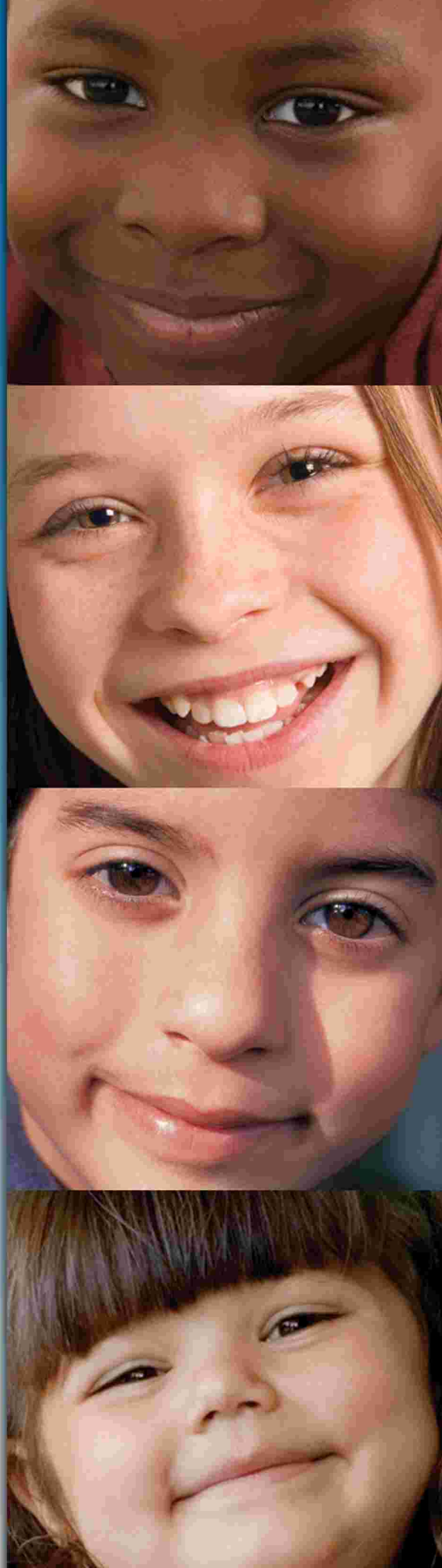
Children's Special Health Care Services Provider Manual



Indiana State Department of Health

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INTRODUCTION

Children's Special Health Care Services (CSHCS)

Mission Statement

The mission of the Children's Special Health Care Services (CSHCS) program is to assist individuals with serious and chronic medical conditions obtain comprehensive systems of care related to the participant's qualifying medical condition. The CSHCS program assists individuals from birth to 21 years of age (with the exception of Cystic Fibrosis participants, who may be on the program for life), who meet the program's financial and medical criteria. The program covers severe chronic medical conditions having lasted, or may be expected to last, at least two years; limits the participants' ability to function; and, without treatment, would produce a chronic disabling physical condition.

The Statutory authority for the CSHCS Program can be found in Indiana Code (IC) 16-35-2 and Indiana Administrative Code (IAC) 410 3.2. See:
http://www.in.gov/legislative/iac/iac_title?iact=410&iaca=3.2

Dear Provider:

Thank you for your interest in serving as a provider for the Children's Special Health Care Services (CSHCS) program. The CSHCS Program provides medical coverage for financially eligible participants with a diagnosis within 23 eligible medical conditions/categories; it does not cover all medical conditions. This manual is being issued to help you understand the services supported by the program.

If you have any questions about any of the topics in this manual please call the CSHCS program at **1-800-475-1355.** The 800 number will provide you the following list of options **(**providers outside of Indiana call **1-317-233-1351**). Please press the option number that best addresses your questions or concerns:

1 = For Spanish callers (Voice Mail)
2 = Eligibility (New applications or re-evaluations)
3 = Prior Authorization (Request for approval of medical services)
4 = Travel Claims (Reimbursement for mileage for trips > 50 miles)
5 = Claims (Providers billing CSHCS for services rendered)
    1 = EDI (Electronic Claims)
    2 = Claim inquiries/problems
6 = Provider (New enrollments or provider changes & terminations)
    1 = EDI (Electronic Claims)
    2 = Provider agreement/Direct deposit
    3 = National Provider Identifier/Other inquiries
0 = Attendant

The CSHCS program looks forward to working with you.

Sincerely,
Children’s Special Health Care Services
Provider Relations

TERMS & DEFINITIONS

BAA – HIPAA Business Associate's Agreement

Claims Unit – The team within CSHCS that tracks, manages, and pays claims submitted by providers for services to eligible CSHCN.

CSHCN – Children with Special Health Care Needs

CSHCS – Children's Special Health Care Services

EDI – Electronic Data Interchange

Eligibility Unit – The team within CSHCS that determines whether applicants or participants are eligible for the program.

Explanation of Payment (EOP) – A summary of claims processed by the CSHCS Program for a particular provider.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Linked Provider – The primary care, specialty care or basic/routine dental care provider from whom the participant receives care. Linkages must be established by the PA Section before claims for unauthorized services, except pharmacy, lab and x-ray, can be paid by CSHCS.

Medical Home – An approach to providing comprehensive primary care that is accessible, continuous, comprehensive, family-centered, coordinated, compassionate and culturally effective.

Primary Care Provider (PCP) – The primary doctor a participant sees for routine health care (e.g., colds, immunizations, etc.) This physician must be enrolled as a provider in the CSHCS program.

Primary Dental Provider (PDP) – The primary dentist a participant sees for routine dental care services. This dentist must be enrolled as a provider in the CSHCS program.

Prior Authorization Unit – The team within CSHCS that sets-up provider linkages and determines whether or not to authorize procedures for eligible CSHCN.

Provider – A health services provider with an agreement allowing them to bill CSHCS for authorized services provided to eligible participants.

Provider Relations Unit – The team within CSHCS that enrolls providers, maintains provider information, and assists providers with questions, concerns, or issues with CSHCS service provision.

