



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

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To: Service Providers to Pregnant Women

Subject: Presumptive Eligibility for Pregnant Women

Overview

This bulletin updates the bulletin that introduced Presumptive Eligibility for Pregnant Women (PE), Bulletin [BT200910](#) dated April 30, 2009. This second PE bulletin provides additional detail and several updates to the topics addressed in the first PE bulletin and should be used in tandem with the first PE bulletin.

The table of contents for this second bulletin follows.

Overview.....	1
PE BT200910 Topics.....	2
How to Locate a Qualified Provider	2
How Providers Can Identify PE Coverage and MCO Enrollment	2
Billing for Services for Presumptively Eligible Members and the PE Period.....	3
Fee-for-Service Considerations	4
Covered Services Provided on the Date of PE Determination.....	4
Covered Services Provided During PE Period.....	4
Non-Covered Services Provided During PE Period	4
Billing after the Medicaid Eligibility Decision is Completed.....	5
Members Approved for Medicaid	5
Members Denied for Medicaid	5
Prior Authorization During and After the PE Period.....	6
Prior Authorization for Covered PE Services.....	6
Retroactive Authorization for Non-Covered PE Services	6
Billing Scenarios	8
Pharmacy Coverage	9
Pre-Birth Selection of Primary Medical Provider (PMP) and MCO.....	10
PE Members and Incarceration Status	10
Frequently Asked Questions	10
What to Know About PE – Quick Reference Guide	11
PE Stepwise Process Document.....	11
Presumptive Eligibility Resources	11
Appendix A: PE Determination Notice – Approval	12
Appendix B: What to Know About PE.....	13
Appendix C: PE Stepwise Process	14

PE BT200910 Topics

The first PE bulletin addressed the following topics.

- Overview
- Presumptive Eligibility – Definition
- Presumptive Eligibility Requirements for Members
- Qualified Provider – Requirements and Provider Types/Specialties
- Enrolling as a Qualified Provider – A step-by-step summary of the enrollment process with sample Web interChange screens
- Registration for Qualified Provider Training
- The Presumptive Eligibility Process – A step-by-step summary of QP duties related to PE with sample Web interChange screens
- PE Considerations and Eligibility Verification Systems
- Contact Information
- Appendices
 - A. Provider Process for Presumptive Eligibility for Pregnant Women
 - B. PE Non-covered Services
 - C. Member Eligibility Requirements for PE for Pregnant Women
 - D. Further Explanation of Qualified Provider Requirements
 - E. Qualified Provider Training Dates
 - F. PE for Pregnant Women Application Descriptions
 - G. DFR Modernized Counties

How to Locate a Qualified Provider

Those who are not Qualified Providers may wish to refer a pregnant woman to a Qualified Provider. To search for a Qualified Provider, go to www.indianamedicaid.com and click Provider Services. Choose Provider Search and click the yes radio button beside “Show only Presumptive Eligibility Qualified Providers?” and click search. To make searching faster, users can limit the search by provider type or specialty, city, county, or ZIP code.

How Providers Can Identify PE Coverage and MCO Enrollment

A pregnant woman with presumptive eligibility coverage will not receive a Hoosier Healthwise identification card. If pregnant women select Anthem as their Managed Care Entity (MCO), they will get an Anthem card within two weeks of enrollment. Women enrolled with MHS and MDwise will not receive an identification card while covered by PE. All women will receive a determination letter from the Qualified Provider (QP) on the date they are approved (or denied) for PE.

Medical providers have several methods by which to verify a woman's PE coverage. PE pregnant women will receive a PE determination letter from the QP on the day that PE is determined. This letter will indicate that the woman has been approved (or denied) for PE. An example of the PE approval notice is included as Appendix A. This letter will indicate that the woman had PE coverage but will not assure providers that the woman's PE coverage is still active.

