the closing of eligibility is an adverse action, and the member must be given 13 days' notice of an impending adverse action.

5. If the applicant is not enrolled in Traditional Medicaid, or Traditional Medicaid eligibility has been end-dated, the HP 590 Program eligibility analyst activates the member's eligibility for the 590 Program. The HP 590 Program eligibility analyst enters a start date in IndianaAIM. The start date

must be a date following the date Traditional Medicaid eligibility was end-dated or the date the member entered the facility, if the member did not have prior Traditional Medicaid coverage.

6. When the start date and eligibility have been updated in *IndianaAIM*, the HP 590 Program eligibility analyst records the member identification number (RID), the 590 Program start date, and the request completion date on the EDT form and faxes the form to the facility.
7. The eligibility analyst files the EDT form in the facility's individual folder.

590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R __) / OMPP 0747 Entered in IndianaAIM

When the HP 590 Program eligibility analyst receives the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R ____)* / OMPP 0747 (Figure 3.2), the analyst enters the member information from the EDT form into the *590 Program Recipient Enrollment* window in *IndianaAIM*. This form is available on the [Forms](#) page on indianamedicaid.com.

The following information is required in Section 1 of the EDT form:

- Entrance date (new enrollments)
- Last name
- First name
- Middle initial
- Date of birth
- Institution name
- Institution street address
- Institution city
- Institution state
- Institution ZIP Code
- Member sex
- Member race
- Member Social Security number
- Member Medicare number and effective date, if applicable

The following TPL (other insurance) information is necessary in Section 2, if applicable:

- Policyholder name
- Relationship
- Policy name
- Policy number
- Type of insurance
- Insurance start date
- Insurance stop date

Note: If no start or stop date is included for the TPL on the EDT form, the form is returned to the facility for completion.

The following *update* information must be completed in Section 2, if applicable:

- Date of death
- Date of release (date patient left facility on leave or final release – whichever is earlier)
- Date of transfer and name of facility being transferred to

An example of the EDT form is provided in Figure 3.2.

Transfers

The 590 Program facility uses the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) to submit transfers. When a patient is being transferred between facilities, the facilities must coordinate care. The originating facility is responsible for completing an EDT form for the member enrolled in the 590 Program and submitting it to HP. A copy of the form must be forwarded with the patient to the new facility for informational purposes. The 590 Program eligibility analyst returns a copy of the completed EDT form to both facilities to confirm the form was processed. The new facility must return the same form to HP with update information. This ensures proper tracking of the member's residency.

The 590 Program eligibility analysts enter the updates indicated on the EDT form in *IndianaAIM* using the same screens as those used for enrollment. When information is entered in *IndianaAIM*, a 590 Program eligibility analyst writes on the EDT form that the transfer is recorded, and faxes a copy to the originating facility and admitting facility. If the facility does not have a fax, the 590 Program eligibility analyst returns a copy to the facility by mail.

Discharges and Deaths of 590 Program Members

For planned discharges of 590 Program members who are IHCP-eligible, the facility's social worker works with a DFR caseworker and/or the member's family to submit the proper IHCP application 90 days before the planned discharge. This allows the member to have Traditional Medicaid coverage upon discharge. It is imperative the facility social worker and a DFR caseworker coordinate the 590 Program end date with the Traditional Medicaid start date to ensure there is no lapse in coverage. In these instances, the facility social worker must take the appropriate measures to ensure HP receives the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) (with the planned discharge date) one week before the DFR caseworker finalizes Traditional Medicaid eligibility. Traditional Medicaid eligibility cannot overlap dates that the member has active 590 Program coverage.

Coverage by the 590 Program must end the calendar day prior to the start date of Traditional Medicaid coverage. If IHCP coverage is given retroactively to the beginning of the month, the facility social worker will request the 590 Program end date be the last day of the month before the Traditional Medicaid coverage start date. Any questions about coordination of dates can be addressed to the 590 Program eligibility analysts at (317) 488-5362.

