Portal "How To" 101

Agenda

- Verify member eligibility
- Eligibility – special programs
- Provider enrollment
- IHCP Portal overview
- Member focused viewing
- Prior authorization – fee-for service (FFS)
- Claims – FFS
- Search payment history
- Reminders
- Helpful tools
- Questions

Verify Member Eligibility

Verify Eligibility

Verification options

- Interactive Voice Response (IVR) system at 1-800-457-4584

- IHCP Provider Healthcare Portal (Portal) at https://portal.indianamedicaid.com

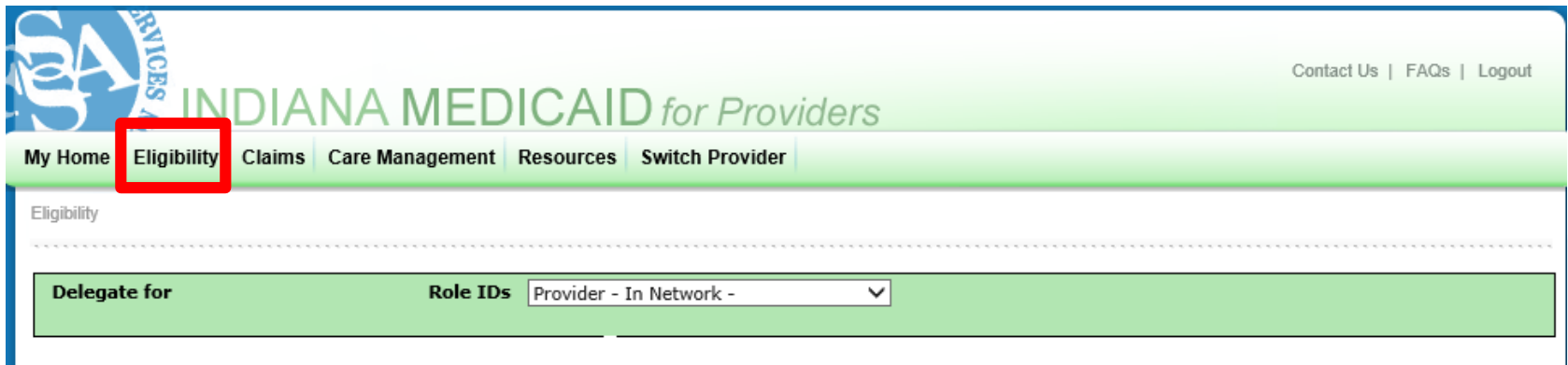- Electronic 270/271 interactive or batch transactions

Verify eligibility on every visit!

Verify Eligibility on Portal

- Eligibility can only be verified as of provider effective date

- Eligibility cannot be verified for future dates

To access the *Eligibility Verification Request* function, log in to the Provider Healthcare Portal and click **Eligibility** on the menu bar.

IMPORTANT!!!!
Eligibility is determined by the Division of Family Resources (DFR). DXC cannot change eligibility demographics.

Verify Member Eligibility

To perform a search, the *Effective From* date is required, in addition to one of the following:

- Member ID
- Social Security number (SSN) and birth date
- Last name, first name, and birth date

Verify Member Eligibility

The ***Effective From*** field is always required.
- If a date is not entered, the Portal defaults this field to the current date.
- This field accepts only current and previous dates.

The ***Effective To*** field is optional.
- The date entered must be on or after the Effective From date and must be within the same calendar month as the Effective From date.
- If a date is not entered, the Portal defaults to the Effective From date.

Eligibility Verification Req

* Indicates a required field

Enter the member information. If ...ber ID is not known, enter SSN and Birth Date, or Last Name, ...ame, and Birth Date.

Member ID		Last Name		First Name	
SSN		Birth Date			
*Effective From		Effective To			

Submit   **Reset**

Verify Member Eligibility

No Results Found:

Error
Member not found, confirm and/or revise search criteria.

Eligibility Verification Request

* Indicates a required field.
Enter the member information. If Member ID is not known, enter SSN and Birth Date, or Last Name, First Name, and Birth Date.

Member ID		Last Name		First Name	
SSN		Birth Date			
*Effective From		Effective To			

Submit   **Reset**

PE Application for Pregnant Women   **PE Application**

When an eligibility search returns no results, qualified providers (QPs) see an additional option below the message to complete a Presumptive Eligibility for Pregnant Women (PEPW) or Presumptive Eligibility (PE) application for the patient.

What is Presumptive Eligibility?

Presumptive Eligibility (PE) is an Indiana Health Coverage Programs (IHCP) process by which individuals are deemed to be presumptively eligible for **temporary** coverage, until the Family and Social Services Administration (FSSA) determines official eligibility.

Verify Member Eligibility

Some members may have more than one coverage type listed. Each benefit plan plays an important role, depending on provider type.

Benefit Details			
Coverage	**Description**	**Effective Date**	**End Date**
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	07/16/2019	07/16/2019
Medicaid Rehabilitation Option	Medicaid Rehabilitation Option for Adults with Level of Need = 3, Service Package 3	07/16/2019	07/16/2019
Qualified Medicare Beneficiary	Qualified Medicare Beneficiary - Members for whom co-insurance and deductibles are paid as well as Medicare Part B premiums	07/16/2019	07/16/2019
Family Supports HCBS Waiver	Authorized Family Supports HCBS Waiver services found in the Notice of Action (NOA)	07/16/2019	07/16/2019

Eligibility − Managed Care

Limit Details	➕

Managed Care Assignment Details	➕

Demographic Details	➕

Managed Care Assignment Details ➖

Managed Care Program		Primary Medical Provider	Provider Phone
Hoosier Care Connect			

Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
08/02/2019	08/02/2019	ANTHEM	1-844-284-1797

Eligibility − Fee-for-Service (FFS)

Southeastrans is the managed care entity for nonemergency medical transportation (NEMT) for fee-for-service (FFS) members.

Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	08/02/2019	08/02/2019

Managed Care Assignment Details

Managed Care Program		Primary Medical Provider	Provider Phone
Fee for Service + NEMT			

Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
08/02/2019	08/02/2019	SOUTHEASTRANS, INC	

What is the Right Choices Program?

Members identified with high utilization are assigned to primary lock-in providers, such as:

- One primary medical provider (PCP)
- One pharmacy
- Approved specialty providers

Bulletin *BT202024*

- Primary lock-in hospital will no longer be required
- Existing hospital lock-in assignments listed on the member's Right Choices Program (RCP) lock-in list ended effective April 30, 2020

Members should be referred to their lock-in provider.

How Do I Know Who the Lock-in Providers Are?

Managed Care Assignment Details	+
Right Choices Program	+
Demographic Details	+

Right Choices Program
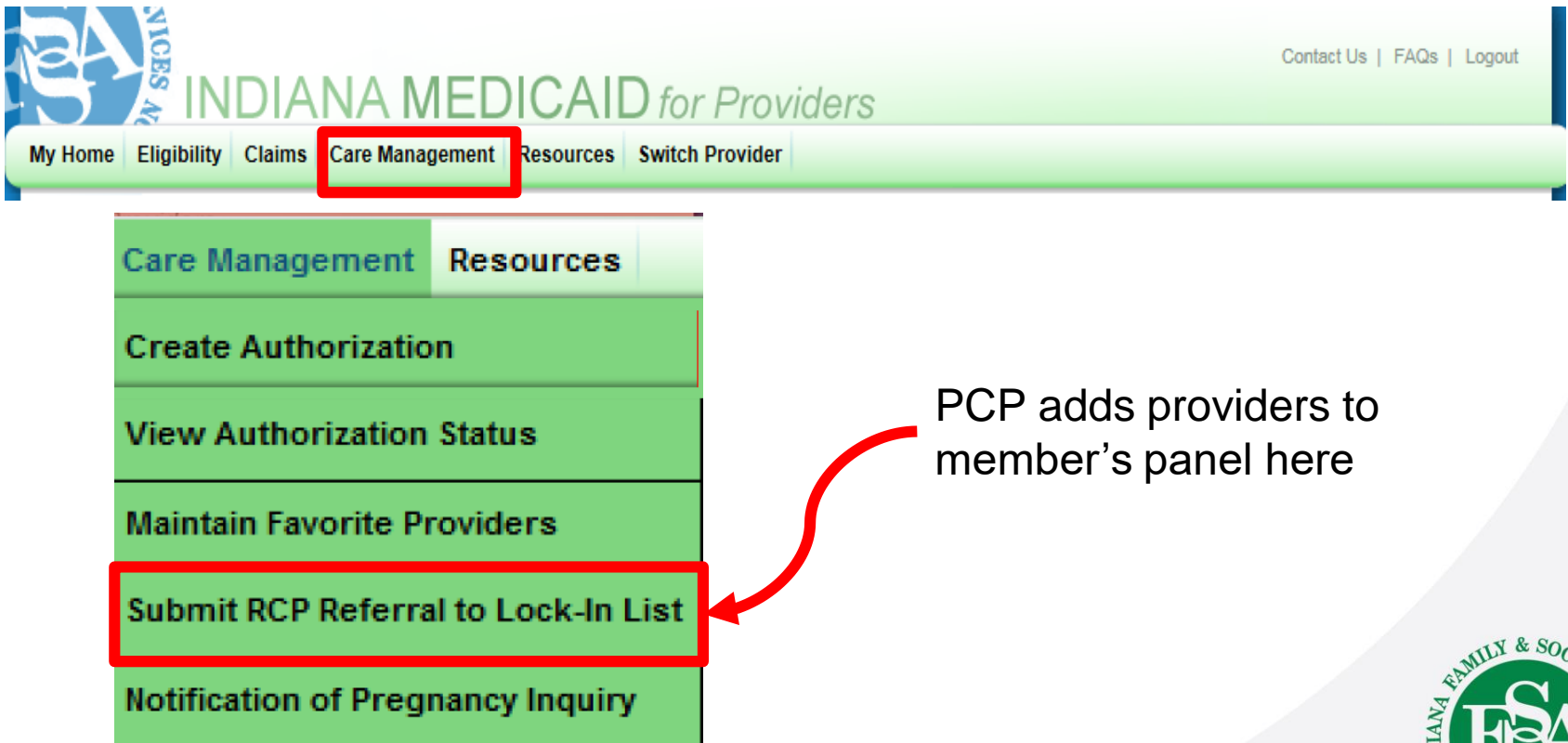
✔ Indicates a PMP Provider.

