

Presumptive Eligibility – Medical Provider FAQs

Note: Medicaid and Hoosier Healthwise are used interchangeably throughout the document.

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A. General Program Information

1. What is presumptive eligibility for pregnant women?

Presumptive eligibility (PE) is a program that allows pregnant women to receive ambulatory (outpatient) prenatal services while their applications for Medicaid are pending and being reviewed for eligibility by the Division of Family Resources (DFR). Women determined eligible for PE may begin receiving pregnancy-related services on the day they are determined PE eligible.

2. When did the program begin?

PE began July 1, 2009.

B. Services Covered by Presumptive Eligibility

1. The PE bulletin ([BT200910](#)) dated April 30, 2009, states that PE covers ambulatory prenatal care. Please define ambulatory prenatal care.

PE-covered services include outpatient pregnancy-related services and services to treat conditions that might complicate the pregnancy.

Pregnancy-related outpatient services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant, are covered by PE. Outpatient services for other conditions that might complicate the pregnancy are covered, including those for diagnoses, illnesses, or medical conditions that might threaten the safe delivery of the fetus.

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Covered services (not all inclusive) include: outpatient prenatal visits, lab work and tests related to pregnancy outcome, transportation to and from medical services, prescriptions, and treatment of conditions that may affect the outcome of the pregnancy.

2. What services are not covered under PE?

Services not covered for PE members include inpatient services, hospice, long-term care, labor and delivery services, abortion services, postpartum services, and services not related to the pregnancy or birth outcome. These services may be covered if the client is determined eligible for ongoing Medicaid coverage.

3. Does PE cover prescription drugs?

Yes. Unless they are provided in an inpatient setting, all drugs are covered.

4. Does the PE member have copayments for prescription drugs?

No. PE members do not have copays, even for brand-name drugs. Pharmacy providers must use the pregnancy indicator when filing claims for women covered by PE.

5. Are there copayments for services received during PE?

PE members do not have copays.

6. Is there a list of covered services for PE?

Covered diagnosis codes can be found in the *Qualified Provider Presumptive Eligibility Manual* at <http://www.indianamedicaid.com/ihcp/MCE/content/peInfo.asp>. PE covers the same services as Hoosier Healthwise Package B, with the exception of noncovered services listed in the response to question B-2.

7. Are services for a pregnancy complication (for example, gestational diabetes) covered?

Yes. Providers are encouraged to contact the member's managed care organization (MCO) to notify the MCO of the additional complications. The MCOs may have programs or services to help the member manage the condition.

8. Can the provider charge the patient a fee for "completing paperwork" to perform qualified provider (QP) functions?

No. Providers are performing QP activities voluntarily and cannot charge for services.

C. Member Eligibility

1. What are the member eligibility requirements for PE?

To be eligible for PE, a woman must meet the following requirements:

- Have a medically verified pregnancy
- Currently reside in Indiana
- Be a U.S. citizen or qualified noncitizen (see question C-3 for more information)
- Have gross family income at or below 200 percent of the federal poverty level

2. Who is not eligible for PE?

- Inmates of public institutions
- Non-qualified non-citizens (see question C-4 for more information)
- Women already enrolled in a Medicaid program
- Women who had been previously granted PE coverage for the current pregnancy

3. What is a "qualified non-citizen"?

- Lawful permanent resident immigrant living lawfully in the U.S. for five years or longer
- Refugee
- Individuals granted asylum by the immigration office
- Individuals whose deportation has been withheld by order from an immigration judge

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- Amerasian from Vietnam
- Veteran of U.S. Armed Forces with honorable discharge

4. What is a “non-qualified, non-citizen”?

- A lawful immigrant living in the U.S. for less than five years
- A visitor/student with a visa
- A person with no immigration papers

5. What is 200 percent of the federal poverty level?

The federal poverty level (FPL) is a federal guideline used to determine eligibility for many state and federal programs. The FPL sets an income threshold for each family based on family size. PE eligibility is set at two times, or 200 percent, the federal poverty level. Two hundred percent FPL is shown in Table 1.

