INDIANA HEALTH COVERAGE PROGRAMS

590 Program

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures current as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of February 13, 2017 *Core*MMIS updates as of February 13, 2017 Published: February 28, 2017	Scheduled review	FSSA and HPE

2.0	Policies and procedures as of October 1, 2017
	
	Published: January 11, 2018
		Scheduled review:
		• Edited and reorganized text as needed for clarity
		• Changed Hewlett Packard Enterprise references to DXC Technology
		• Changed RID references to Member ID
		• Updated the *Facility and Provider Enrollment Information* section and its subsections, including:
		  – Added a reference to the *Provider Enrollment* module
		  – Added information about out-of-state providers
		  – Added Provider Healthcare Portal as an enrollment option
		  – Changed LPI references to IHCP Provider ID
		• Updated the text and table in the *590 Program Contractors and Resources* section
		• Updated the *Verifying 590 Program Enrollment* section, including:
		  – Added 270/271 transactions as eligibility verification option
		  – Removed reference to the EVS systems being down for routine maintenance between 4 a.m. and 5 a.m.
			FSSA and DXC

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Version	Date	Reason for Revisions	Completed By
		• Expanded and updated the *Prior Authorization for the 590 Program* section • Updated where to mail claims and clarified which modules contain filing-limit information in the *Claim Submission* section • Updated the *Third-Party Liability and Medicare* section: – Updated the name and number of the EDT form (per current form) – Clarified that faxing is an option and updated the fax number for the TPL Unit • Updated the fax number for submitting the EDT form in the *Member Eligibility and Enrollment* section • Removed references to former enrollment/coverage in the *New Admissions Without Existing Enrollment in the IHCP* section • Updated information in the *Currently Enrolled IHCP Members* section and its subsections, including correcting the fax number for CMCS-RCP • Updated the eligibility analyst contact number in the *Discharges and Deaths of 590 Program Members* section • Updated *Figure 1 – FSSA OMPP Agreement Between 590 Facilities and OMPP* with current form • Updated *Figure 2 – Enrollment/Discharge/ Transfer (EDT) State Hospitals and 590 Program Form* with current form	

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Introduction

The 590 Program provides coverage for certain healthcare services provided to members between the ages of 21 and 64 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 exists because a federal mandate prohibits federal financial participation (FFP) for individuals between the ages of 21 and 64, in accordance with Code of Federal Regulations *42 CFR 435.1009*. This unique program ensures that these members receive appropriate care and providers are reimbursed, as appropriate, for the services they render to these members. Provider participation in the program is voluntary. However, providers must be enrolled as a 590 Program provider if they wish to be reimbursed for services they provide to this specific member population.

The 590 Program's member data is entered and maintained solely in the Core Medicaid Management Information System (*Core*MMIS) rather than in the Indiana Client Eligibility System (ICES). The 590 Program eligibility process is outlined in the *Member Eligibility and Enrollment* section of this module. 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 Program facility in which the member resides.

The following sections detail information regarding important contacts, provider enrollment, claim submission, member eligibility, and transition planning for members exiting the facility.

590 Program Facilities

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.

Table 1 lists the Indiana facilities currently enrolled in the IHCP as 590 Program facilities.

Table 1 – 590 Program Facilities

Facility Name	Address	Phone	Fax
Evansville State Hospital	3400 Lincoln Ave. Evansville, IN 47714	(812) 469-6800	(812) 469-6847
Madison State Hospital	711 Green Rd. Madison, IN 47250	(812) 265-2611	(812) 265-7394
Logansport State Hospital	1098 S. State Road 25 Logansport, IN 46947	(574) 722-4141	(574) 737-3900
Richmond State Hospital	498 NW 18th St. Richmond, IN 47374	(765) 966-0511	(765) 935-9507
Indiana Veterans' Home	3851 N. River Rd. West Lafayette, IN 4790	(765) 463-1502	(765) 497-8001
Larue D. Carter Memorial Hospital	2601 Cold Spring Rd. Indianapolis, IN 46222-2202	(317) 941-4000	(317) 941-4244

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Facility and Provider Enrollment Information

See the *Provider Enrollment* module for general information about enrolling as a provider in the IHCP. Out-of-state providers are not eligible to enroll in the 590 Program.

