



INDIANA HEALTH COVERAGE
PROGRAMS PROVIDER MANUAL

Chapter 3: Electronic Solutions

Chapter 3: Revision History

Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
Version 1.0	September, 1999 Policies and procedures are current as of March 1, 1999	New Manual	EDS Document Management Unit
Version 2.0	June 2001 Policies and procedures are current as of June 1, 2000	Chapters 1, 2, 3, 6, 7, 8, 9, 10, 13, 14, and Appendix A	EDS Document Management Unit
Version 3.0	April 2002 Policies and procedures are current as of August 1, 2001	All Chapters	EDS Client Services and EDS Publications Unit
Version 4.0	April 2003 Policies and procedures are current as of April 1, 2002	All Chapters	EDS Client Services and EDS Publications Unit
Version 5.0	July 2004 Policies and procedures current as of January 1, 2004	All Chapters	EDS Client Services Department
Version 5.1	March 2005 Policies and procedures current as of January 1, 2005	Quarterly Update	EDS Publications Unit
Version 6.0	December 2006 Policies and procedures current as of April 1, 2006	Quarterly Update	EDS Publications Unit
Version 7.1	February 2008 Policies and procedures as of October 1, 2007	Semiannual Update	EDS Provider Relations and Publications Units
Version 8.0	August 2008 Policies and procedures as of February 1, 2008	Semiannual Update	EDS Provider Relations and Publications Units
Version 8.1	October 2008 Policies and procedures as of August 1, 2008	Semiannual Update	EDS Provider Relations and Publications Units
Version 9.0	March 2009 Policies and procedures as of February 1, 2009	Semiannual Update	EDS Provider Relations and Publications Units

Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
Version 9.1	February 16, 2010 Policies and procedures as of August 1, 2009	Semiannual Update	HP Provider Relations and Publications Units
Version 10.0	March 4, 2010 Policies and procedures as of February 1, 2010	Semiannual Update <ul style="list-style-type: none"> • Replaced EDS references with HP • Added the Eligibility Verification System and Spend-down section • Updated the Managed Care Eligibility section • Updated Check/RA Inquiry section 	HP Provider Relations and Publications Units

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Section 1: Introduction to Electronic Solutions

General Information

Electronic Solutions refers to the means by which providers exchange data electronically with the Indiana Health Coverage Programs (IHCP). Various applications and transactions are available for providers that exchange data with the IHCP using electronic data interchange (EDI). This chapter covers the following items:

- *Section 1: Introduction to Electronic Solutions*
- *Section 2: Electronic Transactions*
- *Section 3: Web interChange*
- *Section 4: Electronic Data Interchange – Secure File Transfer Protocol*
- *Section 5: Omni 380 Terminal*
- *Section 6: Automated Voice Response (AVR) System*

National Provider Identifier

The federal government requires healthcare providers that electronically transmit health information to have a unique provider number. This number is called a National Provider Identifier (NPI). The NPI is a unique 10-digit number, which replaced other healthcare provider identifiers, including the IHCP Legacy Provider Identifier (LPI), in Health Insurance Portability and Accountability Act (HIPAA) standard transactions.

Use of the NPI reduces the need for providers to maintain multiple identification numbers. The IHCP assigns providers multiple legacy identifiers based on the provider's type and service locations.

The IHCP does not issue NPIs. An enumerator under the direction of the Centers for Medicare & Medicaid Services (CMS) issues the NPIs. Providers have been able to apply for NPIs since May 23, 2005.

Healthcare providers are required to submit their NPI on all HIPAA standard transactions, and claims submitted without the NPI are rejected. Atypical providers are excluded from this requirement and will continue using their LPI. The *IHCP Companion Guides* have been updated to reflect NPI information. The Companion Guides are available at: <http://www.indianamedicaid.com> in the EDI Solutions section.

More information about the NPI is available at http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp and the IHCP Web site at <http://www.indianamedicaid.com>.

NPI Reporting Tool

The NPI Reporting Tool allows providers to report their NPI to the IHCP. This application is available in the NPI section on the IHCP Web site at <http://www.indianamedicaid.com>. Providers use a unique ID and password to log on to the NPI Reporting Tool. Letters containing logon information are sent to all active IHCP providers. After logging on to the NPI Reporting Tool, providers must do the following:

- Type a contact name, telephone number, and e-mail address, if applicable. The tool displays all active Medicaid LPIs associated with the provider's tax identification number (TIN).
- Type an NPI for each LPI and service location to continue using a HIPAA standard transaction.
- Select the appropriate taxonomy code(s) for the associated provider specialty.

Group providers must obtain an NPI for each rendering provider and report those NPIs for each service location. All active rendering providers affiliated with the billing provider at a particular service location are displayed in the tool. To report an NPI for a rendering provider, providers must take the following steps:

- Type the NPI for the rendering provider.
- Select the appropriate taxonomy code(s) for the rendering provider's specialty.

The *NPI Reporting Tool User Guide* can be accessed on the IHCP Web site at <http://www.indianamedicaid.com>.

Direct questions about using the NPI Reporting Tool to HP Provider Enrollment Customer Assistance at 1-877-707-5750.

Section 2: Electronic Transactions

HIPAA Compliance

The Indiana Health Coverage Programs (IHCP) is compliant with the *Administrative Simplification* provision of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. This provision mandates standard electronic transactions and code sets across the healthcare industry, standardizing electronic data interchange (EDI) to provide more efficient and effective service. The requirements also regulate format and content standards, and establish security and privacy standards for healthcare information.

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

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

The IHCP has options available for providers to submit claims through EDI and HIPAA content-compliant direct data entry (DDE) electronic transactions.

Electronic Transaction Types

Table 3.1 – Electronic Transactions Processed by the IHCP

Business Category	Transaction Name	Description
Claims Processing	ASC X12N 837 (004010X098) and 004010X098A1 Addenda	Health Care Claim: Professional
Claims Processing	ASC X12N 837 (004010X097) and 004010X097A1 Addenda	Health Care Claim: Dental
Claims Processing	ASC X12N 837 (004010X096) and 004010X096A1 Addenda	Health Care Claim: Institutional
Explanation of Payment/Remittance Advice	ASC X12N 835 (004010X091) and 004010X091A1 Addenda	Health Care Claim: Payment/Advice
Eligibility Verification	ASC X12N 270/271 (004010X092) and 004010X092A1 Addenda	Health Care Eligibility Benefit Inquiry and Response
Claim Status	ASC X12N 276/277 (004010X093) and 004010X093A1 Addenda	Health Care Claims Status Request and Response
Prior Authorization	ASC X12N 278 (004010X094) and 004010X094A1 Addenda	Health Care Services Review – Request for Review and Response
MCE Member Enrollment Roster	ASC X12N 834 (004010X095) and 004010X095A1 Addenda	Member Benefit Enrollment and Maintenance
MCE Capitation Payment Listing	ASC X12N 820 (004010X061) and 004010X61A1 Addenda	MCE Capitation Payment Listing

Eligibility Verification

It is important that providers verify member eligibility on the date of service. Viewing a Hoosier Health Card alone does not ensure member eligibility. If a provider fails to verify eligibility on the date of service, the provider risks claim denial. Claim denial could result if the member was not eligible on the date of service, or if the service provided was outside the member's scope of coverage.

The HP Eligibility Verification System (EVS) restricts providers from accessing member eligibility information for dates of service that are not within an active IHCP provider's program eligibility segment. Providers may verify eligibility for members for any date of service that is within the provider's program eligibility segment.

All eligibility verification applications can be used to verify the eligibility status of a member for current and past dates of service. Eligibility inquiries are limited to a date span of one calendar month.

HP Customer Assistance representatives do not provide eligibility verification information.

Note: The majority of denied claims are denied due to missing or incorrect information that should have been verified through one of the EVS options.

Eligibility Verification Methods

The following can be used to verify eligibility:

- Web interChange (See [Section 3.](#))
- 270/271 eligibility inquiry and response transaction – batch or interactive (See [Section 4.](#))
- Omni swipe card device (See [Section 5.](#))
- Automated Voice Response (AVR) (See [Section 6.](#))

Eligibility Verification System and Spend-down

When a provider verifies member eligibility for a member who has a spend-down, the EVS displays the dollar amount of the remaining spend-down obligation for the month. Providers may not collect the spend-down obligation from the member at the time of service. Providers may bill the member for the amount credited to spend-down after the claim is adjudicated. Consistent with current spend-down policy, a member's obligation to pay the spend-down begins upon receipt of the Monthly Spend-down Summary Notice, which is mailed to the member on the second business day of the following month.

In addition to the remaining spend-down obligation amount, providers also see the following disclaimer:

This amount is based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the spend-down amount deducted from the adjudicated claim; however, with the exception of point of sale (POS) pharmacy claims, the member is not required to pay the provider until the member receives the Monthly Medicaid Spend-down Summary Notice listing the amount applied to spend-down.

The disclaimer reminds providers that the remaining obligation amount is based on real-time data and is accurate at the time of the eligibility verification.

Refer to [Sections 5 and 6](#) for Omni and AVR spend-down details.

Managed Care Eligibility

The EVS provides health plan information if the member is assigned to a managed care organization (MCO), Healthy Indiana Plan (HIP), care management organization (CMO), or Presumptive Eligibility for Pregnant Women (PE) for the time period of the eligibility request. The MCO, HIP, or CMO is referred to as the “managed care entity” (MCE), which is an individual or organization that participates in the managed care program, either by provision of managed care services or through a program administrator.

If a member is assigned to an MCE, the following information is included in the eligibility response:

- Type of managed care member – risk-based managed care (RBMC), HIP, *Care Select*, or PE
- MCE’s name and telephone number
- Primary medical provider (PMP) names and telephone numbers (HIP members will be assigned to a health plan and not to an individual PMP)
- PMP assignment effective date and end dates (not applicable for HIP members)

If the member has been assigned to multiple PMPs during the time period of the eligibility request, the eligibility response will include each PMP and the PMP-MCE information with the date segments that the member was assigned to the PMP.