Table 1 – Gross Family Income Requirements for Presumptive Eligibility for Pregnant Women
(Effective March 1, 2009 – February 28, 2010)

Family Size	Monthly Income (\$)	Annual Income (\$)
2	\$2,429	\$29,148
3	\$3,052	\$36,624
4	\$3,675	\$44,100
5	\$4,299	\$51,588
6	\$4,922	\$59,064
7	\$5,545	\$66,540
8	\$6,169	\$74,028
For each additional person, add:	\$624	\$7,476
FSSA will update these income levels and publish details at http://www.in.gov/fssa/ompp/2997.htm		

6. How is family size determined?

Family size is the number that represents the pregnant woman and her family members **that live with her**. Family members who should be counted in determining family size include those related by blood, marriage, or adoption:

- The pregnant woman and her unborn child(ren)
- The pregnant woman’s spouse
- The pregnant woman’s children under age 18 and those of her spouse
- If the pregnant woman is under 18 and not married, the parents of the applicant and the parents’ children under age 18

7. How is gross family income determined?

Gross income, before taxes and other deductions, is totaled for each person living with the pregnant woman who is counted in the family size determination. Earned or employment-related income for children under 18 who are not the parent(s) is not counted.

8. What types of income are counted for PE?

Income includes wages and salaries, tips, self-employment, dividends, interest, child support (if paid for the pregnant woman’s support), alimony, Social Security, veteran’s benefits, unemployment compensation, worker’s compensation, sick benefits, retirement benefits, pensions, rental income, and cash contributions.

- Do not count employment-related income for children other than the pregnant woman or her spouse

- Count child support for the pregnant woman only if she receives it from her parents for her own support
 - Do not count child support if it is paid for the support of the pregnant woman's children
- 9. Should the income of the applicant's boyfriend be counted if he is the father of the unborn child and lives with the applicant?**
No. The boyfriend should not be included in the calculation of income or family size.
- 10. Are the family size and family income considerations for PE the same as those for other State assistance programs?**
The income and family size requirements for PE are the same as those for Hoosier Healthwise for Pregnant Women. The Family and Social Services Administration (FSSA) follows state and federal rules regarding whose income counts in the eligibility determination and who is counted in the family size. Details can be found at <http://www.in.gov/fssa/ompp/2997.htm>.
- 11. Can a woman enrolled in the Healthy Indiana Plan (HIP) apply for PE?**
A woman cannot simultaneously participate in the Healthy Indiana Plan (HIP) and PE. She must follow the procedure outlined for HIP women to transfer to Hoosier Healthwise Package B. HIP women have coverage for pregnancy-related services during the transition from HIP to Medicaid.
- 12. What if the applicant is going through a divorce at the time of her PE application? Is the husband's income included?**
Yes, all income must be counted while the couple is legally married.
- 13. What if the pregnant woman has no income? Can "zero" be entered for income?**
Yes, "zero" income can be entered if the pregnant woman has no income.
- 14. How long will PE coverage last?**
PE coverage starts on the day the client is determined eligible for the PE program and lasts until a determination is made on her Medicaid application or until her pregnancy ends.
- 15. What should the member do if she miscarries during the PE period? What will happen to her PE benefits?**
Because the member's pregnancy ended, her PE benefit will also be stopped. It is important that this member still complete the DFR process for Medicaid coverage. Because Medicaid coverage can extend 60 days beyond the end of the pregnancy, the woman could receive helpful services after the miscarriage. Also, if any inpatient services were rendered during the PE period, the woman must complete the Medicaid application process to have those services covered.

D. PE Application and Enrollment Process

- 1. What is the process for a woman to gain PE benefits?**
A QP must determine that the woman meets PE eligibility requirements outlined in [BT200910](#). The provider must submit a PE Application for Pregnant Women via Web interChange. If approved, the woman must immediately contact the enrollment broker (MAXIMUS) to select a primary medical provider (PMP) and a managed care organization (MCO) to activate PE coverage.
- 2. How long does it take Web interChange to process a PE decision?**
Once submitted, the PE Application for Pregnant Women is processed within seconds. A determination notice and Hoosier Healthwise Application must be printed by the QP.

3. What are the hours for submitting the PE Application for Pregnant Women?

The PE Application for Pregnant Women can be used to apply for PE benefits during the following days and times:

Monday through Friday, 8 a.m. to 6 p.m. (Eastern Time)
Saturday, 8 a.m. to noon (Eastern Time)

MAXIMUS, the enrollment broker, is available 8 a.m. to 7 p.m., Monday through Friday, and 8 a.m. to 1 p.m. Saturday.