590 Program Facility Enrollment

Facilities that wish to become 590 Program facilities must be State-owned facilities under the direction of the FSSA, DMHA, or ISDH. Facilities are required to complete the *FSSA Office of Medicaid Policy and Planning (OMPP) Agreement Between 590 Facilities and OMPP* (Figure 1), available on the *Forms* page at indianamedicaid.com.

Enrolled 590 Program facilities are assigned an IHCP Provider ID to be used for verifying eligibility of residents.

590 Program Provider Enrollment

To receive reimbursement, any provider rendering services to 590 Program members must be enrolled in the IHCP as a 590 Program provider. When medical care outside the 590 Program facilities is performed by a group entity, both the group and rendering provider must be enrolled in the 590 Program.

During the initial enrollment process, providers can indicate their interest in participating in the 590 Program as follows:

- If enrolling online through the IHCP Provider Healthcare Portal (Portal) at portal.indianamedicaid.com, select **Yes** to the question "Participate in the 590 Program?" in the *Other IHCP Program Participation* section of the application.

- If enrolling by mail, complete the appropriate *Indiana Health Coverage Programs Enrollment and Profile Maintenance Packet* (IHCP provider packet) and check **Yes** in the Participate in the 590 Program box in the *Other IHCP Program Participation* section in Schedule B of the packet. Provider packets are available on the *Complete an IHCP Enrollment Application* page at indianamedicaid.com. Mail the completed packet and all attachments to the following address:

  IHCP Provider Enrollment
  P.O. Box 7263
  Indianapolis, IN 46207-7263

Enrolling providers are required to have obtained a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES) before completing the application. Enrolled 590 Program providers are assigned an IHCP Provider ID.

Existing IHCP providers can update their enrollment information to include 590 Program participation – either via the Portal (under **Provider Maintenance > Other Information**) or by submitting the appropriate IHCP provider packet with **Yes** selected for 590 Program participation and with all sections of the form required for an update completed (see instructions on the form).

See the *Provider Enrollment* module for general information about enrolling as a provider in the IHCP and updating provider information on file.

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590 Program Contractors and Resources

The FSSA is the State agency responsible for administration of the IHCP, which requires coordination with a number of entities. In addition, the FSSA performs medical policy functions. Questions regarding medical policy should be directed to the OMPP Policy consideration inbox at policyconsideration@fssa.in.gov.

The FSSA contracts with DXC Technology, a fiscal agent of the State, as well as other entities to perform the day-to-day program functions associated with administration of the IHCP. Current contractors and responsibilities include the following:

- DXC
    - Claim processing and related services for fee-for-service, nonpharmacy claims
    - Customer service
    - Managed care entity (MCE) and enrollment broker support
    - Provider enrollment and provider relations
    - Third-party liability

- Cooperative Managed Care Services (CMCS)
    - Prior authorization for fee-for-service, nonpharmacy services

- OptumRx
    - Claim processing and related services for fee-for-service pharmacy claims
    - Prior authorization for fee-for-service prescribed drugs
    - Pharmacy rate setting
    - Drug rebate services

- Myers and Stauffer
    - Long-term care audits
    - Nonpharmacy rate setting

Contact information for the FSSA and its contractors is available in the *IHCP Quick Reference Guide* at indianamedicaid.com.

Table 2 lists resources for providers with questions about claims or programs, or in need of clarification on a specific topic.

