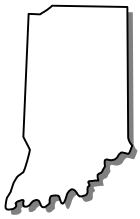
Indiana Health Coverage Programs



P R O V I D E R B U L L E T I N

B T 2 0 0 3 0 3 J A N U A R Y 3 1 , 2 0 0 3

To: All Providers, Clearinghouses, Billing Services, and Value Added Networks

Subject: *270/271 – Eligibility Request and Response* Transaction Implementation

Overview

Effective April 2003 the Office of Medicaid Policy and Planning (OMPP) begins implementation of the most significant change to the Indiana Health Coverage Programs (IHCP) since the introduction of the Hoosier Healthwise Package C – Children's Health Insurance Plan in 2000. The *Health Insurance Portability and Accountability Act* (*HIPAA*) *of 1996* mandates this implementation. This bulletin provides information about the first transaction to be implemented and the associated HIPAA-mandated changes. The first transaction and the associated changes are as follows:

- Trading partner agreement
- Amended provider agreement
- *270/271 – Eligibility Request and Response* transactions

This is the first in a series of publications addressing HIPAA-required changes. An interim provider manual produced in CD format addressing only HIPAA changes will be published prior to the implementation of each transaction. The interim manual will be revised to include new information with the implementation of each transaction.

Provider training is scheduled to occur prior to implementation of each transaction or HIPAA-mandated change. Providers will be notified about the training location, dates, and times with future bulletins.

The goal of the IHCP is to keep the provider community informed of the required changes to the IHCP programs, the business processes, and how and when these changes affect providers.

HIPAA

The *HIPAA of 1996* contains three major provisions:

- Portability
- Medicare Integrity Program/Fraud and Abuse
- Administrative Simplification

The *Administrative Simplification* provision mandates standard electronic transactions and code sets, across the health care industry, standardizing electronic data interchange (EDI) to provide more efficient and effective service. The requirements also regulate format and content standards, and establish security and privacy standards for health care information.

The administrative simplification requirements apply to all covered entities, including the following:

- All health plans, including Medicare, Medicaid, and commercial plans
- Providers that transmit or store health information electronically
- Health care clearinghouses, billing services, vendors, and value added networks (VANs)

Implementation Sequence

The IHCP is following a phased approach for modifying Indiana*AIM* and business processes to comply with HIPAA requirements.

Future plans include user acceptance testing (UAT) for the system modifications, publishing local code cross-walk information and paper claim revisions, and further education and outreach for the provider community. Table 1.1 provides an implementation schedule that may be subject to change. Watch for additional information in upcoming bulletins and banner pages.

Table 1.1– Sequenced HIPAA Implementation Dates

Sequence Implementation		
Transaction or Required Change	**Description**	**Implementation Period**
270/271 – Interactive	Eligibility Request and Response	April/May 2003
270/271 – Batch	Eligibility Request and Response	May/June 2003
820	Premium Payments	May/June 2003
834	Enrollment	May/June 2003
U271	Unsolicited Eligibility Request and Response	May/June 2003
837I	Institutional Claims	July/August 2003
837P	Professional Claims	July/August 2003
837D	Dental Claims	July/August 2003
835	Remittance Advice	August 2003
276/277	Claim Status Request and Response	September/October 2003
278	Referral Certification/Authorization	October 2003
Local Codes	Elimination of Local Codes	October 2003
Anesthesia	Mandated use of CPT (current procedure terminology) Anesthesia Codes	July/August 2003

Amended IHCP Provider Agreement

The *IHCP Provider Agreement* has been amended to accommodate the trading partner agreements required of the OMPP for entities who submit data electronically and to comply with HIPAA Privacy Rule requirements. The following obligation has been added to the provider agreement:

> "Provider agrees to notify the IHCP in writing of the name, address, and phone number of any entity acting on provider's behalf for electronic submission of provider's claims. Provider understands that the State requires 30-days prior written notice of any changes concerning Provider's use of entities acting on Provider's behalf for electronic submission of Provider's claims and that such notice shall be provided to the IHCP."

This bulletin provides the required 45-day notice of a policy change for enrolled providers. It will not be necessary for currently enrolled providers to sign a new agreement. New providers will enroll with, and sign, the amended provider agreement.

Trading Partners

The IHCP prepared the following information to assist with establishing an EDI relationship with the IHCP. Becoming a trading partner is an electronic process initiated through the IHCP Web site. Look for HIPAA information at www.indianamedicaid.com.

A trading partner is defined as an entity exchanging data with an organization electronically. The trading partner may send and receive information electronically. The following are examples of trading partners:

- Providers using approved vendor software
- Clearinghouse
- Billing service
- Managed care organization (MCO)
- Medicare intermediary/carrier
- VAN (interactive transactions only)

The *Provider Implementation Procedures* section of this bulletin explains the process for becoming a trading partner to billing providers.

The *Testing and Implementation Procedures* section of this bulletin describes the testing and implementation process for software vendors, clearinghouses, VANs, MCOs, and Medicare intermediaries/carriers.

Provider Implementation Procedures

IHCP billing providers desiring to exchange data directly to or from the IHCP must use an approved software vendor or clearinghouse. All vendor software products and clearinghouse application systems must go through the testing and approval process before their product can be used for production EDI exchange. Providers creating their own software to send or receive electronic transactions are considered vendors and must follow the testing and implementation procedures in the *Testing and Implementation Procedures* section of this bulletin.

Contact Vendor

Providers must contact their software vendor or clearinghouse to verify they have completed the testing and approval process. If they have not, the software vendor or clearinghouse must follow the

testing and implementation procedures described in the *Testing and Implementation Procedures* section of this bulletin.

Providers creating their own software to send or receive electronic transactions are treated as vendors and must follow the testing and implementation procedures in the *Testing and Implementation Procedures* section of this bulletin.

Providers who are not currently exchanging data electronically can choose from a list of *approved software vendors*. There is no affiliation between the IHCP and any of the companies on the approved vendor list. It is the responsibility of the provider to select a vendor based on specific business needs.

Trading Partner Profile

The IHCP requires that billing providers complete and submit the *IHCP Trading Partner Profile* during the initial assessment period. Click the above link to access, complete, and submit this document. The *IHCP Trading Partner Profile* is the tool that the provider must use to notify the IHCP about the types of transactions they will exchange and the software they will use. The IHCP is implementing the different transactions with a phased approach. Therefore, a billing provider may need to update the profile as transactions are implemented. After the initial setup, the *IHCP Trading Partner Profile* is used to inform the IHCP of any changes to the vendor software, billing service, or clearinghouse selection.

If a provider wants to receive an outbound transaction via a clearinghouse, for example the *835 – Remittance Advice*, it is the provider's responsibility to complete and send the *IHCP Trading Partner Profile* form to EDS as the authorization for the IHCP to release the provider's data to the clearinghouse.