If the member actually leaves the facility on a date other than the planned discharge date, the facility notifies HP of the actual date of discharge, and a 590 Program eligibility analyst adjusts the end date as appropriate.

If the discharge is unplanned, the facility remains responsible for submitting a completed EDT form to HP on the day of discharge. The 590 Program facilities use the EDT form to submit discharges and notifications of a member's death. Because the 590 Program eligibility analyst returns a copy of the EDT form to the facility, the facility should return the same form to HP with updated information.

The 590 Program eligibility analysts use the same screens in *IndianaAIM* as those used for enrollment and enter the appropriate updates indicated on the EDT form. When information is entered in *IndianaAIM*, a 590 Program eligibility analyst writes the completion date on the EDT form and faxes a copy to the facility. If the facility does not have a fax, the 590 Program eligibility analyst returns a copy of the EDT form to the facility by mail.

Name Changes and Corrections for 590 Program Members

The 590 Program facility uses the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) to submit name changes to HP. Because the 590 Program eligibility analyst returns a copy of the EDT form to the facility, the facility should return the same form to HP with updated information. If a member has a legal name change while in a 590 Program facility, the facility must send HP the correction on the EDT form. HP receives the EDT form that includes a copy of legal name change documentation, such as marriage certificate, birth certificate, adoption papers, and so forth. Common-law marriages are **not** acknowledged by the 590 Program.

Eligibility Verification

It is necessary for all facilities to verify IHCP eligibility of individuals within the facility **before** transporting individuals to an outside provider for medical care.

Note: All providers must verify member eligibility and residency of 590 Program members before rendering services.

A family member of the member enrolled in the 590 Program or a representative of the 590 Program facility must accompany the member to any provider rendering services outside the 590 Program facility. If the member enrolled in the 590 Program is unattended, it is imperative that the rendering provider determine if the member resides in a State-owned facility. The provider must then contact the facility (contact information for 590 Program facilities is included in [Section 1, Table 1.1](#)) to verify residency.

Occasionally, a resident is discharged from a facility, and 590 Program enrollment is inadvertently not terminated. If the member is no longer in the facility, the member is no longer eligible for payment of services under the 590 Program and should be considered fee-for-service (FFS). 590 Program facility providers must contact the HP 590 Program eligibility analyst to report that eligibility should be ended. The *590 Program Member Information for Outside the 590 Program Facility (State Form 15899 (R4/7-10))* (Figure 3.3) is a form that can also accompany the member enrolled in the 590 Program to each off-site medical visit. The use of this form is not mandatory; however, use of this form is recommended, as it provides billing information necessary for the rendering provider. This form is available on the [Forms](#) page on indianamedicaid.com.

How to Verify Member Eligibility

Providers can verify eligibility by using one of the following eligibility verification methods:

- Web interChange
- Automated Voice Response (AVR) system
- Omni swipe card

Refer to [Chapter 3](#) of the *IHCP Provider Manual* for more information about eligibility verification. Benefit limitation information is also provided on all these verification methods. The *IHCP Provider Manual* is available on the [Manuals](#) page on indianamedicaid.com.

Using these systems, providers can verify member eligibility seven days a week, 24 hours a day. Routine system maintenance is scheduled during nonpeak processing hours from 4 a.m. to 5 a.m.

Claims billed for services rendered to 590 Program members who no longer reside in a 590 Program facility are subject to repayment to the IHCP.

Department of Corrections

From July 1997 through November 1997, Prison Health Services (PHS) gradually took over the 590 Program claims processing for Department of Correction (DOC) facilities.

Incarcerated individuals are no longer included in the 590 Program. Any questions about PHS or PHS payment of claims for offender services should be directed to PHS at 1-800-729-0069 or (615) 373-3100.

