



INDIANA HEALTH COVERAGE
PROGRAMS PROVIDER MANUAL

Chapter 1: General Information

Chapter 1: Revision History

Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
Version 1.0	September, 1999 Policies and procedures are current as of March 1, 1999	New Manual	EDS Document Management Unit
Version 2.0	June 2001 Policies and procedures are current as of June 1, 2000	Chapters 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, and Appendix A	EDS Document Management Unit
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Version 9.1	September 2009 Policies and procedures as of July 1, 2009	Semiannual Update	EDS Provider Relations and Publications Units
Version 10.0	March 4, 2010 Policies and procedures as of January 1, 2010	Semiannual Update	HP Provider Relations and Publications Units
Version 10.0	March 30, 2010	Correction: <ul style="list-style-type: none"> Updated Anthem's claim submission address 	HP Provider Relations and Publications Units
Version 10.1	August 26, 2010 Policies and procedures as of July 1, 2010	Semiannual Update <ul style="list-style-type: none"> Changed Indiana Family and Social Services Administration to Family and Social Services Administration Changed all checks made payable to IHCP instead of EDS Changed HP Pharmacy Services Point of Service (POS) Help Desk operating hours in the Customer Assistance Telephone Numbers and Addresses section Changed the IHCP Surveillance and Utilization Review (SUR) local Indianapolis telephone number in the Customer Assistance Telephone Numbers and Addresses section Deleted prepayment review and Surveillance and Utilization Review from the list of responsibilities of HP in the Contractors section Updated IHCP Web site links 	HP Provider Relations and Publications Units

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Section 1: Introduction

Indiana Health Coverage Programs

This provider manual is the primary reference for submitting and processing Indiana Health Coverage Programs (IHCP) claims, prior authorization (PA) requests, and other related documents. This manual contains detailed instructions for claims submission and is the first referral source for answers to policy and procedure questions.

The IHCP receives federal and state funds to reimburse providers for reasonable and necessary medical care for people meeting eligibility requirements. Each state administers its own program within broad federal guidelines. In Indiana, the Family and Social Services Administration (FSSA) Office of Medicaid Policy and Planning (OMPP) administers the IHCP. A copy of the Medicaid Covered Services and Limitations Rule, which is published in the Indiana Administrative Code (IAC) at 405 IAC 5, can be accessed at <http://www.state.in.us/legislative/iac/title405.html>. Rules for other programs administered by the IHCP are also published in the IAC:

- Hoosier Healthwise Package C located in 407 IAC 1, 407 IAC 2, and 407 IAC 3
- Medical Review Team (MRT) located in 405 IAC 2-2-3
- Pre-Admission Screening and Resident Review (PASRR) located in 405 IAC 1-14.6
- Other programs

Additional information on services is available in the IAC, which is published online at <http://www.state.in.us/legislative/iac/>.

Visit the IHCP Web site at <http://provider.indianamedicaid.com> for additional program information, such as banner pages, bulletins, newsletters, and a complete version of the *IHCP Provider Manual*. Also located on the IHCP Web site are the IHCP Companion Guides, Web interChange electronic data interchange (EDI) information, IHCP fee schedules, provider enrollment application and maintenance forms, program contact information, schedules of events, general program updates, prior authorization forms, and links to other Web sites.

How to Use this Manual

Specific topics are covered in each chapter of the *IHCP Provider Manual*. For example, member eligibility is covered in [Chapter 2](#) and PA is covered in [Chapter 6](#). Some chapters may appear to contain similar information, but the information is in a different context and is related specifically to that chapter.

Manual Revisions

Throughout the year, changes to the IHCP are published in provider bulletins, provider newsletter articles, and banner page articles. These documents are posted on the IHCP Web site. Changes are captured and inserted into the provider manual at each revision. To ensure that they are aware of any new information that is posted to the Web site, providers should subscribe to receive IHCP E-mail Notifications by going to http://provider.indianamedicaid.com/ihcp/mailling_list/default.asp.

Locating Information

Providers can refer to the [General Table of Contents](#) to locate major information. The *General Table of Contents* contains a list of chapters in the manual. Individual chapter tables of contents provide expanded subsection information, including the specific page number within the chapter.