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Table 2 – Provider Resources

Resource	How to Access	When to Use
IHCP Bulletins and Banner Pages	View or download from the *News, Bulletins, and Banner Pages* page at indianamedicaid.com	*Bulletins* provide official notice of new and revised policies, program changes, and information about special initiatives. *Banner pages* provide official notice of changes to claim processing, billing guidance, as well as details about provider education opportunities and program reminders.
Medical Policy Manual	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers can refer to the *Medical Policy Manual* as the primary resource for IHCP coverage and reimbursement policies. Policy updates are announced in IHCP provider bulletins and added to the published manual at regular intervals.
IHCP Provider Reference Modules	View or download from the *Provider Reference Materials* page at indianamedicaid.com	Providers should always refer to the *IHCP Provider Reference Modules* as a primary reference for information about submitting claims, PA requests, and other related documents. These modules include links to billing-related code tables and answers to billing and other procedural questions. Updates to billing guidance and procedures are announced in IHCP banner pages and bulletins and added to the published reference modules at regular intervals. The most current information about a topic can be found in the posted provider reference module and in publications issued after the effective date of the module.
IHCP website	indianamedicaid.com	This website provides program information, such as banner pages, bulletins, archived newsletters, the *Indiana Health Coverage Programs Provider Reference Modules*, program contact information, schedules of training events, forms, and general program updates.
Provider Healthcare Portal	portal.indianamedicaid.com	New providers can enroll in the IHCP through the Portal. Enrolled providers can become registered Portal users to access functions such as the following: • Update provider information on file • Verify member eligibility and check benefit limits • File claims and check claim status (fee-for-service, nonpharmacy claims only) • Submit PA requests and check PA status (fee-for-service, nonpharmacy PA only)

Resource	How to Access	When to Use
Customer Assistance telephone line	Toll-free at 1-800-457-4584 Automated assistance is available 24 hours a day through the Interactive Voice Response (IVR) system. Live assistance is available 8 a.m. – 6 p.m. Eastern Time, Monday through Friday, excluding holidays.	The Customer Assistance line represents the primary access point for telephone inquiries about IHCP provider enrollment, third-party liability, claim submission and processing, policy, and coverage services. The following functions are available through the IVR system: • Verify member eligibility and check benefit limits • Check claim status (fee-for-service, nonpharmacy claims only) • Check PA status (fee-for-service, nonpharmacy PA only)
Provider Relations field consultants	Field consultant assignments and voice mail extensions are available on the *Provider Relations Field Consultants* page at indianamedicaid.com or from Customer Assistance.	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.
Written correspondence	Contact DXC through a secure message via the Provider Healthcare Portal or by mail to the following address: **DXC 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.

590 Program Coverage and Billing

The following sections include important information about 590 Program coverage, billing, and reimbursement. Providers, including rendering providers, must be enrolled in the program as a 590 Program provider for reimbursement to occur; see the *590 Program Provider Enrollment* section for details.

Covered Services

The 590 Program covers only services rendered outside the 590 Program facilities, and only when the billed amount is over $150. Any claim with a total billed amount less than $150 must be billed to the 590 Program facility in which the member resides. Any service that is $500 or more requires prior authorization (PA). See the *Prior Authorization for 590 Program Services* section.

All services covered under Traditional Medicaid are 590 Program-covered services, with the exception of transportation. Transportation is not a 590 Program-covered service. Transportation must be provided by the facility in which the member resides.

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Eligibility Verification

The facility in which the 590 Program member resides is responsible for contacting outside providers to schedule appointments for medical services. It is necessary for all facilities to verify the IHCP eligibility of individuals within the facility before transporting the individuals to an outside provider for medical care.

In addition, all providers must verify the eligibility and residency of 590 Program members before rendering services.

Verifying Residency in the 590 Program Facility

A 590 Program member should be accompanied to any off-site services. The facility social worker or other appropriate staff person should accompany a member. In the event the member is on leave, 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. In the event 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 Table 1) to verify residency. 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.

> *Note:* *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 Traditional Medicaid. The 590 Program facility provider must contact the 590 Program eligibility analyst to report that eligibility should be ended.*

The *Provider Authorization (590 Program Membership Information for Outside the 590 Program Facility) − State Form 15899 (R4/7-10),* Figure 3, is a form that can also accompany the member enrolled in the 590 Program to each off-site medical visit. Although not mandatory, the use of this form is recommended, because it provides billing information necessary for the rendering provider. This form is available on the *Forms* page at indianamedicaid.com.