> *Note: OMNI users are required to complete and submit the IHCP Trading Partner Profile form to advise the IHCP that they will continue to verify eligibility with OMNI, and will upgrade to the standard HIPAA-compliant 270/271 – Eligibility Request and Response transaction.*
>
> *OMNI users are not required to submit a signed trading partner agreement for eligibility transactions. However, if using another vendor's eligibility software, or sending any other data electronically, a trading partner agreement is required.*

Trading Partner Agreements

Billing providers using approved software products are considered trading partners and must send a signed *IHCP Trading Partner Agreement* before they can send production submissions. The trading partner agreement is a contract between parties who have chosen to become electronic business partners. The trading partner agreement stipulates the general terms and conditions under which the partners agree to exchange information electronically. If billing providers send multiple transaction types electronically, only one signed trading partner agreement is required.

Billing providers must print and complete a copy of the trading partner agreement. Click the above link to access this document. Electronic versions are not accepted. A paper copy of the trading partner agreement can be printed from the above link and must be signed and mailed to the following address:

EDS
Trading Partner Agreement
950 North Meridian Street
10th Floor
Indianapolis, IN 46204

Upon receiving the *IHCP Trading Partner Profile* form and the signed *IHCP Trading Partner Agreement*, the billing provider will be approved to exchange production data. Written notification of approval will be mailed to the trading partner. The written approval contains trading partner ID, login ID, password, and other communication information.

If a billing provider is submitting through a clearinghouse or billing service, the clearinghouse or billing service is the trading partner and a trading partner agreement is not required from the individual provider.

Companion Guides

Companion guides are created for each transaction to explain the IHCP EDI requirements. IHCP companion guides are located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/TP_testing_procedures.asp. Companion guides will be available as they are published.

Testing and Implementation Procedures

Software vendors, clearinghouses, billing services, VANs, MCOs, and Medicare intermediaries/carriers seeking approval of their products should review the IHCP EDI requirements presented in this document. A careful assessment should be made of the changes needed to both their business and technical operations to meet the IHCP HIPAA-compliant EDI processing requirements.

The testing process may take several days or weeks depending on the organization's prior experience with EDI. The IHCP requires each testing entity to complete and submit the *IHCP Trading Partner Profile* during the initial assessment period. The information requested on the form includes the following:

- Company name
- Contact information
- Networking preferences
- Selection of transaction sets

Upon receipt of the profile form, the IHCP sends the testing set-up information required for the initial test transmission to the testing entity. Some of the information included is the trading partner ID, logon ID, password, and additional testing instructions.

Application Development

The testing entity must modify their business application systems to comply with the IHCP companion guides. Accuracy must be tested to ensure that the systems effectively process all transactions. The testing entity must determine the modifications and additions to their technical infrastructure needed to perform and support communication functions. Connectivity testing is performed with the transmissions to ensure a successful connection between the sender and receiver of data.

Testing Process Per Transaction

Three levels of testing are required:

- Compliance testing
- IHCP specification validation testing
- End to end testing

Compliance Testing

All transactions must meet the following basic levels of testing compliance:

- Integrity
- Requirements
- Balancing
- Situational

Although third-party HIPAA certification is not required, the above levels of compliance are required and must be tested. Notification of compliance is accomplished when the transaction is processed without errors and either the response transaction or a *997 – Acknowledgement* is produced.

IHCP Validation Testing

Validation testing ensures conformity to the IHCP companion guides. In this phase, testing ensures the segments or records of data that differ based on certain health care services are properly created and produced in the transaction data formats. Validation testing is unique to specific relationships between entities and includes testing of field lengths, output, security, load/capacity/volume, and external code sets. Please review the IHCP companion guides for specific information.

End to End Testing

This level of testing ensures a successful completion of the transmission. It originates from the sender as an inbound transaction, proceeds through system processing, and ends with a successful outbound transaction back to the sender. For example, this level tests processing inbound *837 – Claims and Encounters* transactions and follows through to create outbound *835 – Remittance Advice* transactions.

Approval Process

The approval and testing process is different for software vendors, billing services, and clearinghouses. The different methods are described in the following subsections.

Software Vendors

Upon completion and approval of testing, the IHCP will send written notification of approval to the testing vendor.

Vendors should inform their providers that they have completed testing. The provider is not activated for production until the IHCP receives the *IHCP Trading Partner Profile* and a signed trading partner agreement from the provider.

Clearinghouses and Billing Services

Upon completion and approval of testing, clearinghouses and billing services must send a signed trading partner agreement for their clearinghouse or billing service. When the signed trading partner agreement is received, the IHCP sends written approval notification to the clearinghouse. The written approval includes trading partner ID, logon ID, password, modem telephone number, and other communication information.

It is the responsibility of the provider to send the trading partner profile form to the IHCP to link the clearinghouse and the provider for outbound transactions such as the *835 – Remittance Advice*.

VANs

Upon completion and approval of testing, the VAN must send a signed trading partner agreement. When the signed trading partner agreement is received, the IHCP sends written approval notification to the VAN. The written approval includes trading partner ID and other communication information.

MCOs

Upon completion and approval of testing, a signed trading partner agreement must be received for the MCO. After the IHCP has received the signed trading partner agreement, written approval notification is sent to the MCO. This written approval includes trading partner ID, logon ID, password, modem telephone number, and other communication information.

Medicare Intermediaries/Carriers

The IHCP must receive a signed trading partner agreement from each Medicare intermediary/carrier. After the IHCP has received the signed trading partner agreement, written approval notification is sent to the Medicare intermediary/carrier.

270/271 – Eligibility and Response Transaction Implementation

The final rule for Transactions and Code Sets establishes standards for EDI and external medical data code sets. Transactions are guidelines for transmitting medical billing information between providers and payers. The HIPAA transaction requirements noted in this bulletin are based on the implementation specifications adopted in the final transaction and code set rule.

Table 1.2 – EDI Transaction Type and HIPAA Requirements

Transaction Type	HIPAA Standard
Eligibility inquiry and response	ASC X12N 270/271 – Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000

The directions for proper execution of each transaction included in the EDI standards are contained in the transaction implementation guides. The X12N transaction HIPAA implementation guides are

available on the Washington Publishing Company Web site at http://www.wpc-edi.com/hipaa/HIPAA_40.asp. As stated previously, companion guides for the IHCP are located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/TP_testing_procedures.asp. The IHCP companion guides are used in association with the implementation guides.