In order to be assured that the woman's PE coverage is still active on the day a PE covered pregnant woman comes to a provider for services, the provider must verify her eligibility. This verification process will also inform the provider of the member's Primary Medical Provider (PMP) and MCO assignment. Providers may use any of the three available eligibility verification options:

- Web interChange
- Omni Machine
- Automated Voice Response System (AVR)

PE members will be identified as "Package P" on each of the three eligibility verification options. Additionally, all PE members will have a Recipient Identification Number (RID) that begins with "550." No other Medicaid programs issue RID numbers that begin with "550."

PE members can change MCOs multiple times during their PE coverage period. Providers must check eligibility for PE members' MCO enrollment each time services are rendered and use this information in order to submit claims to the appropriate entity. While the majority of PE members will be enrolled with an MCO, a small number of PE members will have fee-for-service coverage rather than MCO coverage. Members with fee-for-service coverage will not have an MCO listed on the eligibility verification systems.

Billing for Services for Presumptively Eligible Members and the PE Period

The PE period begins when the pregnant woman is approved for PE. The PE period may end due to one of the following reasons:

1. The woman does not file a Hoosier Healthwise/Medicaid Application by the end of the second month of PE coverage. A Hoosier Healthwise/Medicaid Application must be pending with the Division of Family Resources (DFR) by the last day of the month following PE determination.
2. The woman is approved for Hoosier Healthwise/Medicaid. Eligibility for PE will end on the day after EDS receives the new coverage information from DFR.
3. The woman is denied coverage under Hoosier Healthwise/Medicaid. Eligibility for PE will end on the day after EDS receives the denial for Hoosier Healthwise/Medicaid from DFR.
4. The woman's pregnancy ends. PE is intended for coverage of ambulatory prenatal services and coverage will end if the woman's pregnancy ends, either as a result of miscarriage, abortion, or delivery.

When billing for services provided during a woman's PE period, providers must send claims to the appropriate MCO (or EDS if the member is fee-for-service) using the members '550' identification number. Anthem requires the 'YRH' prefix to be billed with the '550' identification number.

PE only pays for pregnancy related services. To be considered as pregnancy related, claims must indicate a pregnancy diagnosis. **Claims without a pregnancy diagnosis will not be paid.** It is important to use the appropriate pregnancy related diagnosis on non-pharmacy claims and the appropriate pregnancy indicator for pharmacy claims. Pregnancy related diagnosis codes that are covered for PE can be found in Table 6.1 of the *Qualified Provider Presumptive Eligibility Manual*, located at <http://www.indianamedicaid.com/ihcp/MCE/content/peInfo.asp>.

Fee-for-Service Considerations

Billing requirements for PE women with fee-for-service coverage will follow the standard authorization and billing guidelines for fee-for-service claims see the *Indiana Health Coverage Programs (IHCP) Provider Manual, Chapter 6: Prior Authorization*. Claims for fee-for-service women must be submitted to EDS. Fee-for-service prior authorization procedures must be followed. Providers should contact Advantage Health Solutions at 1-800-784-3981, for more information about fee-for-service prior authorization requirements.

Covered Services Provided on the Date of PE Determination

Services provided on the date of PE determination are covered for women who are determined eligible for PE. Providers must submit claims to the appropriate MCO for the services performed for that day. In the case of a PE member with fee-for-service coverage, providers must submit claims to EDS.

Note: Member eligibility will not appear in the Eligibility Verification Systems until the day following PE determination. Providers are encouraged to wait until information can be verified with the EVS before billing claims. This will ensure that claims are submitted to the correct MCO.

All Qualified Providers (QPs) that provide services to a PE enrolled woman on the day her PE coverage was determined will be reimbursed for medically appropriate covered services that are pregnancy related, whether or not the QP is in the MCO's network. To facilitate this process, providers should make sure that each of the MCOs has the necessary financial information on file, regardless of the provider being enrolled as an in-network with the MCO. Providers that are not QPs and render services on the date of PE determination must follow MCO requirements for out-of-network providers and prior authorization of services, when applicable.