Trading Partner – A CHSCS Provider that conducts business with CSHCS via EDI.

MEDICAL HOME OVERVIEW

"Medical Home" is a vision for how all individuals who are involved in the delivery of health care services can partner with their patients and their patients' families to help them achieve their maximum potential.

A medical home is not a building, house, or hospital, but rather an approach to providing health care services in a high-quality and cost-effective manner. Children and their families who have a medical home receive the care that they need from a pediatrician or physician (pediatric health care professional) whom they trust. The pediatric health care professionals and parents act as partners in a medical home to identify and access all the medical and non-medical services needed to help children and their families achieve their maximum potential.

The American Academy of Pediatrics believes that all children should have a medical home where care is:

Accessible

- Care is provided in the child's or youth's community.
- All insurance, including Medicaid, is accepted and changes are accommodated.
- Families or youth are able to speak directly to the physician when needed.

Family-Centered

- Recognition the family is the principal caregiver and the center of strength and support for children.
- Unbiased and complete information is shared on an ongoing basis.
- The family is recognized as the expert in their child's care, and youth are recognized as the experts in their own care.

Continuous

- Same primary pediatric health care professionals are available from infancy through adolescence and young adulthood.
- Assistance with transitions, including those to other pediatric providers or into the adult health care systems, are planned and organized with the child and family.

Comprehensive

- Health care is available 24 hours a day, 7 days a week, 52 weeks a year.
- Preventive, primary, and tertiary care needs are addressed.
- Information is made available about private insurance and public resources.

Coordinated

- A plan of care is developed by the physician, child or youth, and family and is shared with other providers, agencies and organizations involved with the care of the patient.
- A central record containing all pertinent medical information, including hospitalizations and specialty care, is maintained at the practice.
- Families are linked to support, educational and community-based services.

Compassionate

- Concern for well-being of child and family is expressed and demonstrated.
- Efforts are made to understand and empathize with the feelings and perspectives of the family as well as the child or youth.

Culturally Competent

- Family's cultural background, including beliefs, rituals and customs are recognized, valued, respected and incorporated into the care plan.
- All efforts are made to ensure that the child or youth and family understand the results of the medical encounter and the care plan, including the provision of translators or interpreters, as needed.

The CSHCS program values and encourages the efforts of our primary care physicians to provide a medical home for our participants. In a medical home the child or youth, his or her family, primary care physician, and other health professionals develop a trusting partnership based on mutual responsibility and respect for each other's expertise.

The National Center of Medical Home Initiatives for Children with Special Needs provides support to physicians, families, and other medical and non-medical providers who care for children with special needs so that they have access to a medical home. Please visit www.medicalhomeinfo.org to access training materials and to learn more about the seven components of a medical home.

On this Web site, www.medicalhomeinfo.org, under "Tools," you will find information about Care Notebooks, which are used as an organizing tool for families to keep track of important information. You can also find examples of Care Notebooks and Instructions/Forms to enable you to create a Care Notebook. A major role of this notebook is to help parents and caregivers maintain an ongoing record of their child's care, services, providers, and notes. This notebook is a great tool in empowering families to become the experts on their child's care. It is also a way to maintain the lines of communication between the many providers and services that help care for a child and their family. Health professionals recommend that parents/caregivers bring this notebook to all medical appointments, therapies, care conferences, on vacations, etc. Health professionals can encourage the use of these notebooks by either having them available at the first office visit, upon discharge from the hospital or in the waiting room on a resource table. This notebook should be a team responsibility. Office staff should offer families assistance in filling out the various forms. Medical offices can copy visits, check ups, immunization records, specialist reports, clinical pathways, and give them to families to insert into the notebook.

For more information regarding Medical Home contact:

Kimberly Minniear
Integrated Community Services Program
Maternal and Children's Special Health Care Services
Indiana State Department of Health
317-233-7428
kminniear@isdh.IN.gov

PROVIDER ENROLLMENT REQUIREMENTS

General Information

The Children's Special Health Care Services program (CSHCS) is a supplemental program that helps families of children with serious chronic medical conditions pay for treatment related to their child's condition. CSHCS is the payer of last resort for authorized services to eligible children. This means that the participant's primary insurance or Hoosier HealthWise/Medicaid must always be billed prior to billing the CSHCS program. CSHCS is not a Medicaid program. CSHCS is a separate program administered under the Indiana State Department of Health. Although CSHCS is not a Medicaid program, the CSHCS Program reimburses claims at the Medicaid rate, and uses Medicaid coding and claim forms. The CSHCS Program can never pay medical providers more than the maximum allowable Medicaid rate.

In mid 2009, the CSHCS Program will be offering providers access to some program information through a web portal via the internet. This web portal will allow providers to check the participant's enrollment and claims status or history and also enable providers to print an Explanation of Payment (EOP). To access the CSHCS Web Portal, Currently enrolled providers will need to complete a separate enrollment form. Additional information is available on the CSHCS web site at www.in.gov/isdh/19613.htm

Provider Agreement

- Before CSHCS can pay any medical bills, the provider must be enrolled and sign a Provider Agreement through the CSHCS Provider Relations Section. A primary component of the provider's agreement is the provider's commitment to accept payment from the CSHCS Program as final and complete payment for any approved claim. Providers may also sign up to submit claims via Electronic Data Interchange (EDI), and real-time pharmacy claims submission. A Provider Agreement Packet can be obtained by calling 1-800-475-1355, Provider Relations option.
- All providers submitting claims for payment to the Indiana CSHCS Program must agree to be reimbursed by electronic funds transfer (EFT).
- W-9 and EFT information is provided to the State Auditor's Office to allow final processing of payment. The CSHCS Provider Relations section is available to assist with coordination with the Auditor's Office.

Assigning Participant to Providers (Provider Linkages)

- Every participant in the CSHCS program is linked to a primary care provider (PCP) and, based on need, a specialty care provider (SCP). This linkage covers care that is provided in those providers' offices. This linkage remains in place until either the participant requests a change or leaves the CSHCS program, or the provider withdraws from the program. When the PCP also provides necessary specialty care, a separate SCP need not be assigned.
- All specialty care must have prior authorization or be performed in the office of a linked provider.
- Each participant may have a Dental Care Provider (DCP). The DCP is a dentist or clinic that provides routine dental care to keep the participant's teeth and gums healthy. The program may also authorize specialty dental care to treat a participant's eligible medical condition, such as cleft lip and palate.