Helpful Hints about Member Eligibility Verification

Whatever eligibility verification method a provider chooses to use, it is important that the provider correctly interprets the eligibility messages received. The following are some helpful hints:

- Dates of Service – The EVS is programmed to verify eligibility for the current date unless the provider specifically requests verification for different dates of service. To verify eligibility for dates of service prior to the current date, the provider must enter the specific date of service. When verifying eligibility for a date other than the current date (the date when verification is being made), the provider must be careful to enter the actual date of service.
- Program Type – The EVS is programmed to provide verification of eligibility for all the IHCP, including the 590 Program. (See [Chapter 2](#) of this manual.)
- When service type codes are required, refer to [Section 5, Table 3.4 – Service Type Codes and Benefit Limitations](#).
- For past filing limit (PFL) documentation for claim submission, the provider must use a real-time EVS application. Documentation from a batch eligibility transaction should not be used for PFL documentation.
- Access to eligibility information on members is denied if the dates of service do not fall within a provider’s active IHCP program eligibility segment.
- When requesting eligibility for a date span, every date within the date span must fall within the provider’s active program eligibility date segment.

Claim Submission

Claim submission allows providers to submit claims electronically to the IHCP. All institutional, professional, and dental claims can be entered in this manner. This includes inpatient, outpatient, home health, long-term care, and medical claims, as well as Medicare crossover claims. Pharmacy claims can

be submitted through Point of Sale (POS) or in batch format. Pharmacy claims cannot be submitted via Web interChange. Claims can be submitted seven days a week, 24 hours a day.

Claim Submission Methods

Claims can be submitted using the following:

- Web interChange (See [Section 3.](#))
 - 837P – Professional Claims
 - 837I – Institutional Claims
 - 837D – Dental Claims
 - Medicare Crossover Claims
- Batch claim submission using HIPAA-compliant transactions (See [Section 4.](#))
 - 837P – Professional Claims
 - 837I – Institutional Claims
 - 837D – Dental Claims
 - Medicare Crossover Claims
 - Pharmacy National Council for Prescription Drug Programs (NCPDP) Version 1.1
- Interactive claim submission – pharmacy only
 - Pharmacy NCPDP Version 5.1

Claim Status Inquiry

Providers can verify the status of a claim before receipt of the Remittance Advice (RA) summary or 835 transaction.

Claim Status Inquiry Methods

Inquiry on claim status can be made using the following:

- Web interChange (See [Section 3.](#))
- 276/277 claim status inquiry and response transactions – batch or interactive (See [Section 4.](#))
- AVR (See [Section 6.](#))

Check/RA Inquiry

Check/RA Inquiry allows the provider to inquire about previously received payments. A list of checks, electronic funds transfers (EFTs), and RAs can be found by searching within the date range or by searching for a specific check number. For more information related to financial transactions, see [Chapter 12](#) of this manual.

Check Inquiry Methods

The following check inquiry methods can be used:

- Web interChange (See [Section 3.](#))
- AVR (See [Section 6.](#))

Prior Authorization Submission

Prior authorization (PA) submission allows providers to submit nonpharmacy PA requests electronically. This tool is designed to help IHCP providers file requests for PA more efficiently. Even though a PA request is submitted through the Internet, the rules for making PA decisions still follow the same 10-day time line. Providers should be specific and concise with required information to avoid suspensions.

Prior Authorization Submission Method

Prior authorization can be submitted through Web interChange. (See [Section 3.](#))

Note: Managed care entities will follow the guidelines for each MCE regarding the PA process.

Prior Authorization Inquiry

Providers can submit an inquiry for any known prior authorization number or confirmation number.

PA requests submitted electronically via Web interChange during business hours are viewable within two hours of submission.

Prior Authorization Inquiry Methods

Prior authorization inquiry can be made using the following:

- Web interChange (See [Section 3.](#))
- 278 prior authorization batch transaction (See [Section 4.](#))
- AVR (See [Section 6.](#))

Electronic Remittance Advice

The 835 electronic Remittance Advice transaction is available to providers that request their Remittance Advice information in an electronic format. The 835 returns information for paid and denied claims.

Effective September 1, 2009, Remittance Advices are now available on the IHCP Web site via Web interChange. The Remittance Advice is no longer printed or mailed to providers.

Electronic Remittance Advice Method

Electronic Remittance Advice is provided through the 835 Health Care Claim Payment and Remittance Advice transaction.

Providers interested in receiving the 835 transaction must fill out the *EDI Outbound Transactions Request Form* located under Forms on the www.indianamedicaid.com Web site.

Questions about the 835 transactions should be directed to the HP EDI Solutions Help Desk at 1-877-877-5182 or (317) 488-5160.

Section 3: Web interChange

Overview

Web interChange is an interactive Web application that allows providers to access the Indiana Health Coverage Programs (IHCP) system through the Internet. Web interChange is fast, free, and does not require special software.

Web interChange Features

Features of Web interChange include the following:

- Eligibility Inquiry
- Claim Submission
- Claim Inquiry
- Check/RA Inquiry
- Notification of Pregnancy (NOP) Inquiry
- Prior Authorization Submission
- Prior Authorization Inquiry
- Provider Profile View / Edit
- Provider Maintenance
- User Lists
- User Profile
- Help
- FAQ

Providers can access Web interChange from the IHCP Web site at <https://interchange.indianamedicaid.com>.

System Requirements

Microsoft Internet Explorer 6.0 or higher is required.

Web interChange will not function properly if you are using special software that blocks pop-up windows. Users are encouraged to disable pop-up blockers when accessing Web interChange. Pop-up windows, such as the internal control number (ICN) verification of submitted claims or the temporary password assigned during the automated password reset process, will not appear if pop-up blockers are enabled.

See *System Requirements* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Web interChange Security

Web interChange is Health Insurance Portability and Accountability Act (HIPAA)-compliant for direct data entry (DDE). Encryption and secured socket layer (SSL) connections protect the data in transit.

HIPAA security regulations require that passwords are not shared; therefore, each user of Web interChange must have a unique user ID.

Web interChange allows organizations to assign one or more administrators to oversee their members' use of the Web site and enforces HIPAA security regulations for password usage.

See *System Requirements and Data Security* on the FAQ screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Web interChange Password Regulations

Web interChange password regulations meet the qualifications for HIPAA security. All passwords are case-sensitive.

Web interChange users have the capability of resetting their own passwords by answering their personal reset questions.

Users may change their passwords one time per day with the Web interChange Change Password function. Users may reset their passwords up to three times per day with the Web interChange Reset Password function. Web interChange administrators have the capability to change passwords outside these parameters.

See *Automated Password Reset* on the Help screen and *User IDs and Passwords* on the FAQ screen on Web interChange at <https://interchange.indianamedicaid.com> for valid password formatting guidelines.

Web interChange Audit Reports

To protect the integrity and privacy of the information received by Web interChange users, HIPAA security requires that the IHCP audit user activity and privileges on the Web interChange site.

Administrative Group Report

The *Administrative Group Report* is a tool provided to all Web interChange administrators to allow them to monitor all users with access to the organization's data, the type of access given to each user, and the functions the users can perform. This report can be viewed by clicking **View Group Report** on the Web interChange *Group Administration* page. It is each administrator's obligation to review his or her report regularly.

If an administrator has not reviewed the group report for 90 days, a reminder displays each time the administrator signs on to Web interChange. A button is available on the *Group Report* screen for administrators to click to verify that they have reviewed the report.

If a group has more than one administrator, each administrator is prompted to review the report. If a person is the administrator for multiple organizations, the group report must be reviewed for each organization.

Group Owner E-mail

An e-mail is sent every 90 days to the registered *owner* e-mail address for organizations accessing Web interChange. This e-mail contains a list of the active administrators associated with the owner's organization. This allows the owner to verify that the list is complete and that the appropriate person is the administrator for Web interChange.

Web interChange Administrator

Organizations must designate a Web interChange administrator if they do not already have one.

To apply for a Web interChange administrator User ID, complete the *interChange Administrator Request Form*. The form can be found by clicking **How to Obtain an ID** on the Web interChange logon page at <https://interchange.indianamedicaid.com>. A note on the company letterhead signed by the practice owner or highest authority with the organization approving the administrator must accompany the *interChange Administrator Request Form*.

Mail the request form along with the letter of approval to the address shown on the form. Administrators are notified via e-mail when the application is approved.

The following are the advantages and responsibilities of an administrator:

- Maintain compliance to HIPAA security; and ensure that users do not share passwords.
- Create and maintain users within an organization. Users choose their own unique User ID.
- Reset passwords for users within an organization. Individual users can also reset their own passwords.
- Assign specific Web interChange access rights to users within an organization according to the user's business need. Users have access only to the information that the administrator assigns to them.
- Monitor users at least every 90 days to verify that the appropriate users are active and have permission to access approved information.

See *FAQ for Web Membership* on the FAQ screen of Web interChange at <https://interchange.indianamedicaid.com> for more information about Web interChange administrators.

Web interChange Updates for National Provider Identifier

As of May 23, 2008, all healthcare providers are required to submit their National Provider Identifier (NPI) on all HIPAA standard transactions. Claims submitted without the NPI will be rejected. Atypical providers are excluded from this requirement and will continue using their Legacy Provider Identifier (LPI). NPI information will be available only if the provider has reported its NPI to the IHCP. If the NPI is associated with multiple Legacy Provider Identifiers (LPIs), select the proper service location when prompted.

Note: The proper service location address and ZIP Code + 4 must be on the Provider Profile for it to be displayed on Web interChange.

Existing Web interChange security mechanisms ensure that users are allowed to view only the information for which they have been granted access.

For more information about NPI, including how to receive and report NPI to the IHCP, visit the NPI section of the IHCP Web site at <http://www.indianamedicaid.com>.

Eligibility Inquiry

Eligibility Inquiry must be requested by NPI for healthcare providers. Only an atypical provider can verify eligibility by using the LPI.

Access to eligibility information on members is denied if the dates of service do not fall within a provider's active IHCP program eligibility segment.

Providers may search by Member ID number, Social Security number, Medicare number, or name and date of birth. The response provides the same information found using the Automated Voice Response (AVR) or Omni swipe card system. The third-party liability (TPL) information provided includes carrier number, carrier name, address, telephone number, and policyholder name. Web interChange also provides benefit limitation information. It indicates if a member has reached the benefit limits for chiropractic, dental, durable medical equipment (DME), and vision services. Benefit limitation information is based on paid claim data. Refer to *Section 5*, [Table 3.4](#), for service type codes.

Web interChange provides managed care information if the member is assigned to a managed care health plan for the time period of the eligibility request.