Covered Services Provided During PE Period

Services provided during the PE period should be submitted using the member's PE '550' RID number, to the appropriate MCO or to EDS for a PE member with fee-for-service coverage. The PE '550' identification number is only valid for dates of service beginning on the date of PE determination until PE coverage ends (see page 3 for the reasons that PE coverage will end.). If the member is approved for Hoosier Healthwise/Medicaid, the providers must use the identification number that begins with '10' and ends with '99' for services provided after the PE period ends.

Non-Covered Services Provided During PE Period

Non-covered services during the PE period include hospital inpatient, hospice, long term care, abortions, sterilizations and hysterectomy services. These services, if determined to be pregnancy-

related, may be retroactively covered if the woman is later determined to be eligible for Hoosier Healthwise/Medicaid benefits. Refer to the *PE/QP Manual*, Section 6 for more information.

Providers must notify PE members that the services listed in the prior paragraph are not covered by PE and must obtain a waiver from the member. These services are considered self-pay until Hoosier Healthwise/Medicaid eligibility is approved for the date of service on which these services were provided.

Billing after the Medicaid Eligibility Decision is Completed

Once DFR has determined Hoosier Healthwise/Medicaid eligibility and the Hoosier Healthwise segment is open in IndianaAIM, PE coverage will be terminated. The Hoosier Healthwise eligibility information will be entered into ICES and communicated to IndianaAIM daily. The eligibility verification systems will be updated to indicate an ongoing Medicaid eligibility under the '10_99' identification number and the termination date for PE will be displayed. If women are denied Medicaid coverage, PE will end the day after EDS receives the DFR decision.

Medicaid coverage may be applied retroactively to the date of the Hoosier Healthwise application or earlier. When retroactive coverage is provided, claims for previously non-covered services should be billed to the appropriate MCO or fee-for-service. Coverage may also be applied for up to three months retroactive from the Hoosier Healthwise application. Providers must verify eligibility for specific dates of service using the EVS and bill claims to the appropriate entity.

Members Approved for Medicaid

Once a PE woman is approved for ongoing Hoosier Healthwise/Medicaid, the provider must submit claims with the regular Medicaid '10_99' RID number. Non-covered PE services should be rebilled to the appropriate MCO (or EDS for fee-for-service women) with the '10_99' identification number and the provider should refund any amount paid to them by the member.

PE members approved for Hoosier Healthwise/Medicaid will receive a Hoosier Healthwise identification card and may present the card with the '10_99' identification number as proof of eligibility for Hoosier Healthwise/Medicaid. The Hoosier Healthwise identification card does not assure providers that her eligibility is still active. Providers should continue to verify eligibility using one of the three EVS options.

The MCO assignment that existed during PE will continue when the member is approved for Hoosier Healthwise/Medicaid. Providers must continue to check eligibility using the EVS to ensure that claims are submitted to the appropriate MCO (or EDS for fee-for-service members).

Members Denied for Medicaid

PE coverage will end on the day following the day DFR makes a decision regarding ongoing Medicaid eligibility and the information has been communicated to IndianaAIM, or other scenarios listed on page 2 of this bulletin. If a PE woman is denied Medicaid eligibility, she may appeal the decision with DFR. PE coverage will not continue while her appeal is in process. PE is only permitted once per pregnancy, so she will not be able to re-apply for PE if denied for Hoosier Healthwise/Medicaid.

Prior Authorization During and After the PE Period

In general, the same prior authorization requirements that exist for Package B women (pregnancy-related coverage) will apply to PE covered women. Services non-covered under PE (e.g., inpatient care) do not require formal prior authorization until the woman's Hoosier Healthwise/Medicaid is approved. The MCOs request that providers voluntarily notify the MCO prior to rendering any of the non-covered PE services to streamline the process of prior authorization at a later date.

Prior Authorization for Covered PE Services

MCOs and fee-for-service PE coverage will require prior authorization (PA) for some PE covered services. Providers should contact the appropriate MCO or, for PE members with fee-for-service coverage, Advantage Health Solutions, for more information about services that require PA and procedures for requesting PA.