RCP Provider	PMP	RCP Provider Phone	Service	Effective Date	End Date
XXXXXXXXXX	Yes ✔	XXXXXXXXXX	RCP-Physician	07/29/2019	07/29/2019
XXXXXXXXXX	No	XXXXXXXXXX	RCP-Pharmacy	07/29/2019	07/29/2019

Right Choices Program

Contact the Right Choices Program member's primary care physician (PCP) to be added to member's panel.

PCP adds providers to member's panel here

Retroactive Eligibility and Claim Billing

- 180 days to bill claims from the date the member becomes retroactive eligible
  - Add claim note: "Retroactive member Eligibility, please waive timely filing"

- Payments made by retroactively approved members should be refunded to the member and claims billed to the payer

- Member is responsible for notifying providers of retroactive eligibility
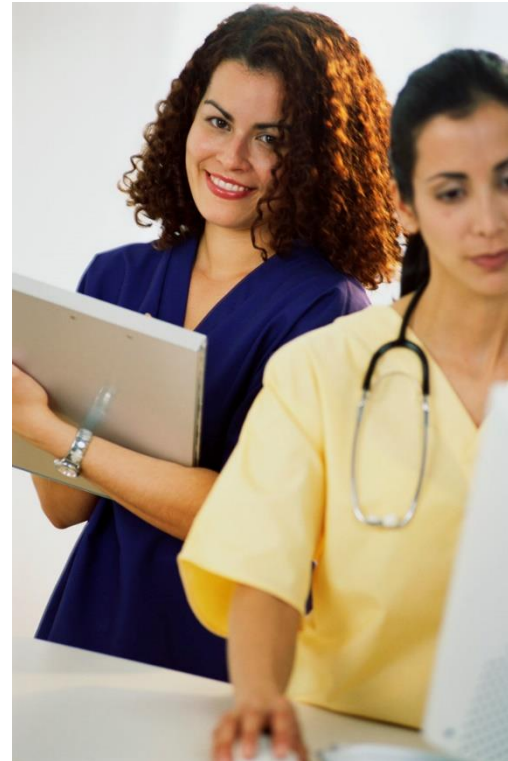
Timely Filing Reminder!

REMEMBER

- Timely filing is 180 days from the "from" date of service
- Claim corrections should be done via the Portal, however:
  - Do NOT adjust claims on the Portal if the "from" date of service is more than 180 days from the current date
- If there is proof of timely filing following the guidelines and exceptions listed in the *Claim Submission and Processing* module online:
  - Proof MUST be attached to the claim
  - Note MUST be entered explaining why the waiver of timely filing is being requested
  - All dates on documentation attached that validate the timely filing MUST be circled and noted "waive timely filing"

Eligibility – Special Programs

Eligibility – Special Programs

The following are Medicare premium benefits only, and do not require a waiver to bill member:

- **Specified Low-Income Medicare Beneficiary (SLMB)** – *Medicare Part B premiums only*

- **Qualified Individual (QI)** – *Medicare Part B premiums only*

- **Qualified Disabled Working Individual (QDWI)** – *Medicare Part A premiums only*

These members do not have any Medicaid benefits.

Eligibility – Preadmission Screening Resident Review (PASRR)

Benefit Details				
Coverage	**Description**	**Effective Date**	**End Date**	
PASRR Mental Illness (MI)	Pre-Admission Screening and Resident Review (PASRR) Mental Illness claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams.	07/16/2019	07/16/2019	

- PASRR for nursing homes are the only payable codes
- No other benefits when PASRR is the **only** coverage
- Waiver not required to bill a member for a noncovered service
- Provider must be a PASRR enrolled provider

Eligibility – Medical Review Team (MRT)

- Disability-determining codes only, per the Medicare Review Team Codes

- Provider must be an MRT provider

- No other benefits when MRT is the only coverage

- No waiver form required when MRT is the only coverage

Benefit Details				
Coverage	**Description**	**Effective Date**	**End Date**
Medical Review Team	Medical Review Team procedure codes only	08/02/2019	08/02/2019

Eligibility − 590 Program

- 590 Program members reside in a State institution
- Full array of benefits, except transportation
- Claims for $150 or less − billed to institution
- $150 or more − billed to the IHCP
- $500 or more – requires prior authorization
- Provider must be enrolled in 590 program

Benefit Details				−
Coverage		**Description**	**Effective Date**	**End Date**
590 Program		590 Program - Residents in State Mental Health Facilities	08/02/2019	08/02/2019
PASRR Mental Illness (MI)		Pre-Admission Screening and Resident Review (PASRR) Mental Illness claims processing for community mental health centers (CMHC) and diagnostic and evaluation (D&E) teams.	08/02/2019	08/02/2019

Qualified Medicare Beneficiary

What's the difference?

QMB ALSO

The IHCP pays member's Medicare, Part B premium and ALSO the member has full Medicaid benefits

Coverage
Full Medicaid
Qualified Medicare Beneficiary
Medicaid Rehabilitation Option
Other Insurance Detail Information

QMB ONLY

The IHCP pays the member's Medicare Part B premiums and coinsurance and deductible ONLY. If Medicare does not allow the charge, the IHCP does not allow the charge.

Coverage
Qualified Medicare Beneficiary
Other Insurance Detail Information

Waiver Required!

