INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

590 Program

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Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures 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	Semiannual review	FSSA and HPE

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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 prohibiting 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, the provider must be enrolled as a 590 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 *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. Only 590-enrolled providers can render services to members enrolled in the 590 Program.

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

590 Program Facilities

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 N.W. 18th St. Richmond, IN 47374	(765) 966-0511	(765) 935-9507
Indiana Veterans Home	3851 N. River Rd. West Lafayette, IN 47906	(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

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.

Provider Enrollment Information

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) 590 Program Facilities Agreement* (Figure 1). Enrolled 590 Program facilities are assigned an IHCP provider number to be used for eligibility verification of residents. The *FSSA Office of Medicaid Policy and Planning (OMPP) 590 Program Facilities Agreement* is available on the *Forms* page at indianamedicaid.com.

590 Program Provider Enrollment

To receive reimbursement, any provider rendering services to 590 Program members must be enrolled in the IHCP as a 590 provider. 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) before 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 *IHCP Provider Enrollment Transactions* page at indianamedicaid.com.

590 Program Contractor and Contact Information

Fiscal Agent Contractors

The FSSA contracts with Hewlett Packard Enterprise (HPE), a fiscal agent of the State, to perform the day-to-day program functions associated with administration of the IHCP.

The current fiscal agent service packages includes:

- HPE
  - Claims Processing and Related Services
  - Customer Service
  - Managed Care
  - Provider Relations
  - Third-Party Liability
  - Waiver
- Cooperative Managed Care Services (CMCS)
  - Prior authorization (PA)
- OptumRx
  - OptumRx Drug Rebate Services
  - Prior authorization for prescribed drugs
- Myers and Stauffer
  - Long-Term Care

In addition to the services listed, the FSSA performs medical policy functions. Questions regarding medical policy should be directed to the OMPP Policy consideration inbox at policyconsideration@fssa.in.gov.

590 Program Avenues of Resolution

The information in Table 2 is intended to help providers contact the appropriate area to best answer an inquiry. When providers have questions about claims or the IHCP, or require clarification about a specific topic, the following avenues of resolution, listed in Table 2 in order of use, are available.

Table 2 – Provider Avenues of Resolution

Area of Client Services	Contact Information	When to Contact
IHCP Provider Reference modules	View or download from the *Provider Reference Materials* page at indianamedicaid.com Send request in writing to HPE at the following address: **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 *Indiana Health Coverage Programs Provider Reference modules* as a primary reference for submitting and processing claims, PA requests, and other related documents. These modules contain detailed instructions for claims submission and are 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, archived newsletters, the *Indiana Health Coverage Programs Provider Reference* modules and all program supplemental modules, program contact information, schedules of training events, forms, and general program updates.
Customer Assistance	Toll-free at 1-800-577-1278 8 a.m. – 6 p.m. Eastern Time Monday through Friday, excluding holidays	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 at indianamedicaid.com or call 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. Consultants can also provide additional information about electronic claims capture (ECC).
Written Correspondence	Contact HPE at the following address: **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.

Area of Client Services	Contact Information	When to Contact
Claim Status	Claim status is accessible using the Provider Healthcare Portal at indianamedicaid.com. Providers can also obtain claim status through the Interactive Voice Response (IVR) system toll-free at 1-800-577-1278 (Option 3). Both systems provide access 24 hours a day, seven days a week.	As needed

Claim Submission and Claim Processing

Services provided to members enrolled in the 590 Program are unique from other programs in IHCP. Important claim submission and processing information is detailed in the following sections. Providers, including rendering providers, must be enrolled in the program as a 590 provider for reimbursement to occur.

Eligibility Verification

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.

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

A 590 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.

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). The 590 Program facility provider must contact the HPE 590 Program eligibility analyst to report that eligibility should be ended. The *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.

How to Verify Member Eligibility

Providers are always responsible for verifying member eligibility prior to rendering services. A 590 member will not receive a Hoosier Health Card at the time of admission into a 590 facility. The facility in which the member resides is responsible for contacting the provider to schedule appointments for medical services. Providers can verify eligibility by using one of the following eligibility verification methods:

- The Provider Healthcare Portal
- Interactive Voice Response (IVR) system

See the *Member Eligibility and Benefit Coverage* module for more information about eligibility verification. Benefit limitation information is also provided on all these verification methods. The *IHCP Provider Reference* modules are available on the *Provider Reference Materials* page at indianamedicaid.com.