The following information is included in the eligibility response:

- Managed care entity (MCE) name, MCE telephone number, primary medical provider (PMP) name, PMP telephone numbers, PMP assignment effective date and end dates based on the “to” and “from” date of service, and, if applicable, the MCE's network names. This information appears in the *Managed Care* section of the response.
- If the member has been assigned to multiple PMPs during the time period of the eligibility request, the eligibility response will include each PMP and the PMP-MCE information with the date segments that the provider was assigned to the member based on the “to” and “from” date of service.
- If the member has been assigned to *Care Select*, a **Care Select Notification** button appears under the *Managed Care* section of the response. When *Care Select* members go to a facility for emergency room, outpatient surgery, or inpatient care services, providers can click this button and enter the date of treatment, type of service, and presenting signs, symptoms, or diagnoses. The appropriate care management organization receives and reviews the generated report on a daily basis via Web interChange and performs follow-up with the member to ensure appropriateness and continuity of care.
- See *Eligibility Verification Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Claim Submission

Claim Submission allows providers to submit individual claims electronically to the IHCP using the Internet. All institutional, professional, and dental claims can be entered in this manner. This includes inpatient, outpatient, home health, long-term care, and medical/waiver claims, as well as Medicare crossover claims.

A claim submitted through Web interChange is assigned an ICN and available for viewing through claim inquiry approximately two hours after submission.

See [Chapter 8](#) of the *IHCP Provider Manual* for claim billing instructions.

Note: Providers cannot use Web interChange to submit claims to managed care entities.

Web interChange may not be used for submitting pharmacy claims to the IHCP.

See *Claim Submission Help* on the Help screen and *FAQ for Transactions* on the FAQ screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Voids and Replacements

Providers are able to submit an electronic void or replacement for a previously submitted claim in a paid status. A void or replacement can be completed on the same day or in the same week as a claim submission or after the payment is finalized. This applies only to noncheck-related replacements; however, it applies to both prefinancial and postfinancial claims. New region codes are assigned to postfinancial claims for electronic voids or replacements. Pharmacies may submit voids and replacements either via point-of-sale or paper.

See *Claim Submission Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information on submitting electronic voids and replacements.

Coordination of Benefits Information in Web interChange

Coordination of benefits (COB) information can be submitted for crossover and TPL claims on Web interChange.

See *Claim Submission Help* on the Help screen and *FAQ for Transactions* on the FAQ screen on Web interChange at <https://interchange.indianamedicaid.com> for more information on coordination of benefits.

See [Chapter 8](#) of the *IHCP Provider Manual* for claim billing instructions.

See [Chapters 5](#) and [10](#) of the *IHCP Provider Manual* for crossover claim processing procedures.

User Lists

User Lists are created to help a user store and retrieve frequently used data, such as Member ID, rendering provider, diagnosis codes, and modifiers. This eases the process of submitting claims and prior authorizations.

Data entered via a User List is not validated against IHCP data for accuracy. It is the responsibility of the user to maintain any data stored in a User List. Any data entered in this User List may be analyzed by HP to ensure validity.

See *Claim Submission Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information on user lists.

Claim Inquiry

Claim Inquiry allows providers to inquire about previously submitted claims, even before they appear on the Remittance Advice (RA) summary or 835 transaction. Claims submitted via Web interChange are accessible within two hours and remain accessible for seven years. Claims are located by searching within a date range, by claim type, by member ID, or by ICN. When the basic claim information displays, click the desired claim ICN for more detail. In keeping with HIPAA privacy requirements, built-in security features allow only billing providers to view the claims they submitted.

Note: Web interChange cannot be used to view the status of claims submitted to managed care entities.

See *Claim Inquiry Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Check/RA Inquiry

Check/RA Inquiry allows the provider to inquire about previously received payments. A list of checks, electronic funds transfers (EFTs), and RAs can be found by searching within the date range or by searching for a specific check number. When the basic check information displays, click on that line to obtain a list of all claims associated with that check. The link to download the RA displays regardless of check availability. If no check was issued in conjunction with the RA, the check number displays as "000000000." RAs can be saved or printed if desired.

Note: A rolling four weeks of RAs are available.

In keeping with HIPAA privacy requirements, built-in security features allow only billing providers to view the checks and RAs they have received.

See *Check Inquiry Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

NOP Inquiry

NOP Inquiry allows the provider to search for a previously submitted Notification of Pregnancy (NOP). The NPI/LPI used to enter the NOP via member eligibility must be the same NPI/LPI used for the NOP Inquiry function. The provider can search for all NOPs, a specific NOP, or by the member identification number (RID), member name, or member Social Security number.

Prior Authorization Submission

Note: Requests for drugs, such as nonpreferred medications and the Medical Necessity Review Form for mental health medications, cannot be submitted via the Web.

Web interChange Prior Authorization Submission allows providers to submit PA requests electronically through the Internet. This tool is designed to help IHCP providers file PAs faster and more easily. Even though a PA request is submitted through the Internet, the rules for making PA decisions still follow the same 10-day time line. Providers should be specific, clear, and concise on all

PA requests to avoid PA suspensions. All information required for paper PA submissions is also required for Web submissions.

As specified in *Indiana Administrative Code (IAC)* citations 405 IAC 5-3-10, 405 IAC 5-30-4, and 405 IAC 5-34-11, the providers that may submit PA requests are as follows:

- Doctor of Medicine
- Doctor of Osteopathy
- Dentist
- Optometrist
- Podiatrist
- Chiropractor
- Home health agency
- Hospital
- Hospice
- Psychologist endorsed as a health service provider in psychology (HSPP)
- Transportation providers (authorized agents)

Note: DME providers cannot submit PA requests via Web interChange.

See *Prior Authorization Submission Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Prior Authorization Inquiry

PAs submitted electronically during business hours are viewable within two hours of submission.

PAs can be located by using the search fields of *Service Location*, *Member ID*, *Procedure Code*, *Modifiers*, *Revenue Code*, *Service Date*, and *Assignment Code*.

Providers can inquire about PA for any known prior authorization number or confirmation number.

See *Prior Authorization Inquiry Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

Provider Profile

The Provider Profile enables providers to view their IHCP profile information.

Accessing the Provider Profile function allows providers to view information on file with the IHCP, including name, current addresses and telephone numbers, type and specialties, license number, Clinical Laboratory Improvement Amendments (CLIA) information, Medicare number, EFT information, tax identification number information, and PMP managed care information. Groups are also able to view all the rendering providers associated with the practice. Copies of the *Provider Profile* can be printed from Web interChange.

Effective July 29, 2008, provider enrollment profile updates that do not require supportive documentation can be made through Web interChange quickly, easily, and securely without submitting

paper forms. For example, users who have appropriate permissions can change the address or bank account information for EFT. Examples of changes that cannot be made online include changing a primary specialty, which requires certification, or changing the home office address or legal name, which requires a new W-9 form.

Terminations cannot be made online at this time because of managed care PMP considerations. For example, an accidental termination could result in the loss of a PMP's assigned patient panel, causing confusion for members.

The Provider Profile update function is available to any user within the provider's organization who has been granted Provider Maintenance access by his or her Web interChange administrator. It is the administrator's responsibility to provide Edit access to only the appropriate users. By limiting personnel who have access to this function, administrators can prevent unauthorized changes to the profile. Administrators should also ensure that users do not share their user IDs and passwords. Access to a specific function is user-ID specific and is available to anyone using that ID and password.

See *Provider Inquiry/Maintenance Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

User Profile

User Profile is available to users that have been assigned the Profile Maintenance permission to update their own profile. This screen allows a user to update various basic information about the owner of the ID, including telephone number, e-mail address, and user-specific security questions and answers.

See *Profile Maintenance Help* on the Help screen on Web interChange at <https://interchange.indianamedicaid.com> for more information.

If you have questions about accessing Web interChange, contact the HP EDI Solutions Help Desk at (317) 488-5160, option 2, in the Indianapolis area or toll-free at 1-877-877-5182. Questions can also be sent by e-mail to INXIXElectronicSolution@hp.com.

For claims questions, contact the HP Customer Assistance Help Desk at (317) 655-3240 in the Indianapolis area or toll-free at 1-800-577-1278.

Section 4: Electronic Data Interchange – Secure File Transfer Protocol

Overview

Trading partners with the Indiana Health Coverage Programs (IHCP) have options for transmitting data electronically. The *Electronic Data Interchange (EDI) Communications Guide* identifies the choices available for submitting and receiving transaction data and provides specific details for each option.

The *EDI Communications Guide* is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section, under IHCP Companion Guides.

Trading Partners

A trading partner is defined as an entity sending and receiving data with another entity electronically. The following are examples of a trading partner:

- Provider using approved vendor software
- Clearinghouse
- Billing service
- Managed care entity (MCE)
- Medicare intermediary or carrier
- Value-added network (VAN) (interactive transactions only)

Trading partner information is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Trading Partner Procedures

IHCP billing providers desiring to exchange data directly to or from the IHCP must use an approved software vendor or clearinghouse. HP works with many software vendors throughout the United States and has created a list of approved software vendors that provide Health Insurance Portability and Accountability (HIPAA)-compliant billing and software services to the IHCP provider community. There is no affiliation between HP and any of these companies. It is the responsibility of the provider to select the vendor based on specific business needs. A list of approved software vendors is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Providers interested in programming software for sending claims electronically should review the trading partner testing information on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Trading Partner Profile

The IHCP requires that vendors and billing providers complete and electronically submit the *IHCP Trading Partner Profile* during the initial assessment period. The *IHCP Trading Partner Profile* is the

tool a provider must use to notify the IHCP about the types of transactions they will exchange and the software they have chosen.

After the initial setup, the *IHCP Trading Partner Profile* is used to inform the IHCP of any changes to the vendor software, billing service, or clearinghouse selection.

The *IHCP Trading Partner Profile* is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Communication Options

Inbound batch transactions, outbound transactions, and reports are exchanged through secure file transfer protocol (FTP). Additionally, some transactions can be submitted interactively. *Section 2: Batch Submission* of the *EDI Communications Guide* contains information about submitting batch transactions, and *Section 3: Interactive Submission* contains information about sending interactive transactions. This guide is available on the www.indianamedicaid.com under EDI Solutions > IHCP Companion Guides.

The following table identifies submission options available for each transaction.

Table 3.2 – Transaction Options

Transaction	Options	
	Secure FTP	Interactive
837I Health Care Claim Institutional	X	
837P Health Care Claim Professional	X	
837D Health Care Claim Dental	X	
835 Remittance Advice (RA)	X	
270/271 Eligibility Benefit Inquiry and Response	X	X
276/277 Claim Status Request and Response	X	X
278 Prior Authorization (PA) Request for Review and Response	X	
834 Managed Care Member Enrollment Roster	X	
820 Managed Care Capitation Payment Reporting	X	
National Council for Prescription Drug Programs (NCPDP) – Pharmacy Claims	X	X

Electronic Standards

HIPAA specifically names several electronic standards that must be followed when certain healthcare information is exchanged. These standards are published as *National Electronic Data Interchange*

Transaction Set Implementation Guides. They are commonly called *Implementation Guides (IGs)*. An addendum to most *IGs* was published and must be used to properly implement each transaction. The *IGs* are available for download through the Washington Publishing Company Web site at <http://www.wpc-edi.com/>. Developers should obtain copies of the respective *IGs* prior to any process development.