Transaction Impact

Changes were made to the Eligibility Verification Systems (EVS) to achieve compliance with the requirements of the *270/271 – Eligibility Request and Response* transaction. EVS includes the Automated Voice Response (AVR) system, National Electronic Claims Submission (NECS), Provider Electronic Solutions, EDS interChange, and the OMNI terminal. Changes to the EVS affected the following three subsystems:

- AVR
- EDS interChange
- OMNI

The following two subsystems will not be affected by the 270/271 transaction but will no longer be supported after October 15, 2003:

- NECS
- Provider Electronic Solutions

Regardless of the method used to verify eligibility, the following guidelines apply:

- If the member has a primary care provider, the physician identified must be contacted to determine if a referral is needed.
- If the member is a risk-based managed care (RBMC) member, the MCO identified in the response must be contacted for more specific eligibility and benefit limitations.
- It is important to consult the *IHCP Provider Manual*, especially *Chapter 2: Member Eligibility and Services*, *Chapter 6: Prior Authorization*, and *Chapter 8: Billing Instructions*. The *IHCP Provider Manual* is available at www.indianamedicaid.com.
- If the member is covered under an MCO for services other than dental, the benefit limitation information provided in the eligibility verification response may not be an accurate reflection of the services provided.
- Benefit limits only reflect claims that process and pay in Indiana*AIM*.

Eligibility Verification Systems

Providers should obtain eligibility information before providing service to a member. This information includes eligibility dates, third party liability, benefit limits, lock-in status, and personal resources. The provider submits a transaction with the pre-determined query information. In response, a transaction is returned that identifies the member's eligibility status in various areas. Verifying eligibility at the point of service reduces the risk of providing services to ineligible members.

AVR System

There are no changes to the current AVR system accessed by telephone. AVR continues to communicate the IHCP benefit packages, basic eligibility, and benefit limitations currently displayed.

Provider access to the AVR does not have any changes related to HIPAA because it is not an electronic transaction. The information communicated back to the provider about a member's eligibility and related benefit package information remains the same. It is important to listen to the entire message. There may be information about a member's eligibility, including the transaction verification number, that can affect covered services and reimbursement.

NECS Eligibility Verification System

Due to changes required by HIPAA, the NECS software will only be supported through October 15, 2003.

> *Note: NECS is only available during the transition period through October 15, 2003. Providers verifying eligibility electronically on October 16, 2003, and after, must use a HIPAA-compliant transaction.*

It is important to note that during the transition period through October 15, 2003, the current method for submitting a request to obtain eligibility information using the NECS does not change. It is important that providers read the entire eligibility message. There may be information about a member's eligibility that affects covered services and reimbursement. On October 16, 2003, and after, the NECS option will not be available.

Provider Electronic Solutions

Due to changes required by HIPAA, the Provider Electronic Solutions software will only be supported through October 15, 2003. Until that time the IHCP basic eligibility and benefit limitation information continues as currently displayed.

> *Note: Provider Electronic Solutions is only available during the transition period through October 15, 2003. Providers verifying eligibility electronically on October 16, 2003, and after, will be required to use a HIPAA-compliant transaction.*
>
> *It is important to note that during the transition period until October 15, 2003, the current method for submitting a request to obtain eligibility information using the Provider Electronic Solutions software is not changing. It is important to read the entire eligibility message. There may be information about a member's eligibility that can affect covered services and reimbursement. On October 16, 2003, and after, the Provider Electronic Solutions option will not be available.*

EDS interChange

Eligibility inquiries by EDS interChange continues to allow providers to verify eligibility by member ID number, Social Security number, Medicare number, or name and date of birth. The response provides the same information as the other EVS options.

> *Note: At some point during the transition period on or before October 15, 2003, the current process and display information for both the inquiry and response using EDS interChange will undergo the changes required for direct data entry (DDE) HIPAA-compliance. It is important to read the entire eligibility message. There may be information about a member's eligibility that can affect covered services and reimbursement.*

To apply for an EDS interChange user ID and password, complete the access request form available at https://interchange.indianamedicaid.com. Print the form and mail it to the address shown on the form. Providers are notified by e-mail when the application is approved. Direct questions about EDS interChange to the Electronic Solutions Help Desk at (317) 488-5160.

OMNI 380 Terminal

The OMNI 380 terminal, commonly referred to as the OMNI Swipe Card Device or OMNI, is a swipe card or manual entry terminal similar to credit card machines used by businesses. The OMNI terminal is a box about the size of a small telephone answering machine. The OMNI 380 terminal is equipped with a keypad, similar to a touch-tone telephone. The required information can be keyed manually if the member ID card is not available. The terminal uses the optional Verifone P250 printer that can be purchased with the OMNI 380 terminal or separately.

The OMNI 380 terminal is designed to take advantage of the magnetic strip on the member ID card. By swiping the member's plastic ID card, providers can obtain eligibility verification online. The information can also be printed if a printer is available. The OMNI provides information required to ensure a member meets eligibility requirements for the applicable services.

Information about purchasing an OMNI 380 terminal and a Verifone P250 printer can be obtained by contacting the OMNI Help Desk at (317) 488-5051 locally or (800) 284-3548.

> *Note: Pharmacy providers cannot use the OMNI terminal as a point of service system to submit claims. Pharmacy providers must contact ACS for information about NCPDP eligibility or claims transactions. Watch future bulletins and banner pages for the official pharmacy transition date.*

Providers who want to purchase the OMNI terminal and printer can contact EDS at the phone number listed in Table 1.3. Providers who have an OMNI terminal must download the upgrade information. Providers have until October 15, 2003, to download the HIPAA-compliant version of the OMNI 380 terminal. Download instructions are provided in the section of this bulletin titled *Download Instructions for OMNI Terminal Upgrade.*

Table 1.3 – OMNI Equipment Pricing Information

OMNI Equipment Pricing Information			
Equipment Description	**Subtotal**	**6 Percent IN Sales Tax**	**Grand Total**
OMNI 380 Terminal	$391.00	$23.46	$414.46
Verifone P250 Printer	$258.00	$15.48	$273.48
Combination OMNI 380 + P250 Printer	$649.00	$38.94	$687.94
1) Comes with a one year warranty and includes shipping and handling. 2) Prices are subject to change. Contact the OMNI Help Desk locally at (317) 488-5051 or 1-800-284-3548 for additional information.			

Upgraded OMNI System Information

Beginning April 30, 2003, the upgraded OMNI will display new HIPAA-compliant basic eligibility and benefit limitation information associated with the benefit packages listed below:

- Traditional Medicaid Program
- *Medicaid Select*
- 590 Program
- Hoosier Healthwise Program
  - Hoosier Healthwise Package A – Standard Plan
  - Hoosier Healthwise Package B – Pregnancy Coverage
  - Hoosier Healthwise Package C – Children's Health Insurance Plan
  - Hoosier Healthwise Package D – Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses
  - Hoosier Healthwise Package E – Emergency Services

Basic eligibility includes all of the information included in the current display and printout. Provider specific benefit limitation information may or may not be included on what is seen and received on the display. After implementation of the 270/271 transaction, benefit limitation information is received only if the option is specifically selected in the requesting transaction.

Note: Benefit limitation audit information continues to be determined by provider type and specialty. However, providers wishing to receive benefit limitation information for their provider type and specialty are required to include the appropriate Service Type Code for these benefit limitations in the original transaction requesting eligibility.