Reporting Updates to Provider Information

Providers must give notice to CSHCS **60 days** before the effective date of the change for any of the following:

- Name (legal name);
- DBA (doing business as);
- Address (service, legal, mail to, pay to, bill to);
- Federal tax ID number(s);
- National Provider Identifier (NPI); or
- Change or addition of Taxonomy Code.

CSHCS PROVIDER RELATIONS SECTION CONTACT INFORMATION

Telephone number: 1-800-475-1355, select the provider relations option
Fax number: (317) 233-1342

Indiana State Department of Health
CSHCS Provider Relations
2 North Meridian Street, Section 7B
Indianapolis, IN 46204

REIMBURSEMENT CONSIDERATIONS

Calculation of payments

CSHCS will pay the lowest of the following:

- Charge Amount (Usual & Customary), less Other Insurance payment,
- Program Allowed Amount, less Other Insurance payment, or
- Co-Payment Amount billed.

Coordination with Other Insurance

- CSHCS may ask a participant to appeal a denial by an insurance company, HMO, PPO, or Medicaid, for services which the participant, provider, and CSHCS consider necessary and allowed. Providers must cooperate with a participant's request for information necessary to aid the participant in this appeal process.
- The CSHCS program is structured like a supplemental medical insurance plan and only pays after other insurance (private and/or Hoosier HealthWise/Medicaid) has been billed. The participant must follow the rules of their other insurance coverage.
- CSHCS will not override the rules of the participant's insurance. CSHCS will not approve payment for a service that the insurance company has denied because the participant did not follow the rules, or because the participant sought services outside their primary network.
- CSHCS may cover all or part of the participant's insurance deductibles, co-insurance and/or co-payments; however, the total paid for services cannot exceed the Indiana Medicaid rate. This may result in no payment by CSHCS for an approved claim if the insurance has paid more than the Medicaid rate. If this occurs, the provider may not bill the participant for the unpaid balance, deductible or co-payment.

Billing Participants

- Providers may not bill the participant for any service covered by the CSHCS Program.
- If CSHCS approves the billing for any medical services, the provider must accept the CSHCS payment as final payment-in-full. CSHCS participants may not be billed for any balance on a claim approved by CSHCS.
- If you have any questions about a participant's information related to the eligible diagnosis or covered services, please call the CSHCS Program at 1-800-475-1355 and press the option for the Prior Authorization Section.

CLAIMS SUBMISSION

Forms and Coding

- CSHCS utilizes the same billing forms and coding classifications used by Indiana Medicaid. Claim forms utilized as of 10/1/2007 are as follows:
    1. UB04 form, effective 5/23/07 (Previously, the CMS-450, UB92 Form)
    2. CMS 1500 Form, effective 4/1/07
    3. 2006 ADA Dental Form effective, 5/23/07
    4. Indiana Medicaid Drug Claim Form, effective 5/23/07
    5. Indiana Medicaid Compound Prescription Claim Form, effective 5/23/07
- CSHCS utilizes national code sets, including HCPCs for medical or supply claims, revenue codes for inpatient, outpatient, or home health claims, National Drug Codes (NDC) for pharmacy claims, and ICD-9-CM for diagnoses. Providers must utilize the most appropriate code when billing. Documentation in the medical records maintained by providers must substantiate the medical necessity and coding for the billed service.

Adjustments:

- Providers may request adjustments of previously denied or incorrectly paid claims. Providers may submit a copy of the Explanation of Payment (EOP) denoting the claim in question and the reason for the adjustment. If you have questions, please call the CSHCS Program at 1-800-475-1355, and press the option for the Claims Section.

CSHCS Processing/Response to Claims

- CSHCS will mail a paper copy of the EOP to all billing providers, including those that receive the electronic 835 transaction. The EOP details processing information such as provider name, participant name, claim number, amount paid, reason for denial or other processing details.

Code Updates

- The CSHCS program makes every effort to enter code and pricing changes into the claims processing system as quickly as possible. However, there may be occasions when a provider bills for a service for which the new or revised code has not yet been loaded into the CSHCS Claim Processing System. This might result in a claim denial for an "invalid code." Additionally, the claim payment amount could be affected if a pricing update applicable to the claim's date of service has not been entered into the CSHCS claim processing system by the time the claim is processed. Should either of these situations arise, providers should contact the CSHCS Claims Section at 1-800-475-1355, claim option, to request reconsideration of the claim**.**
- In the area of pharmaceutical services, revisions in pricing and coding are based upon information from a drug pricing vendor, currently First Data Bank (FDB). The CSHCS program receives an electronic update from FDB near the first of every month that provides changes to National Drug Codes (NTSC) and/or pricing that occurred during the previous month. When the CSHCS program receives a pharmacy claim for an NDC that is not found in our system, the claim's final adjudication is delayed. The CSHCS Program manually checks information to determine whether or not the drug code is valid and processes the claim accordingly. Updates in NDC pricing that were not applied to a claim, due to the delay in system updating, will not be identified by CSHCS. Therefore, it is the provider's responsibility to submit an adjustment request for any claims he/she

believes are not priced accurately. As noted above, an adjustment request would consist of a copy of the CSHCS EOP which notes or highlights the claim that is in question. For pharmacy pricing adjustment requests, providers should also submit verification from Medicaid that their allowance is different. This request could be mailed or faxed. The adjustment processor will review the latest pricing updates and correct the claim payment accordingly. It is suggested that providers submit these adjustments no earlier than the end of the third week of the month following the month of the original claim submission to ensure the latest FDB update has been loaded into the claims processing system.

Filing Limit and Waivers

- Claims for services must be submitted within one year of the date of service. Any requests for exceptions to this policy must be submitted in writing to CSHCS and attached to the claim. The request should include an explanation of why a waiver of the filing limit is being requested and, if applicable, a copy of any supporting documentation.