Verifying 590 Program Enrollment

Providers are always responsible for verifying member eligibility prior to rendering services. 590 Program members do not receive a Hoosier Health Card at the time of admission into a 590 Program facility. Providers can verify enrollment in the 590 Program by using one of the following eligibility verification methods:

- Provider Healthcare Portal at portal.indianamedicaid.com

- Interactive Voice Response (IVR) system at 1-800-457-4584

- Approved vendor software for the 270/271 batch or interactive eligibility benefit transactions

Using these systems, providers can verify member eligibility 24 hours a day, seven days a week. All these verification methods also provide benefit limit information.

See the *Provider Healthcare Portal*, *Interactive Voice Response System*, and *Electronic Data Interchange* modules for details about using these systems. See the *Member Eligibility and Benefit Coverage* module for general information about eligibility verification. The IHCP provider reference modules are available on the *Provider Reference Materials* page at indianamedicaid.com.

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Coverage While the Member Is Away from the 590 Program Facility

The only situation in which a member can obtain services under the 590 Program without prior arrangements from the 590 Program facility is when the member is on leave for a weekend. 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 enrollment. When the member leaves for a weekend, the facility must instruct the family how to use the 590 Program. The *590 Program Membership Information for Outside the 590 Program Facility − State Form 15899 (R4/7-10)* ([Figure 3](#)), available on the *[Forms](#)* page at indianamedicaid.com, 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.

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

In the following situations, a member is **not eligible** for 590 Program coverage of services outside the facility:

- *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 enrollment in 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 member's 590 Program enrollment when the member starts short-term leave. After the member's 590 Program enrollment is terminated, the member can reenroll in the IHCP if he or she meets the eligibility criteria.

- *The member goes to jail.* Members who leave the facility to be incarcerated are not eligible for coverage under the 590 Program.

Prior Authorization for 590 Program Services

PA requirements for members of the 590 Program differ from Traditional Medicaid PA requirements. The following PA requirements apply for the 590 Program:

- PA is required for any service that the provider estimates is $500 or more, regardless of whether the service requires PA in the Traditional Medicaid program.

- PA is not required, unless provided by an out-of-state provider, for any service that the provider estimates is less than $500, regardless of whether the service requires PA in the Traditional Medicaid program.

- Transportation is **not** a covered service; therefore, PA cannot be granted for 590 Program transportation requests.

590 Program providers must submit PA requests for nonpharmacy expenses to Cooperative Managed Care Services (CMCS) via the Portal, 278 electronic transaction, phone, fax, or mail, following the procedures described in the *[Prior Authorization](#)* module. PA requests for pharmacy expenses must be directed to OptumRx according to the procedures described in the *[Pharmacy Services](#)* module. See the *[IHCP Quick Reference Guide](#)* at indianamedicaid.com for CMCS and OptumRx contact information.

Services for 590 Program members may be prior authorized retroactively.

Claim Submission

A separate claim for covered services must be submitted for each service instance. Claims cannot report span dates, and multiple dates of service cannot be lumped together on one claim form.

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 in which the member resides. Claims with a billed amount totaling $150 or more must be submitted to DXC (for nonpharmacy claims) or OptumRx (for pharmacy claims) for processing. PA is required for services submitted with billed amounts of $500 or more.

Claims can be submitted electronically or on paper. Services must be billed on the appropriate claim type (professional, institutional, dental, or pharmacy) based on the services performed. All claims require the National Provider Identifier (NPI) of the billing provider.

Paper claims for services totaling $150 or more should be mailed to DXC (nonpharmacy) or OptumRx (pharmacy) at the appropriate claim address for the claim type. See the *IHCP Quick Reference Guide* for the claim addresses.