*Note: All providers using the OMNI terminal must download upgrades to their terminal **on or after May 1, 2003,** to activate the eligibility changes. Complete download procedures are provided in this bulletin.*

Download Instructions for OMNI Terminal Upgrade

Table 1.5 provides complete instructions for downloading the upgrades for the OMNI terminal. Read the download instructions and complete the steps in the order listed. The download procedure takes approximately 15 to 20 minutes to complete. If the OMNI terminal is connected to a fax machine or other telephone line, please disconnect any other lines and connect the OMNI line directly to the phone outlet during the download period. Failure to do so could result in a failed download. The download procedures must be completed for each OMNI terminal.

Do not download to the OMNI terminal until May 1, 2003, or later. Providers have until October 15, 2003, to download the HIPAA-compliant version. Your OMNI terminal will not be available for eligibility verifications during the entire download process. Providers can upgrade anytime between May 1 and October 15. It is suggested that providers use the download schedule in Table 1.4.

Table 1.4 – Suggested OMNI Upgrade Download Schedule

OMNI Upgrade Download Schedule		
Provider Last Name	**From**	**To**
A-E	May 1, 2003	May 31, 2003
F-H	June 1, 2003	June 30, 2003
I-L	July 1, 2003	July 31, 2003
M-R	August 1, 2003	August 31, 2003
S-T	September 1, 2003	September 30, 2003
U-Z	October 1, 2003	October 15, 2003

Table 1.5 – Description of OMNI Terminal Upgrade

Step	**OMNI Display Reads**	**Action**
1	WELCOME TO INAIM/SELECT A TRANS	Press **7**
2	MAINTENANCE	Press **FUNC/ENTER**
3	SET DATE/TIME	Press **FUNC/ENTER**
4	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 5.)
5	PROV KEY CHANGE	Press **FUNC/ENTER**
6	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 7.)
7	RETRY PRINTER	Press the **FUNC/ENTER** key
8	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 9.)
9	CHANGE CONFIG	Press **FUNC/ENTER**
10	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 11.)

(Continued)

Table 1.5 – Description of OMNI Terminal Upgrade

Step	OMNI Display Reads	Action
11	INFO DISPLAY	Press **FUNC/ENTER**
12	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 13.)
13	ACTIVITY REPORT	Press **FUNC/ENTER**
14	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 15.)
15	KEY BEEP ON/OFF	Press **FUNC/ENTER**
16	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 17.)
17	DOWNLOAD	Press **FUNC/ENTER**
18	(Y or N)	Press ***** for yes
19	`Dial 18009319001, or Dial 9,18009319001`	No action required.
20	`CONNECTED`	No action required.
21	`START DOWNLOAD`	The telephone line connection to the OMNI terminal must not be interrupted at this time. The terminal displays `START DOWNLOAD` for approximately 15 to 20 minutes.
22	`DOWNLOAD SUCCESS` (Download is complete)	Press **CLEAR** twice
23	`IS PRINTER OK`	If a printer is connected to the OMNI, press ***** twice for yes. If there is no printer attached, press **#** twice for no.

Download Failed Message

A `Download Failed` message could indicate that all download telephone circuits were busy when the download was initiated. To restart the download dial-up, please perform the steps in Table 1.6.

Table 1.6 – Description of Download Restart

Step	OMNI Display Reads	Action
1	`DOWNLOAD FAILED`	Press **CLEAR**
2	`System = V8`	Press **0** (zero)
3	`Download Partial or Full`	Press **FUNC/ENTER**

(Continued)

Table 1.6 – Description of Download Restart

Step	OMNI Display Reads	Action
4	`Dial 1,800,931.9001 or your access number followed by a comma and 1,800,931,9001`	No action required.
5	`CONNECTED`	Continue with step 21 of Table 1.5.

If the `Download Failed` message continues, call the OMNI Support Help Desk at (317) 488-5051 in the Indianapolis local area or 1-800-284-3548.

Download Success

When a `Download Success` message appears, on or after May 1, 2003, the OMNI terminal download includes HIPAA compliant *270/271 – Eligibility Request and Response* formats.

Terminal Setup

If the telephone line connection to the OMNI terminal requires an access code such as a **9** to access an outside line, that access code must be replaced in the OMNI *dial-out* phone number after the download is successful.

If a provider number is mapped to one particular key, the provider number must be remapped after the download is successful.

Tables 1.7 and 1.8 provide complete instructions for adding an access code and mapping a provider number.

Please complete the instructions in Table 1.7 to add an access code to the dial-out phone number.

Table 1.7 – Adding An Access Code

Step	OMNI Display Reads	Action
1	`WELCOME TO INAIM/SELECT A TRANS`	Press **7**
2	`MAINTENANCE`	Press **FUNC/ENTER**
3	`SET DATE/TIME`	Press **FUNC/ENTER**
4	`(Y or N)`	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 5.)
5	`PROV KEY CHANGE`	Press **FUNC/ENTER**

(Continued)

Table 1.7 – Adding An Access Code

Step	OMNI Display Reads	Action
6	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 7.)
7	RETRY PRINTER	Press **FUNC/ENTER**
8	(Y or N)	Press **#** for no (Do not press the ENTER key at this time. Proceed to step 9.)
9	CHANGE CONFIG	Press **FUNC/ENTER**
10	(Y or N)	Press ***** for yes
11	#PH = 18009319001 or #PH = 9505829 Either number is correct, depending on your location in the State. This number is used in Step 13.	Press **8** (change key)
12	INPUT #PH	Type specific access code (for example, 9)
		Press ***** for yes
		Press **ALPHA**
13	9, or your access code followed by a comma	Type in **18009319001** or **9505829.** This number depends on the number in the configuration. Use the number displayed in step 11.
14	9,18009319001 or your access code followed by a comma and 18009319001. Or 9,9505829 or your access code followed by a comma and 9505829.	Press **FUNC/ENTER**
15	#PT = 04	Press **CLEAR**
16	WELCOME TO INAIM/ SELECT A TRANS	Access code has been added. Eligibility transactions can now be sent.

Table 1.8 provides instructions for mapping a provider number.

Table 1.8 – Mapping a Provider Number

Step	OMNI Display Reads	Action
1	WELCOME TO IN/AIM SELECT A TRANS	Press **7**
2	MAINTENANCE	Press **FUNC/ENTER**
3	SET DATE/TIME	Press **FUNC/ENTER**

(Continued)

Table 1.8 – Mapping a Provider Number

Step	OMNI Display Reads	Action
4	(Y or N)	Press **#** for no
5	PROVIDER KEY CHANGE	Press **FUNC/ENTER**
6	(Y or N)	Press ***** for yes
7	KEY NUMBER	Press the desired key (0-9)
8	PROVIDER ID	Type the nine-digit provider number. The number typed displays. Press **FUNC/ENTER**
9	KEY = X = XXXXXXXXX (Displays numbers keyed)	Verify that the key number and the provider number are correct. Press **FUNC/ENTER**
10	UPDATE KEY	Press **FUNC/ENTER**
11	(Y or N)	Press ***** for yes
12	PROVIDER KEY CHANGE	Press **FUNC/ENTER**
13	(Y or N)	Press ***** for yes to add more provider keys. This returns you to Step 7. Press **#** for no to map only one number and continue to Step 14.
14	RETRY PRINTER	Press **CLEAR** to exit MAINTENANCE.
15	WELCOME TO IN/AIM	Ready for transaction

Upgraded OMNI Provider Inquiry Request Prompts

Table 1.9 describes the process for performing an eligibility transaction using the OMNI terminal. Ensure that the display reads WELCOME TO INAIM / SELECT A TRANS before beginning the transaction. Press the **Clear** key to return to the *Welcome* screen.