Waivers

Can I Use the Medicare Advanced Beneficiary Notice (ABN) as My Waiver Form? (for Charging Members)

- No, the ABN cannot be used as a waiver form for charging members

- The waiver should state specifically what services are not covered and why, and explain that the member will be financially liable

    - *The waiver must not include **conditional language** such as "if the service is not covered by the IHCP, or not authorized by the member's PMP, the member is responsible for payment."*

- Providers should compose *their own waiver* to provide advance notice to a member that a service is noncovered

- The waiver is to protect the provider, as it provides documentation that the member was informed in advance of noncoverage and financial liability

Retroactive Eligibility

Can the Portal Eligibility Function Show the Date Retroactive Eligibility was Granted? And the Start and End Date of Eligibility?

- Providers should be checking eligibility only for the dates of service (DOS) in question

- Providers should ask the member for a copy of the Medicaid approval letter in retroactive eligibility situations

- Use the *Claim Notes* feature to indicate retroactive eligibility dates, in timely filing limit situations
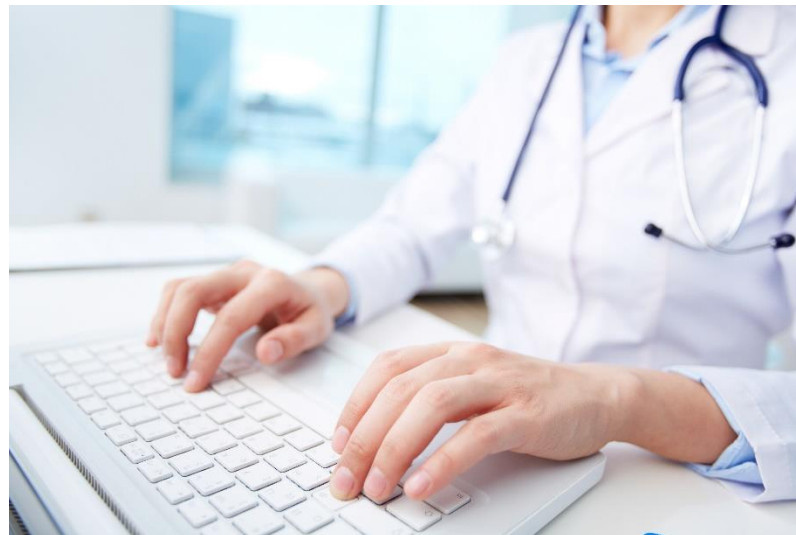
Provider Enrollment

How Can I Update My Provider Information on File?

Provider Enrollment

Login

*User ID

[   ]

Log In

Forgot User ID?

Register Now

Where do I enter my password?

Protect Your Privacy!
Always log off and close all of your browser windows

Would you like to enroll as a Provider?

Provider Enrollment

Drug Resources

Fee-for-Service Pharmacy Resources

- Provider enrollment transactions can be done on the Portal
  - New enrollments
  - Revalidation
  - Profile updates

Provider Enrollment

How do I know when my revalidation is due?

- ▸ Disenroll
- ▸ Provider Profile
- ▸ Provider Maintenance
- ▸ Enrollment / Revalidation Status
- ⚠ **Revalidation**

Revalidation warnings post 90 days before the revalidation is due. Failure to complete revalidation can result in enrollment termination.

Provider Enrollment

What is the Correct Way to Submit a W-9 Form with a Provider Enrollment Application, Update, or Revalidation?

- **#1 reason enrollment applications and updates are denied!!**

- Make sure you use the latest version of the W-9 form from the irs.gov website

IHCP Portal Overview

Portal Home Page

WELCOME HEALTH CARE PROFESSIONAL!

We are committed to make it easier for physicians and other providers to perform their business. In addition to providing the ability to verify member eligibility and submit claims, our secure site provides access to benefits, answers to frequently asked questions, and the ability to search for providers.

Contact Us

Notify Me

Secure Correspondence

DXC contact information (phone, fax, mail)

Sign up to receive important emails

- Claim administrative review requests
- Submit third-party liability (TPL) updates
- Portal assistance

Ask your administrator to give you full access to these features.

Where do I Find Information?

- The resources of the Provider Healthcare Portal will take you to locations for research on the IHCP website at in.gov/medicaid/providers

- Modules, bulletins, banner pages, and special pages dedicated to provider education

Portal Resources

INDIANA MEDICAID *for Providers*

Contact Us | FAQs | Logout

My Home | Eligibility | **Resources** | Switch Provider
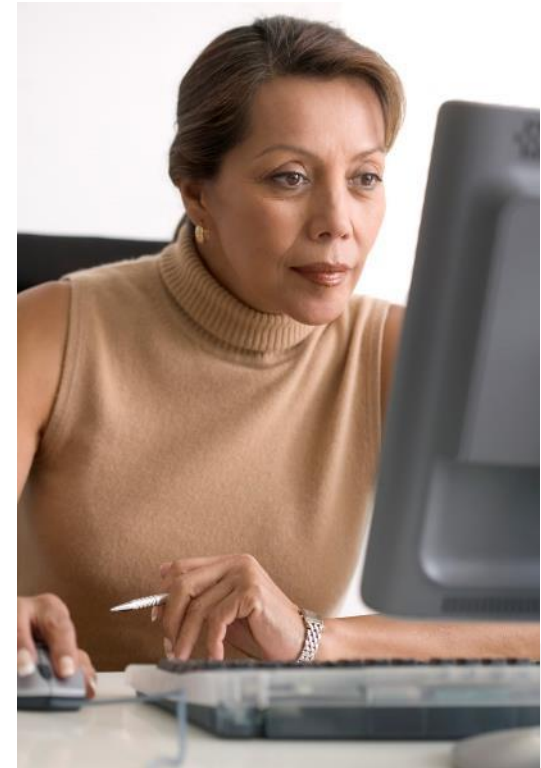
Resources

▶ Claims/Billing

▶ Electronic Data Interchange

▶ Fee Schedule ← Quick access to the IHCP Fee Schedules

▶ Forms

- Claim adjustment forms
- TPL forms
- Provider correspondence forms

▶ Provider Reference Materials

▶ Pharmacy Services

▶ Provider Search

▶ Provider Education

- Workshop registration
- Presentations
- Webinar training

▶ Email Notifications

Multiple Locations

- I work for a provider with multiple locations and legacy provider identifiers IHCP Provider IDs. How do I best work within the Portal?