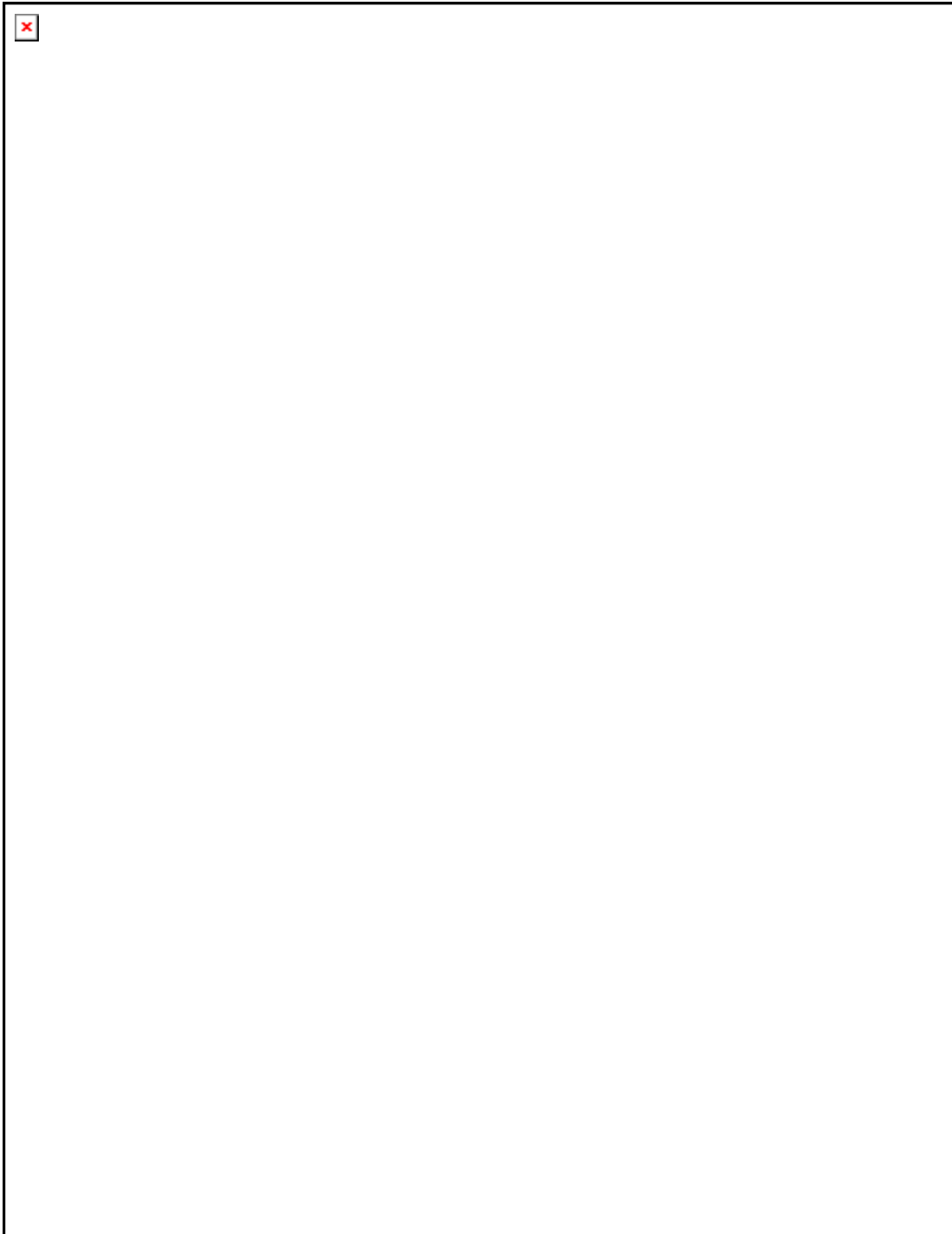


Figure 3.3 – State Form 15899 – 590 Program Member Information for Outside the 590 Program Facility

Section 4: 590 Program Services and Claim Processing

Services outside a 590 Program Facility

The following situation is the only instance in which an individual can obtain services without prior arrangements from the 590 Program facility:

- * *The member leaves for a weekend:* The facility must instruct the family how to use the 590 Program. If the member is away from the facility more than 72 hours and a family member does not call to extend the leave, the facility must terminate the member's 590 Program eligibility segment. When the member leaves for a weekend, the *590 Program Member Information for Outside the 590 Program Facility (State Form 15899 (R4/7-10))* (Figure 3.3) should be given to the family. The family should present the completed form to any provider outside the 590 Program facility if medical services are required. The *590 Program Member Information for Outside the 590 Program Facility (State Form 15899 (R4/7-10))* is available on the [Forms](#) page on indianamedicaid.com.