Using these systems, providers can verify member eligibility 23 hours a day, seven days a week. 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.

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 Membership Information for Outside the 590 Program Facility − State Form 15899 (R4/7-10,* Figure 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 Membership Information for Outside the 590 Program Facility − State Form 15899 (R4/7-10)* is available on the *Forms* page at indianamedicaid.com.

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

In the following situations, a member is not eligible for 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.

Covered Services

All IHCP-covered services are 590 Program-covered services with the exception of transportation. Transportation is not a 590 Program-covered service. 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) from CMCS. Prescription drug services costing more than $500 require PA from OptumRx. See the *IHCP Quick Reference Guide* at indianamedicaid.com. In addition, see the *Medicaid Rehabilitation Option Services* module for information specific to MRO services.

Prior Authorization

Prior authorization procedures are located in the *Prior Authorization* module and in *Section 5* of the *Medicaid Rehabilitation Option Services* module. Prior authorization procedures for pharmacy can be found in the *Pharmacy Services* module.

Claim Submission

A claim for covered services must be submitted for each service instance. Services cannot be combined with services having different dates 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 in which the member resides. Claims with a billed amount totaling $150 or more must be submitted to HPE for processing. PA is required for services submitted with billed amounts 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 the *Claim Adjustments* module.

Currently, claims can be submitted to HPE 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 HPE at the following address:

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

Note:	*See the Claim Submission and Processing module for billing instructions.*

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 HPE.
- 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. For IHCP-eligible members residing in a facility, follow the procedures for PA outlined in the *Prior Authorization* module. For information on pharmacy prior authorization, see the *Pharmacy Services* module.
- 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 form for the services rendered.

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 2) 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 a member in the 590 Program has other insurance, the other insurance carrier is considered the primary payer and must be billed before billing the IHCP.

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

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

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

Member Eligibility and Enrollment

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 his or her original IHCP coverage. If the individual does not currently have IHCP coverage, the facility should work with their DFR liaison to ensure the individual becomes enrolled in IHCP under the appropriate enrollment category, if eligible. This ensures continuity of care once the individual is released from the facility.

If an individual will be a resident of a 590 Program facility for **more than 30 days**, the following instructions apply. If an individual is between the age of 21 and 64 and will be a resident of the facility for more than 30 days, he may be placed into the 590 program. Any facility that is placing a member on 590 must complete a *590 Program Enrollment/Discharge/Transfer (EDT) Form − State Form 32696 (R _____)/OMPP 0747* (Figure 2) and may mail or fax the form to the HPE 590 Program eligibility analyst for processing. The completed form must be faxed to (317) 488-5217 or mailed to HPE at the following address:

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

Any EDT form that is faxed to HPE is confirmed by return fax to the facility. The HPE 590 Program eligibility analyst activates the member's eligibility for the program. The HPE 590 Program eligibility analyst also enters a start date in *Core*MMIS. The start date must be a date following the date their 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 HPE 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.

The eligibility analyst files the EDT form in the facility's individual folder.

New Admissions without Existing Enrollment in the IHCP

For persons between the ages of 21 and 64, upon an individual's admission into a 590 facility, the facility should verify eligibility and determine if there is any prior or current coverage through IHCP. If the individual is eligible and the individual is not a current or former IHCP member, the facility must submit a *590 Program Enrollment/Discharge/Transfer (EDT)* form (Figure 2) to HPE. An HPE eligibility analyst will verify the member's information in ICES manually and use the Add Member panel to add the member in *Core*MMIS. The eligibility analyst will also use the 590 Facility panel to associate the member to the requesting facility. When a member's eligibility for the 590 Program is completed in *Core*MMIS, the RID is forwarded to the facility for its records. A Hoosier Health Card is **not** issued to a 590 member. The HPE 590 Program eligibility analyst answers provider questions about the 590 Program and interacts with FSSA staff related to 590 Program issues.

If an individual, under the age of 21 or over the age of 64, enters the facility and has no prior 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 590.