Electronic Billing

- The CSHCS Program is committed to conducting its business transactions with the health care provider community as efficiently as possible. Therefore, CSHCS invites all participating providers to utilize Electronic Data Interchange (EDI) to submit claims electronically, as appropriate and practical.
- All providers wishing to begin submitting claims electronically must complete a trading partner agreement and profile, and test with our EDI staff before submitting live transactions. Providers may contact our EDI office at 1-800-475-1355, EDI option, to schedule testing or inquire further about electronic filing. Please also visit our Web site which is found at www.in.gov/isdh/19617.htm.
- CSHCS will mail a separate paper copy of the Explanation of Payment (EOP) to all billing providers, including those that receive the electronic 835 transaction. The EOP details processing information such as provider name, participant name, claim number, amount paid, reason for denial or other processing details.

Pharmacy / Real-time Claims

- The CSHCS program offers real-time pharmacy claims processing in the NCPDP 5.1 format. This allows providers to verify patient eligibility and to receive prompt and accurate claims payments. If a claim is rejected due to improper submission, providers will receive immediate feedback to allow them to correct and resubmit the claim.
- The CSHCS Program requires that the provider service address and/or pay-to-address used for billing match the service address and/or pay to address that was submitted on the Provider Agreement.

ELECTRONIC DATA INTERCHANGE AND TRADING PARTNERS

Trading Partner Agreement

- To assist providers who wish to bill electronically, an EDI Trading Partner Agreement Form and EDI Trading Partner Profile Form are included for your review, execution and return to ISDH. If appropriate, please have your billing service or clearinghouse complete and return these forms on your behalf.
- Only providers who wish to exchange data electronically directly with ISDH are required to become an Indiana State Department of Health (ISDH) trading partner. Please read the following descriptions to determine the scenario that best fits your situation.

Providers who ARE required to become an ISDH Trading Partner

- Billing providers who have purchased software to electronically bill the ISDH must become an ISDH trading partner by completing the following two steps:
    1. Complete an EDI Trading Partner Profile.
    2. Complete a Trading Partner agreement.
- Providers creating their own software to send or receive electronic transactions must follow the same testing and approval process as a software vendor. An EDI Trading Partner Profile and agreement must be completed prior to testing.

Providers who are NOT required to become an ISDH Trading Partner

- Billing providers who exchange electronic data via a billing service or clearinghouse do NOT need to submit a trading partner agreement. The billing service or clearinghouse is the trading partner and will need to submit the EDI Trading Partner Profile and Agreement. However, if a provider wants to receive an outbound transaction via a billing service or clearinghouse, for example, the 835-Remittance Advice, it is the provider's responsibility to send the EDI Trading Partner Profile form to the ISDH as authorization for the ISDH to release the provider's data to the billing service or clearinghouse.

Completing the EDI Trading Partner Profile

- The ISDH requires all providers exchanging electronic data directly or through an intermediary with the ISDH to complete and submit the EDI Trading Partner Profile. The EDI Trading Partner Profile is the tool the provider or its intermediary must use to notify the ISDH about the types of transactions they will exchange and the protocols they will use. After the initial setup, the EDI Trading Partner Profile - Provider Change Form will be used to inform the ISDH of any changes to their vendor software, billing service or clearinghouse selection.

Completing the Trading Partner Agreement

- 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.
- If a billing provider is submitting transactions 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. Please forward the enclosed EDI Trading Partner Profile – Billing Service / Clearinghouse form and Trading Partner Agreement – EDI Addendum to your intermediary for them to complete and return to the ISDH.

- The Trading Partner Profile and/or Agreement form must be signed and mailed to the following address:

Office of HIPAA Compliance
Indiana State Department of Health
2 North Meridian Street, Section 3K
Indianapolis, IN 46204-3010

- Upon receiving the signed EDI Trading Partner Profile form and the signed Trading Partner Agreement, the billing provider's system and procedures will be evaluated for exchanging production data. The trading partner will receive written notification of approval. The written approval contains trading partner ID, login ID, password and other communication information.

CSHCS PROGRAM INFORMATION

Eligibility Information

- Children under the age of 21 who are in need of special medical care, or persons of any age who have cystic fibrosis, may be enrolled in the CSHCS program. Eligibility is based upon both financial and medical criteria, and is determined at the time of application and reviewed annually thereafter.

Financial Criteria

- A family with an income at a program specified percentage of the federal poverty level may be eligible for the program.

Medical Criteria

- Qualified applicants must have a medical condition that has lasted or is expected to last at least two (2) years if not treated and the physical condition necessitates more health care services than is usually required for a child of that age. The physical condition also produces or will produce disability, disfigurement, limitation of function, need for a special diet, or dependence on an assistive device; or without intervention will, within one (1) year, lead to a chronic disabling physical condition.
- Physicians assist with the application and annual revalidation process by providing a physician's statement as to the diagnosis or health status of the child to the family for submission to the CSHCS Program.
- If assistance with payment of diagnostics is needed, please see the Section on Authorization of Services (p. 16).

Applying for Services

- To apply for services, a parent, legal guardian or emancipated child shall complete a written application. The following persons may apply for a child to receive health care services through the CSHCS program:
    1. A child's parent (regardless of parent's age).
    2. A child's legal guardian.
    3. An emancipated child.
    4. A county department, if a child is a ward of the county.
    5. A licensed child placement agency, if a child has been placed in their legal guardianship.
- All participants of the CSHCS Program are issued a participant's manual and a complete enrollment packet with pertinent participant and program information.
- If you have any questions about eligibility, please call the CSHCS program at 1-800-475-1355, eligibility option.
- Note that the CSHCS Program serves as the payer of last resort for these services, as for all services for CSHCS participants.