Table 1.9 – OMNI Provider Inquiry

Step	OMNI Display Reads	Action
1	WELCOME TO INAIM/SELECT A TRANS	Press **1** or swipe the member's Hoosier Health card
2	PROVIDER ID	Type in the nine-digit IHCP provider ID, or press the number that is mapped in for the provider ID and press the **FUNC/ENTER**

(Continued)

Table 1.9 – OMNI Provider Inquiry

Step	OMNI Display Reads	Action
3	XXXXXXXXX	Verify that the provider number is correct, then press the **FUNC/ENTER** key
4	LOCATION CD	Press the **FUNC/ENTER** key to accept the A location code or type in the correct location code, then press **FUNC/ENTER**. To insert a space for the provider location code, press 0 and then <alpha><alpha>. Press the **Func/Enter** key.
5	SEARCH CRITERIA	Type in the search criteria code used to identify the member and press the **Func/Enter** key. Valid values are **R** for member ID, **N** for name/date of birth, **S** for Social Security number, or **M** for Medicare number. To type **R,** press **7** once, and **ALPHA** twice. The display reads **R**. Press the **FUNC/ENTER** key. To type **N**, press 6 once, and **ALPHA** twice. The display reads **n**. Press the **FUNC/ENTER** key. To type **S**, press **7** once, and **ALPHA** three times. The display reads **S**. Press the **FUNC/ENTER** key. To type in **M**, press **6** once, **ALPHA** once. The display reads **M**. Press the **FUNC/ENTER** key.
6a	**R** Depending on the search criteria selected the display reads RID NO.	Type in the RID number and press the **FUNC/ENTER** key.
6b	**S** SSN NO.	Type in the social security number and press the **FUNC/ENTER** key.
6c	**M** MEDICARE NO.	Type in the Medicare number and press the **FUNC/ENTER** key.
6d1	**N** FIRST NAME,	Type in the first name and press the **FUNC/ENTER** key.
6d2	LAST NAME	Type in the last name and press the **FUNC/ENTER** key. The DOB displays.
6d3	DOB	Type in the date of birth in the MMDDCCYY format.

(Continued)

Table 1.9 – OMNI Provider Inquiry

Step	OMNI Display Reads	Action
7	FM DOS MMDDCCYY	The current date displays in the MMDDCCYY format. If the member ID card is swiped, the member ID automatically populates. Press the **FUNC/ENTER** key to verify the current date, or type in the desired date in the MMDDCCYY format. Press the **FUNC/ENTER** key
8	TO DOS MMDDCCYY	The current date displays in the MMDDCCYY format. Press the **FUNC/ENTER** key to verify the current date, or type in the desired date in the MMDDCCYY format. Press the **FUNC/ENTER** key.
9	SERVICE TYPE	Type in **30** for basic eligibility. For basic eligibility only, it is not necessary to type in any other codes. Press the **FUNC/ENTER** key. For more specific benefit limitations, type in the designated two-character alpha number for the service type being requested for benefit limits. Any code selected includes basic eligibility, so service type 30 does not need to be included when requesting other benefit limitations. Press the **FUNC/ENTER** key to type in more benefit limitation requests or press ***** to end this list and continue on to the next field. *(A provider can request up to twenty service types per member.) Please refer to the list below to determine which audits have been mapped for each provider type. Choosing codes other than those listed below returns only basic eligibility.*
	Your can repeat this step up to 20 times.	Then press ***** to end.
10	Send or Review	Press **0/Send** to begin the dialing process, or press **FUNC/ENTER** to review or change information.
11	DIAL XXXXXXXXX displays	The phone number displays as 1,8009319001 or 9505829. Wait for a response from the host.
12	WAIT ON RESPONSE	Take no action at this point.
14	PRINT OR DISPLAY	Displays when the response is received. Press the **ALPHA/Print** key to print the reply message or press the **FUNC/ENTER** key to review the reply message on the screen.
	Welcome to INAIM	Ready for another transaction

It is important to note that OMNI is still available to providers. The terminal can still be purchased and the member ID card can still be used with OMNI to verify eligibility. However, providers are now required to enter the *Service Type Code* for benefit limitations that are available for the inquiring

provider's type and specialty. Providers desiring only basic eligibility can type in **30** as the *Service Type Code*.

Table 1.10 provides the benefit limitation options that return information when selected by the appropriate inquiring provider. Only exceeded limits are provided.

Table 1.10 – Benefit Limitations

Provider Type	Service Type Code	Benefit Limitation Information
Transportation	56	20 one way trips
Optometry	AO	Lenses
Optometry	AM	Frames
Optometry	AL	Vision exams
Dental	23	X-rays – full mouth or panoramic
Dental	35	Oral exams
Dental	41	Preventive- prophylaxis
Dental	28	Fluoride treatments
Dental	24	Periodontal root planning
Dental	25	Restorative – dental cap
Physical Therapist	AE	Physical therapy treatments
Speech Therapist	AF	Speech therapy services
Occupational Therapist	AD	Occupational therapy services
Chiropractor	34	Chiropractic office visits
Chiropractor	33	Chiropractic treatments
Chiropractor	04	Chiropractic x-rays
Podiatrist	93	Podiatric services
Podiatrist	94	Podiatric office visits
Audiologist	71	Audiology assessments
Physician	98	Medical office visits
DME provider	18	$2000 annual limit
DME provider	12	$5000 lifetime limit
Mental health provider	A8	Outpatient mental health/substance abuse service limit without PA
Mental health provider	AI	Prior authorized outpatient mental health/substance abuse service limit
Rehabilitation facility	AB	Inpatient rehab services limit

Data communicated back to the provider about a member's basic eligibility and related benefit package information will have minimal changes. The member's address information is now displayed and prints on the OMNI print strip. There are also minor changes to the labels on the display and print strip derived from the industry standard naming conventions provided in the *National Electronic Data*

Interchange Transaction Set and Implementation Guide for the 270/271 standard transaction. Refer to Table 1.11 and Table 1.12 for a printout legend.