Note: Use of this form is not mandatory; however, the IHCP recommends its use.

There are situations where the member is **not** eligible for services outside the facility, including the following:

- *The member goes on **extended leave** (defined as more than 30 days):* Members are not eligible for coverage of the 590 Program during an extended leave. The facility must terminate the member's eligibility for the 590 Program and reenroll the member when he or she returns from leave.
- *The member goes on **short-term (therapeutic) leave** to determine if he or she can function within the community:* Members are not eligible for coverage of the 590 Program during a short-term leave. The facility must terminate the 590 Program enrollment when the individual starts short-term leave. When the 590 Program enrollment is terminated, the member can enroll in the IHCP, if he or she meets eligibility criteria.
- *The member goes to jail:* Members who leave the facility to be incarcerated are not eligible for coverage under the 590 Program. While in jail, Prison Health Services is responsible for their medical needs and services (see [Section 3](#) of this manual).

Covered Services

All IHCP-covered services are 590 Program-covered services with the exception of transportation. Any claim with a total billed amount less than \$150 must be billed to the 590 Program facility where the member resides. Any service that is \$500 or more requires prior authorization (PA) from ADVANTAGE Health Solutions. Refer to the [Indiana Health Coverage Programs Quick Reference](#) on indianamedicaid.com. In addition, please refer to the *Medicaid Rehabilitation Option (MRO) Provider Manual* located on the [Manuals](#) page on indianamedicaid.com for recent changes to MRO services.

Prior Authorization

Prior authorization procedures are located in [Chapter 6](#) of the *IHCP Provider Manual* and in *Section 5* of the *MRO Provider Manual*. The *IHCP Provider Manual* and *MRO Provider Manual* are available on the [Manuals](#) page on indianamedicaid.com.

Claim Submission

A claim for covered services must be submitted for each service instance. Services cannot be combined with services having a different date of service. The 590 Program facilities are responsible for paying claims when the total billed amount for a single date of service is less than \$150. Claims for services totaling less than \$150 must be submitted to the facility where the member resides. Claims with a billed amount totaling \$150 or more must be submitted to HP for processing. PA is required for services submitted with a billed amount of \$500 or more. Claims for the 590 Program are subject to a one-year filing limit from the date of service. Claims older than one year from the date of service cannot be paid without filing limit documentation. In addition, all other claim submission guidelines must be met. Filing limit documentation requirements are available in [Chapter 10](#) of the *IHCP Provider Manual*. The *IHCP Provider Manual* is available on the [Manuals](#) page on indianamedicaid.com.

Currently, claims can be submitted to HP electronically or on paper. Services must be billed on the appropriate claim form based on the services performed. All claims require the National Provider Identifier (NPI) of the billing provider. Paper claims should be mailed to the following address:

HP 590 Program Claims
P.O. Box 7270
Indianapolis, IN 46207-7270

*Note: See [Chapter 8](#) of the *IHCP Provider Manual* for billing instructions. The *IHCP Provider Manual* is available on the [Manuals](#) page on indianamedicaid.com.*

Claim Payment

When the member in the 590 Program is enrolled in IndianaAIM, claims are subject to the same criteria, including filing limits (one year from the date of service), as other claims with the following exceptions:

- The 590 Program does not reimburse transportation expenses.
- Only providers enrolled as 590 Program providers can render services to 590 Program members. When medical care outside the 590 Program facilities is performed by a group entity, the group and rendering provider must be enrolled in the 590 Program.
- Claims totaling less than \$150 must be submitted to the facility where the member resides.
- Claims totaling \$150 or more must be submitted to HP.
- PA is required for any procedure totaling \$500 or more for members receiving coverage through the 590 Program. For IHCP-eligible members residing in a facility, follow the procedures for PA outlined in [Chapter 6](#) of the *IHCP Provider Manual*. The *IHCP Provider Manual* is available on the [Manuals](#) page on indianamedicaid.com.