Retroactive Authorization for Non-Covered PE Services

As previously stated, there are some PE non-covered services that may be covered when Hoosier Healthwise/Medicaid is approved. The most common of these will be inpatient services. The process for each of the MCOs is outlined below. For more information, please contact the specific MCO.

Anthem

Providers that need to file claims for a previously non-covered PE service must submit medical records to support medical necessity (e.g., reason for inpatient stay) with the claim. The medical records must substantiate the care rendered. Anthem will review the medical records and the claim for medical necessity and make an appropriate determination for payment or denial. Since the claim will be a Retro review, the cases will be reviewed in the Retro Unit. Claim and medical records can be sent to Anthem Correspondence; Retro Review; PO Box 6144; Indianapolis, IN; 46206-9210.

Providers may choose to pre-notify Anthem on an inpatient stay through the Indiana Pre-Cert Line, 1-866-408-7181. Precertification forms are available on the Anthem website and will be handled as any other request. Providers may also call the number listed in the final sentence of the form.

MDwise

Providers must contact the member's MDwise delivery system for prior notification requirements. Individual delivery system phone numbers and fax numbers for prior notification purposes can be found at the following link: <http://www.mdwise.org/pdfs/hoosier/hhwquickcontact.pdf>.

Managed Health Services (MHS)

Providers are encouraged to call MHS at 1-877-MHS-4U4U, option "2" to provide notification of their intent to perform a scheduled non-covered service for a PE member. This should be done at least 2 days in advance for scheduled services or as soon as possible for urgent request for services. After the provider provides MHS "notification" of service needs for a non-covered PE benefit, clinical documentation must be submitted to MHS within two business days. MHS will issue guidance to the provider to advise if reimbursement will be provided if the member is later approved for Hoosier Healthwise/Medicaid.

Providers that participate in the voluntary notification process will not be required to submit any additional documentation with the claim once the member is approved for Hoosier Healthwise/Medicaid. If providers elect not to participate in the notification process, claims submitted for previously non-covered PE services will be subject to retrospective review.

Documentation for consideration as part of the voluntary prospective notification program for PE members may be faxed to 1-866-912-4245 within 2 days after the notification is called in to the MHS Medical Management department at 1-877-MHS-4U4U, option "2".

For those providers who choose not to participate in the voluntary prospective notification program and receive a claim denial requesting medical records for retrospective review, please call the medical management department to indicate you are seeking a retrospective review and then fax the clinical information along with a copy of the denied claim to 1-866-912-4245 within 30 days.

Authorization for the following ancillary services remains unchanged for PE enrollees:

Vision Services Authorization - Routine vision services do not require PA.

- Phone: 1-877-MHS-4U4U, option "2" or 1-866-599-1774
- Fax: 1-252-451-2182

Behavioral Health Services Authorization - Mental health/chemical dependency admissions, any psychological testing, and any outpatient therapy in excess of 6 visits require PA.

- Phone: 1-877-MHS-4U4U, option "2"
- Fax: 1-866-694-3649

Pharmacy Services Prior Authorizations - Any medication not on the MHS formulary and other certain medications require prior authorization. Please visit www.managedhealthservices.com to obtain more information on specific medications subject to PA.

- US Script Phone: 1-866-399-0928
- US Script Fax: 1-866-399-0929

For a listing of detailed prior authorization requirements, you may obtain a copy of MHS' detailed authorization requirements by visiting our website, www.managedhealthservices.com, contacting your MHS Provider Representative, or calling us at 1-877-MHS-4U4U, option "2."

MHS hours of operation for authorization and notification are 8AM-12 Noon and 1PM-5PM daily, Monday through Friday. Confidential voice mail messages may be left during the lunch hour or before and after normal business hours.

Advantage Health Solutions – Fee-For-Service

PA is given after services have begun or supplies have been delivered only under the following circumstances:

- Pending or retroactive member eligibility
 - The PA request must be submitted within 12 months of the date when the member's caseworker entered the eligibility information (405 IAC 5-34-4 (i)(3) Pending or retroactive

approval of nursing facility Level of Care). The hospice authorization request must be submitted within one year of the date nursing facility Level of Care is approved by the office.