> *Note: It is important to read the entire message, as there may be information about the member's basic eligibility that can affect covered services and reimbursement.*

Table 1.11 – OMNI Screen Display Changes

Before April 30, 2003 you see:	On and After April 30, 2003 you see:
Indiana Eligibility Verification	Indiana Eligibility Verification
Provider Number 999999999 First Name: XXXXXXXX Last Name: XXXXXXX	**Provider** 999999999 **XXXXXXXXXXXXXXX** **XXXXXXXXXXXXXXX** **Street and Apt.** **Address line 2** **City** **State, ZIP**
RID No. 999999999999	**RID 999999999999**
	SSN 999 99 9999
Date of Birth mm/dd/ccyy	**DOB mm/dd/ccyy**
MEMBER IS ELIGIBLE/NOT ELIGIBLE	**ELIGIBLE/NOT ELIGIBLE**
FROM MM/DD/CCYY TO MM/DD/CCYY	**FRM MM/DD/CCYY** **TO MM/DD/CCYY**
FOR THE **590** PGM	FOR THE **XXXXXXXXXX** PGM (No change)
End of eligibility segments	
Verification Number: xxxxxxxxx	**Trace Number: xxxxxxxxx**
	BASIC ELIGIB
Managed Care No/Risk/Prim care case mgt/HHPD	Managed Care No/RBMC/PCCM/HHPD
LOCKIN N	**RESTRICTED N** /Y
SPENDDOWN Y	**SPENDDOWN Y** /N
SPENDDOWN NOT MET	
	MET MM/DD/CCYY
MEDICARE: PART A B AB	**MEDICARE PART A B AB**
MEDICARE ID NUMBER: 999999999A	**MEDICARE ID 999999999A**
Medicare Coinsurance Deductible Only	**Coinsurance Deductible Only** (Only if applicable)
QMB ONLY also/n	**QMB ONLY** also/n
OTHER PRIVATE	**COMMERCIAL Y** /N
Nursing Home I/S/R/ICF-MR/ Resident	**Nursing No** I/S/R/ICFMR

(Continued)

Table 1.11 – OMNI Screen Display Changes

Before April 30, 2003 you see:	On and After April 30, 2003 you see:
Patient Liability amt: $0.00	**HCF LIAB $999,999.99**
PRIM MED PROV	**PRIMARY PROV**
PROVIDER LAST NAME	**XXXXXXXXXXXXX**
PROVIDER FIRST NAME	**XXXXXXXXXXXXXX**
PROVIDER PHONE NUM (999) 999-9999	**PROVIDER PHONE #** **(999) 999-9999**
Man Care Org XXXXXXXXXXXXXX	Man Care Org XXXXXXXXXXXXXX
MCO PHONE NUM (999) 999-9999	MCO PHONE NUM (999) 999-9999
No LOCK-IN	**No Restr. Prov.**
MEMBER IS RESTRICTED TO XXXXXXXXXXXXXX	MEMBER IS RESTRICTED TO XXXXXXXXXXXXX
PROV TYPE XXXXXXXXXXX	PROV TYPE XXXXXXXXXXX
Provider number 999999999	**PROV NUMBER** **999999999**
NO INSURANCE	NO INSURANCE
Carrier Name XXXXXXXXXXXXX	**OTHER PAYER** **XXXXXXXXXXXXX**
POLICY NUMBER 9999999999999999	**POLICY NO** **99999999999999**
Carrier Code XXXXXXXXXX	Carrier Code XXXXXXXXXX
Coverage Types XXXXXXXXXXXXXXX	**TYPE OF COVER** **XXXXXXXXXXXXXXX**
End of TPL segments	
BENEFIT LIMITS REACHED FOR PROVIDER TYPE NONE	**BENEFIT LIMITS** **REACHED** (Displays audits that have been exhausted)
	PLEASE REFER TO **THE PROVIDER MANUAL FOR MORE DETAILS**
PRESS ENTER	**PRESS ENTER**
PRINT or DISPLAY	**PRINT or DISPLAY**
	See below for benefit limitation information examples
Benefit Limit Exhausted Responses	**BENEFIT LIMITS REACHED** (Displays only if exceeded)
Transportation Services	**TRANSPORTATION Y**

(Continued)

Table 1.11 – OMNI Screen Display Changes

Before April 30, 2003 you see:	On and After April 30, 2003 you see:
TRANPORTATION SERVICES: Y **Chiropractic Services** **CHIROPRACTIC VISITS: Y** **Physician Office Visits** **OFFICE VISITS: Y**	**CHIRO – OFFICE Y** **OFFICE – VISITS Y**

Note: Benefit limitations only appear when the appropriate provider type and specialty are verified and the requested service information has been exceeded.

Figure 1.1 provides an example of the OMNI eligibility verification response (EVR) reply printout. The fields are numbered on the example to correspond with the explanation offered in the legend on the left of the slip. The fields are not numbered on the actual OMNI slip. All fields are not shown on the OMNI print strip every time. The legend in Table 1.12 explains when those fields appear.

Indiana
Eligibility Verification

1. MM/DD/CCYY HH:MM
2. PROVIDER 999999999999
3. FIRSTNAME LASTNAME
4. Street Address, APT
5. City, State, Zip
6. MEMBER ID:: 999999999999
7. SSN: 999 99 9999
8. DATE OF BIRTH: MM/DD/CCYY

9. MEMBER IS ELIGIBLE/NOT ELIGIBLE
10. FROM MM/DD/CCYY TO MM/DD/CCYY
11. FOR THE XXXXXX XXXXXXXX PROGRAM

12. INQUIRY TRACE NO: 9999999999
13. BASIC ELIGIBILITY INDICATORS:
14. MANAGED CARE: No/HHPD/RBMC/PCCM
15. RESTRICTED: N/Y
16. SPEND DOWN: N/Y
17. SPEND DOWN MET DATE: MM/DD/CCYY
18. MEDICARE: PART A/B/AB
19. MEDICARE ID NUMBER: 9999999999
20. MEDICARE COINSURANCE/DEDUCTIBLE ONLY
21. QMB: N/O/A
22. COMMERCIAL INS: N/Y
23. NURSING FACILITY RESIDENT: N/I/S/R or NF/ICF/MR
24. HCF LIAB AMT: $999,999.99