Note: MAXIMUS will be closed on the following days. In addition, the PE Application for Pregnant Women will not be available on these dates:

December 24 and 25, 2009

4. How soon after PE determination do pregnant women have coverage for services?

Services are covered beginning the day the PE is approved.

5. How soon after PE determination can a provider submit a claim for payment to the member's MCO?

Updating the eligibility systems and the MCOs takes approximately two business days. Providers should wait a few days before submitting claims to the MCO; however, the member is covered on the date of PE determination and activation (see D-1).

6. Will the PE member be sent a Hoosier Healthwise Card for PE?

No. There is no identification card for PE. The PE Determination Notice serves as the woman's proof of PE. The woman also receives a PE member welcome letter that includes the member's RID (recipient identification number) and PMP/MCO information.

7. What is the expectation of accuracy with regard to gross income on the PE application?

Applicants must provide the most accurate information possible.

8. What if the applicant is under 18 years of age and doesn't know her parents' income?

If an applicant under age 18 cannot provide her parents' income, she must either request that a parent return with her to complete the application or ask her parent for the information. The QP cannot proceed with the PE Application without this information.

9. What if the income amount provided by the applicant is found to be different from the amount the DFR verifies when processing the woman's Medicaid application?

If the amount stated by the applicant for the PE application is less than the amount indicated in the documentation provided to the DFR, she will be denied Medicaid.

If the income indicated in the documentation provided to the DFR is higher than what was stated on the PE Application, she may be denied Medicaid. Once she is denied Medicaid, the PE coverage ends.

10. Can the PE application be started, saved, and restarted at a later date/time?

No. The QP must have all the necessary information before starting a PE Application for Pregnant Women.

11. What if the PE Application for Pregnant Women is started, but the applicant discovers she doesn't know all the required information?

The QP needs to exit the PE Application for Pregnant Women. When the woman returns to the QP office with complete information, a new application can be started. We recommend asking the applicant if she knows her family income before starting the application

12. Can a pregnant woman with a pending Hoosier Healthwise application apply for PE?

Yes.

13. Can enrollment centers that are not QPs complete the Hoosier Healthwise application?

Enrollment centers not enrolled as QPs for presumptive eligibility for pregnant women that provide services to a pregnant woman who is not covered by any form of Medicaid should complete the Hoosier Healthwise application for her and refer her to a QP to complete the PE application.

14. When does the woman covered by PE apply for Medicaid?

The application for Medicaid is completed at the same time as the PE application. The Web interChange system populates the Hoosier Healthwise Application (HHW) for Medicaid based on information entered on the PE application. The pregnant woman must review the Hoosier Healthwise Application, add a few additional details, and sign it. The QP must fax the signed application, along with proof of pregnancy, from the QP site to the DFR. QPs have been instructed in the past to fax the HHW application to the Division of Family Resources (DFR), even if an enrollment center has already completed and submitted an HHW application for her. **Effective October 2009**, QPs should contact the enrollment center and verify that the HHW application has been successfully submitted to the DFR, document whom they spoke with to get the verbal authorization, and maintain the printed copy of the HHW application printed during the PE application process in the applicant's file. **Do not fax a duplicate application to the DFR.**

15. Why might a woman be denied PE?

PE is denied if the woman:

- Has income above 200 percent of the federal poverty level
- Does not meet citizenship requirements
- Is not an Indiana resident
- Is incarcerated
- Is already covered by Medicaid, or
- Was previously granted PE coverage for the current pregnancy

16. Can women denied for PE still apply for Medicaid?

Yes. Women denied for PE can still apply for Medicaid.

17. Would an applicant denied for PE be considered self-pay?

Yes.

18. Can women appeal a PE application that was denied?

No. Medicaid eligibility denials can be appealed, but PE denials cannot be appealed.

19. How are the MCOs notified that a PE member has been enrolled with a particular plan?

A daily file of PE-eligible members is sent by HP to the MCOs.

20. How will a provider identify individuals for whom the provider should complete the PE Application for Pregnant Women?

It is up to the QP to determine how to manage identification of potential PE members. Providers may want to screen women over the phone during the scheduling process. A provider who signs up to be a QP must complete a PE application for any pregnant woman who asks to apply.