  - Ensure your Delegate access has been added to all locations/LPIs you work under

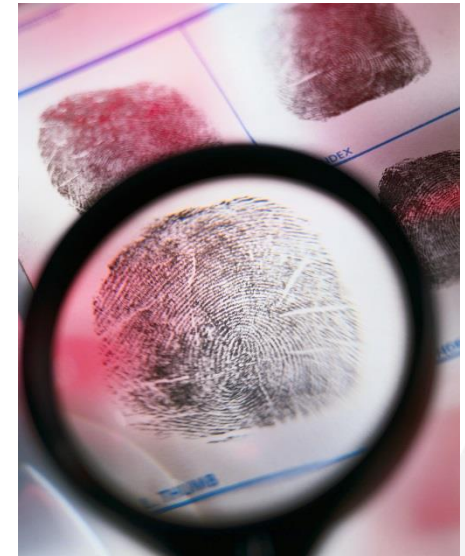 - One click Switch Provider option

Switch Providers

Member Focused Viewing

Member Focused Viewing
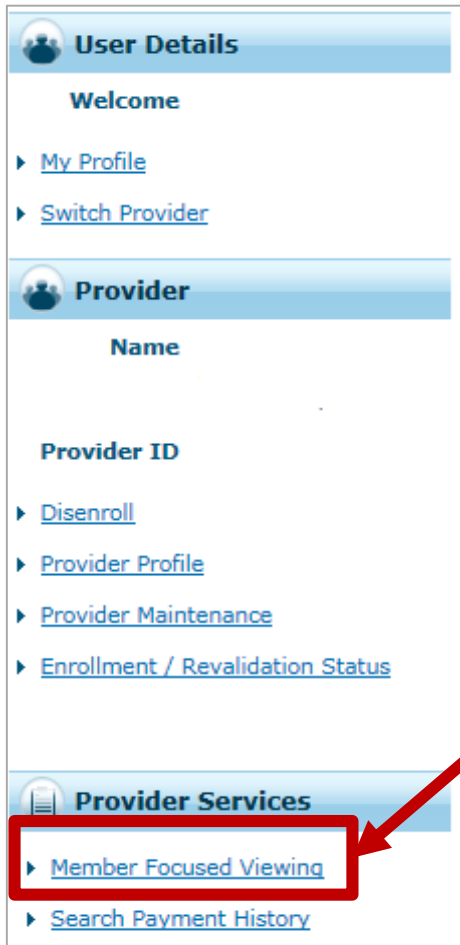
Member focused viewing allows quick access to:

- Member details

- Coverage details

- Claim search and submission

- Prior authorization search and submission

Member Focused Viewing

Same search criteria as the *Eligibility* screen

Member Focus Search

Last Members Viewed | Search

* Indicates a required field.

Enter the Member ID or Last Name, First Name and Birth Date.

Member ID

Last Name   First Name   Birth Date

City   ZIP Code

Search   **Reset**

Member Details

Member ID	
Name	
Birth Date	
City	
State	Indiana
Gender	Male
Primary Language	ENGLISH

Coverage Details

To see details about the member's eligibility information, click **View eligibility verification information**.

Coverage	Effective Date	End Date
Package A-Standard Plan		
Medicaid Rehabilitation Option		

▶ View eligibility verification information

Other Details

✉ **Secure Correspondence**
Review previously sent messages or send new secure messages.

Your Member Claims

Medical/Dental/Institutional

To start entry of a new claim, click the Submit link for the appropriate claim type.
To see details about a specific claim, click the Claim ID.

▶ Submit a Professional Claim   ▶ Submit a Dental Claim

▶ Submit an Institutional Claim

There are no claims for this member.

Your Member Authorizations

To start entry of a new authorization, click **Submit an Authorization**.
To see details about a specific authorization, click the Authorization #.

▶ Submit an Authorization

There are no authorizations for this member.

Prior Authorization
Fee-for-Service

Prior Authorization (PA)

Where do I find prior authorization? I've looked everywhere!

Prior Authorization (PA)

Complete the required information and submit the request by clicking **Confirm**.

Viewing Prior Authorization Status

- The authorization request is assigned an authorization number
- Results list the first 20 authorizations with beginning service dates of today or greater
- Results list only authorizations for which the viewing provider was on the request as the requesting provider

View Authorization Status

Search Options | Prospective Authorizations

Prospective authorizations identifying you as the Requesting or Rendering Provider are listed below. These results include the first (20) authorizations with a beginning Services Date of today or greater. Click the Authorization Number to view the authorization response details or select the Search Options tab to search for a different authorization.