- Providers must file the appropriate claim form for the services rendered.
- The 590 Program does not cover or reimburse for targeted case management (TCM) services.

Third-Party Liability and Medicare

When a member is enrolled in the 590 Program, the 590 Program eligibility analyst checks the *590 Program Enrollment/Discharge/Transfer (EDT) Form State Form 32696 (R _____) / OMPP 0747* (Figure 3.2) for third-party liability (TPL) and/or Medicare coverage. The eligibility analyst enters any Medicare and/or third party liability (TPL) coverage in IndianaAIM. This form is available on the [Forms](#) page on indianamedicaid.com.

If a member in the 590 Program has other insurance, the other insurance carrier is considered the primary payer and must be billed prior to billing the IHCP.

If the member in the 590 Program is eligible, or becomes eligible for Medicare and/or other insurance, the 590 Program facility must notify the HP Third Party Liability Unit of the member's Medicare eligibility and/or other insurance status. Notification must be made by U.S. Mail or [Web interChange](#) via the *Eligibility Inquiry*, **TPL Update Request** link. If the notification is made by mail, it must be sent to the following address:

**HP Third Party Liability
Third Party Liability Update
P.O. Box 7262
Indianapolis, IN 46207-7262
Fax: (317) 488-5217**

Appendix A: Indiana Code IC 12-16-1, Indiana Administrative Code 470 IAC 12-1

Indiana Code IC 12-16-1

ARTICLE 16. PAYMENT FOR HEALTH SERVICES OTHER THAN MEDICAID

IC 12-16-1

Chapter 1. Medical Services for Inmates and Patients

IC 12-16-1-1

Sec. 1. As used in this chapter, “affected agency” means any of the following:

1. The department of correction.
2. The state department of health.
3. The division of mental health and addiction.
4. The division of disability, aging, and rehabilitative services.

As added by P.L.2-1992, SEC.10. Amended by P.L.40-1994, SEC.22; P.L.215-2001, SEC.46.

IC 12-16-1-2

Sec. 2. As used in this chapter, “covered medical services” refers to medical services that meet the following qualifications:

1. Cost more than one hundred fifty dollars (\$150).
2. Are provided to a committed individual or patient of an institution under the jurisdiction of an affected agency.
3. Are provided outside of an institution under the jurisdiction of an affected agency.

As added by P.L.2-1992, SEC.10.

IC 12-16-1-3

Sec. 3. (a) The division shall, with the advice of the division’s medical staff, representatives of affected agencies, and other individuals selected by the director of the division, adopt rules under *IC 4-22-2* to do the following:

1. Provide for prior review and approval of covered medical services, including special review and approval procedures for emergency covered medical services.
2. Establish limitations consistent with medical necessity on the duration of services to be provided.
3. Specify the amount of and method for reimbursement for services.
4. Specify the conditions under which payments will be denied and improper payments will be recovered.

(b) To the extent possible, rules adopted under this section must be consistent with Title XIX of the federal Social Security Act and with *IC 12-15-21-2* and *IC 12-15-21-3*.

As added by P.L.2-1992, SEC.10.

IC 12-16-1-4

Sec. 4. (a) The division shall contract with the same contractor with which the office contracts under IC 12-15-30 to provide administrative and fiscal services to implement this chapter.

(b) A contract for services is not subject to IC 5-22.

As added by P.L.2-1992, SEC.10. Amended by P.L.49-1997, SEC.45.