21. Does the Office of Medicaid Policy and Planning (OMPP) have any objection to a provider implementing a PE screening process?

A screening process is acceptable as long as it does not in any way serve as a barrier to the application process. A provider who signs up to be a QP must complete a PE application for any pregnant woman who asks to apply.

22. If a provider has a patient whom the provider has been seeing for prenatal care for several months, is the provider required to perform another pregnancy test on the individual?

No. As long as the patient's medical record substantiates that the pregnancy is ongoing, a new test is not required. A professionally administered test must have been administered and be documented in the patient record at some point during treatment.

23. If a patient applied for PE and was denied due to "income too high," and she subsequently has a change in income, can she re-apply for PE?

Yes.

E. MAXIMUS (Enrollment Broker) Process

1. What documentation should the QP provide to the applicant prior to contacting MAXIMUS?

To reduce the time spent educating applicants about selecting their primary care providers (PMPs) and managed care organizations (MCOs) during the PE application process, the IHCP has updated its Web site at <http://www.indianamedicaid.com/ihcp/MCE/content/peInfo.asp> with a side-by-side comparison of the MCOs. QPs must give a copy of the side-by-side comparison, along with the approval letter, to the applicant prior to contacting MAXIMUS.

2. How do we as QPs provide information about which doctors are contracted with the MCOs for which we do not provide primary care?

MAXIMUS will still be responsible for providing the PMP information to PE applicants. The side-by-side comparison was created specifically to educate applicants about the MCOs, so applicants know what services are offered by each MCO, and have contact information and other information specific to the MCOs, when they choose a doctor that is contracted with that MCO. We don't want you to have to explain or be responsible for educating applicants about PMPs.

3. What if our providers are only contracted with one of the three MCOs? Do we still need to pass out the side-by-side comparison?

Yes, you still want to pass this out to each of your members, so members can make informed decisions.

4. Why does the pregnant woman have to contact MAXIMUS on the same day as the PE determination?

The woman's PE is activated when she calls the enrollment broker and selects a PMP and an MCO. If the woman does not contact MAXIMUS, her PE coverage will not be activated. Services provided by the QP on that date will not be covered.

5. What if there are no primary medical providers (PMPs) in the member's area?

If there are no PMPs available in the woman's geographic area, MAXIMUS activates the woman's PE eligibility as fee-for-service. The member is considered fee-for-service until a PMP and MCO selection can be made. The Eligibility Verification System (EVS) reports the member eligible for Package P, and managed care PMP/MCO information is not listed. Claims for PE women who are covered by fee-for-service must be submitted to HP for reimbursement.

6. What if the PE woman doesn't contact MAXIMUS on the date of her PE determination?

If the woman fails to contact the enrollment broker to select a PMP and MCO, her PE coverage is not activated and services are not covered.

7. What are the hours of MAXIMUS?

MAXIMUS, the enrollment broker, is available 8 a.m. to 7 p.m., Monday through Friday, and 8 a.m. to 1 p.m. Saturday.

Note: MAXIMUS will be closed on the following days. In addition, the PE Application for Pregnant Women will not be available on these dates in 2010.

New Year's Day - January 1
Martin Luther King Day - January 18
Memorial Day - May 31
Independence Day - July 5
Labor Day - September 6
Thanksgiving - November 25
Friday After Thanksgiving - November 26
Christmas - December 24

8. How does open enrollment fit into PE?

PE women are not subject to open enrollment rules until after Medicaid is approved. After Medicaid is approved, pregnant women have a 90-day free change period to change MCOs until they select and remain with one MCO in excess of 90 days.

9. Can a PE member be auto-assigned?

Auto-assignment does not occur for PE women. PE women must select a PMP and an MCO on the date of PE determination to have the PE coverage activated. If there are PMP access issues in the woman's area, the process described in the answer to question D-2 applies.

10. Can a PE member change PMPs during PE enrollment?

PE members may change PMPs during the PE period. To change PMPs or MCOs, PE members must contact the enrollment broker, MAXIMUS, at 1-800-889-9949. The same procedures that apply to Hoosier Healthwise members apply to PE members.

11. Can a PE member change MCOs during PE enrollment?

PE members may change MCOs during the PE period. To change PMP or MCO, PE members must contact the enrollment broker, MAXIMUS, at 1-800-889-9949. The same procedures that apply to Hoosier Healthwise members apply to PE members.