> *Note:*   *Except as outlined in this module, 590 Program claims are subject to the same billing and reimbursement criteria as other claims. See the Claim Submission and Processing module for billing instructions for professional, institutional, and dental claims. See the Pharmacy Services module for billing instructions for pharmacy claims.*

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 proper supporting documentation. In addition, all other claim submission guidelines must be met. See the *Claim Submission and Processing* module for information about claim filing limits and exceptions. See the *Claim Adjustments* module for information about claim adjustment filing limits.

Claim Payment

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

- 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 in which the member resides.

- Claims totaling $150 or more must be submitted to DXC (for nonpharmacy services) or OptumRx (for pharmacy services).

- 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 any procedure totaling $500 or more for members receiving coverage through the 590 Program. See the *Prior Authorization for the 590 Program* section.

- 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 in which the member resides.

- Providers must file the appropriate claim type for the services rendered.

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Third-Party Liability and Medicare

If a member in the 590 Program has other insurance, including private insurance, TRICARE, and Medicare, the other insurance carrier is considered the primary payer and must be billed before billing the IHCP.

When a member is enrolled in the 590 Program, the 590 Program eligibility analyst checks the *Enrollment/Discharge/Transfer (EDT) State Hospitals and 590 Program − State Form 32696 (R3/2-16)/ OMPP 0747* ([Figure 2](#)), known as the EDT form, for third-party liability (TPL) and Medicare coverage. The eligibility analyst enters any TPL and Medicare coverage in *Core*MMIS. This form is available on the *[Forms](#)* page at indianamedicaid.com.

If the member in the 590 Program is eligible or becomes eligible for Medicare or other insurance, the 590 Program facility must notify the DXC Third Party Liability Unit of the member's Medicare eligibility and other insurance status. Notification must be made via the Portal or by U.S. mail or fax.

If the notification is made by mail or fax, it must be sent to DXC at the following address or fax:

Third Party Liability Update
P.O. Box 7262
Indianapolis, IN 46207-7262

Fax: 1-866-667-6579

See the *[Third Party Liability](#)* module for more information.

Member Eligibility and Enrollment

If an individual is expected to be a resident of a 590 Program facility for 30 days or less and is a current IHCP member, the member **should not** be enrolled in the 590 Program but should keep his or her current IHCP coverage. If the individual does not currently have IHCP coverage, the facility should work with their Division of Family Resources (DFR) liaison to ensure that the individual becomes enrolled in the IHCP under the appropriate enrollment category, if eligible. This process ensures continuity of care after the individual is released from the facility.

If an individual is expected to be a resident of a 590 Program facility for **more than 30 days** and is between the ages of 21 and 64, he or she may be placed in the 590 Program. The following instructions apply. Any facility that is placing a member in the 590 Program must complete an Enrollment/Discharge/ Transfer (EDT) form ([Figure 2](#)) and may mail or fax the form to the 590 Program eligibility analyst for processing. The completed form must be submitted to DXC at the following address or fax number:

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

Fax: 1-866-667-658

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

The 590 Program eligibility analyst activates the member's eligibility for the program. The eligibility analyst also enters a start date in *Core*MMIS. The start date must be a date following the date the member's previous eligibility was end-dated (or the date the member entered the facility, if the member did not have prior IHCP coverage).

When the start date and eligibility have been updated in *Core*MMIS, the eligibility analyst records the Member ID (also known as RID), the 590 Program start date, and the request completion date on the EDT form and faxes the form to the facility. The eligibility analyst files the EDT form in the facility's individual folder.

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> *Note:*   *When a member is enrolled in the 590 Program, DXC must be informed of all TPL coverage, including private insurance, TRICARE, and Medicare. Providers **must** bill liable third parties before billing the IHCP. See the [Third-Party Liability and Medicare](#) section for more information.*

New Admissions Without Existing Enrollment in the IHCP

Upon an individual's admission into a 590 Program facility, the facility should verify eligibility to determine whether there is any current coverage through the IHCP.