IC 12-16-1-5

Sec. 5. Payment for covered medical services approved by the fiscal agent shall be paid:

1. From money for the Medicaid program if the requirements of IC 12-15 are met; or
2. If a payment cannot be made under subdivision (1), from a state appropriation either made for an affected agency or for covered medical services for all affected agencies.

As added by P.L.2-1992, SEC.10.

Indiana Administrative Code 470 IAC 12-1

ARTICLE 12. PRIOR REVIEW OF OFF-SITE MEDICAL SERVICES; DEPARTMENT OF CORRECTION, STATE BOARD OF HEALTH, AND DEPARTMENT OF MENTAL HEALTH

Rule 1. Prior Review and Authorization of Requests for Off-Site Medical Services

470 IAC 12-1-1 Definitions

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-15-30; IC 12-16-1

Sec. 1. (a) “Affected agency” means the department of correction, the state board of health or the department of mental health.

(b) “Eligible individual” means any person, other than a Medicaid recipient, who requires medical or dental services while in the custody or care of an affected agency.

(c) “Health facility” means hospital, dispensary, out-patient department, practitioner’s office, dental clinic, or other appropriate treatment facility.

(d) “Medical services” means services requested by a physician (M.D. or D.O.) or dentist, including the provision of supplies and use of appropriate health facilities. The term includes medical services or supplies provided by such other licensed practitioners, institutions or suppliers as a physician may specifically prescribe. Transportation services are specifically exempted from this rule [470 IAC 12].

(e) “Covered medical services” means medical services subject to review by the department, hereinabove defined, which are provided to an eligible individual in a health facility or place other than an institution, at a total cost of more than \$150.00. Such services include any medical or dental procedure, or series of such procedures related to a specific diagnosis, illness, injury, condition, or syndrome.

(f) “Department” means the state department of public welfare (SDPW).

- (g) “Request” means written or telephonic request for approval of medical services in the form and manner specified by the department.
- (h) “Institution” means a facility housing, or responsible for, eligible individuals and operating under the jurisdiction of an affected agency.
- (i) “SDPW 590 Program element” means the licensed medical professional staff of the department charged with the responsibility to prior review requests for medical services.
- (j) “Emergency services” means those covered medical services which, by their medical nature, do not allow time for formal prior review by SDPW (see section 6 [470 IAC 12-1-6]).
- (k) “Off-site services” means medical services delivered by a provider who is outside the administrative jurisdiction of any of the institutions of the affected agencies.
- (l) “Prior review” means the professional review by the licensed medical professional staff of the SDPW 590 Program element, in advance of delivery, of a request for specific covered medical services for eligible individuals.
- (m) “590 Program contractor” means the same fiscal agent with which it contracts under *IC 12-1-7-17* [Repealed by Acts 1984, P.L.80, SECTION 10. See *IC 12-1-7-17.1*], as it provides administrative and fiscal services in support of this rule [470 IAC 12].
- (n) “Provider” means a licensed or certified practitioner or institution which provides any medical or dental service, and which is properly enrolled in this program. (Division of Family and Children; 470 IAC 12-1-1; filed Oct 26, 1983, 10:22 am: 7 IR 42; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-2 Criteria for authorization; procedural manual; private services not precluded

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 2. (a) Pursuant to *IC 12-5-7*, this rule [470 IAC 12] establishes procedures for prior review, and approval, conditional approval or denial, of requests for authorization of covered medical services.

(b) When acting upon requests, the department will consider the diagnosis and clinical summary of the individual, and the nature, duration and cost of the requested services, and will authorize only those that are requested by a physician or dentist and an official of an agency or institution, and are determined by licensed medical personnel of the department to be medically necessary and reasonable. For the purposes of this rule [470 IAC 12], medically necessary and reasonable services are those which medical staff personnel of the SDPW 590 Program element determine, under the circumstances of each case, to be essential to the restoration or maintenance of physical or mental health.

(c) Each affected agency will be responsible for developing and maintaining a procedures manual which prescribes their policies for processing the request for and delivery of medical services.