12. Can a PE member make a prebirth PMP selection for her child(ren)?

Yes. The member may select a PMP for her child when she selects her PMP with the enrollment broker (MAXIMUS).

13. What if the PMP has a full panel?

If the PMP the member wants to select is also a rendering provider at the QP location, staff from the QP office can verbally authorize the panel addition when the member is on the phone with MAXIMUS.

If the PMP the member wants to select is not a rendering provider at the QP location, the member needs to select a different PMP. The member will be advised to select a PMP in the same network/MCO as the first-choice PMP to help facilitate a transition. The member needs to work with her first-choice PMP to complete a panel addition.

14. What if the PMP has a panel on hold?

If the member wants to select a PMP that has a panel **on hold**, the member needs to select a different PMP. The member will be advised to select a PMP in the same network/MCO as the first-choice PMP to help facilitate a transition. The member needs to work with the first choice PMP to have the panel hold lifted.

F. Hoosier Healthwise Application Process

1. When does the presumptively eligible woman apply for Medicaid?

The application for Medicaid is completed at the same time as the PE Application. The Web interChange system populates the Hoosier Healthwise Application for Medicaid based on information entered on the PE application. The pregnant woman must review the Hoosier Healthwise Application, add a few additional details, and sign it. The QP must fax the signed application, along with proof of pregnancy, from the QP site to the Division of Family Resources (DFR).

2. What does the QP have to include with the member's Hoosier Healthwise Application?

The QP should also fax, along with the Hoosier Healthwise application, a statement signed by the physician or nurse indicating the applicant is pregnant and the date the pregnancy began.

3. To which DFR office should Hoosier Healthwise Applications be submitted?

Modernized counties: In counties included in the DFR modernization, based on the woman's county of residence, fax the completed Hoosier Healthwise application to the DFR Document Center at 1-800-403-0864. [BT200910](#), Appendix G, has more information.

Questions regarding the Hoosier Healthwise application should be directed to the DFR Document Center at 1-800-403-0864.

Marion County: If the woman resides in Marion County, Hoosier Healthwise Applications should be faxed to the Center Township Trustee's (CTT) office at 863 Massachusetts Avenue. The fax number is (317) 232-2038. Faxes should be to the attention of Eric Pangburn or Carol Heckel.

Nonmodernized counties: In counties not yet included in the DFR modernization, fax the completed Hoosier Healthwise application to the county DFR office, based on the woman's county of residence. Questions may also be directed to the county office.

Visit <http://www.in.gov/fssa/dfr/2999.htm> to locate the telephone and fax information in counties not included in the DFR modernization. Click "Where Do I Apply?" and scroll to the applicant's county of residence to find the contact information.

4. What if the woman does not complete the Hoosier Healthwise application?

If the woman does not have a pending Medicaid/Hoosier Healthwise application in the DFR system by the last day of the month following the month in which she was approved for PE, her PE is terminated. She is not able to re-apply for PE during the same pregnancy.

For example, if the woman is approved for PE on July 14, she must have a pending Medicaid application display as pending in the DFR systems by August 30.

5. Is there still three months of retroactive coverage for pregnant women who are eligible?

If the woman is eligible for coverage prior to the Hoosier Healthwise Application date, there is a period of retroactive coverage added to the system. Any coverage period that is prior to the PE determination date is billed as fee-for-service to HP.

6. How long does it take for a PE-eligible woman to receive a decision with regard to her eligibility for Medicaid?

The DFR strives to make eligibility determinations within 45 days.

7. What if a woman's Medicaid application takes longer than 45 days for the DFR to complete?

To remain eligible for PE, the woman's Medicaid application must show as pending with the DFR before the end of the month following the month in which she was approved for PE. She must comply with any requests from the DFR for information. As long as the woman is complying with requests from the DFR

for additional information and her application is pending, she will remain on PE until the DFR makes a decision on her Medicaid application.

8. If the member provides supporting documentation at the visit with the QP (for example, pay stubs, citizenship documents), should the documentation be faxed with the Hoosier Healthwise Application?

The provider should fax the documentation to the DFR office with the woman's Medicaid application. A cover sheet should be used to identify how many pages are included in the fax.

Note: The QP cannot require documentation as part of the PE Application process.