If the individual is between the ages of 21 and 64 and is not a current IHCP member, the facility must submit an Enrollment/Discharge/Transfer (EDT) form ([Figure 2](#)) to DXC. An eligibility analyst then verifies the individual's information in ICES manually and adds the member in *Core*MMIS and associates the member with the requesting facility. When a member's enrollment in the 590 Program is completed in *Core*MMIS, the Member ID is forwarded to the facility for its records. A Hoosier Health Card is **not** issued to a 590 Program member. The 590 Program eligibility analyst answers provider questions about the 590 Program and interacts with FSSA staff related to 590 Program issues.

If the individual entering the facility is under the age of 21 or over the age of 64 and has no IHCP coverage, the facility will work with their respective DFR liaison to determine eligibility for Traditional Medicaid. If the application is accepted, the individual will receive benefits associated with Traditional Medicaid. The individual will not be enrolled into the 590 Program.

> *Note:*   *Individuals without IHCP coverage but with other health insurance or third-party liability (TPL) can be enrolled in the 590 Program as long as the other health insurance or TPL information is provided on the EDT form.*

Currently Enrolled IHCP Members

As with all new admissions, the facility should first verify eligibility. If the individual entering the facility has current IHCP coverage, the facility then contacts their respective DFR liaison to notify the DFR of the member's admittance into the 590 Program facility, which may result in a change to the member's eligibility status. Additional steps are outlined in the following sections, dependent on the member's program enrollment and age at the time of entry into the facility.

Managed Care

If a member is enrolled in a managed care program (such as Hoosier Healthwise or Hoosier Care Connect), and the anticipated length of stay is over 30 days, the facility must fax the Enrollment/Discharge/Transfer (EDT) form ([Figure 2](#)) to the enrollment broker, MAXIMUS, at (317) 238-3120 as soon as possible to remove that individual from his or her managed care plan. An individual, regardless of age, may not be a resident of a 590 Program facility and participate in managed care. The facility must also contact their DFR liaison so that the DFR can suspend the member's current managed care enrollment.

- If the member is between the ages of 21 and 64 – After the EDT form has been submitted to the enrollment broker and the DFR has suspended the enrollment, the facility must fax the EDT form to DXC. The 590 Program eligibility analyst processes the eligibility for the 590 Program after the DFR suspends the managed care coverage.

- If the member is under the age of 21 or over the age of 64 – After the facility submits the EDT form to MAXIMUS to remove the member from managed care, the facility then works with the DFR to place the member in the appropriate eligibility category for Traditional Medicaid. The member will not be placed in the 590 Program.

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Healthy Indiana Plan (HIP) members should be directed to an alternative psychiatric treatment facility, if possible. In the event a HIP member does enter a 590 Program facility, the member's enrollment with the HIP MCE must be end-dated if the anticipated length of stay will exceed 30 days. The facility should follow the same procedures as with other managed care members. The facility must fax the EDT form to MAXIMUS at (317) 238-3120 as soon as possible to remove that individual from his or her managed care plan. Members between the ages of 21 and 64 should be placed in the 590 Program, while those under 21 or over 64 will be transferred to Traditional Medicaid.

Traditional Medicaid

Traditional Medicaid coverage is identified in the Portal, IVR, or 271 electronic transaction as either the Full Medicaid or Package A – Standard Plan benefit plan with no managed care assignment.

Members under the age of 21 or over the age of 64 who are enrolled in Traditional Medicaid may continue to stay on Traditional Medicaid and will not be enrolled in the 590 Program.

> *Note:*   *In accordance with Indiana Administrative Code 405 IAC 5-20-1(b), the member may remain on Traditional Medicaid until his or her22nd birthday if he or she began receiving inpatient psychiatric services immediately before his or her 21st birthday.*

For Traditional Medicaid members between the ages of 21 and 64, the facility will contact their DFR liaison to suspend their current eligibility and submit the Enrollment/Discharge/Transfer (EDT) form (Figure 2) to DXC so the member will be placed in the 590 Program.