(d) This rule [470 IAC 12] does not preclude any medical service from being provided at the expense of persons or entities other than the state of Indiana. (Division of Family and Children; 470 IAC 12-1-2; filed Oct 26, 1983, 10:22 am: 7 IR 43; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-3 Request forms

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 3. (a) Requests for medical services must be made on forms specified by the department, using procedures developed by the department.

(b) Request forms shall contain such information as the department deems necessary to implement the provisions of *IC 12-5-7*.

(c) The department is not required to review any request form which is not properly signed and co-signed, and which has not been completed in its entirety. Request forms shall be returned without action if they are incomplete, illegible, or if they bear rubber-stamp; facsimile; machine-drawn, or any other substitute signature. (Division of Family and Children; *470 IAC 12-1-3*; filed Oct 26, 1983, 10:22 am: 7 IR 43; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-4 Provider agreements

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 4. A licensed provider of medical services may participate under this rule [*470 IAC 12*] upon signing a provider agreement. This agreement will not obligate the provider to participate in Title XIX of the Social Security Act. Said agreement shall include, among other provisions, assignment of a provider number, standards of provider performance, sanctions for provider abuses, and grounds for cancellation of the provider agreement. (Division of Family and Children; *470 IAC 12-1-4*; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-5 Review of requests

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 5. The department will review each request, and approve, conditionally approve, or deny same, without unnecessary delay. The department's decision will be made within ten (10) working days after it has received necessary documentation. If the original request is incomplete, or if additional information is required to clarify or supplement the request, the ten (10) day period shall begin upon receipt of such additional information. (Division of Family and Children; *470 IAC 12-1-5*; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-6 Emergency services

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 6. (a) The provider shall be compensated for emergency services if:

1. The services are provided to an eligible individual requiring the treatment of a medical or surgical emergency, the nature of which precludes submission of a request to the SDPW 590 Program element.
2. The services are provided to an eligible individual whose condition which, though not a bona fide medical or surgical emergency, is such that delay of immediate medical attention would cause deterioration of the patient's condition. This provision does not authorize any service which safely can be delayed pending SDPW 590 Program element approval of a request.

(b) Claims for emergency medical services described in section 6(a)(1) above are exempted from the prior approval provisions of this rule [470 IAC 12], but must be appropriately and clearly identified and certified as such on billing forms.

(c) During the normal work week, telephonic requests may be made for services mentioned in section 6(a)(2) of this rule [470 IAC 12], where delay of such services would cause deterioration of the patient's condition or result in unnecessary confinement or expense. For such services required during other than the normal work week, such telephonic requests shall be made on the first state working day following delivery of the service. The procedure for making telephonic requests will be specified by the department, and will include the requirement for follow-up with a formal request. Telephone approval of a service shall not serve as the basis for billing. All telephone approvals must be documented through the formal request process, and the approved documentation used to support any claims resulting from the services. (Division of Family and Children; 470 IAC 12-1-6; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-7 Authorization, denial, or conditional approval; notice

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 7. (a) A request may be approved, denied, or conditionally approved. Conditional approval authorizes a service subject to the SDPW 590 Program element limitations on the nature, extent, duration, or cost of the service.

(b) The department shall give prompt notice of any approval, denial or conditional approval to the affected agency having jurisdiction over the eligible individual, and it shall be the responsibility of such affected agency to promptly notify the eligible individual of the department's action. (Division of Family and Children; 470 IAC 12-1-7; filed Oct 26, 1983, 10:22 am: 7 IR 44; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-8 Appeals

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-16-1

Sec. 8. (a) The department's action in denying a request for covered medical services, or in granting conditional approval of such request, may be appealed by the individual in whose behalf the request was made.

(b) A person or entity who has provided any covered medical service may appeal the department's denial of compensation for same.