Companion Guides

The IHCP has developed technical companion guides to assist application developers. Information contained in the *IHCP Companion Guides* is intended only to supplement the adopted *IGs* and provide guidance and clarification as it applies to the IHCP. The *IHCP Companion Guides* are never intended to modify, contradict, or reinterpret the rules established by the *IGs*.

The *Companion Guides* are available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Batch Submission – Secure File Transfer Protocol

File Exchange

File Exchange is an application provided by the IHCP for secure file processing, storage, and transfer. It is designed to safely and securely collect, store, manage, and distribute sensitive information between the IHCP and its trading partners.

Advantages of File Exchange

The File Exchange solution offers the following advantages:

- Ensures secure data transfer between trading partners.
- Uploads and downloads more quickly, dependent upon the chosen method of connection.
- Provides capability to send files 24 hours a day, seven days a week.
- Compresses incoming files.
- Maintains outgoing files in the trading partner's home directory for 30 days.

The *EDI Communications Guide* containing information about using secure FTP for electronic data interchange is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section under the IHCP Companion Guides link.

Note: Direct questions about File Exchange to the HP EDI Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area, or 1-877-877-5182. Questions can also be sent by e-mail to inxixTradingPartner@hp.com.

Testing Procedures

Software vendors, clearinghouses, billing services, VANs, and MCEs seeking approval of their products should review the IHCP EDI requirements.

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

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

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

Testing information is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Approval Process

Vendor

HP e-mails approval to the testing vendor upon completion and approval of testing. Vendors should inform their providers that they have completed testing. The provider is set up with a production ID upon receipt of the *IHCP Trading Partner Profile* and signed *Trading Partner Agreement*.

Clearinghouse, Billing Service, Value Added Network, Managed Care Entity

Upon completion and approval of testing, a signed *Trading Partner Agreement* must be sent to the IHCP. When the signed *Trading Partner Agreement* is received, HP e-mails notification of production approval to the trading partner. The notification contains trading partner ID, logon information, and secure FTP information.

Trading Partner Agreement

Billing providers using approved software products to send claims directly to the IHCP must send a signed *IHCP Trading Partner Agreement* before they can send production submissions. The *Trading Partner Agreement* is a contract between parties that have chosen to become electronic business partners and 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.

The *Trading Partner Agreement* must be signed and mailed to the following address. Electronic versions are not accepted.

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

If a billing provider submits claims 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.

The *IHCP Trading Partner Agreement* is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

997 Functional Acknowledgement

The 997 Functional Acknowledgement is an X12 transaction that acknowledges the receipt of the batch transaction and reports the acceptance or rejection of a functional group, transaction set, or segment.

The 997 is available approximately two hours after electronic submission between 7 a.m. and 5 p.m. to verify whether the claim file has been accepted for processing or rejected.

Refer to the *Reports and Acknowledgements Companion Guide* for 997 Functional Acknowledgement information. The companion guide is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Billers Summary Report

The Biller Summary Report (BSR) is created to report the results of pre-adjudication edit checking to verify two levels of compliance, HIPAA compliance and IHCP-specific compliance of 837D, 837I, and 837P transactions. BSRs are produced for each file received from a trading partner that contains an 837 transaction.

The BSR is available approximately two hours after electronic submission between 7 a.m. and 5 p.m. to verify whether the claim file has been accepted for processing or rejected.

Refer to the *Reports and Acknowledgements Companion Guide* for Biller Summary Report information. The companion guide is available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Voids and Replacements

837 transactions allow providers to submit an electronic void or replacement for a previously submitted claim. A void or replacement can be completed on the same day, in the same week as a claim submission, and after the payment is finalized. This applies to only noncheck-related replacements; however, it applies to both prefinancial and postfinancial claims. New region codes are assigned to postfinancial claims for electronic voids or replacements.

A replacement request that includes a check still requires submission through the paper adjustment request process.

Provider-initiated electronic replacements, known as adjustments when performed on paper, are submitted with claim frequency code **7** and become new claims, including attachments and claim notes.

Provider-initiated electronic voids, formerly called claim reversals, are submitted with claim frequency code **8**.

A void is the cancellation of an entire claim. Providers should note the following information related to voids:

- A void cancels a claim.
- A denied claim cannot be voided.
- A denied claim can be replaced via the electronic method using only EDI or Web interChange.

Note: The IHCP Companion Guides contain more information about voids and replacements. The companion guides are available on the IHCP Web site at <http://www.indianamedicaid.com> in the EDI Solutions section.

Section 5: Omni 380 Terminal

Omni Swipe Card Device

The Omni 380 terminal, more commonly referred to as the Omni swipe card device, is a swipe card or manual entry device. It is designed to take advantage of the magnetic strip on the member's Hoosier Health Card. By swiping the member's plastic identification card through the device, providers are able to get eligibility verification that can be viewed online or printed, if a printer is available. The Omni provides all information required to ensure that a member meets eligibility requirements for the services to be rendered.

The Omni 380 terminal is a box the size of a small telephone answering machine. The device uses the optional Verifone P250 printer that can be purchased with the Omni 380 terminal or separately.

HP is no longer able to provide new Omni terminals. However, support of existing Omni terminals and printers is ongoing. Technical support for existing equipment is available by calling the HP Omni Help Desk at (317) 488-5051 in the Indianapolis area or toll-free at 1-800-284-3548.

Replacement support is only available for one year from the purchase date. The Omni 380 terminal can be used as long as it is operational. If a unit becomes nonoperational after the one-year warranty period has expired, contact the Omni Help Desk for information or another vendor for replacement.

The Omni 380 terminal is equipped with a keypad that is similar to a touch-tone telephone. Healthcare providers must submit a request using a National Provider Identifier (NPI). Atypical providers may submit a request with a Legacy Provider Identifier (LPI). If the member ID card is not available, the NPI or LPI, member ID, and date of service may be entered manually.

To enter a space for the location code, press the number **0** and then the **Alpha|Print** key twice at the **Location Code** prompt.

Note: Pharmacy providers cannot use the Omni terminal as a point of service system to submit pharmacy claims. Questions about interactive pharmacy claim submission should be directed to the HP Electronic Data Interchange (EDI) Solutions Help Desk.

The Hoosier Health Card is used with the Omni swipe card device. An example of the Hoosier Health Card is in [Chapter 2](#) of this manual. This information can also be keyed into the Omni terminal keypad.

Omni Information

The Omni displays Health Insurance Portability and Accountability Act (HIPAA)-compliant basic eligibility and benefit limitation information associated with the benefit packages listed below:

- Medicaid Program
 - Traditional
- 590 Program

- *Care Select* (Utilizes the benefit package of Standard Plan Package A)
- Hoosier Healthwise Program
 - Hoosier Healthwise Package A – Standard Plan
 - Hoosier Healthwise Package B – Pregnancy Coverage
 - Hoosier Healthwise Package C – Children’s Health Insurance Plan
 - Hoosier Healthwise Package E – Emergency Services
 - Hoosier Healthwise Package P – Presumptive Eligibility
- Healthy Indiana Plan (HIP)
 - Limited information is given, including insurer’s name, telephone number, and emergency room copay

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

Omni provides managed care information if the member is assigned to a managed care health plan for the time period of the eligibility request. The following information is included in the eligibility response: managed care entity (MCE) name, MCE telephone number, primary medical provider (PMP) name, PMP telephone numbers, PMP assignment effective date and end dates based on dates of service entered, and, if applicable, the MCE network name. This information appears in the Managed Care section of the response. If the member has been assigned to multiple PMPs during the time period of the eligibility request, the eligibility response will include each PMP and the PMP’s MCE information with the date segments that the provider was assigned to the member.

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

The HIPAA-Compliant Eligibility Transaction

The 270/271 eligibility benefit requests and responses must be compliant in content and format. The new standard requires data to be sent and returned as determined by the HIPAA standard. Direct data entry (DDE) eligibility transaction must be compliant for content only.

The 270 eligibility benefit request must use a service type code for basic eligibility or the benefit limitation information for the Indiana Health Coverage Programs (IHCP). See *Section 5*, [Table 3.4](#) for the complete list of available service type codes.

HIPAA-Compliant Omni Provider Inquiry Request Prompts

Table 3.3 describes the process for performing an eligibility verification transaction using the Omni terminal. Ensure that the display reads WELCOME TO INAIM/SELECT A TRANS before beginning the transaction. Press the **Clear** key to return to the Welcome screen.

Table 3.3 – Omni Eligibility Inquiry

Step	Omni Will Display	Action
1	Welcome to INAIM/ Select a Trans	Press 1 .
2	Provider/ NPI?	Press P (7 ALPHA) to enter the legacy provider identifier. or Press N (6 ALPHA ALPHA) to enter the NPI. or Press the mapped key. (See Table 3.9)
3	P or N	Press FUNC/ENTER .
If the mapped key was pressed in Step 2, skip to Step 6.		
If 'P' was pressed in Step 2, complete these steps:		
4a	Provider ID	Type the Legacy Provider Identifier and press FUNC/ENTER .
4b	Location Cd A	If location code A is correct, press FUNC/ENTER . or To use a different location, type the location code and press FUNC/ENTER .
4c		Skip to Step 6.
If 'N' was pressed in Step 2, complete these steps:		
5a	NPI	Type the 10-character NPI and press FUNC/ENTER .
5b	ZIP	Type the nine-digit ZIP Code and press FUNC/ENTER . or To skip entering the ZIP Code, press FUNC/ENTER .
5c	TAXO	Type the 10-digit taxonomy code that was reported to the IHCP with the NPI, then press FUNC/ENTER . or To skip entering the taxonomy code, press FUNC/ENTER .
5d		Proceed to Step 6.
Choose the Search Method		
6	Search Criteria	There are four search options you can use: Enter R (7 Alpha, Alpha) to search by Member ID. or Enter S (7 Alpha, Alpha, Alpha) to search by Social Security number. or Enter M (6 Alpha) to search by Medicare number. or Enter N (6 Alpha, Alpha) to search by Name and DOB.
7	R, S, M, or N	Press FUNC/ENTER .