- Mechanical or administrative delays or errors by the contractor or county office of the Division of Family Resources (DFR)
- Services rendered outside Indiana by a provider that had not yet enrolled as an IHCP provider
- Transportation services authorized under *405 IAC 5-30*
 - The PA request must be submitted within 12 months of the date of service.
- Provider unaware that the member was eligible for services at the time services were rendered PA is granted in this situation only if the following conditions are met:
 - The provider's records document that the member refused or was physically unable to provide the RID number.
 - The provider can substantiate that reimbursement was continually pursued from the member until IHCP eligibility was discovered.
 - The provider submitted the request for PA within 60 days of the date that IHCP eligibility was discovered.
 - Any situation in which the physician cannot determine the exact procedure to be done until after the service has been performed.

Providers should submit Care Select requests to the correct Care Management Organization (CMO) based on current eligibility. Providers should submit requests for Risk Based Managed Care (RBMC) members to the correct MCO based on the date of service.

Prior Authorization Requests can be submitted via Phone, Fax, or Mail:

Phone requests :

ADVANTAGE Health Solutions-FFS
1-800-269-5720

Fax Requests:

ADVANTAGE Health Solutions-FFS
Fax: 1-800-689-2759

Mail Requests:

ADVANTAGE Health Solutions-FFS
Prior Authorization Department P.O. Box 40789
Indianapolis, IN 46240

Billing Scenarios

1. A pregnant woman has a hospital stay prior to becoming eligible for presumptive eligibility. During the hospital visit she is determined to be pregnant. After being released from the hospital she visits her family practitioner, a QP for PE, to apply for PE. The family practitioner's office completes the PE application and she is approved. Thirty days later, the DFR makes the determination approving her for Hoosier Healthwise/Medicaid, Package B, and coverage is made retroactive to a date prior to the date of her hospital stay. How will her eligibility and billing work, including the time that she was covered by PE?
 - The day after EDS receives the Medicaid eligibility from the DFR, the PE coverage period will end. Hoosier Healthwise/Medicaid will overlay the PE segment. Since she is retroactively eligible for coverage prior to PE determination date, there will be a fee-for-service time period with no MCO or PMP assignment.

- The hospital stay falls into this fee-for-service time period. As long as her hospital claims contain a pregnancy-related diagnosis, the stay would be covered by Hoosier Healthwise/Medicaid. These claims should be billed using the traditional Hoosier Healthwise identification number
 - Any PE covered services rendered during the PE period are to be billed using the PE '550' identification number to the appropriate MCO.
 - Any non-covered services incurred during the PE period can be billed to the appropriate MCO using the traditional Hoosier Healthwise identification number.
 - Services provided after PE is terminated and Hoosier/Healthwise is extended should be billed to the appropriate MCO using the traditional Hoosier Healthwise identification number.
 - PMP and MCO selections that existed under PE will continue to exist under the Hoosier Healthwise/Medicaid period unless the member requests a change.
2. An uninsured woman breaks her leg and goes to the emergency room on May 1st. On June 15th, she goes to her internist and it is determined she has been pregnant since approximately April 15th. Her internist is a QP and the office assists her with completing the PE application and she is approved. On July 2nd her Hoosier Healthwise/Medicaid application is approved coverage starting June 15th. She is not given retroactive coverage because her income was too high from April 15th – July 14th.
- The emergency room visit is self-pay. The PE period only provides coverage beginning June 15th, the date that she applied for PE and Hoosier Healthwise/Medicaid.
 - Any PE covered services provided during the PE period would be billed using the PE '550' identification number. These claims must be submitted to the MCO of record (or to EDS if she is assigned to fee-for-service).
 - Any non-covered PE services provided during the PE period and all services provided after the PE eligibility ended, would be billed to the appropriate MCO using the traditional Hoosier Healthwise identification number (or to EDS if she is assigned to fee-for-service.).