42. BENEFIT LIMITS REACHED: exceeded y/n

PLEASE REFER TO THE PROVIDER MANUAL

FOR MORE DETAILS

Figure 1.1 – OMNI Eligibility Verification Slip

Table 1.12 – OMNI Verification Slip Legend

INDIANA ELIGIBILITY VERIFICATION SYSTEM LEGEND FOR THE OMNI ELIGIBILITY VERIFICATION SLIP	
Display Field	**Print Slip Value**
Basic eligibility provided for all Service Type Code selections	**Any code selected plus Basic Eligibility (Service Type Code 30)**
1. MM/DD/CCYY, HH:MM	Current date and time
2. PROVIDER NUMBER	Provider number
3. NAME	Member's name, first and last
4. ADDRESS	Member's Street, APT. Address
5. ADDRESS line 2	City, State, Zip
6. MEMBER ID	Member Identification number
Item 7 prints out only if keyed or swiped into the OMNI terminal	
7. SSN	Member Social Security number
8. DATE OF BIRTH	Member date of birth
9. MEMBER IS ELIGIBLE/ NOT ELIGIBLE	Only one displays
10. FROM/TO	Date of Service date range (more than one date range may appear)
Item 11 does not print out if not eligible	
11. FOR THE XXXXXX PROGRAM	Print out: **TRADITIONAL MEDICAID** **MEDICAID SELECT** **590 PROGRAM** **HH PKG A STANDARD** **HH PKG B PREGNANCY** **HH PKG C CHILDRENS PLAN** **HH PKG D WITH DISABILITIES AND CHRONIC ILLNESS SERVICE** **HH PKG E EMERGENCY SVCS**
12. INQUIRY TRACE NO.	Eligibility verification number
13. BASIC ELIGIBILITY INDICATORS	Header for section about Eligibility Indicators
14. MANAGED CARE	Print out indicates one of the following: No MS RBMC HHPD HH RBMC RBMC HH PCCM PCCM MS PCCM
15. RESTRICTED	**N**=No, **Y**=Lock-in applies, see items 32-36
16. SPEND DOWN	**N**=No, **Y**=Spenddown applies, see item 18
17. SPEND DOWN MET DATE	Only prints out if item 17 is Y and Spenddown has been met
18. MEDICARE	Medicare Part indicator **(PART A, PART B, PART AB**, or blank, see item 20 if item 19 is not blank)
19. MEDICARE ID NUMBER	Number prints out only if item 19 is not blank
20. MEDICARE COINSURANCE DEDUCTIBLE ONLY	**MEDICARE DEDUCTIBLE/CO-INS ONLY (Prints only for QMB only)**
21. QMB	Qualified Medicare Beneficiary indicator (**N**=No, **O**=Only, **A**=Also)
22. COMMERCIAL INS	**N**=No, **Y**=Other insurance, see items 38-41

(Continued)

Table 1.12 – OMNI Verification Slip Legend

INDIANA ELIGIBILITY VERIFICATION SYSTEM LEGEND FOR THE OMNI ELIGIBILITY VERIFICATION SLIP	
Display Field	**Print Slip Value**
23. NURSING FACILITY RESIDENT	For dates of service before October 1, 1998- N=No, I=Intermediate, S=Skilled For dates of service on or after October 1, 1998- NF=Nursing Facility, ICF/MR=Intermediate Care Facility for Mentally Retarded, N=NO, R=Rehabilitation
24. HCF LIAB AMT	Displays in dollars and cents
*If item 14 is **R** or **P**, items 26-28 print out:*	
25. THIS MEMBER'S PRIMARY CARE PROV IS	
26. PROVIDER NAME	PMP's Name
27. PROVIDER PHONE NUM	PMP's telephone number
*If item 14 is **RBMC** or **HHPD** items 28-30 print out*	
28. MANAGED CARE ORG	MCO's name
29. PHONE NUM	MCO's telephone number
*If item 15 is **Y**, then items 31-35 display. Items 31-35 can display up to 7 providers. If item 15 is **N**, then only item 31 prints out.*	
30. NO RESTRICTED PROV	
31. THE MEMBER IS RESTRICTED TO:	Header for the Lock-In information
32. PROVIDER NAME	Lock-In provider Name
33. PROVIDER TYPE	Lock-In provider type
34. PROVIDER NUMBER	**Lock-In Number of the Restricted Provider**
*If item 22 is **Y**, items 36-40 print out with up to 7 carriers. The Types of Coverage field can display up to 9 types of coverage per carrier. If item 22 is **N**, only item 35 prints out.*	
35. NO INSURANCE	
36. OTHER PAYER INFORMATION	Header for Other Insurance information
37. PLAN NAME	Insurance carrier name
38. POLICY NUMBER	Insurance policy number
39. CARRIER CODE	Carrier Code
40. TYPE OF COVERAGE	Listing of coverage on the policy
41. BENEFITS LIMITS REACHED FOR PROVIDER TYPE	Header for the benefits limits information. If the service types that were requested are code sets that AIM supports, then the appropriate audit messages should say exceeded or not exceeded. If non-supported service types are requested, then basic eligibility is given without the audit information. The word NONE should appear after line 42 in this case. The line below the OMNI print message indicates what the OMNI display should look like.
42. (Display of audits that have been exhausted)	**See examples below**
Print out legend (top) ***Display legend (bottom)***	**Service Type Code** **Benefit Explanation not provided in display or print out**
43. TRANSPORTATION SERVICES ***TRANSPORTATION***	**(Service Type Code 56)** Transportation benefit limit reached. (EOB 6803)

(Continued)

Table 1.12 – OMNI Verification Slip Legend

INDIANA ELIGIBILITY VERIFICATION SYSTEM LEGEND FOR THE OMNI ELIGIBILITY VERIFICATION SLIP	
Display Field	**Print Slip Value**
44. OPTOMETRY-LENSES ***OPT – LENSES***	**(Service Type Code AO)** Optometry Services for lenses benefit limit reached: (EOB 6600) For members 18 years of age and under. (EOB 6604) For members over 18 years of age.
45. OPTOMETRY-FRAMES ***OPT-FRAMES***	**(Service Type Code AM)** Optometry Services for frames benefit limit reached: (EOB 6601) For members 18 years of age and under. (EOB 6603) For members over 18 years of age.
46. OPTOMETRY-EXAMS ***OPT-EXAMS***	**(Service Type Code AL)** Optometry Services for exams benefit limit reached: (EOB 6610) For members 18 years of age and under. (EOB 6611) For members over 18 years of age.
50. DENTAL- DIAG XRAYS ***DIAG XRAYS***	**(Service Type Code 23)** Dental Services for full mouth, and panoramic x-rays benefit limit reached. (EOB 6209)
51. DENTAL CARE- EVALUATIONS ***ORAL EVALUATIONS***	**(Service Type Code 35)** Dental Services for periodic or limited oral evaluations benefit limit reached. (EOB 6211)
52. DENTAL-PREVENTIVE ***PREVENTIVE***	**(Service Type Code 41)** Dental Services for prophylaxis benefit limit reached: (EOB 6210) For non-institutionalized members age 18 months to 20 years. (EOB 6235) For non-institutionalized members 21 years of age and over. (EOB 6033) For prophylaxis benefit limit reached for institutionalized members of any age.
55. ADJUNCTIVE-FLUORIDE <= 20 YRS ***FLUORIDE <= 20***	**(Service Type Code 28)** Dental Services for fluoride treatments benefit limit reached for members, age 18 months to 20 years. (EOB 6212)
56. DENTAL-PERIODONTICS ***PERIODONTICS***	**(Service Type Code 24)** Dental Services for periodontal root planing benefit limit reached: (EOB 6221) For non-institutionalized members 4 to 20 years. (EOB 6223) For non-institutionalized members 21 and over. (EOB 6222) For institutionalized members of any age.
59. PHYSICAL MEDICINE ***THER-PHYSICAL***	**(Service Type Code AE)** Physical Therapy Services benefit limit reached. (EOB 6752) (EOB 6115)
61. THERAPY-SPEECH ***THER-SPEECH***	**(Service Type Code AF)** Speech Therapy Services benefit limit reached. (EOB 6060) (EOB 6116)