Step	Omni Will Display	Action
If 'R' was pressed in Step 6, complete these steps:		
8a	RID NO	Type the Member ID number and press FUNC/ENTER .
8b		Skip to step 12.
If 'S' was pressed in Step 6, complete these steps:		
9a	SS NO	Type the Social Security number and press FUNC/ENTER .
9b		Skip to step 12.
If 'M' was pressed in Step 6, complete these steps:		
10a	MEDICARE NO	Type the Medicare number and press FUNC/ENTER .
10b		Skip to step 12.
If 'N' was pressed in Step 6, complete these steps:		
11a	FIRST NAME	Type the First Name and press FUNC/ENTER .
11b	LAST NAME	Type the Last Name and press FUNC/ENTER .
11c	DOB	Type the Date of Birth and press FUNC/ENTER . Type the date of birth in the MM/DD/YYYY format.
11d		Proceed to step 12.
If 'N' was pressed in Step 6, complete these steps:		
12	FM DOS 01072000 (From Date of Service)	Type the From Date of Service and press FUNC/ENTER or To use the current date, press FUNC/ENTER .
13	TO DOS 01072000 (To Date of Service)	Type the To Date of Service and press FUNC/ENTER or To use the current date, press FUNC/ENTER .
14	SERVICE TYPE See Table 3.4 below for a list of service type codes.	Type the service type code and press FUNC/ENTER . or Press * and press FUNC/ENTER .
15	Send or Review	Press 0 (zero) to send the information to IndianaAIM.
16	Dial 18009319001 (Telephone number may also include access code)	No action required.
17	Waiting on Response	No action required.

Step	Omni Will Display	Action
18	Print or Display	To print, press Alpha Print . or To display on screen, press FUNC/ENTER .
19	Eligibility Information	When done reviewing information, press FUNC/ENTER .
20	WELCOME TO INAIM/SELECT A TRANS	Ready for another transaction.

Errors Displayed

If the NPI sent in the eligibility verification transaction does not cross walk to a unique LPI, error 43 – *Missing / Invalid Provider Identification* will display on the terminal. To increase the likelihood of a successful crosswalk, send the ZIP Code + 4 and if necessary, the taxonomy code that was reported to the IHCP. In most cases, your nine-digit ZIP Code will achieve a one-to-one match to a unique LPI.

Other possible errors received on the Omni response that may indicate a communication error are errors 26 and 42. If you receive these errors, wait and retry your transaction a few minutes later.

It is important to note that Omni terminals and the member ID card can still be used to verify eligibility. However, providers are now required to enter the *Service Type Code* for benefit limitations that are available for the inquiring provider's type and specialty. Providers desiring only basic eligibility can type **30** as the *Service Type Code*, or they can push the ***** key.

To enter a service type code that includes an alpha character, press the key that contains the letter and press the **Alpha|Print** key until the desired letter appears on the display. For example, to enter service type code **AB**, press **2** and the **Alpha|Print** key once. The letter **A** displays. Press **2** and the **Alpha|Print** key twice. The letter **B** displays. Press the **Func|Enter** key.

Table 3.4 provides the benefit limitation options that return information when selected by the appropriate inquiring provider. Only the codes listed here are available through the Omni search options. Only exceeded limits are provided.

Table 3.4 – Service Type Codes and Benefit Limitations

Provider Type	Service Type Code	Audit Number	Benefit Limitation Information
Audiologist	71	6054	One hearing test per 36 months without PA
Chiropractor	34	6101	New patient chiropractic office visit limited to one per lifetime
Chiropractor	33	6099	Maximum of 50 chiropractic services per year
Chiropractor	33	6100	Maximum of 50 chiropractic therapeutic physical medicine treatments per year
Chiropractor	33	6112	Maximum of 14 chiropractic therapeutic physical medicine treatments per year
Chiropractor	33	6122	Chiropractic therapeutic physical medicine treatments exceeding 14 up to a maximum of 50 per calendar year
Chiropractor	4	6105	One full spinal X-ray per year for chiropractor
Chiropractor	81	6102	Chiropractic office visits limited to five per year

Provider Type	Service Type Code	Audit Number	Benefit Limitation Information
Chiropractor	81	6111	Chiropractic office visits limited to five per year
Dental	28	6212	Fluoride treatments limited to one every six months
Dental	35	6211	Periodic or limited oral evaluations limited to one every six months
Dental	24	6221	Periodontal root planing/scaling limited to four every two years for noninstitutionalized members between the ages of 3 and 20
Dental	24	6222	Periodontal root planing/scaling limited to four every two years for institutionalized members
Dental	24	6223	Periodontal root planing limited to four per lifetime for noninstitutionalized members 21 years and older
Dental	41	6033	Prophylaxis limited to two per six months for institutionalized members
Dental	41	6210	Prophylaxis limited to one treatment every six months for noninstitutionalized members between the ages of 18 months to 21 years
Dental	41	6235	Prophylaxis limited to one every 12 months for noninstitutionalized members 21 years and older
Dental	25	6236	Dental services limited to \$600 per year for members 21 years and older
Dental	23	6209	Full mouth or panoramic X-rays limited to one every three years
Dental	60	6225	One dental sealant per tooth per lifetime for members 21 years or younger
Durable medical equipment (DME) provider	18	6113	DME limited to \$2,000 per recipient per calendar year
DME provider	12	6114	DME limited to \$5,000 per recipient per lifetime
DME provider	42	6085	Incontinence supplies limited to \$1,950 every 12 months
Mental health provider	A8	6120	Outpatient mental health/substance abuse services limited to 30 per calendar year without PA
Mental health provider	AI	6121	Outpatient mental health/substance abuse services limited to 50 per calendar year with PA
Optometry	AO	6600	Initial or replacement lenses limited to two every year for recipients 18 years or younger
Optometry	AO	6604	Initial or replacement lenses limited to two every two years for recipients 19 years or older
Optometry	AM	6601	Initial or replacement frames limited to one every year for recipients 18 years or younger
Optometry	AM	6603	Initial or replacement frames limited to one every two years for recipients 19 years or older

Provider Type	Service Type Code	Audit Number	Benefit Limitation Information
Optometry	AL	6610	Routine vision exam limited to one every 12 months for recipients 18 years or younger
Optometry	AL	6611	Routine vision exam limited to one every 24 months for recipients 19 years or older
Physician	98	6012	Medical services limited to 30 per year
Podiatrist	94	6090	Office visits limited to one per year
Podiatrist	93	6855	Routine foot care treatments limited to six every 12 months
Rehabilitation facility	AB	6119	Inpatient rehabilitation services limited to 50 days per year
Physical Therapist	AE	6115	Physical therapy services limited to 50 visits per year
Physical Therapist	AE	6752	Physical therapy evaluation limited to one every 12 months
Speech Therapist	AF	6060	Speech therapy evaluations limited to one per year
Speech Therapist	AF	6116	Speech therapy services limited to 50 visits per year
Occupational Therapist	AD	6118	Occupational therapy services limited to 50 visits per year
Occupational Therapist	AD	6753	Occupational therapy evaluation limited to one every 12 months
Transportation	56	6803	Transportation services limited to 20 one-way trips every 12 months

Data communicated back to the provider includes a member's basic eligibility and related benefit package information. The member's address information displays and prints on the Omni strip.

Note: It is important to read the entire message, as there may be information about the member's basic eligibility that can affect covered services and reimbursement. The HIPAA-compliant eligibility response does not contain a verification number. Providers must use a copy of the Omni printout as proof of eligibility verification.

Benefit limitations appear only when the appropriate provider type and specialty are verified, the appropriate service type code is entered, and the requested service information has been exceeded.

The Omni Strip

After performing the above eligibility process, the Omni prints the eligibility verification response Omni strip. A detailed explanation of the eligibility responses is provided in Table 3.5.

Table 3.5 – Omni Verification Slip Legend

Indiana Eligibility Verification System Legend for the Omni Eligibility Verification Slip	
Display Field	Print Slip Value
Basic eligibility provided for all Service Type Code selections	Any code selected plus Basic Eligibility (Service Type Code 30)
1. MM/DD/CCYY, HH:MM	Current date and time <i>Note: Information displayed in item 2 depends on whether an NPI or LPI or both an NPI and LPI is returned in a type 271 record).</i>
2a. PROVIDER NUMBER	999999999 (nine-digit LPI)
2b. NPI:	XXXXXXXXXX (10-digit NPI)
2c. NPI:	XXXXXXXXXX (10-digit NPI)
2d. PROVIDER NUMBER	999999999 (nine-digit LPI)
3. NAME	Member's name, first and last
4. ADDRESS	Member's street, apt. address
5. ADDRESS LINE 2	City, state, ZIP Code
6. MEMBER ID	Member identification number
7. SSN	Member Social Security number
8. DATE OF BIRTH	Member date of birth
9. MEMBER IS ELIGIBLE/ NOT ELIGIBLE	Only one displays
10. FROM/TO	Date of service date range (more than one date range may appear)
<i>Item 11 does not print out if not eligible</i>	
11. FOR THE XXXXXX PROGRAM	Printout: TRADITIONAL MEDICAID 590 PROGRAM PKG A STANDARD PKG B PREGNANCY PKG C CHILDRENS PLAN PKG D PKG E EMERGENCY SVCS PKG P PRESUMPTIVE ELIGIBILITY PACKAGE H HEALTHY INDIANA PLAN
12. BASIC ELIGIBILITY INDICATORS	Header for section about eligibility indicators
13. RESTRICTED	N=No, Y=Member is Restricted to a certain provider
14. SPEND-DOWN	N=No, Y=Spend-down applies. Only prints if spend-down is N or spend-down has been met
15. SPEND-DOWN MET DATE	Only prints out if Line 14 is Y and spend-down has been met
16. MEDICARE	Number prints out only if item 16 is not blank
17. MEDICARE ID NUMBER	Number prints out only if item 16 is not blank
18. QMB	Qualified Medicare Beneficiary indicator (N=No, Only, Also)
19. MEDICARE COINSURANCE DEDUCTIBLE ONLY	MEDICARE DEDUCTIBLE/CO-INS ONLY (Prints only if the indicator on Line 18 is 'ONLY')
20. COMMERCIAL INS	N=No, Y=Commercial insurance applies, see items 32-36.