Prospective Authorizations

Click on a Column Heading to change the sort order

Authorization Number	Service Date ▲	Member Name	Member ID	Service Type	Requesting Provider	Rendering Provider

Click to view the authorization

Member name and ID are displayed

Requesting provider is listed

Claims
Fee-for-Service

Search Claims

Why did my claim deny? First…search by:

- Claim ID

    – Member information and date of service that matches your claim **EXACTLY**

Claim Search Results

- To view the claim summary, click the plus sign (**+**) next to the Claim ID
- To view the claim explanation of benefits (EOBs), click the **Claim ID**

Search Results

To see service line information or to view a remittance advice, click on the '+' next to the claims ID.

Total Records: 558

+/-	Claim ID	Claim Type	Claim Status	Service Date ▼	Member ID	Rendering Provider ID	Medicaid Paid Amount	Paid Date	Member Responsibility
+	000000000000	Professional	Finalized Payment				$101.23		
+		Professional	Finalized Payment				$82.28		
+		Professional	Finalized Payment				$51.99		
+		Professional	Finalized Payment				$76.88		
+		Professional	Finalized Payment				$137.16		

Why Did My Claim Deny?

Always review the Claim Explanation of Benefits (EOB) as they are IHCP specific denials

Claim EOB Information			
Claim / Service #	**Disposition**	**EOB Code**	**Description**
Claim	Deny	0815	TPL REQUIRED AT DETAIL AND MUST SUM TO EQUAL THE HEADER TPL AMOUNT
Claim	Deny	0815	TPL REQUIRED AT DETAIL AND MUST SUM TO EQUAL THE HEADER TPL AMOUNT

Claim Updates

Claim EOB Information	⊞
Claim Adjustment Reason Code Information	⊞
Adjudication Errors	⊞
No Occurrence Codes exist for this claim	
No Surgical Procedures exist for this claim	
No Attachments exist for this claim	
No Claim Notes exist for this claim	

Copy **Print Preview**

Click COPY when rebilling a denied claim

Claim Updates

Claim EOB Information ➕

Claim Adjustment Reason Code Information ➕

No Other Insurance Details exist for this claim

No Condition Codes exist for this claim

No Occurrence Codes exist for this claim

No Value Codes exist for this claim

No Surgical Procedures exist for this claim

No Attachments exist for this claim

No Claim Notes exist for this claim

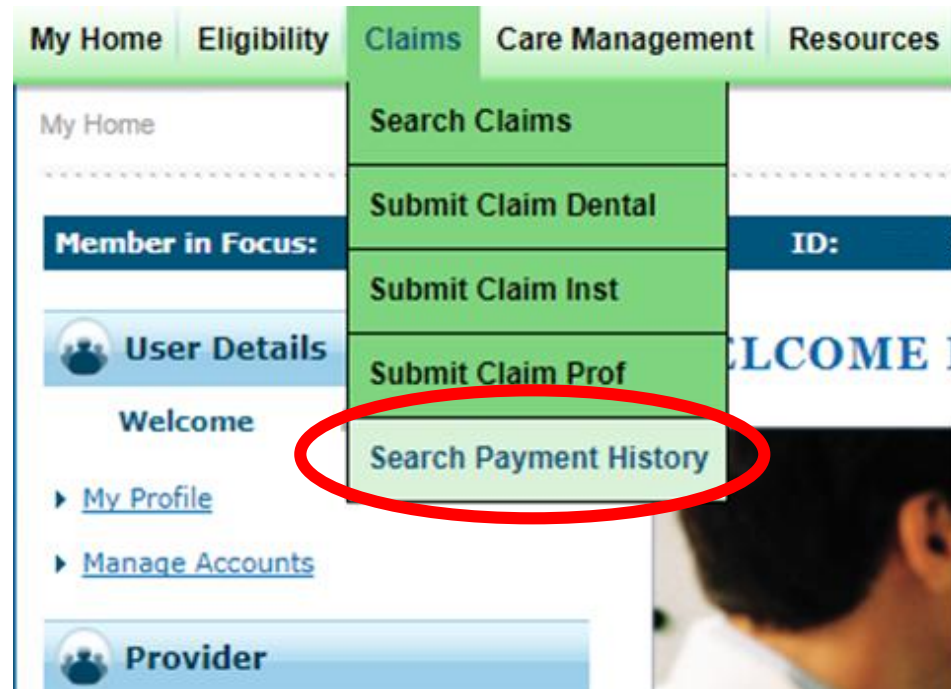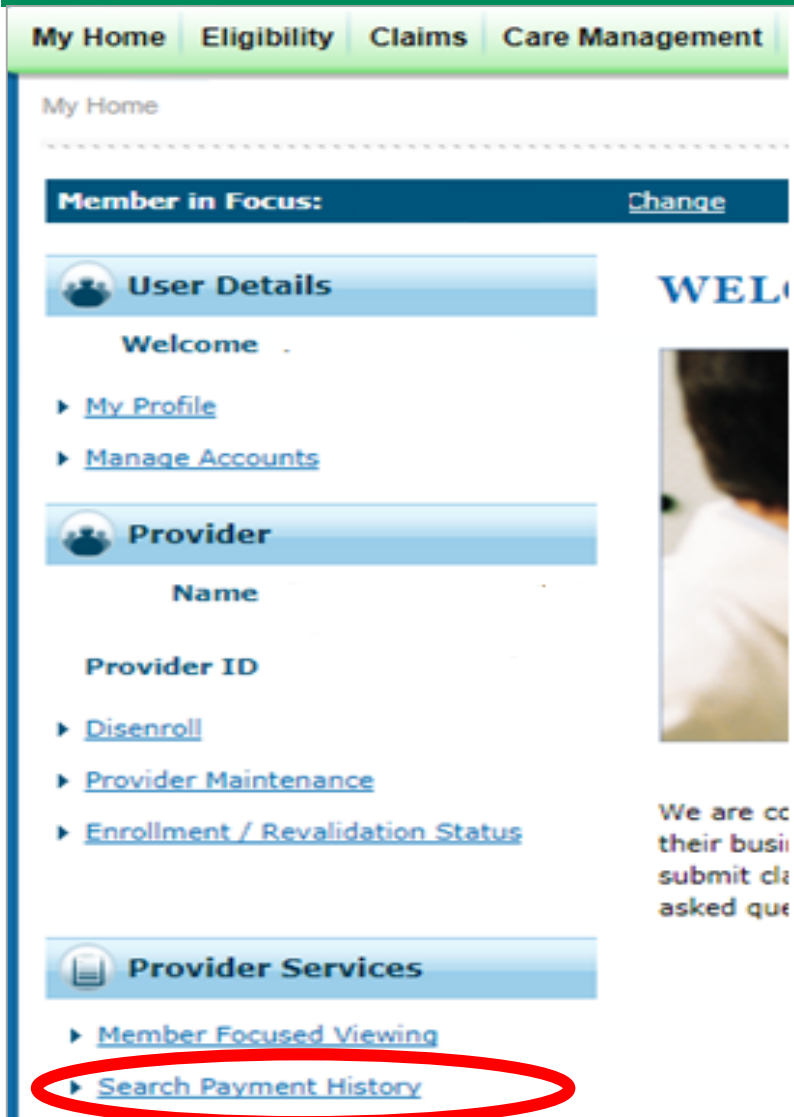No Adjudication Errors exist for this claim