Re-evaluations

- CSHCS re-evaluates participants/families annually to maintain enrolled status. During re-evaluation, participants must update income status, insurance information, and household members and notify us of any other changes that have occurred since the initial application or most recent re-evaluation. Primary Care Providers (PCPs) are also required to complete a Physician's Health Summary to document that the participant's condition still exists and update or add any new conditions that exist. See Appendix C for a copy of the Physician's Health Summary Form.
- If a provider has any questions as to the enrollment status of a patient, he/she may call the CSHCS Program at 1- 800-475-1355, eligibility option.

AUTHORIZATION OF SERVICES

Prior Authorization

- All services, except pharmacy, lab and X-ray, must be approved by either a prior authorization (PA) or by a linkage of the provider to the participant for services related to the participant's eligible medical condition. A PA confirms medical necessity and the relationship of the service to an eligible medical diagnosis. Services provided by a linked provider in their office do not require PA.
- Providers are responsible for obtaining PA from CSHCS for covered services when necessary. Providers should contact the prior authorization section by telephone and fax a copy of their evaluation or consultant records from the patient's medical chart.
- The fax number for the CSHCS Program, PA Section is 317-233-1390.
- The telephone number for the CSHCS Program is 1-800-475-1355, PA option.
- If a service covered by CSHCS requires prior authorization and authorization is not obtained before the service is rendered, the participant/family may not be billed unless the family consents to receiving the service before the prior authorization decision is made. However, if the service is denied by prior authorization or is not a covered service, the provider may bill the participant/family if the family decides to receive the service anyway.
- If a provider is unable to obtain a prior authorization and the participant/family insists on having the unauthorized procedure/service, providers should consider having the participant/family sign a wavier stating they understand they are responsible for the cost of these services.
- Covered services include routine primary care and specialty services as described in 410 IAC 3.2-7-2 (basic services included in the health care service package) and 410 IAC 3.2-7-3 (limited health care services included in the health care service package). Specialty services must be for treatment of an eligible medical condition. Providers may bill families for specialty services provided to a participant for a non-covered medical condition.
- Below is a list of services that require either prior authorization or an additional provider linkage to allow payment by CSHCS; however, this list is not all-inclusive.
    1. Inpatient services (hospitalizations)
    2. Equipment and supplies
    3. Surgery
    4. Specialized dental care
    5. Therapy (occupational, physical, speech)
    6. Home health care
    7. Emergency Room Services for covered conditions
    8. Specialized medical care for covered conditions
    9. Over-the-Counter nutritional formulas or vitamins

- Prior Authorization requests will be reviewed, and, if approved, a PA number will be given over the phone. A letter stating whether or not the request is approved in whole, in part or denied is faxed to the provider and mailed to both the provider and the participant or their family. If additional medical information is needed to determine the PA decision, it is requested from the provider, and must be reviewed before a decision can be rendered.

Assistance with Payment of Diagnostic Tests

- Diagnostic examinations may be arranged upon establishing the possible existence of a program-covered medical condition and determining that the family is financially eligible for the program. Diagnostic examinations to establish the presence of a CSHCS covered condition will be reimbursed for children who have applied for the CSHCS program who meet CSHCS financial criteria. Diagnostic examinations may also be reimbursed for a suspected but undiagnosed covered illness or condition of a patient already in the CSHCS program.
- Prior Authorization is not a guarantee of payment. Although the prior authorization does confirm coverage of the service, the patient must be eligible on the date of service for the charges to be reimbursed. Additionally, the provider would need to submit a claim for the service on the appropriate claim form or electronic format. All claims would be subject to third party payment provisions as discussed in the "Reimbursement Considerations" section of this manual (p. 9).
- CSHCS will consider payment for over-the counter (OTC) vitamins, nutritional supplements and formula for treatment of an eligible diagnosis. These items require prior authorization and must not be available through other programs, for example, the Special Supplemental Food Program for Women, Infants, and Children (WIC).

Authorization for Emergency Services

- The provider must notify the CSHCS program of emergency care and unscheduled hospitalizations within five (5) working days of the emergency care (does not include Saturdays, Sundays, or legal holidays). **Emergency means an unexpected or sudden event or occurrence that requires immediate attention, intervention and medical care to prevent serious harm or loss of life.** An authorization for payment may be written only after the PA Section receives the discharge summary or medical notes from the emergency room visit **or other emergency care**. Providers are **responsible for mailing or faxing** these documents to the program. Only services related to the eligible medical condition(s) will be authorized for reimbursement by the CSHCS Program.

Coverage Exclusions

- There are some services, supplies, equipment and medications that CSHCS will not cover at all. These exclusions are listed below. This list is not all-inclusive. You may confirm that a specific item or service is covered by calling 1-800-475-1355, prior authorization option.
    1. Over-the-counter drugs (e.g., Tylenol, cough syrup, vitamins, etc.) even with a doctor's prescription;
    2. Over-the-counter supplies (diapers, non-sterile gloves, alcohol, tape, bleach, Band-Aids, etc);
    3. Services for mental health conditions, counseling, testing and substance abuse treatment;
    4. Emergency room visits for reasons not related to the participant's eligible diagnosis (e.g., if the eligible diagnosis is Asthma, the CSHCS program will not cover an emergency room visit for a broken arm);
    5. Hospitalization for reasons not related to the eligible diagnosis;
    6. Organ transplant surgery;
    7. Eyeglasses, if not related to the eligible diagnosis;
    8. Earplugs;
    9. Supplies such as egg crate mattress covers, etc.

If you are in doubt about whether or not a service is covered, please call the CSHCS program at 1-800-475-1355, PA Option.

Request for Review of Denied Prior Authorizations

- Although providers may not appeal, in consultation with the family they may request reconsideration of prior authorization decisions with which they disagree. Additionally, if providers have information that may not have been considered with the original request, they may submit this additional information to CSHCS for review and reconsideration. Providers' requests for reconsideration should be submitted in writing to the CSHCS Prior Authorization Section and should include the reason they believe the service should be covered. This information will be reviewed by the Medical Review Committee comprised of medical professionals and program managers. Providers and families will receive a written response to their request for reconsideration.