Indiana Eligibility Verification System Legend for the Omni Eligibility Verification Slip	
Display Field	Print Slip Value
21. NURSING FACILITY RESIDENT	<p>NF=Nursing Facility ICF/MR=Intermediate Care Facility for Mentally Retarded N=No R=Rehabilitation W=Waiver H=Hospice S=Skilled</p> <p>If during the eligibility period identified in the inquiry, there is either a Waiver or Hospice segment available, either alone or in combination with the existing level-of-care (LOC) information, the basic eligibility identifies W=Waiver and/or H=Hospice. The specific dates of each healthcare facility will not be identified. If multiple segments of any or all of these level-of-care types are identified, the provider needs to contact HP Customer Assistance to determine the specific dates and/or specific waivers or hospice, or nursing home provider coverage identified.</p>
22. HCF LIAB AMT	Displays in dollars and cents.
23. MANAGED CARE	Printout indicates one of the following: RBMC, Care Select, or HIP
<i>If item 23 is RBMC, HIP, or Care Select, items 24-30 print as required by program.</i>	
24. FROM/TO	The dates the member was eligible with the PMP in accordance with the date span of the eligibility inquiry. The eligibility inquiry date span is limited to a calendar month.
25. MANAGED CARE ENTITY	MCE name
26. PHONE NUM	MCE telephone number
27. MCO NETWORK	MCO network name (RBMC only)
28. THIS MEMBER'S PRIMARY CARE PROVIDER	
29. PROVIDER NAME	PMP name (Not applicable for HIP)
30. PROVIDER PHONE NUM	PMP telephone number (Not applicable for HIP)
<i>If the member was eligible for multiple PMPs during the eligibility inquiry date span, fields 23-30 are repeated for each PMP in eligibility date order.</i>	
31. NO RESTRICTED PROVIDER	Only displays if Line 13 is an 'N'
32. THE MEMBER IS RESTRICTED TO:	Header for the Lock-In information
33. PROVIDER NUMBER TYPE	Lock-In number of the restricted provider (<i>Displays the LPI</i>) information
<i>If item 20 is Y, items 34-38 print out with as many as seven carriers. The Types of Coverage field can display as many as nine types of coverage per carrier.</i>	
<i>If item 20 is N, a "NO INSURANCE" message is displayed.</i>	
34. OTHER PAYER INFORMATION	Header for other insurance information
35. PLAN NAME	Insurance carrier name
36. POLICY NUMBER	Policy number
37. CARRIER CODE	Carrier code information
38. TYPE OF COVERAGE	Listing of coverage on the policy
39. NO INSURANCE	Prints out only if Line 20 is an 'N'
40. ANNUAL DENTAL CAP TOTAL SPENT	Displays in dollars and cents the amount of dollars spent toward the dental cap of \$600
41. TOOTH #s SEALED	Displays the teeth numbers that have been sealed

Indiana Eligibility Verification System Legend for the Omni Eligibility Verification Slip	
Display Field	Print Slip Value
42. SUPPLIES TOTAL SPENT	Incontinence supplies for service type code-42 for DME providers only. Displays in dollars and cents the amount of dollars spent on incontinence supplies toward the rolling \$1,950 limit. The TOTAL SPENT includes all incontinence supply purchases within the 12 months prior to the date included in the eligibility request.
43. BENEFITS LIMITS REACHED FOR PROVIDER TYPE	Header for the benefits limits information. If the service types that were requested are code sets that IndianaAIM supports, the appropriate audit messages should say exceeded or not exceeded. If nonsupported service types are requested, basic eligibility is given without the audit information. The word NONE should appear after line 43 in this case. The line below the Omni print message indicates what the Omni display should look like.
44. (Display of audits that have been exhausted)	See the examples in Table 3.6.
45. SPEND-DOWN	Y=Spend-down applies. Only prints out if Spend-down is Y and spend-down has not been met.
46. REMAINING OBLIGATION	Remaining Spend-down obligation amount for the month at the time if the eligibility verification.
47. This amount is based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the spend-down amount deducted from the adjudicated claim; however, with the exception of point-of-sale pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Spend-down Summary Notice listing the amount applied to spend-down.	Only prints out if Spend-down is Y and spend-down has not been met

Table 3.6 – Omni Printout Legend and Service Type Code

	Printout Legend (top) Display Legend (bottom)	Service Type Code Benefit Explanation not provided in display or printout
Transport	TRANSPORTATION SERVICES <i>TRANSPORTATION</i>	(Service Type Code 56) Transportation benefit limit reached. (EOB 6803) Twenty one-way trips.
Vision	OPTOMETRY-LENSES <i>OPT – LENSES</i>	(Service Type Code AO) Optometry services for lenses benefit limit reached: (EOB 6600) For members 18 years of age and under. (EOB 6604) For members over 18 years of age.
Vision	OPTOMETRY-FRAMES <i>OPT-FRAMES</i>	(Service Type Code AM) Optometry services for frames benefit limit reached: (EOB 6601) For members 18 years of age and under. (EOB 6603) For members over 18 years of age.

Printout Legend (top) Display Legend (bottom)		Service Type Code Benefit Explanation not provided in display or printout
Vision	OPTOMETRY-EXAMS <i>OPT-EXAMS</i>	(Service Type Code AL) Optometry services for exams benefit limit reached: (EOB 6610) For members 18 years of age and under. (EOB 6611) For members over 18 years of age.
Dental	DENTAL CARE-EVALUATIONS <i>ORAL EVALUATIONS</i>	(Service Type Code 35) Dental services for periodic or limited oral evaluations benefit limit reached. (EOB 6211)
Dental	DENTAL-PREVENTIVE <i>PREVENTIVE</i>	(Service Type Code 41) Dental services for prophylaxis exams benefit limit reached: Noninstitutionalized age 18 months to 21 years (EOB 6210). Noninstitutionalized 21 and over. (EOB 6235) For prophylaxis benefit limit reached for institutionalized members of any age. (EOB 6033)
Dental	ADJUNCTIVE-FLUORIDE <= 20 YRS <i>FLUORIDE <= 20</i>	(Service Type Code 28) Dental services for fluoride treatments benefit limit reached for members 0 to 20 years of age. (EOB 6212)
Dental	DENTAL-DIAG XRAYS <i>DIAG XRAYS</i>	(Service Type Code 23) Full mouth and panoramic X-rays. (EOB 6209)
Dental	DENTAL-PERIODONTICS <i>PERIODONTICS</i> DENTAL-PREVENTIVE <i>PREVENTIVE</i>	(Service Type Code 24) Dental services for periodontal root planing prophylaxis benefit limit reached. (EOB 6221) (EOB 6223) (EOB 6222)
Dental	DENTAL RESTORATIVE-CAP <i>DENTAL CAP</i>	(Service Type Code 25) Dental cap, total dollars spent up to \$600, ages 21 and older for each calendar year. (EOB 6236)
Dental	DENTAL SEALANTS <i>DENTAL SEALANTS</i>	(Service Type Code 60) Dental services for tooth reached. When a tooth has been sealed, this benefit shows exhausted. The <i>Tooth #s Sealed</i> field (42) after TPL shows the numbers of the teeth that have been sealed. This shows exhausted any time there is data in the <i>Tooth #s Sealed</i> line above but is only shown once in each inquiry. (EOB 6225)
PT	PHYSICAL MEDICINE <i>THER-PHYSICAL</i>	(Service Type Code AE) Physical therapy services benefit limit reached. (EOB 6115) (EOB 6752)
ST	THERAPY-SPEECH <i>THER-SPEECH</i>	(Service Type Code AF) Speech therapy services benefit limit reached. (EOB 6060) (EOB 6116)
OT	THERAPY-OCCUPATIONAL <i>THER-OCCUPATNL</i>	(Service Type Code AD) Occupational therapy services benefit limit reached. (EOB 6753) (EOB 6118)
Chiro.	CHIROPRACTIC-OFFICE <i>CHIRO-OFFICE</i>	(Service Type Code 34) Chiropractic initial office visits benefit limit reached. (EOB 6101)
Chiro.	CHIROPRACTIC-TREATMENTS <i>CHIRO-TREATMENT</i>	(Service Type Code 33) Chiropractic therapeutic physical medicine treatment services benefit limit reached. (EOB 6099) (EOB 6100) (EOB 6112) (EOB 6122)
Chiro.	DIAGNOSTIC-XRAY <i>DIAG XRAY</i>	(Service Type Code 04) Chiropractic X-rays services benefit limit reached. (EOB 6105)
Chiro.	ROUTINE OFFICE VISIT <i>CHIRO-ROUTINE</i>	(Service Type Code 81) Chiropractic routine office visits benefit limit reached. (EOB6102) (EOB 6111)

Printout Legend (top) Display Legend (bottom)		Service Type Code Benefit Explanation not provided in display or printout
Foot care	PODIATRY-FOOTCARE <i>PODIA-FOOTCARE</i>	(Service Type Code 93) Podiatry foot care services benefit limit reached. (EOB 6855)
Foot care	PODIATRY-OFFICE <i>PODIA-OFFICE</i>	(Service Type Code 94) Podiatry office visits services benefit limit reached. (EOB 6090)
Hearing	AUDIOLOGY EXAMS <i>AUDIO EXAMS</i>	(Service Type Code 71) Audiological assessments benefit limit reached. (EOB 6054)
Medical	OFFICE VISITS <i>OFFICE VISITS</i>	(Service Type Code 98) Medical office visit services benefit limit reached. (EOB 6012)
DME	DME-\$2000/YR <i>DME-\$2000/YR</i>	(Service Type Code 18) DME services benefit limit reached. (EOB 6113)
DME	DME-\$5000/LIFETIME <i>DME-\$5000/LIFE</i>	(Service Type Code 12) DME services benefit limit reached. (EOB 6114)
DME	DME – SUPPLIES/\$1950 LIMIT <i>DME - \$1950 LIMIT</i>	(Service Type Code 42) DME incontinence supplies benefit reached. (EOB 6085)
Mental Health	OUTPAT MNTL HLTH-W/O PA <i>OTPT MH NO/PA</i>	(Service Type Code A8) Routine outpatient mental health and substance abuse services benefit limit reached. (EOB 6120)
Mental Health	OUTPAT MNTL HLTH- W/ PA <i>OTPT MH W/PA</i>	(Service Type Code AI) Prior authorized outpatient mental health and substance abuse services benefit limit reached. (EOB 6121)
Rehab.	INPATIENT-REHAB <i>INPATIENT-REHAB</i>	(Service Type Code AB) Inpatient rehabilitation services benefit limit reached. (EOB 6119)

Error Reporting with the Omni Terminal

If information is incorrectly entered in the Omni swipe card device, or if the member is not eligible, the Omni display indicates what the errors are. It can report as many as nine errors per display.