Pharmacy Coverage

Women will have coverage beginning on the date of PE determination. Eligibility information for newly approved PE members will be in the eligibility verification systems (EVS) and in MCO systems on **the day following** PE determination. It will take as much as an additional two and a half days for information to be passed from the MCO to the pharmacy benefit manager (PBM) for each MCO.

Providers are encouraged to advise women with PE coverage to wait 2-3 days after PE determination before filling prescriptions. If an emergency prescription is needed, the MCOs will work with pharmacy providers to expedite manual transmission of eligibility information to PBMs and pharmacies.

Table 2 indicates each MCO's timeline and processes for emergency transmission of eligibility information to PBMs. Women enrolled in fee-for-service will need to wait until the day after PE determination for information to be available in the EDS system that processes pharmacy claims.

Table 2 - MCO Eligibility Timing for PBM

Managed Care Organization (MCO)	Standard PBM Timing	Process for Emergency Prescriptions
Anthem www.Anthem.com phone 1-866-408-6132	PE information will be in the PBM system 2 business days after the PE approval.	Call Anthem at 1-866-408-6132

Managed Care Organization (MCO)	Standard PBM Timing	Process for Emergency Prescriptions
Mdwise www.MDwise.org phone 1-800-356-1204	PE information will be in the PBM system the second business day after the PE approval.	Call MDwise at 1-800-356-1204
MHS www.managedhealthservices.com phone 1-877-647-4848	PE information will be in the PBM system 2 business days after MHS' receipt of the eligibility file from EDS.	Call MHS 1-877-647-4848

Pre-Birth Selection of Primary Medical Provider (PMP) and MCO

MAXIMUS will accept a pre-birth selection of an MCO and PMP for a covered woman's unborn child whether the woman is on PE or Hoosier Healthwise/Medicaid (Hoosier Healthwise) coverage. A child born to a woman with Hoosier Healthwise/Medicaid coverage on the day the child is born may be automatically enrolled in Medicaid with the MCO and PMP selected through the pre-birth selection process. If the pregnant woman has not yet been determined eligible for Hoosier Healthwise/Medicaid, her child is not automatically enrolled in Medicaid at birth and the pre-birth selection will not be applied.

PE Members and Incarceration Status

A pregnant woman who is incarcerated is not eligible for PE. Incarceration means that the applicant is an inmate serving time for a criminal offense or confined involuntarily in a prison, jail, juvenile detention center, or any other type of penal facility. This eligibility prohibition applies regardless of the age of the applicant and regardless of the length of time she is incarcerated. Inmates are not eligible for PE if the facility is a public institution owned by a governmental entity or over which a governmental unit has administrative control.

A pregnant woman is still eligible for PE if she is on parole or probation, charged with an offense and is out on bail awaiting trial, serving sentence on "home release" not in a correctional facility, or a juvenile offender who has served the length of her sentence, but is remaining voluntarily in the detention facility until a group home placement is finalized for her.

A pregnant woman would be ineligible for PE if she was awaiting trial and being held in jail without bond, serving her sentence in an "alternative jail" such as a wilderness camp under governmental control, is serving her sentence in a half-way house that is under governmental administrative control, or is serving a short term jail sentence (e.g., 30-90 days).

Frequently Asked Questions

A list of questions asked during Qualified Provider training sessions is posted on the IHCP website, <http://www.indianamedicaid.com/ihcp/MCE/content/peInfo.asp>. This question and answer document will continue to be updated. Providers are encouraged to refer to this document for questions about PE coverage, policies and procedures.

What to Know About PE – Quick Reference Guide

A quick reference document titled **Presumptive Eligibility for Pregnant Women – What You Need to Know** is included as Appendix B. Other informational documents are listed in the next section of this bulletin under “Presumptive Eligibility Resources”.

PE Stepwise Process Document

A document outlining the steps for Qualified Providers is contained in Appendix C. This document will also be posted on the PE Resources webpage discussed in the next section.