9. If the individual's PE is denied, is it still necessary to fax the Hoosier Healthwise application?

If the individual wants to apply for Medicaid, the Hoosier Healthwise application must be faxed by the QP.

10. When the QP faxes the Hoosier Healthwise/Medicaid Application, should the PE determination be included?

No, only the Hoosier Healthwise Application, proof of pregnancy and any other verification should be submitted to DFR.

11. Does PE change how the DFR processes Hoosier Healthwise/Medicaid Applications?

No.

12. What should the member do if the DFR office states it didn't receive the Hoosier Healthwise/Medicaid Application?

The member should resubmit the Hoosier Healthwise Application to the DFR.

13. Are members notified when PE coverage is going to be terminated for lack of a pending Medicaid application at DFR?

Yes, members are sent a letter from HP to notify them that in 10-13 days PE coverage will be closed due to lack of a pending Medicaid/Hoosier Healthwise Application.

G. Pharmacy Instructions

1. Can a PE member get a prescription filled on the same day as PE determination?

Yes, a Presumptive Eligibility member can have a prescription filled on the same day as the PE determination. Effective December 31, 2010 all prescription claims should be submitted to HP, not the members MCO for adjudication.

2. What members are affected by the Consolidation?

All Hoosier Healthwise and Healthy Indiana Plan (HIP) members. This includes members covered by Presumptive Eligibility.

3. Which Preferred Drug List applies to PE members?

You can find the PDL at <http://www.indianamedicaid.com> and <http://www.indianapbm.com> under Pharmacy Services. Effective December 31, 2009, one Preferred Drug List will be used for all Medicaid enrollees, including PE members.

4. Will PE members have a copay for their prescriptions?

Members covered by Presumptive Eligibility will not have a copay for services that are pregnancy related.

5. Do I need Prior Authorization for Drugs for PE members?

You may need to prescribe a drug that requires prior authorization. In this case, you will need to provide information about the member's health and then a decision will be made about whether or not Indiana Medicaid can pay for the drug.

You must submit a prior authorization request if:

- A drug is listed as non-preferred on the PDL, or if certain conditions need to be met prior to the member receiving the drug.
- The dose prescribed is more than what is usually prescribed.
- There are other drugs that should be tried first.

For drugs that require prior authorization, the member may get up to a 72-hour supply while waiting for the decision. For more information, please refer to <http://www.indianapbm.com/emergencySupply.htm>.

The prior authorization decision will be made within 24 hours of receipt of the request (not including Sundays or some holidays), and you will be notified of the decision

Contact Affiliated Computer Service (ACS) Prior Authorization at 1-866-879-0106.

H. Billing for Services during the PE Period

1. How soon after PE determination can a provider submit a claim for payment to the member's MCO?

Updating the eligibility systems and the MCOs takes approximately two business days. Providers should wait a few days before submitting claims to the MCO; however, the member is covered on the date of PE determination.

2. What if the applicant selects a PMP that is not the QP? Is the QP reimbursed for services provided on the date of the PE determination?

The QP is still reimbursed for services provided on the date of PE determination.

3. What if the PE determination notice is lost? How can a provider bill for services without the identification number for PE? A provider can use the woman's name and date of birth or Social Security number to look up her eligibility status using one of the IHCP eligibility verification methods. The eligibility response notes that the woman is eligible for Package P – Presumptive Eligibility if the woman is enrolled in PE.

4. Can a PE member get a prescription filled on the same day as PE determination?

There is a delay of approximately three business days when information is passed from HP to the MCOs, and ultimately, to the pharmacy benefit manager (PBM) for each MCO. Providers are encouraged to advise members to wait three to five days after PE determination before attempting to fill a prescription.

5. Will the PE member be sent a Hoosier Healthwise Card for PE?

No. There is no identification card for PE. The PE determination notice serves as the woman's proof of PE. The woman also receives a PE member welcome letter that includes the member's RID and PMP/MCO information.

6. If the member doesn't bring a card or PE determination letter to her appointment, how should providers bill for services?