Request for Review of Denied Claims

- A provider may request a reconsideration of a claim which is denied by the CSHCS Program. Informal reviews may be requested by calling the CSHCS Claims Section at 1-800-475-1355. Providers may also request reconsideration of a denied claim by sending a copy of the EOP, marking the claim in question and indicating why the provider disagrees with the denial. Providers should also indicate a contact number where they can be reached, if necessary, to discuss the request. If the claim is approved, the provider will receive payment. If the denial is upheld, the provider will be notified.

Appeals

- Participants/families may appeal either eligibility or prior authorization decisions with which they disagree. Appeal requests should be submitted in writing to the following address:

  Court Administrator
  Office of Legal Affairs
  Indiana State Department of Health
  2 N. Meridian Street, Section 3H
  Indianapolis, IN 46204

- Participants/families may either appeal immediately if they disagree with an eligibility or prior authorization decision and/or may request an informal review of the action. It should be noted, however, that all appeals must be filed within 18 days of the decision which is being appealed, whether or not an informal review is requested by the family or the physician.

TRADING PARTNER AGREEMENT
ELECTRONIC DATA INTERCHANGE (EDI)

State Form 51402 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (*EDI*) between the Trading Partner listed under the Signatures heading in this agreement and the Indiana State Department of Health (*ISDH*).

A. Definitions.

1. "HIPAA" means the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder.

2. "PHI" means protected health information as defined by HIPAA, but limited to the PHI that is exchanged between the parties to this agreement.

3. "Confidential Information" means information concerning ISDH health plan participants or any information obtained by Trading Partner from ISDH.

4. "Providers" are healthcare providers who are clients and Business Associates of Trading Partner, as defined under the Administrative Simplification provisions of HIPAA.

B. The Trading Partner agrees:

1. That it will conform to the requirements of HIPAA as concerns PHI and that it will take no action which adversely affects ISDH's HIPAA compliance.

2. That it will promptly notify ISDH of any and all unlawful or unauthorized disclosures of Confidential Information or PHI that come to its attention and that it will cooperate with ISDH in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential information or PHI.

3. That it will use sufficient security procedures to ensure that all HIPAA transmissions with ISDH are authorized and to protect all participant-specific PHI from improper access.

4. That all files it transmits to ISDH will comply with the national Electronic Data Interchange (*EDI*) Transaction Set Implementation Guide effective on the date of transmission.

5. That it will establish and maintain procedures and controls so that Confidential Information shall not be used by agents, officers, or employees of the trading partner other than for its intended purpose.

6. That the information stated in any EDI Trading Partner Profile(*s*) submitted with this Agreement, or subsequently, is correct and complete.

7. That it will allow ISDH 30 days after receipt of written notice from the provider if there is any change in the trading partner representative or location where electronic transactions are sent.

8. That it is bound by written agreement with the provider to comply with state and federal law, if the Trading Partner is an intermediary for the billing provider.

C. Indiana State Department of Health agrees:

1. That it will conform to the requirements of HIPAA as concerns PHI and that it will take no action which adversely affects the trading partner's HIPAA compliance.

2. That it will use sufficient security procedures to ensure that all HIPAA transmissions are authorized and to protect all participant-specific PHI from improper access.

3. That all files it transmits to Trading Partner will comply with the national Electronic Data Interchange (*EDI*) Transaction Set Implementation Guide effective on the date of transmission.

D. Both parties agree:

1. That data transmitted between them will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.

2. That upon receiving any HIPAA transaction from the other, to prepare and transmit a timely response or an acknowledgment of transaction receipt. If acceptance of a transaction is required, a document is not considered received until an acceptance acknowledgement is returned.

3. That it will notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.

4. That it will provide and maintain the equipment, software, services, and testing necessary to transmit data with the other party.

5. That it will conduct business and perform under this agreement as required by this agreement and as required by any applicable rules or regulations.

6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the Trading Partner or provider is disqualified through a federal administrative action or state action.

7. That any document transmitted according to this agreement will be considered an original and signed when received electronically. Neither party will contest the validity or enforceability of signed documents under any applicable law concerning whether certain agreements must be signed in writing to be binding. Neither party will contest the admissibility of copies of signed documents under the business records exception to the hearsay rule, the best evidence rule, nor the basis that the signed documents were not originated in documentary form.

8. That neither party will be liable to the other for any special, incidental, exemplary, or consequential damages resulting from any delay, omission, or error in the electronic transmission or receipt of any document, even if either party has been advised such damages are possible.

9. That both parties will attempt to resolve any issues relating to this agreement.

E. Signature:

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Trading Partner: _____

Authorized Signature: _____

Title of Authorized Signatory: _____

Date: _____

Address: _____

City: _____ State: _____ ZIP +4: _____

Phone: _____

Remittance Address:

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204-3010
317-233-9803

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE – PROVIDER

State Form 51401 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204 – 3010
(317) 233-9803

Provider of Service:

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor Information:

(Providers, please complete this section if you are currently working with any Software vendor)
Please list all Software Vendor(s) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Software Vendor 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*): _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Software Vendor 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse Information:

(*Providers, please complete this section if you are currently working with any clearinghouse / switch to submit transactions to the Indiana State Department of Health)*
Please list all Clearinghouse(*s*) used for submission of Medical, Dental, Vision, and Pharmacy electronic claims.

Clearinghouse 1:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Clearinghouse 2:

☐ X12 ☐ NCPDP V5.1

Name

_____

Address (*include suite*) _____

City _____ State _____ ZIP + 4 _____

Contact Name

_____

Telephone number _____ Fax number_____

E-Mail _____

Indicate your request(s) for the EDI transactions below

Inbound (*sent from you to ISDH*):

- ☐ Health Care Claim (*837*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*270*)
- ☐ Claim Status Request (*276*)
- ☐ Prior Authorization (*NCPDP P1-P4*)
- ☐ Billing / Reversal (*NCPDP B1, B2*)
- ☐ Re-bill (*NCPDP B3*)
- ☐ Eligibility Verification (*NCPDP E1*)

Outbound (*sent from ISDH to you*):

- ☐ Payment Advice (*835*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*271*)
- ☐ Claim Status Request (*277*)
- ☐ Response (*NCPDP B1, B2*)

Remittance Advices are provided twice weekly and include claims submitted electronically and on paper.