If a printer is used with the Omni, a printout indicates the errors. Figure 3.1 shows an example of a slip. Not all fields print every time. As shown in Figure 3.2, the legend indicates when fields are included or excluded from the report. The item numbers do not print on the report; they appear here for easy reference in the legend.

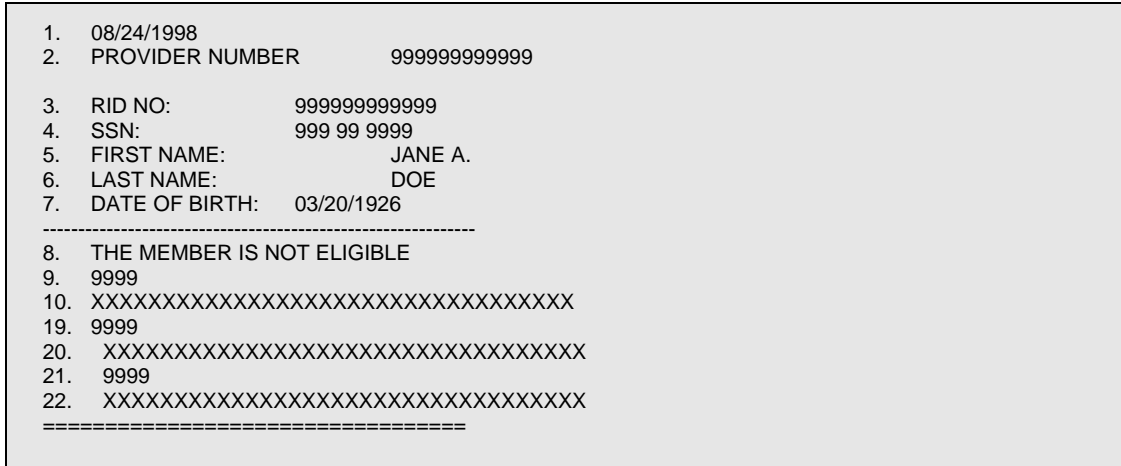


Figure 3.1 – Omni Eligibility Verification Slip

Transaction Type	Eligibility Verification
1. MM/DD/YY, HH:MM	Current date and time
2. PROVIDER NUMBER	Provider number (Displays the NPI or LPI)
3. RID NO	Member identification number
Items 4-5 print out only if keyed or swiped into the Omni device	
4. SSN	Member Social Security number
5. FIRST NAME	Member first name
6. LAST NAME	Member last name
7. DATE OF BIRTH	Member date of birth
8. MEMBER IS NOT ELIGIBLE	Prints only if member is not eligible or information entered does not fully match what is in IndianaAIM
The Omni slip can reflect up to nine error codes and the corresponding description per verification, as can be seen in the example above.	
9. ERROR CODE	Error code
10. ERROR TEXT	Error text

Figure 3.2 – Omni Verification Slip Error Legend

Refer to the *Communications* section of the *Companion Guide: 270/271 Eligibility Benefit Transaction* for the point of sale (POS) errors provided by the VAN.

Instructions for the Omni Terminal Download

Table 3.7 provides complete instructions for downloading enhancements to the Omni terminal. Carefully read the download instructions and complete the steps in the order listed. This download procedure will take 15 to 20 minutes to complete.

Table 3.7 – Description of Omni Download Process

Step	Omni Display Will Read	Action
1	WELCOME TO INAIM/SELECT A TRANS	Press 7 .
2	MAINTENANCE	Press FUNC/ENTER .
3	SET DATE/TIME	Press FUNC/ENTER .
4	(Y or N)	Press # for No.
5	PROV KEY CHANGE	Press FUNC/ENTER .
6	(Y or N)	Press # for No.
7	RETRY PRINTER	Press FUNC/ENTER .
8	(Y or N)	Press # for No.
9	CHANGE CONFIG	Press FUNC/ENTER .
10	(Y or N)	Press # for No.
11	INFO DISPLAY	Press FUNC/ENTER .
12	(Y or N)	Press # for No.
13	ACTIVITY REPORT	Press FUNC/ENTER .
14	(Y or N)	Press # for No.
15	KEY BEEP ON/OFF	Press FUNC/ENTER .
16	(Y or N)	Press # for No.
17	DOWNLOAD	Press FUNC/ENTER .
18	(Y or N)	Press * for Yes.
19	Dial 18009319001, or Dial <access code>,18009319001	No action required.
20	CONNECTED	No action required.
21	START DOWNLOAD	The telephone line connection to the Omni terminal must not be interrupted at this time. The terminal will display START DOWNLOAD for approximately 15 to 20 minutes. If the connection is interrupted, the download will fail and display DOWNLOAD FAILED. The user must then start the download process from the beginning.
22	DOWNLOAD SUCCESS	Download is complete. Press CLEAR twice.
23	IS PRINTER OK	If a printer is connected to the Omni terminal, press * twice, for Yes. If there is no printer attached, press # twice, for No.

Download Failed Message

If you receive the message, “DOWNLOAD FAILED,” contact the HP Omni Help Desk toll-free at 1-800-284-3548.

Additional Instructions

If the telephone line connection to the Omni terminal requires that a “9” or any other access code be dialed to gain access to an outside line, the “9” or the access code must be replaced in Omni’s dial-out telephone number after the download is successful.

Additionally, if a provider number had been mapped to one particular key on the Omni keypad, the provider number must be remapped after the download is completed. To assist users in entering NPI information, the NPI, taxonomy code, and ZIP Code+4 can also be mapped to one key.

Tables 3.8 and 3.9 provide complete instructions for adding an access code and mapping a provider number or mapping NPI information.

Table 3.8 – Adding an Access Code

Step	Omni Display Will Read	Action
1	WELCOME TO INAIM/SELECT A TRANS	Press 7 .
2	MAINTENANCE	Press FUNC/ENTER .
3	SET DATE/TIME	Press FUNC/ENTER .
4	(Y or N)	Press # for No.
5	PROV KEY CHANGE	Press FUNC/ENTER .
6	(Y or N)	Press # for No.
7	RETRY PRINTER	Press FUNC/ENTER .
8	(Y or N)	Press # for No.
9	CHANGE CONFIG	Press FUNC/ENTER .
10	(Y or N)	Press * for Yes.
11	#PH = 18009319001	This is the dial-out telephone number. To add the access code, press 8 .
12	INPUT #PH	Type your specific access code (for example, 9). Press * for Yes. Press ALPHA .
13	<access code> ,	Type 18009319001.
14	<access code> ,18009319001	Press FUNC/ENTER .
15	#PP=	Press CLEAR .
16	WELCOME TO INAIM/SELECT A TRANS	The access code has been added. You may now send an eligibility transaction.

Table 3.9 – Mapping a Provider Number or NPI Information

Step	Omni Display Will Read	Action
1	WELCOME TO INAIM/SELECT A TRANS	Press 7.
2	MAINTENANCE	Press FUNC/ENTER .
3	SET DATE/TIME	Press FUNC/ENTER .
4	(Y or N)	Press # for No.
5	PROV KEY CHANGE	Press FUNC/ENTER .
6	(Y or N)	Press * for Yes.
7	KEY NUMBER	Press the desired key (0-9).
8	Provider/NPI?	To map the provider number, press P (7 ALPHA). or To map the NPI number, press N (6 ALPHA ALPHA).
9	P or N	Press FUNC/ENTER .
If 'P' was pressed in Step 2, complete these steps:		
10a	Provider ID	Type the nine-digit provider ID and press FUNC/ENTER .
10b	Location Cd A	If location code A is correct, simply press FUNC/ENTER . or To use a different location, type the location code and press FUNC/ENTER .
10c		Skip to step 12.
If 'N' was pressed in Step 2, complete these steps:		
11a	NPI	Type the 10-character NPI and press FUNC/ENTER .
11b	ZIP	Type the nine-digit ZIP Code and press FUNC/ENTER . or To skip entering the ZIP Code, press FUNC/ENTER .
11c	TAXO	Type the 10-digit taxonomy code that was reported to the IHCP with the NPI and press FUNC/ENTER . or To skip entering the taxonomy code, press FUNC/ENTER .
Complete the key mapping process:		
12	K = <n>X = NXXXXXXXXX or K = <n> = PXXXXXXXXX <n> represents the key to which the number was mapped	Verify that the key number and provider or NPI number are correct. Press FUNC/ENTER .
13	UPDATE KEY	Press FUNC/ENTER .

Step	Omni Display Will Read	Action
14	(Y or N)	Press * for Yes.
15	PROV KEY CHANGE	Press FUNC/ENTER .
16	(Y or N)	Press * for Yes to add more provider keys. Then return to Step 7. or Press # for No.
17	RETRY PRINTER	Press the CLEAR key.
18	WELCOME TO INAIM/SELECT A TRANS	Provider number or NPI information has been mapped. You may now use the mapped keys when sending an eligibility transaction.

Section 6: Automated Voice Response System

Introduction

The purpose of the Automated Voice Response (AVR) system is to help providers obtain eligibility information through the use of a touch-tone telephone. The AVR system provides the following information:

- Member eligibility
- Benefit limitation
- Check information
- Prior authorization
- Claim status

All information obtained from the AVR system is confidential.

By using a voice response application, information about the Indiana Health Coverage Programs (IHCP) is as close as a touch-tone telephone. Information is received through a computerized voice response system. This system, through a series of prompts and responses, asks providers to enter certain data using the telephone keypad.

AVR System Telephone Numbers

For Indiana, Michigan, Ohio, Kentucky, and Illinois, the AVR system toll-free telephone number is 1-800-738-6770. Providers in the 317 area code should use (317) 692-0819.

The AVR system is capable of handling multiple calls in response to call demand.

How to Use the AVR System

When a provider reports its National Provider Identifier (NPI) to the IHCP, the AVR system allows the provider to enter either a Legacy Provider Identifier (LPI) or NPI.