The indexes located at the end of each chapter and at the back of the manual are available to help readers find specific information.

Supplemental Provider Manuals

Supplemental provider manuals are available for subprograms of the IHCP that have unique requirements. Supplemental provider manuals are available for download from the IHCP Web site at <http://provider.indianamedicaid.com>, by calling Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278, or by submitting a request in writing to HP Written Correspondence at P.O. Box 7263, Indianapolis, IN 46207-7263. Supplemental provider manuals include the following programs:

- HealthWatch Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Hospice
- Medicaid Rehabilitation Option (MRO)
- 590 Program
- Home and Community-Based Services Waiver Provider Manual
- Qualified Provider Presumptive Eligibility Manual

Managed care organizations (MCOs) and care management organizations (CMOs) also produce provider manuals. Contact the appropriate MCO or CMO to obtain necessary provider manuals. See [Section 2](#) of this chapter for MCO and CMO contact information.

Ordering Manuals

All *IHCP Provider Manuals* are available online at <http://provider.indianamedicaid.com>. Providers may also request copies of the *IHCP Provider Manual* on CD-ROM at no charge. Providers may request one paper copy at no expense.

To obtain additional copies of the provider manual, send a request in writing to the following address:

**HP Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263**

The following applies to paper and CD-ROM copy orders of the *IHCP Provider Manual*:

- Enrolled IHCP providers can purchase an additional paper copy for \$105 per copy.
- Enrolled IHCP providers can request CD-ROM copies at no additional charge.
- Nonproviders can purchase paper copies for \$105 per copy.
- Nonproviders can purchase CD-ROMs for \$20.
- Providers should make checks payable to IHCP.

Suggestions

Comments and suggestions are important in making the provider manual practical, relevant, and user-friendly. Please forward comments and suggestions about the *IHCP Provider Manual* to the following address:

Provider Manual Suggestions
HP Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

Programs Overview

This section introduces and provides a high-level overview of the IHCP and associated benefit packages.

The OMPP has categorized benefits into the following programs:

- 590 Program
- Traditional Medicaid
- Hoosier Healthwise
- *Care Select*
- Healthy Indiana Plan (HIP)
- Presumptive Eligibility for Pregnant Women

590 Program

The 590 Program allows for processing claims for services provided off-site to members who are residents of State-owned facilities under the direction of the FSSA Division of Mental Health and Addiction (DMHA) and the Indiana State Department of Health (ISDH).

Providers can verify eligibility for the 590 Program using the Eligibility Verification System (EVS). See [Chapter 3](#) for more information about EVS options.

Detailed information about the 590 Program is included in the *590 Program Provider Manual*, which is available online at:

http://provider.indianamedicaid.com/media/23411/590_program_provider_manual.pdf.

Traditional Medicaid

The Traditional Medicaid program provides services to nonmanaged care members on a fee-for-service (FFS) basis. The types of members associated with Traditional Medicaid under the standard plan may include the following:

- Qualified Medicare beneficiary (QMB)
- Wards of the State
- Foster children
- Spend-down

- Waiver
- Long-term care (LTC)
- Emergency Services Only (Package E)

Detailed information about Traditional Medicaid is included in [Chapter 2](#) of this manual.

Hoosier Healthwise

Hoosier Healthwise provides coverage to children, pregnant women, and low-income families. This program encompasses the following four member eligibility packages:

- Package A – Standard Plan
- Package B – Pregnancy Coverage Only
- Package C – Children’s Health Insurance Plan (CHIP)
- Package P – Presumptive Eligibility for Pregnant Women

Detailed information about Hoosier Healthwise is included in [Chapter 2](#) of this manual.

Care Select

The *Care Select* program is designed to improve the member’s health status; enhance quality of life; improve client safety, client autonomy, and adherence to treatment plans; and control fiscal growth. The *Care Select* program replaced the *Medicaid Select* program through a phased-in plan with a completion date of March 1, 2008. The following IHCP members are covered by the *Care Select* program:

- Aged
- Blind
- Physically and mentally disabled
- Members receiving adoption assistance
- Members in the waiver program
- Medicaid for Employees with Disabilities (M.E.D. Works) participants
- Wards not Title IV-E eligible under 18
- Ward and foster children under 18
- Former foster children

Detailed information about *Care Select* is included in [Chapter 2](#) of this manual.

Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is a program sponsored by the state of Indiana that provides more affordable healthcare choices to thousands of otherwise uninsured individuals throughout Indiana. HIP provides health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose income is up to 200 percent of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid. Unlike many other government-sponsored programs, parents and childless adults can participate. Eligible participants must be uninsured for at least six months and cannot have access to employer-sponsored health insurance. Participants are required to make minimal contributions toward coverage based on their income.

The Enhanced Services Plan (ESP) is a special plan for some HIP enrollees with certain high-risk medical conditions. The ESP is administered by the Indiana Comprehensive Health Insurance Association (ICHIA). HIP applicants are screened for complex medical conditions, such as cancer, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), hemophilia, transplants, and aplastic anemia. Questionnaires are sent to medical professionals to validate the high-risk conditions and qualify members. HIP enrollees, who qualify, are assigned to the ESP. The ESP provides all HIP benefits in addition to comprehensive disease management services. Affiliated Computer Services (ACS) processes medical claims for the ESP. HP processes the pharmacy claims. Contact information can be found in [Section 2](#) of this chapter.

Presumptive Eligibility for Pregnant Women

Presumptive Eligibility (PE) for Pregnant Women is a process to provide coverage to women while the Hoosier Healthwise Application is under review by the Division of Family Resources (DFR). This program began July 1, 2009.

Women found to be presumptively eligible have coverage for ambulatory prenatal services while the application and determination process for Hoosier Healthwise/Medicaid is completed. Providers will be reimbursed for covered services provided during the PE period, beginning on the date that a qualified provider (QP) determines the woman to be presumptively eligible. The woman's Hoosier Healthwise/Medicaid eligibility determination will subsequently be completed by the DFR.

Enrollment centers that are not qualified providers for the PE program can assist pregnant women by helping them complete and submit Hoosier Healthwise (HHW) Applications and providing a referral to a qualified provider. However, it is critical that only *one* HHW Application be submitted for a member.

Delivery Systems

The following sections describe IHCP delivery systems.

Fee-for-Service

The FFS delivery system reimburses providers on a per-service basis. Providers bill the IHCP claims processing contractor, HP, for services rendered to members in programs subject to FFS.

Note: The IHCP Fee Schedule can be downloaded for free from the IHCP Web site at <http://provider.indianamedicaid.com>. To obtain a paper copy of the IHCP Fee Schedule, make checks payable to IHCP for \$43 to the following address:

***HP Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263***

The IHCP Fee Schedule contains a complete list of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes and includes indicators specific to each code, such as program coverage, anesthesia base units, reimbursement, and prior authorization. Users can search the online version by code or keyword.

CPT® is registered trademark of American Medical Association.

Care Select

Care Select is similar to Traditional Medicaid in that payments for care are made on an FFS basis. In addition, a per-member, per-month administration fee is paid to primary medical providers (PMPs) with the exception of rural health clinics and Federally Qualified Healthcare Centers.

Care Select operates as an FFS delivery system with a gatekeeper approach. Providers submit claims to HP for processing. PMPs in this program contract with CMOs through an addendum to the *IHCP Provider Agreement*. *Care Select* members are linked to a PMP who provides or authorizes most medical care. If the PMP is not providing the care, the service may require PMP authorization.

Some services are exempt from PMP authorization. The following services are known as self-referral services and do not require PMP authorization for payment:

- Chiropractic services
- Community mental health services and services under the mental health rehabilitation option
- Dental services
- Family planning services
- Home and community-based services
- Mental health services (by provider type and specialty)
- Methadone maintenance (refers to the drug *methadone*, not methadone treatment programs)
- Nonsurgical ophthalmology services
- Pharmacy services
- Podiatry services
- Services rendered for the treatment of a true medical emergency
- Transportation services
- Vision care services (optometry services and eyeglasses)
- HIV/AIDS targeted case management services
- Immunizations
- Diabetes self-management

The following services are not considered self-referral services. However, they do not require the PMP certification code for payment:

- Pathology services
- Laboratory services
- Radiology services
- Anesthesia services
- Physical therapy services
- Occupational therapy services
- Respiratory therapy services
- Speech therapy services
- Home health services