(c) All appeals from department action under 470 IAC 12 shall be governed by the provisions of 470 IAC 1-4. (Division of Family and Children; 470 IAC 12-1-8; filed Oct 26, 1983, 10:22 am: 7 IR 44; filed May 22, 1987, 12:45 pm: 10 IR 2284, eff Jul 1, 1987; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

470 IAC 12-1-9 Payment for services

Authority: IC 12-13-2-3; IC 12-13-5-3; IC 12-16-1-3

Affected: IC 12-15-30; IC 12-16-1

Sec. 9. (a) The rate of payment for the services and materials provided under this rule [470 IAC 12] shall be the same as that applied to Title XIX services and materials pursuant to IC 12-1-7-17 [Repealed by Acts 1984, P.L.80, SECTION 10. See IC 12-1-7-17.1], except that, when an estimate has been provided, and the estimate is lower than either the submitted charge or the Title XIX

reimbursement rate (where available), the reimbursement will be in the amount of the estimate. Payment made under this rule [470 IAC 12] shall be considered payment in full.

(b) Claims for payment shall be submitted on forms specified by the department. Claims shall be denied if they do not include all the information required by the department, or if they cover services which have not been approved by the department.

(c) A provider shall not bill this program more than the usual and customary charge to the provider's private pay customers.

(d) The procedure provided in 470 IAC 5-1-3.6 [405 IAC 1-1-5] for recovery of overpayments shall apply to the recovery of overpayments made to providers under this rule [470 IAC 12].

(e) The provisions of 470 IAC 5-5-1 [405 IAC 1-5-1] respecting maintenance of records shall apply to providers of covered medical services under this rule [470 IAC 12]. (Division of Family and Children; 470 IAC 12-1-9; filed Oct 26, 1983, 10:22 am; 7 IR 45; readopted filed Jul 12, 2001, 1:40 p.m.: 24 IR 4235)

4		I	
470 IAC 12-1.....	A-1	IC 12-16-1.....	A-1
5		introduction.....	1-1
590 Program		L	
Enrollment/Discharge/Transfer (EDT)		length of stay.....	3-3
Form.....	3-4, 3-6	M	
member enrollment.....	3-5	Medicare	4-3
member enrollment eligibility	3-1	member	
member information for outside the 590		590 Program eligibility.....	3-1
Program facility	3-10	65 years old and older	3-3
A		between 21 and 64.....	3-3
ACS	2-1	corrections	3-8
C		death	3-7
Care Select member		discharge	3-7
leaves 590 Program facility	3-3	eligibility	3-1
claim		eligibility verification.....	3-9
payment	4-2	enrollment	3-1
processing	4-1	enrollment in 590 Program.....	3-5
submission	4-2	enters 590 Program facility with IHCP	
contact information	2-1	coverage.....	3-3
contractor information.....	2-1	in 590 Program facility prior to Care Select	
corrections	3-8	enrollment.....	3-1
covered services	4-1	name change.....	3-8
D		younger than 21	3-3
death of 590 Program member	3-7	MRO services.....	4-1, 4-2
Department of Corrections	3-9	N	
discharge of 590 Program member.....	3-7	name changes	3-8
discharges	3-8	new admissions	
E		with Medicaid/Hoosier Healthwise	
EDT form	3-4, 3-6	coverage.....	3-1
590 Program	3-6	notifications of a member's death.....	3-7, 3-8
IndianaAIM	3-6	O	
electronic data transmission form.....	3-6	overview.....	1-1
eligibility verification.....	3-8	P	
F		prior authorization.....	1-1
facilities	1-2	program avenues of resolution	2-1
facility enrollment	1-3	program services	4-1
fiscal agent contractors.....	2-1	provider enrollment.....	1-3
FSSA OMPP 590 Program Facilities		R	
Agreement	1-3	revision history.....	i
H		S	
HP.....	2-1	service packages.....	2-1
		services.....	4-1

covered4-1
outside a facility4-1
State Form 15899 3-10
State Form 32696 (R _____) / OMPP 0747 3-6
State Psychiatric Hospital *Care Select*
Disenrollment/Enrollment Form.....3-1

T

third-party liability 4-3
TPL 4-3
transfers..... 3-7

V

verification of member eligibility 3-9