Data Transmission / Retrieval Method
(please complete if you will be submitting transactions directly from your office to Indiana State Department of Health):

- ☐ Asynchronous Dial-up
- ☐ Secure FTP (*planned for future use*)
- ☐ Side by Side VPN connection

I am authorizing the outbound transactions indicated to be retrieved by:

- ☐ Provider of Service
- ☐ Software Vendor /Third party vendor
- ☐ Clearinghouse / Switch

Authorized Signature _____

Title of Authorized Signatory _____

Date (*mm/dd/yyyy*)_____

ELECTRONIC DATA INTERCHANGE (EDI) TRADING PARTNER PROFILE – CLEARINGHOUSE

State Form 51441 (R/1-08) / Part of State Publication 286
Indiana State Department of Health

Indiana State Department of Health
Office of HIPAA Compliance
EDI Division 3K
2 North Meridian Street
Indianapolis, IN 46204 – 3010
(317) 233-9803

Provider of service, _____ has informed us that they would like to begin doing Electronic Data Interchange (*EDI*) transactions with the Indiana State Department of Health (*ISDH*). They have informed us that you are their Business Associate for their EDI transactions. Therefore, in order to begin the process, please complete this document and sign the EDI Trading Partner Agreement. Please return these documents to the address above. Upon receipt of the Trading Partner Profile and Trading Partner Agreement, a member of the ISDH EDI staff will contact you concerning your EDI setup and testing. If you have already submitted a profile and an agreement to the ISDH, please notify us; you will not need to complete these forms again.

Clearinghouse:

Name
_____

Address (*include suite*)_____

City_____ State_____ ZIP + 4 _____

Contact Name
_____

Telephone number _____ Fax number_____

E-Mail: _____

Indicate below which EDI transactions you will be submitting

☐ X12 ☐ NCPDP V5.1

Inbound (*sent from you to ISDH*):

- ☐ Health Care Claim (*837*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*270*)
- ☐ Claim Status Request (*276*)
- ☐ Prior Authorization (*NCPDP P1-P4*)
- ☐ Billing / Reversal (*NCPDP B1, B2*)
- ☐ Re-bill (*NCPDP B3*)
- ☐ Eligibility Verification (*NCPDP E1*)

Outbound (*sent from ISDH to you*):

- ☐ Payment Advice (*835*)
- ☐ Prior Authorization (*278*)
- ☐ Eligibility Request (*271*)
- ☐ Claim Status Request (*277*)
- ☐ Response (*NCPDP B1, B2*)

Remittance Advices are provided twice weekly and include claims submitted electronically and on paper. Outbound transmissions will only be available with prior authorization from billing provider.

Data Transmission / Retrieval Method

☐ Asynchronous Dial-up
☐ Secure FTP (*planned for future use*)
☐ Side by Side VPN connection

Authorized Signature _____

Title of Authorized Signatory _____

Date (*mm/dd/yyyy*)_____

INSTRUCTIONS FOR AN INDIVIDUAL TO COMPLETE A VENDOR INFORMATION FORM (STATE FORM 53788)

1. Enter your legal name on the first line. Your legal name is the one that appears on your Social Security Card.
2. Enter your remit address on the next line.
3. Write in your social security number if you are listing yourself as an "individual". If you are a business you would list the EIN#.
4. Next select the organization type for your name (most people would be an "individual").
5. Check the box corresponding to your citizenship (US Person including resident aliens or not a US Person).
6. Check the box for either "Add Deposit" if you are a new vendor to the State of Indiana or "Change Deposit" if you are already a vendor but would like to change the bank account on file with the Auditor of State's Office.
7. Complete Section 1 by inserting the Account Holder's Name, Account Number, and Type of Account (Checking or Savings).
8. Complete Section 2 by attaching a voided check or have your financial institution complete this section.
9. Complete Section 3 only if you would like to request electronic notification of EFT Deposits made to your account. You may supply up to four email addresses.
10. Complete the certification section, by printing or typing your name, title, date, and phone number. You must also sign this form on the Authorized Signature line.

This form must be completed and submitted to the Accounts Payable Department by fax (317-233-0401) or via email to Rhonda Evans at rhevans@dhs.in.gov for any individual sending an Individual Assistance Claim to the State of Indiana.

Reset Form

Vendor Information

State Form 53788 (12-08)
Approved by Auditor of State, 2008
Approved by State Board of Accounts, 2008

Name and telephone number of the Person who completed this document must be provided.

Name: _____

Daytime Telephone Number: _____

Send completed form to Auditor of State, 240 Statehouse, 200 W. Washington St., Indianapolis, IN 46204 or fax to (317) 234-1916

Print or Type

Legal Name (OWNER OF THE EIN OR SSN AS NAME APPEARS ON YOUR TAX RETURN. DO NOT ENTER THE BUSINESS NAME OF A SOLE PROPRIETORSHIP ON THIS LINE.)

Trade Name (Doing Business as Name D/B/A) (Complete only if payment is to be made payable to the DBA name)

Remit Address

Purchase Order Address - Optional

Enter 9-digit Taxpayer Identification Number (TIN) of the legal name:
(SSN=Social Security Number, EIN=Employer Identification Number)

(Individual's SSN) __ __ __ - __ __ - __ __ __ __ or EIN __ __ - __ __ __ __ __ __ __

Check legal entity type (A box must be checked in this section. Check only one box.)