Currently Enrolled IHCP Members

As with all new admissions, the facility should first verify eligibility. The facility then contacts their respective DFR liaison in order to notify the DFR of the member's admittance into the 590 facility, which may result in a change to the member's eligibility status. Additional steps are outlined below, 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, the facility must fax the EDT form to the enrollment broker, Maximus, at (317) 238-3120 as soon as possible in order to remove that individual from their managed care plan. An individual, regardless of their age, may not be a resident of a 590 facility and participate in managed care. The facility must also contact their DFR liaison so that the DFR can suspend the member's current eligibility. If the member is between the ages of 21 and 64, the enrollment must be suspended prior to submitting the EDT form to HPE. The 590 Program eligibility analyst processes the eligibility for the 590 Program after the IHCP coverage is suspended by the DFR.

For members under the age of 21 or over the age of 64, the facility will submit the EDT form to Maximus in order to remove the member from managed care. The facility will then work with the DFR to place the member in the appropriate eligibility category for Traditional Medicaid. The member will not be placed into 590.

Healthy Indiana Plan (HIP)

HIP members shall be directed to an alternative psychiatric treatment facility, if possible. In the event a HIP member enters a 590 facility, the member's enrollment with the HIP managed care entity (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 their managed care plan. Members between the ages of 21 and 64 should be placed on 590, while those under 21 or over 64 will transfer to Traditional Medicaid.

Traditional Medicaid

For individuals under the age of 21 or over the age of 64 who are on Traditional Medicaid, they may continue to stay on Traditional Medicaid and will not be enrolled into 590. In accordance with *Indiana Administrative Code 405 IAC 5-20-1(b)*, the member may remain on Traditional Medicaid until his or her

twenty-second birthday, if he or she has begun receiving inpatient psychiatric services immediately before his or her twenty-first birthday. For members between the ages of 21 and 64, the facility will contact their DFR liaison to suspend their current eligibility and submit the EDT form to HPE so the member will be placed into the 590 program.

Right Choices Program

If the member is enrolled in the Right Choices Program, the 590 Program facility needs to call the member's health plan and select the option for the Right Choices Program. For HIP, Hoosier Care Connect, and Hoosier Healthwise, call the member's managed care plan:

Anthem: 1-866-902-1690, option 3

MHS: 1-877-647-4848

MDwise: 1-800-356-1204

CareSource: 1-800-488-0134 (telephone) 1-877-603-5119 (fax)

For fee-for-service members, contact:
CMCS: 1-800-784-3981 (telephone)
1-800-689-2759 (fax)

The 590 Program facility must report that the member is now in a 590 Program facility. At that time, the 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 health plan to advise that the member is being discharged from the 590 Program facility.

Third Party Liability

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, HPE must be informed of all TPL coverage including private insurance, TRICARE, and Medicare. Providers **must** bill liable third parties before billing the IHCP.

Transfers

The 590 Program facility uses the *590 Program Enrollment/Discharge/Transfer (EDT) Form − State Form 32696 (R _____)/OMPP 0747* (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 HPE. 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 the form was processed. The new facility must return the same form to HPE with updated information. This process ensures proper tracking of the member's residency.

The 590 Program eligibility analyst enters the updates indicated on the EDT form in *Core*MMIS using the same screens as those used for enrollment. When information is entered in *Core*MMIS, 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 coordinates with their assigned DFR liaison and the member's family to submit the proper IHCP application 90 days before the planned discharge. This 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 there is no lapse in coverage. In these instances, the facility social worker must take the appropriate measures to ensure HPE receives the *590 Program Enrollment/Discharge/Transfer (EDT) Form − State Form 32696 (R _____)/OMPP 0747* (Figure 2) (with the planned discharge date) one week before the DFR caseworker finalizes Traditional Medicaid eligibility. IHCP 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 Traditional Medicaid coverage. If IHCP 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 Traditional Medicaid coverage start date. Any questions about coordination of dates can be addressed with an HPE eligibility analyst at 1-800-457-4510, extension 4885308 or 4885021.

If the member leaves the facility on a date other than the planned discharge date, the facility notifies HPE 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 HPE 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 HPE with updated information.