A provider can use the woman's name and date of birth, or Social Security number to look up her eligibility status using one of the IHCP eligibility verification methods. The eligibility response notes that the woman is eligible for Package P – Presumptive Eligibility if the woman is enrolled in PE. The eligibility verification methods include the following:

Web interChange

<https://interchange.indianamedicaid.com>

Automated Voice Response System (AVR)
(317) 692-0819 or 1-800-738-6770

Omni Machine, using either the swipe machine or by entering pertinent information about the member (provider, member, date of service) and receiving a display or printed confirmation

7. **If a PE member receives a service that is not covered under the PE program, is the provider required to provide written notification to the member that the service is not covered under PE?**
Yes. The same requirements that exist for current Medicaid members apply to PE members. The provider must inform the woman that the service is not covered under PE. The provider must also inform her about the amount she is responsible for paying for the service.
8. **In the situation where a PE-covered woman delivers prior to Medicaid eligibility determination, is the provider required to notify the member that the delivery is not covered by PE?**
Yes.
9. **How does the MCO process claims for services provided the same day that the PE determination is made? What if the QP is out-of-network for the MCO selected by the PE woman?**
MCOs pay QPs for the initial services provided the same day the QP made the PE determination. QPs are paid regardless of their affiliation status with the MCO chosen by the PE member. MCOs consider QP locations to be in-network providers when processing medical claims for services provided on the date the PE determination was made by the QP.

Providers should make sure they are registered with each MCO so claims can be processed in a timely manner. Providers should contact the MCOs at the Provider Services telephone numbers below to determine if the providers are registered.

Anthem: 1-866-408-6232

MHS: 1-877-647-4848

MDwise: 1-800-356-1204

10. **How can I identify women covered by PE in the eligibility systems?**
PE is identified as Medicaid Package P.
11. **If a provider's claim for a service is denied during the PE period and the woman gains Medicaid eligibility covering the date of service for the claim, how should the provider submit a claim for payment?**
Once a Medicaid RID has been assigned to the member, the provider must bill with the Medicaid RID, not the PE RID. A new claim must be submitted for a previously denied claim, not an adjustment.
12. **What actions can be taken to help ensure proper claims payment?**
- **Providers should verify IHCP eligibility using one of the following verification methods before providing services.**
 - Web interChange: <https://interchange.indianamedicaid.com>
 - Automated Voice Response System (AVR): (317) 692-0819 or 1-800-738-6770
 - Omni Machine
 - **The correct member identification number should be used on the claim.** During the PE period, RIDs begin with the digits 550. The "550" RID for PE should be billed during the PE period. Once the Hoosier Healthwise application process has been completed, if the woman is approved, the provider submits claims using the woman's Hoosier Healthwise RID, which begins with 10 and ends with 99.
 - When billing for pregnancy-related services, providers must indicate a diagnosis of pregnancy on the claim.

13. If the PE member needs a service that is not covered under the PE program, is the provider required to provide written notification to the individual that the service is not covered under PE?

Yes. The same requirements that exist for current Medicaid members apply to PE. The provider must inform the member that the service is not covered by PE and must also inform the member of the amount the member will be responsible for paying the provider.

I. Billing for Services after the PE Period and Medicaid Approval

1. What happens when a woman who is approved for Medicaid switches from PE to Medicaid?

The day after HP receives notice of the woman's Medicaid approval from the DFR, her PE eligibility is terminated and she is enrolled in Medicaid Package A, B, or C. She is assigned to the last MCO with which she was enrolled during her PE. After a PE member gains Medicaid eligibility, she is assigned a traditional Medicaid RID, which begins with a 10 and ends with 99. The PE RID, which begins with the numbers 550, is linked to the new RID.

2. If an individual's Hoosier Healthwise application is approved and her PE segment is converted to Package A or Package B, is the eligibility retroactive to the date of the Hoosier Healthwise application and/or retroactive to a prior date?

The start dates of Hoosier Healthwise coverage is the date that the DFR receives a complete Hoosier Healthwise application. It is important that QPs fax the completed Hoosier Healthwise application to the DFR on the same date PE is determined. Some women may also be eligible for coverage prior to the date PE began if the woman met eligibility requirements.