Edit　　**Copy**　　**Void**　　**Print Preview**

Click EDIT to make claim corrections

Click VOID to have the claim recouped

Search
Payment History

Where Do I Find My Remittance Advice on the Portal?

52

Search Payment History

Search Payment History

Provider Information

| Provider ID | ID Type | NPI | Name | . |

* Indicates a required field.

Enter a From and To Issue Date that does not span more than 90 days. To further refine the search, select a Payment Method and/or enter a Payment ID.

Payment Method [All ▾]   **Payment ID** [ ]

Issue Date   *From❶ [04/18/2019] 🗓   *To❶ [07/17/2019] 🗓

[Search] [Reset]

- Auto-populates last 12 weeks, or search by 12-week span

* Indicates a required field.

Enter a From and To Issue Date that does not span more

Payment Method [All ▾]
   - All
   - Check
   - EFT
   - None
   - Other

Issue Date   *From❶

- You can search ALL payments, or search for paper checks or electronic funds transfer (EFT) only

Search Payment History

Search Results

To see payment details, click on the Payment ID link.
To access a copy of the Remittance Advice, select the RA icon. Access to the RA will require Adobe Acrobat Reader.
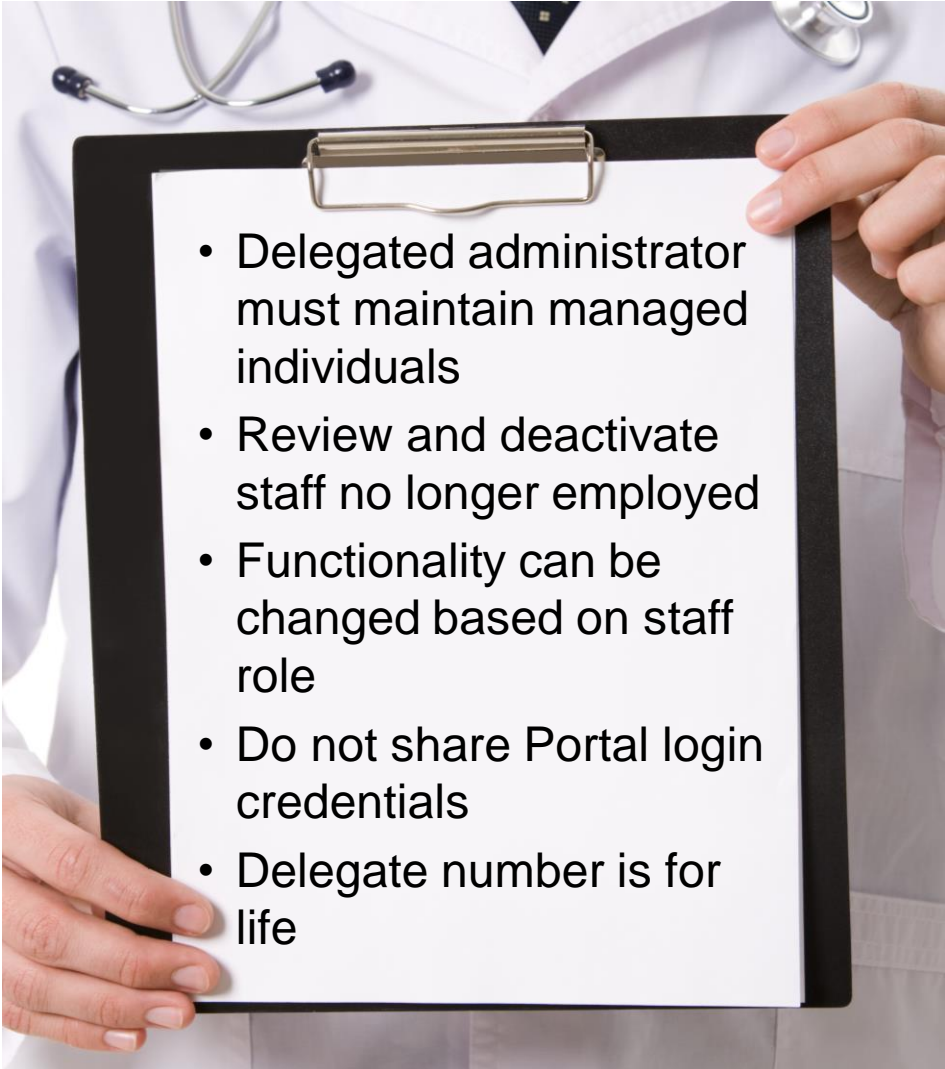
Total Records: 13