Right Choices Program

If the member is enrolled in the Right Choices Program (RCP), the 590 Program facility needs to contact the member's RCP Administrator to report that the member is now in a 590 Program facility:

- For HIP, Hoosier Care Connect, and Hoosier Healthwise members, contact the member's managed care plan:
    - Anthem: 1-866-902-1690, option 3
    - CareSource: 1-800-488-0134 (telephone); 1-877-603-5119 (fax)
    - MHS: 1-877-647-4848
    - MDwise: 1-800-356-1204

- For Traditional Medicaid members, contact:
    - CMCS: 1-800-784-3981 (telephone); 1-877-392-6894 (fax)

When the 590 Program facility reports that the member is now in a 590 Program facility, the member's Right Choices Program will be ended while the member remains a resident at the 590 Program facility. When the member is discharged from the 590 Program facility, the facility again contacts the same RCP Administrator to advise that the member is being discharged from the 590 Program facility.

Transfers

The 590 Program facility uses the Enrollment/Discharge/Transfer (EDT) form (Figure 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 DXC. A copy of the form must be sent 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 that the form was processed. The new facility must return the same form to DXC with updated information. This process ensures proper tracking of the member's residency.

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The eligibility analyst enters the updates indicated on the EDT form in *Core*MMIS. After the information is entered in *Core*MMIS, the eligibility analyst writes on the EDT form that the transfer is recorded and faxes a copy to the originating facility and the admitting facility. If the facility does not have a fax, the eligibility analyst sends a copy to the facility by mail.

Discharges and Deaths of 590 Program Members

For planned discharges of 590 Program members who are Medicaid-eligible, the facility's social worker coordinates with the assigned DFR liaison and the member's family to submit the proper IHCP application 90 days before the planned discharge. This process allows the member to have IHCP coverage upon discharge. It is imperative that the facility social worker and the DFR liaison coordinate the 590 Program end date with the new IHCP eligibility start date to ensure that there is no lapse in coverage. In these instances, the facility social worker must take the appropriate measures to ensure that DXC receives the Enrollment/Discharge/Transfer (EDT) form (Figure 2) – with the planned discharge date – one week before the DFR caseworker finalizes Medicaid eligibility. Medicaid eligibility cannot overlap dates that the member has active 590 Program coverage.

Coverage by the 590 Program must end the calendar day before the start date of Medicaid coverage. If Medicaid coverage is given retroactively to the beginning of the month, the facility social worker requests that the 590 Program end date be the last day of the month before the Medicaid coverage start date. Any questions about coordination of dates can be addressed with a DXC eligibility analyst at (317) 617-9107.

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

If the discharge is unplanned, or in the case of a member's death, the facility remains responsible for submitting a completed EDT form to DXC 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 DXC with updated information.

The 590 Program eligibility analyst enters the appropriate updates indicated on the EDT form into *Core*MMIS. After entering the information in *Core*MMIS, the 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 eligibility analyst sends 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 Enrollment/Discharge/Transfer (EDT) form (Figure 2) to submit name changes to DXC. Because the 590 Program eligibility analyst returns a copy of the EDT form to the facility, the facility should return the same form to DXC with updated information. If a member has a legal name change while in a 590 Program facility, the facility must send DXC the correction on the EDT form along with a copy of legal name change documentation, such as a marriage certificate, birth certificate, adoption papers, and so forth. Common-law marriages are **not** acknowledged by the 590 Program.

Figure 1 – FSSA OMPP Agreement Between 590 Facilities and OMPP

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 ID for the exclusive purpose of obtaining 590 Program eligibility information. Eligibility information is available using the Interactive Voice Response (IVR) system, Provider Healthcare Portal, or web solution, collectively referred to as the Eligibility Verification System (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 ID, 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

April 2017

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Figure 2 – Enrollment/Discharge/Transfer (EDT) State Hospitals and 590 Program Form

ENROLLMENT / DISCHARGE / TRANSFER (EDT) STATE HOSPITALS AND 590 PROGRAM
State Form 32696 (R3 / 2-16) / OMPP 0747
FAMILY AND SOCIAL SERVICES ADMINISTRATION

Sections I, II, and III are to be completed by the institutional facility.