The 590 Program eligibility analyst uses the same screens in *Core*MMIS as those used for enrollment and enters the appropriate updates indicated on the EDT form. After entering the information in *Core*MMIS, the 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 2) to submit name changes to HPE. Because the 590 Program eligibility analyst returns a copy of the EDT form to the facility, the facility should return the same form to HPE with updated information. If a member has a legal name change while in a 590 Program facility, the facility must send HPE 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 590 Program Facilities Agreement

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

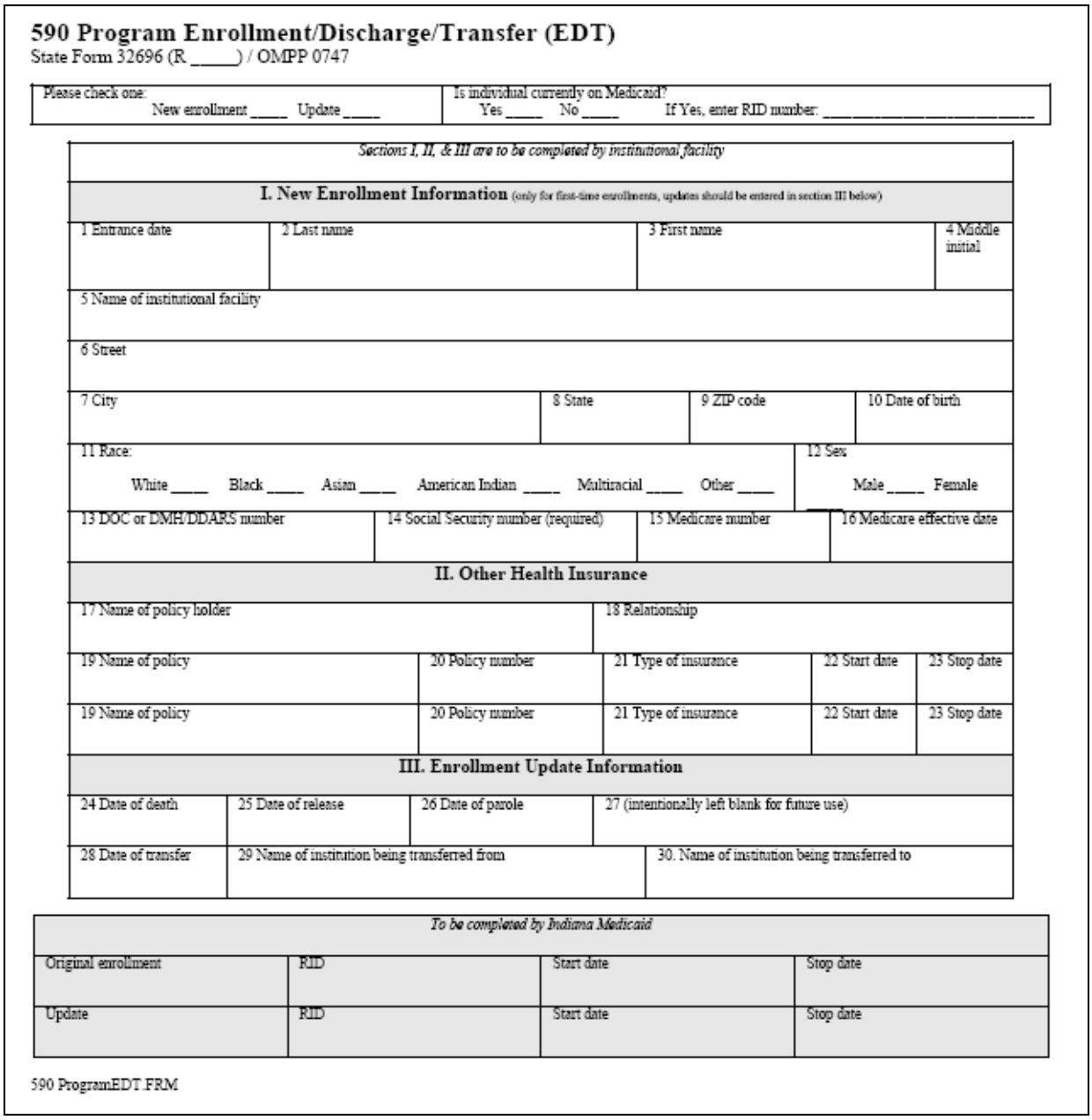
Name of Authorized Representative – Signature

Title

Date of Signature

Facility Address Phone Number

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



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: _____

Sections I, II, & III are to be completed by institutional facility

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

To be completed by Indiana Medicaid

Original enrollment	RID	Start date	Stop date
Update	RID	Start date	Stop date

590 ProgramEDT.FRM

Figure 3 – State Form 15899 – 590 Program Membership Information for Outside the 590 Program Facility

Reset Form

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.