Issue Date ▼	Payment Method	Payment ID	Total Paid Amount	RA Copy (PDF)
07/17/2019	Check	000000000	$0.00	🗐
07/10/2019	Check	000000000	$0.00	🗐
07/03/2019	Check	000000000	$0.00	🗐

To view the Remittance Advice for claims associated with the EFT or check, click the icon for the PDF file.

Reminders

Reminders

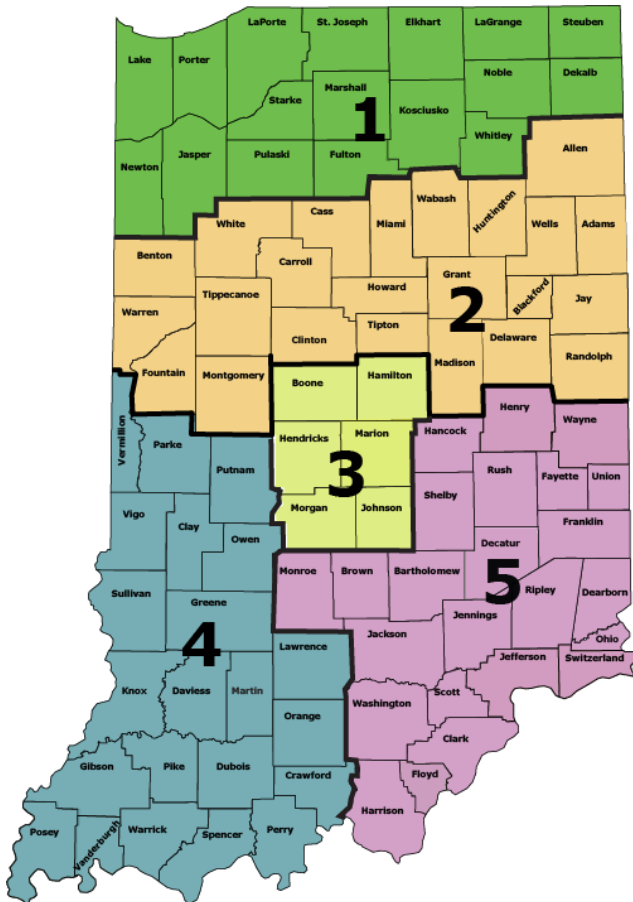- Delegated administrator must maintain managed individuals
- Review and deactivate staff no longer employed
- Functionality can be changed based on staff role
- Do not share Portal login credentials
- Delegate number is for life

Helpful Tools

Helpful Tools

Provider Relations Consultants

Region	Field Consultant	Email	Telephone	Counties Served
1	Jean Downs	INXIXRegion1@dxc.com	(317) 488-5071	Dekalb, Elkhart, Fulton, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Whitley
2	Shari Galbreath	INXIXRegion2@dxc.com	(317) 488-5080	Allen, Adams, Benton, Blackford, Cass, Carroll, Clinton, Delaware, Fountain, Grant, Howard, Huntington, Jay, Madison, Miami, Montgomery, Randolph, Tippecanoe, Tipton, Wabash, Warren, Wells, White
3	Crystal Woodson	INXIXRegion3@dxc.com	(317) 488-5324	Boone, Hamilton, Hendricks, Johnson, Marion, Morgan
4	Amber Keegan & Emily Redman (interim)	INXIXRegion4@dxc.com	(317) 488-5153	Clay, Crawford, Daviess, Dubois, Gibson, Greene, Knox, Lawrence, Martin, Orange, Owen, Parke, Perry, Pike, Posey, Putnam, Spencer, Sullivan, Vanderburgh, Vermillion, Vigo, Warrick
5	Virginia Hudson	INXIXRegion5@dxc.com	(317) 488-5186	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Hancock, Harrison, Henry, Jackson, Jefferson, Jennings, Monroe, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington, Wayne

Helpful Tools

IHCP website at in.gov/medicaid/:

- *IHCP Provider Reference Modules*

- Contact Us – Provider Relations Field Consultants

Customer Assistance available:

- Monday – Friday, 8 a.m. – 6 p.m. Eastern Time

- 1-800-457-4584

Secure Correspondence:

- Via the Provider Healthcare Portal
  - After logging in to the Portal, click the **Secure Correspondence** link to submit a request

Questions?