J. Qualified Providers

1. What is a qualified provider (QP)?

A QP is a provider that meets the following criteria:

- Enrolled as a provider in the Indiana Health Coverage Programs (IHCP)
- Capable of verifying pregnancy via a professionally administered pregnancy test (home-administered tests do not meet this requirement)
- Attended a qualified provider training session provided by the FSSA or designee
- Currently providing outpatient hospital, rural health clinic, or clinic services, as defined in [BT200910](#)
- Able to access Web interChange, a printer, and a fax machine
- Allows PE applicants to use an office phone to facilitate the PE and Hoosier Healthwise enrollment process

2. What type of providers should consider signing up to be a QP?

A QP may be one of the following provider types: a family or general practitioner; a pediatrician; an internist; an obstetrician or gynecologist; a certified nurse midwife; an advanced practice nurse practitioner; a federally qualified healthcare center; a medical clinic; a rural health clinic; an outpatient hospital; a local health department; or a family planning clinic.

3. What are the responsibilities of a QP?

Qualified providers help women enroll in the PE program by explaining PE and facilitating the joint PE and Medicaid application process. The application process follows:

- The qualified provider verifies the client's pregnancy. Tests performed by the qualified provider or by other licensed practitioners are acceptable forms of verification. Home pregnancy tests are not acceptable forms of verification.
- The qualified provider gathers information from the pregnant woman and enters this information into the Web interChange PE application system.
- If the woman meets all eligibility requirements, the system responds with a determination notice of PE approval, which the QP provides to the pregnant woman.
- If the woman does not meet all eligibility requirements, the system responds with a determination notice of PE denial, which the QP provides to the pregnant woman.

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- The qualified provider directs pregnant women approved for PE coverage to use the QP's telephone to contact the enrollment broker to select a primary care provider and an MCO.
- The enrollment broker activates the pregnant woman's PE once her PMP and MCO selections have been made.
- The QP provides the Hoosier Healthwise Application for the pregnant woman to review and sign.
- The QP faxes the Hoosier Healthwise Application to the DFR.
- To complete the process for determining if she is eligible for ongoing Medicaid coverage, the DFR contacts the client at a later date and directs her to schedule an interview and submit verification documents (for example, proof of income, residency, and so on). If the woman does not respond to the DFR's requests within the timeframes provided by the DFR, she is denied ongoing Medicaid coverage and her PE coverage ends.

4. How can I become a qualified provider?

To become a qualified provider, you must meet all the requirements listed in question J-1. Refer to [BT200910](#) for detailed instructions.

5. How do I sign up for training?

Your office administrator should complete the prequalification questions on Web interChange at <https://interchange.indianamedicaid.com/Administrative/logon.aspx>.

[BT200910](#) contains detailed instructions.

6. What if training has already occurred in my area, but I missed the session?

HP Provider Relations staff can come to your office and provide one-on-one training for you and your office personnel. Please contact the PE Provider Relations Field Representatives at (317) 488-5363 if you have any questions.

7. Can eligibility assistance companies perform QP functions for PE?

Eligibility assistance companies may not perform qualified provider functions for presumptive eligibility (PE). Only employees of the qualified provider may perform QP functions. If there are questions about which staff can perform QP functions on behalf of the QP, the QP can submit questions by email to Pehelp@fssa.in.gov.

8. Can I train other people in my office, or does everyone have to be trained by the HP Provider Relations Field Consultant?

You may train other staff in your office to complete the PE Application for Pregnant Women.

9. Are we required to submit the names of the people in our office who have been trained?

No.

10. What if we decide we no longer want to be a qualified provider for presumptive eligibility?

You may change your Web interChange enrollment settings; however, before discontinuing the program, please contact the HP Provider Relations Representative. If you have specific concerns about the PE program, you may also submit them to Pehelp@fssa.in.gov.

K. Other

1. Will notifications of pregnancy (NOP) be reimbursed for PE members?

Yes. When performing NOP tasks for a woman determined to be eligible for presumptive eligibility and who has been enrolled with one of the MCOs, the provider should print a blank NOP form and complete the required information gathered from the patient. On the day after the QP makes the PE determination, the provider may enter the PE member's NOP into Web interChange. Upon successful submission of the NOP for the member, the provider should submit a claim to the member's MCO. Providers receive \$60 for submitting each valid NOP form.

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More information about the NOP process can be found at the following Web site:
<http://www.indianamedicaid.com/ihcp/MCE/content/nopInfo.asp>.

- 2. How is the OMPP planning to communicate information about this program in communities?**
The OMPP is developing a PE brochure which will be available to providers, community organizations, and others for distribution to potential members.

- 3. Will there be TV or print media to notify the public that this program is available?**
There are no plans for a media campaign at this time. A member brochure is currently under development.