Please check one: ☐ New enrollment ☐ Update	Is the individual currently on Medicaid? ☐ Yes ☐ No	If Yes, enter RID number

I. NEW ENROLLMENT INFORMATION (Only for first-time enrollments; updates should be entered in section III below.)

1. Entrance date (month, day, year)	2. Last name	3. First name	4. Middle initial

5. Name of institutional facility

6. Address (number and street)

7. City	8. State	9. ZIP code	10. Date of birth (month, day, year)

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 (month, day, year)

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 (month, day, year)	23. Stop date (month, day, year)
19. Name of policy	20. Policy number	21. Type of insurance	22. Start date (month, day, year)	23. Stop date (month, day, year)

III. ENROLLMENT UPDATE INFORMATION

24. Date of death (month, day, year)	25. Date of release (month, day, year)	26. Date of parole (month, day, year)	27. (Intentionally left blank for future use.)
28. Date of transfer (month, day, year)	29. Name of institution being transferred from		29. Name of institution being transferred to

TO BE COMPLETED BY INDIANA MEDICAID.

Original enrollment	RID number	Start date (month, day, year)	Stop date (month, day, year)
Update	RID number	Start date (month, day, year)	Stop date (month, day, year)

14

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Figure 3 – State Form 15899 – Provider Authorization (590 Program Membership Information for Outside the 590 Program Facility)

PROVIDER AUTHORIZATION
State Form 15899 (R4 / 7-10) / OMPP 2021
FAMILY AND SOCIAL SERVICES ADMINISTRATION

Name of provider	Date (*month, day, year*)

FACILITY INFORMATION

Name of facility

Department / division

Address of facility (*number and street, city, state, and ZIP code*)

Telephone number	Fax number	TDD number
( )	( )	( )

PATIENT INFORMATION

Name of patient	Date of birth (*month, day, year*)

Type of commitment	Health care representative / guardian ☐ Yes ☐ No	Other

Insurance number	Medicare number	Medicaid number

590 identification number (*do not use if patient has a Medicaid number*)

AUTHORIZATION

Name of authorized person	Title of authorized person

As an authorized person at the above named facility, I authorize the staff of your facility to provide medical services for the patient named above and referred to your care for services not available in our hospital, according to IC12-27-5-1 and IC 12-27-5-2.

If the charge is less than $150, will assume responsibility for charges incurred by the patient after all Medicare, Medicaid, insurance, etc., have been applied. When services are complete, please submit your statement in duplicate so your payment can be processed.

If the charge is $150 or more, the 590 Program, administered by the Office of Medicaid Policy and Planning (OMPP) should be billed after all Medicare, insurance, etc., have been supplied. Prior approval by the 590 Program is required if charges are $500 or over. Emergencies do not require prior authorization; however, if the patient has not been enrolled in the 590 Program, the hospital will apply for an identification number.

Questions regarding claims submitted to the 590 Program should be directed to the 590 Program Eligibility Analyst, HP Member and Provider Relations Unit, P.O. Box 7262, Indianapolis, IN 46207-7262, telephone (317) 655-3240 or 1-800-577-1278.

Signature of authorized person	Date (*month, day, year*)

INFORMATION REGARDING REFUSAL OF TREATMENT

The Indiana Code addresses the process used for a patient's refusal of treatment as follows:

IC 12-27-5-1 **Voluntary patients; right to refuse treatment**
Sec. 1. An adult voluntary patient who is not adjudicated mentally incompetent may refuse to submit to treatment or a habilitation program.
As added by P.L.2-1992, SEC.21.

IC- 12-27-5-2 **Involuntary patients, petition to refuse treatment**
Sec.2. (a) An involuntary patient who wants to refuse to submit to treatment or a habilitation program may petition the committing court or hearing officer for consideration of the treatment or program.
(b) In the absence of a petition made under subsection (a), the service provider may proceed with the proposed treatment or habilitation program.
As added by P.L.2-1992, SEC.21.

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