☐ Individual ☐ Sole Proprietorship ☐ Partnership
☐ Estate / Trust Note: Show above, the name and number of the legal trust, or estate, not personal representatives
☐ Other [Limited Liability Company (LLC) (attach IRS Form 8832 if applicable), Joint Venture, Club, etc.]
☐ Corporation Do you provide legal or medical services? ☐ Yes ☐ No
☐ Government (or Government operated entity)
☐ Organization Exempt from Tax under Section 501(a)

One box must be checked ☐ I am a U.S. Person (including a U.S. resident alien) ☐ I am not a U.S. Person (a W-8 must be filed with the Auditor of State)

☐ Add Deposit ☐ Change Deposit **Indiana law (I.C. 4-13-2-14.8) requires that YOU receive PAYMENT(S) by means of electronic transfer of funds.**

SECTION 1: AUTHORIZATION

According to Indiana law, your signature below authorizes the transfer of electronic funds under the following terms:

Account Holder's Name: _____ Account Number: _____

Type of Account: ☐ Checking (Demand) ☐ Savings

ATTACH VOIDED CHECK HERE

SECTION 2: FINANCIAL INSTITUTION'S APPROVAL (Attach a voided check or have your financial institution complete this section)

The financial institution identified below agrees to accept automated deposits under the terms set forth herein:

Name of Financial Institution: _____

Telephone: (_____)_____

Address: _____ _____
Number and Street, and/or P.O. Box No. Financial Institution's Authorized Signature

_____ _____
City, State, and Zip Code (00000-0000) Title

_____ _____, 20_____
ABA Transit-Routing Number Date

ATTACH VOIDED CHECK HERE

SECTION 3: ELECTRONIC NOTIFICATION OF ELECTRONIC FUND TRANSFER (EFT) DEPOSITS
(Complete this section only if you are requesting electronic notification. You may provide up to four email addresses.)

I hereby request that all future notices of EFT deposits to the bank account specified above be sent to the following email addresses:

_____ _____

_____ _____

I agree to the provisions contained on the reverse side of this form.

NAME (Print or Type) _____ TITLE_____

AUTHORIZED SIGNATURE _____ DATE _____ PHONE_____

REQUEST FOR VENDOR INFORMATION

THIS FORM APPLIES TO YOU, IF YOU ARE:

1) A U.S. person (including a U.S. resident alien); and
2) A person, business, or other entity who has or will receive a payment from the state; or
3) A state employee who has or will receive a payment, other than payroll, from the state.

PURPOSE OF FORM:

The Auditor of State of Indiana (Auditor) must have correct vendor information to make payments to vendors. This includes the vendor's legal name, doing business as name (if any), address, Taxpayer Identification Number (TIN), entity type, and banking information. This form allows you to provide your correct name, address, TIN, entity type, and banking information.

If you do not provide us with the information, your payments may be subject to federal income tax withholding. In addition, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service per I.R.C. 6723.

Federal law on withholding preempts any state and local law remedies, such as any rights to a mechanic's lien. If you do not furnish a valid TIN, we are required to withhold a percentage of our payment to you. Withholding is not a failure to pay you. It is an advance tax payment. You should report all withholdings as a credit for taxes paid on your federal income tax return.

INSTRUCTIONS:

1) Enter your legal name on the designated line. Your legal name is the one that appears on your Social Security Card or, if you are a business, the Employer Identification Number (EIN) as it is in the IRS records. If you are a sole proprietor, then your legal name is the business owner's name. If you have a "doing business as" (d/b/a) name, enter this on the trade name line. Enter your remit address on the next line, and if you have a separate address for purchase orders, enter that address on the appropriate line.
2) Record the appropriate TIN in the space provided and check the box that corresponds to the correct organization type for your name. Note that individuals and sole proprietors are the only types that should record a social security number (SSN). a) If you are a corporation, you must indicate whether you provide legal or medical services. b) If you are a sole proprietor, you must show the business owner's name in the legal name box and you may show the business name in the trade name box. You cannot use only the business name. For a sole proprietor, you may use either the individual's SSN or the EIN of the business. However, we prefer you provide the SSN.
3) Check the appropriate box that indicates whether you are or are not a U.S. person.
4) Complete Section 1: Authorization
5) Have your financial institution complete Section 2: Financial Institution's Approval. Your financial institution should return the completed form to you. A voided check may be provided in lieu of having your financial institution complete this section. Deposit slips will not be accepted.
6) Complete Section 3: Electronic Notification of Electronic Fund Transfer (EFT) Deposits, only if you choose to receive electronic EFT notifications by email. If this section is not completed, your notification will be sent by U.S. Mail to the remit address designated on the reverse side of this form.
7) Fax the completed form to (317) 234-1916 or mail to the Indiana Auditor of State, 240 Statehouse, 200 W. Washington St., Indianapolis, IN 46204.
8) Retain a copy of the completed form for your records.
9) Any form submitted without an authorized signature will be destroyed and will not be entered into the Auditor's vendor file.

BY SIGNING THIS FORM:

You represent that you understand and agree that:

1) You are authorized to provide this information on behalf of yourself or your organization.
2) The State of Indiana is authorized to initiate credits (deposits) in various amounts, by EFT through automated clearing house (ACH) processes, to the checking (demand) or savings account in the financial institution designated on the reverse side of this form.
3) If necessary, you will accept reversals from the State for any credit entries made in error to a bank account per National Automated Clearing House Association (NACHA) regulations.
4) You may only revoke this request and authorization by notifying the Auditor in writing, at the above address, at least fifteen (15) days before the effective date of revocation.
5) Any change to the account or to a new financial institution will require a new Vendor Information form be completed and submitted to the Auditor of State at the above address. Failure to provide timely notification to the Auditor that your account has changed will result in a delay in payment.
6) The State of Indiana and its entities are not liable for late payment penalties or interest if you fail to provide information necessary for an EFT transaction and/or you do not properly follow the Instructions above.
7) The email addresses provided in Section 3 for electronic EFT notification will allow for appropriate application of all payments.
8) You acknowledge that it will cause disruption to the notification process if the email addresses provided for electronic EFT notification are frequently changed or changed without promptly providing an updated email address to the Auditor.
9) You acknowledge that an email notification returned as undeliverable may be removed from the Auditor's email notification system and all future notices of EFT deposits to you will be provided by the Auditor via U.S. Mail to the remit address designated on the reverse side of this form until you have provided a valid email address to the Auditor.
10) You are responsible for contacting the Auditor if you are not receiving electronic notices of EFT deposits.