Presumptive Eligibility Resources

The IHCP Provider Web site at <http://www.indianamedicaid.com/ihcp/MCE/content/peInfo.asp> includes the following Qualified Provider training materials:

- Quick Reference Sheet
- Family size and Income Scenarios
- Training Presentation
- What to Know about Presumptive Eligibility
- Provider Frequently Asked Questions – **Great Resources for Providers!!**
- Presumptive Eligibility Bulletin [BT200910](#)
- Presumptive Eligibility Qualified Provider Manual

Submit questions to the Office of Medicaid Policy and Planning (OMPP) by email:

PEhelp@fssa.in.gov

Submit written correspondence to EDS by mail:

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

Contact the EDS field consultant for Presumptive Eligibility/Notification of Pregnancy:

Relia Manns, (317) 488-5363

View a current territory map and contact information for EDS Provider Relations Field Consultants online:

http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm

Appendix A: PE Determination Notice - Approval



"People
helping people
help
themselves"

Mitchell E. Daniels, Jr., Governor
State of Indiana

Indiana Family and Social Services Administration
402 W. WASHINGTON STREET, P.O. BOX 7083
INDIANAPOLIS, IN 46207-7083

Anne Waltermann Murphy, Secretary

03/12/2009

XXX MAIN STREET
APT 1
FISHERS, IN 2334-3243

Dear _____,

You have been determined eligible for Presumptive Eligibility for Pregnant Women. You are now able to receive services related to your pregnancy, such as: visits to your doctor, lab work, prescriptions, and other pregnancy related care. Remember to take this letter with you to your doctor visits.

There are a few things that you must do so that you may keep your coverage:

- Complete and submit a Hoosier Healthwise (HHW) application before you leave today. Have your doctor fax your application to HHW.
- If you can not complete the application today or you need help, please call HHW at 1-800-889-9949.
- Call HHW at 1-800-889-9949 within the next month (30 days) if you have not heard anything about your application. This is to make sure you have a pending HHW application.

IMPORTANT: If you have not submitted a HHW application by 04/30/2009 your PE coverage will end.

The doctor you selected at today's visit is:

PMP Name: _____

PMP Address: _____

PMP Phone: _____

Your PE ID number is: 000000000r

Your doctor is in a health plan called:

- | | | |
|--------------------------|--------|----------------|
| <input type="checkbox"/> | Anthem | 1-866-408-6131 |
| <input type="checkbox"/> | MDWise | 1-800-356-1204 |
| <input type="checkbox"/> | MHS | 1-877-647-4848 |

Sincerely,

The Presumptive Eligibility for Pregnant Women Program

Si usted tiene alguna pregunta por favor llame a línea de ayuda del Programa de Hoosier Healthwise al 1-800-889-9949.

www.IN.gov/fssa
Equal Opportunity/Affirmative Action



Appendix B: What to Know About PE

PRESUMPTIVE ELIGIBILITY (PE) FOR PREGNANT WOMEN

What You Need to Know

1. Presumptive eligibility (PE) allows a pregnant woman to receive ambulatory prenatal services while her Hoosier Healthwise application is being processed.
 - *Think of PE as "Package B" with a few exceptions.*
2. A Qualified Provider (QP) must complete the PE Application for Pregnant Women for a woman to be determined eligible for the program.
3. No documentation is required from the pregnant woman for the QP to make the determination that a woman is presumptively eligible.
 - The QP must clinically verify the pregnancy
 - Women must know their gross family income, social security number, citizenship status, and other information to complete the PE Application.¹
4. PE coverage starts on the date of determination by the QP.
 - Women must select a Primary Medical Provider (PMP) and Managed Care Organization (MCO) to activate PE coverage
5. On the day of PE determination, the QP must assist the woman by:
 - a) Providing access to telephone for the woman to contact MAXIMUS at 1-800-889-9949 to select a PMP and MCO
 - b) Faxing the woman's Hoosier Healthwise Medicaid Application to the Division of Family Resources (DFR) on the same day as PE determination².
6. If the woman does not submit an application for Medicaid, she will lose PE benefits on the last day of the month following the month in which her PE determination was made. PE can only be granted once per pregnancy.
7. The woman may remain on PE until her Medicaid application is approved or denied, or her pregnancy ends. If denied Medicaid, she has the right to appeal the decision.
8. PE does not cover inpatient services, delivery and postpartum care³. If the woman is found eligible for Medicaid, reimbursement for these services during the PE period may be covered.⁴
9. Providers that bill for services while a woman is on PE will not have reimbursement taken back if the woman is later found ineligible for Medicaid.