(Continued)

Table 1.12 – OMNI Verification Slip Legend

INDIANA ELIGIBILITY VERIFICATION SYSTEM LEGEND FOR THE OMNI ELIGIBILITY VERIFICATION SLIP	
Display Field	**Print Slip Value**
63. THERAPY-OCCUPATIONAL ***THER-OCCUPATNL***	**(Service Type Code AD)** Occupational Therapy Services benefit limit reached. (EOB 6753) (EOB 6118)
65. CHIROPRACTIC-OFFICE ***CHIRO-OFFICE***	**(Service Type Code 34)** Chiropractic Office Visits benefit limit reached (EOB 6101) (EOB 6111)
67. CHIROPRACTIC-TREATMENTS ***CHIRO-TREATMENT***	**(Service Type Code 33)** Chiropractic Therapeutic Physical Medicine Treatment Services benefit limit reached. (EOB 6100) (EOB 6112) (EOB 6122)
70. DIAGNOSTIC-XRAY ***DIAG XRAY***	**(Service Type Code 04)** Chiropractic X-rays Services benefit limit reached. (EOB 6105)
71. PODIATRY-FOOTCARE ***PODIA-FOOTCARE***	**(Service Type Code 93)** Podiatry Foot Care services benefit limit reached. (EOB 6855)
72. PODIATRY-OFFICE ***PODIA-OFFICE***	**(Service Type Code 94)** Podiatry Office Visits services benefit limit reached. (EOB 6090)
73. AUDIOLOGY EXAMS ***AUDIO EXAMS***	**(Service Type Code 71)** Audiological Assessments benefit limit reached. (EOB 6054)
74. OFFICE-VISITS ***OFFICE-VISITS***	**(Service Type Code 98)** Medical Office Visit Services benefit limit reached. (EOB 6012)
75. DME-$2000/YR ***DME-$2000/YR***	**(Service Type Code 18)** DME services benefit limit reached. (EOB 6113)
76. DME-$5000/LIFETIME ***DME-$5000/LIFE***	**(Service Type Code 12)** DME services benefit limit reached. (EOB 6114)
77. OUTPAT MNTL HLTH-W/O PA ***OTPT MH NO/PA***	**(Service Type Code A8)** Routine outpatient Mental Health/Substance Abuse Services benefit limit reached. (EOB 6120)
78. OUTPAT MNTL HLTH- W/ PA ***OTPT MH W/PA***	**(Service Type Code AI)** Prior authorized Outpatient Mental Health/Substance Abuse Services benefit limit reached. (EOB 6121)
79. INPATIENT-REHAB ***INPATIENT-REHAB***	**(Service Type Code AB)** Inpatient Rehab Services benefit limit reached. (EOB 6119)

Error Reporting with the OMNI Terminal

If information is incorrectly entered in the OMNI or the member is not eligible, the OMNI display indicates the errors. It can report up to nine errors per display.

If a printer is used with the OMNI, a print slip indicates the errors. Figure 1.2 is an example of a slip. Not all the fields print every time. Table 1.13 indicates when fields are included or excluded from the report. The item numbers do not print on the report, they appear in this example for easy reference to the legend.

```
1.  08/24/1998
2.  PROVIDER NUMBER:          999999999999
3.  RID NO:                   999999999999
4.  SSN:                      999 99 9999
5.  FIRST NAME:                     JANE A.
6.  LAST NAME:                      DOE
7.  DATE OF BIRTH:            03/20/1926
------------------------------------------------------------
8.  THE MEMBER IS NOT ELIGIBLE
9.  9999
10. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
11. 9999
12. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
13. 9999
14. XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
==================================
```

Figure 1.2 – OMNI Eligibility Error Report Slip

Table 1.13 – OMNI Error Report Slip Legend

INDIANA ELIGIBILITY VERIFICATION SLIP VERIFICATION SYSTEM LEGEND FOR THE OMNI ELIGIBILITY	
Display Field	**Print Slip Value**
1. MM/DD/YY, HH:MM	Current date and time
2. PROVIDER NUMBER	Provider number
3. RID NO	Member identification number
Items 4 prints out only if keyed or swiped into the OMNI terminal.	
4. SSN	Member Social Security number
5. FIRST NAME	Member first name
6. LAST NAME	Member last name
7. DATE OF BIRTH	Member date of birth
8. MEMBER IS NOT ELIGIBLE	Prints out only if member is not eligible or information entered does not fully match what is in the Indiana*AIM* System
The OMNI slip can reflect up to nine error codes and the corresponding description per verification as can be seen in the example above.	
9. ERROR CODE	Applicable error codes: 43 Invalid/missing provider identification 72 Invalid/missing subscriber/insured ID 57 Invalid/missing dates of service 43 Invalid/missing provider identification 56 Inappropriate data 15 Required application data missing 75 Subscriber/insured not found 62 Date of service not within allowable inquiry period 76 Duplicate subscriber/insured ID number 63 Date of service in future 51 Provider not on file 80 No response received
10. ERROR TEXT	Error text (See above)

Software Vendor, Clearinghouse, Private, or In-house Programming

Providers choosing to use software or EVS systems other than the systems provided by the IHCP must consult software vendors, clearinghouses, or other programmers to obtain these products. EDS works with many software vendors throughout the United States and continues to provide a list of approved software vendors to the IHCP provider community. There is no affiliation between EDS and any of these companies. It is the responsibility of the provider to select the appropriate vendor based on their specific business needs.

Providers, software vendors, and clearinghouses must refer to the IHCP Web site at www.indianamedicaid.com for trading partner information and the companion guides for the *270/271 – Eligibility Request and Response* transactions. EDS will be able to accept real-time and batch eligibility transactions from approved vendors or clearinghouses.

Resources

The following Web sites provide additional information about HIPAA:

- http://www.hcfa.gov/medicaid/HIPAA/adminsim/
- http://aspe.hhs.gov/admnsimp/
- http://www.hhs.gov/ocr/hipaa/
- http://aspe.os.dhhs.gov/admnsimp
- http://www.wpc-edi.com/hipaa/HIPAA_40.asp

Contact Information

Providers are reminded that any bulletins referenced in this publication are available on the IHCP Web site at www.indianamedicaid.com. If there are questions about the information in this bulletin, please call the OMNI Help Desk at (317) 488-5051 in the Indianapolis local area or 1-800-284-3548.