If you want more information about PE go to BT200910 at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp

If you have further questions, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278. Questions can also be emailed to: PEHelp@fssa.in.gov

¹ Refer to BT200910 for a listing of the PE Application questions.

² Documentation (e.g., pay stubs, citizenship documentation, expenses, etc) is **not required** to be submitted with the Hoosier Healthwise Application. The DFR will contact the woman to notify her of the documentation that must be submitted. The QP is encouraged to assist the member with submitting additional documentation to the DFR.

³ Refer to BT200910, *Appendix B* for a complete list of non-covered services during PE.

⁴ Medicaid eligibility will be retroactive to cover the PE coverage time period.

Appendix C: PE Stepwise Process

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN - THE PROCESS

- Step 1.** A Qualified Provider (QP)¹ verifies a patient's pregnancy by administering a pregnancy test or by reviewing the results of a pregnancy test administered by another licensed practitioner.
- Step 2.** A QP employee who has been trained on Presumptive Eligibility logs on to Web interChange and clicks on the **Eligibility Inquiry** menu option to verify that the patient is not already enrolled in Medicaid.
- The employee enters the NPI number for the location at which the patient is being seen. This must be a location that is enrolled as a QP.
 - The employee performs an eligibility inquiry by entering the woman's information and the date of service.
- Step 3.** If the patient is not currently enrolled in Medicaid, the QP employee:
- a. Clicks on the **PE Application For Pregnant Women** button to complete the PE application.
 - b. Enters the following patient information into the online PE application.
 - Name
 - Date of Birth
 - Mailing Address (if different)
 - Gender
 - Race and Ethnicity
 - Family Gross Income
 - Social Security Number
 - Home Address
 - Phone Number (at least one is required)
 - Marital Status
 - Number of Persons in the Family
 - c. The QP employee also enters a yes or no answer to each of the following questions for the patient.
 - Are you an Indiana resident?
 - Are you a U.S. citizen?
 - Are you incarcerated?
 - Do you have a pending Medicaid/Hoosier Healthwise application?
 - d. Clicks the **Submit Application** button.
- Step 4.** For patients who are approved for PE, the QP employee clicks on the **Print Acceptance Letter and Hoosier Healthwise Application** button. For patients who are not approved for PE the QP employee clicks on the **Print Denial Letter and Hoosier Healthwise Application** button. The QP employee hands the Hoosier Healthwise application to the patient.
- Step 5.** The QP employee hands the printed Acceptance Letter or Denial Letter to the patient for her to keep and clicks the **Close** button.
- Step 6.** For patients who are approved for PE, the QP employee:
- a. Directs the patient to a phone in the QP's office that the patient can use to call MAXIMUS, the enrollment broker, at 1-800-889-9949. MAXIMUS will assist the woman in choosing a Primary Care Provider (PMP) and a Managed Care Organization (MCO).
 - b. Directs the patient to record her PMP and MCO choices on the approval letter in the spaces provided.
- Step 7.** The QP employee:
- a. Asks the applicant to review the Hoosier Healthwise application, answer questions that were not asked as part of the online PE application and sign the application.
 - b. Faxes the signed Hoosier Healthwise application to the appropriate DFR office.²

If you want more information about PE go to http://www.indianamedicaid.com/hcp/Publications/bulletin_results.asp and BT200910

If you have further questions, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278. Questions can also be emailed to: PEHelp@fssa.in.gov

¹ To be a QP, the provider must meet all state and federal requirements, pre-qualify online through Web interChange and have at least one designated employee attend PE training.

² To determine the appropriate DFR office and fax number go to <http://www.in.gov/fssa/dfr/2999.htm>