Depending on the information needed, the provider must have a touch-tone telephone and the following information at hand when accessing the AVR system:

- NPI or LPI (provider number and provider location code)
- Member identification number (RID), Social Security number (SSN), or Medicare number
- *From* date of service
- *To* date of service
- PA number, if applicable
- PA start date, if applicable

The subsequent sections explain how to use the AVR system and include the following:

- Time and inquiry limits for each AVR system call
- How to use special function keys
- Quick entry techniques
- How to enter alphabetic data
- Step-by-step walkthrough of the AVR system

AVR Call Limitations

- The AVR system limits the number of inquiries allowed during one telephone call. After four inquiries, the AVR system ends the call automatically.
- The AVR system limits the number of attempts allowed to enter information correctly. After three attempts, the AVR system ends the call automatically.
- The provider has 10 seconds to enter data after receiving an AVR system prompt. After 10 seconds, the system reminds the caller to enter the requested data. If information is not entered after the second prompt, the system disconnects.
- Each AVR system call is limited to 10 minutes from start to finish. There is no limit to the number of calls that can be made.
- The provider must listen carefully for special characters contained in the member's name, such as apostrophes, commas, periods, spaces, and hyphens. These special characters are spoken by the AVR and must be included on a claim form.
- The AVR is limited. It provides four managed care PMP assignments during a member eligibility request. A message instructs the user to access the Web interChange for the additional managed care PMP assignment information.

Special Function Keys

Using the asterisk (*) and pound (#) keys allows efficient movement through the AVR system. Table 3.10 outlines operator-directed shortcuts that use * and #.

Table 3.10– AVR Special Function Keys1

Special Function Keys		
Key(s)	Explanation	Instructions
*	Converts data from numeric to alphanumeric	Press * to enter alphanumeric data using the telephone keypad. For example, to enter a location code, press *; then select the number key that corresponds to the letter and the number that corresponds to the position of that letter on the key. For example, to enter a B location, press *22.
#	Data entry complete or use previous data	Always press # after entering data at a prompt. Pressing # provides the fastest response from the system. Use # to re-use data if it is the same as the data entered on the previous transaction. For example, if another transaction is needed on RID 123456789012, press # when the AVR asks for another member identification number.

Special Function Keys		
Key(s)	Explanation	Instructions
* #	Repeat the last response	To repeat what the AVR just said, press * #.
** new data #	Change incorrect data as it is entered	To correct a mistake when entering a response, press * twice; then enter the correct data and press #. For example, if 12567 is entered and 12345 should have been entered, the whole sequence would be 12567 ** 12345#.
* 99 #	Abort function	To cancel a transaction at any prompt and return to the main menu, press * 99 #.

Quick-Entry Techniques

As providers become more familiar with the AVR system, they can enter information more quickly using the techniques in Table 3.11.

Table 3.11 – AVR Quick-Entry Techniques

Quick Entry Techniques	
Speed Entry	Explanation
Entering information before AVR finishes speaking	AVR lets keystrokes be entered over prompt messages. It is not necessary to listen to the entire message before a response is entered. A good technique is to listen to the first word or two of the prompts and then begin entering information. By listening to the first part of the prompt, it is verified that the correct data is being entered.
Entering information quickly	After an AVR transaction is completed, to return to the main menu and perform another transaction for the same member identification number, press # instead of re-entering the member identification number. To use the current date for any date of service, press #.

Entering Alphabetic Data

The AVR system requires numeric information; therefore, all alphabetic data, such as the location code suffix at the end of a provider number, must be converted to numeric data. Procedures to enter alphabetic data as numeric data in the AVR system are provided in Table 3.12.

Note: After the transaction is complete, the user must press #

Table 3.12 – Entering Alphabetic Data in the AVR System

<i>Note: Press * on the touch-tone keypad followed by a two-digit numeric code.</i>	
Data Entry	Explanation
The two-digit numeric code for the LPI number	The first digit represents the number on the keypad. (The touch-tone telephone keypad has individual keys with the numbers 1, 2, 3, 4, 5, 6, 7, 8, 9, and 0.) The second digit represents the corresponding position of the alphabetic character on the numbered keys of the keypad. For example, the number 2 key has the letters A B C assigned to it on the keypad. A, B, and C are in positions 1, 2, and 3, respectively.
<i>Example 1: Converting AA to a numeric code</i>	A corresponds with the number 2 key. A is in the first position among the alphabetic characters on the number 2 key (A B C). Enter * 2 1 to designate the letter A.
<i>Example 2: Converting H to a numeric code</i>	H is found on the number 4 key. H is in the second position in the alphabetic characters on the number 4 key (G H I). Enter * 4 2 to designate the letter H.
Using Q or Z	Enter * 1 1 to designate the letter Q. Enter * 1 2 to designate the letter Z.

Table 3.13 shows how to use the *Alphabetic Data to Numeric Data Translation* table to translate alphabetic data into numeric data for the AVR system.

Table 3.13 – Alphabetic Data to Numeric Data Translation

Letter	Enter	Letter	Enter	Letter	Enter
A	* 2 1	J	* 5 1	S	* 7 3
B	* 2 2	K	* 5 2	T	* 8 1
C	* 2 3	L	* 5 3	U	* 8 2
D	* 3 1	M	* 6 1	V	* 8 3
E	* 3 2	N	* 6 2	W	* 9 1
F	* 3 3	O	* 6 3	X	* 9 2
G	* 4 1	P	* 7 1	Y	* 9 3
H	* 4 2	Q	* 1 1	Z	* 1 2
I	* 4 3	R	* 7 2		

*Note: Rendering providers do not have a location code. To enter a space at the location code prompt, press *13.*

AVR System Walkthrough

The following pages provide a step-by-step walkthrough of data entry and responses provided by the AVR system. They also include possible responses the provider can get from the system.

The AVR system is also referred to as the IHCP Voice Response System (VRS).

The AVR System is reached by calling (317) 692-0819 in the Indianapolis local area or 1-800-738-6770.

Global Messages

Several categories of messages are used throughout the system. The information shown in Tables 3.14 through 3.17 can be used as reference tools if an error message is received from the AVR system.

Table 3.14 – General AVR Error Messages

When the AVR System says this...	...this is the problem:
“Invalid data. Please re-enter.”	A keystroke was entered that the AVR system did not recognize. Check the information and re-enter it.
“In order to service as many callers as possible, we must limit the number of input errors.”	In three attempts, the information the AVR system was expecting was not entered. The system terminates the call with this message.
“In order to service as many callers as possible, we must limit the time between your responses.”	It has taken too long to enter the requested information. The AVR system allows two user timeouts (10 seconds each) to enter the requested data. The system terminates the call with this message.
“In order to service as many callers as possible, we must limit the number of inquiries per call. Please call again for any additional inquiries you may have.”	The AVR system allows a maximum of four inquiries per call session. This limit has been exceeded. The system terminates the call with this message.
“In order to service as many callers as possible, we must limit the connect time per call. Please call again for any additional inquiries you may have.”	The AVR system allows a maximum of 10 minutes per call session. This limit has been exceeded. The system terminates the call with this message.
“Please wait while the requested information is retrieved.”	The host computer allows a certain time limit to respond to a request. This is the message received while information is being retrieved.
“Currently the system is unable to process your request.”	The AVR system is currently unavailable. Try again in 10 to 15 minutes.
“AVR is able to provide a maximum of four PMP assignments. There are additional PMP assignments for this member that can be obtained through the Web InterChange.”	The AVR system is limited to providing four managed care PMP assignments. To obtain additional PMP assignment information for the member, the user must access the Web interChange.

Table 3.15 – AVR Provider Number and Location Code Errors

When the AVR System says this...	...this is the problem:
<p><i>Note: Information depends on whether an NPI or LPI is entered. The NPI must contain 10 digits, or the LPI must contain nine digits and the correct provider location code.</i></p>	
“Invalid provider number (PROVIDER-NO). Please re-enter.”	The provider number entered is not in the correct format, or a non-numeric key was used while entering the identification number.
“Invalid provider location code (PROV-LOC-CODE). Please re-enter.”	The location code entered is not in the correct format, a non-numeric key was used while entering the code, or * was not used to convert numeric to alphabetic data.

Table 3.16 – AVR RID Errors

When the AVR System says this...	...this is the problem:
“Invalid Member number (RECIP-ID). Please re-enter.”	The RID entered is not in the correct format, or a non-numeric key was used while entering the identification number.
“Invalid Social Security number (RECIP-SSN). Please re-enter.”	The SSN entered is not in the correct format, or a non-numeric key was used while entering the identification number.
“Invalid Medicare number (RECIP-MCARE-NO). Please re-enter.”	The Medicare number entered is not in the correct format, or an incorrect alphanumeric key was used while entering the identification number.

Table 3.17 – AVR Date Errors

When the AVR System says this...	...this is the problem:
“Invalid <i>From</i> date-of-service (FROM-DATE-OF-SVC). Please re-enter.”	The <i>From</i> date-of-service entered is not in the correct format, or the date entered does not exist. Check the date and re-enter it in MMDDCCYY format. Example: January 1, 2008, is entered as 01012008.
“Invalid <i>To</i> date-of-service (TO-DATE-OF-SVC). Please re-enter.”	The <i>To</i> date-of-service entered is not in the correct format, or the date entered does not exist. Check the date and re-enter it in MMDDCCYY format. Example: January 1, 2008, is entered as 01012008.
“Invalid dates-of-service entered. The <i>From</i> date-of-service is greater than the <i>To</i> date-of-service.”	The <i>To</i> date-of-service entered is prior to the <i>From</i> date-of-service. Check the dates and re-enter.
“Invalid dates-of-service entered. The <i>From</i> date-of-service and the <i>To</i> date-of-service need to be in the same month.”	The dates-of-service entered are not in the same calendar month. Check the dates and re-enter.
“Invalid dates-of-service entered. Dates-of-service cannot be greater than today’s date.”	The dates-of-service entered are in the future. Check the dates and re-enter.

Initial Options for AVR System

Table 3.18 shows the options that are first encountered when dialing the AVR system. The information that the provider enters depends on whether the provider uses its NPI or LPI. If using an NPI, the NPI must contain 10 numeric digits, and does not require a provider location code. However, if using an LPI, the number must contain nine digits and the correct provider location code.

The following information should be available when dialing in, because the system has time and attempt limits for data entry:

- The LPI, which is the IHCP Provider Number and location code
- or
- The NPI – If sending NPI – the ZIP Code+4 (nine digits) of the provider’s office location
- The taxonomy code that was reported with the NPI to the IHCP

Note: Sending the nine-digit ZIP Code+4 and, if necessary, the taxonomy code in the transaction may assist in determining a one-to-one NPI to LPI match. In most cases, the nine-digit ZIP Code achieves a one-to-one match to a unique LPI.

- RID, SSN, or Medicare number
- From date of service
- To date of service
- PA number, if applicable
- PA assignment code, if applicable
- PA start date, if applicable
- Claim effective date, if applicable

Table 3.18 – AVR System Initial Options

Step	If the AVR System says the following complete the following
Step 0 – Introduction	“Welcome to the Indiana Health Coverage Programs voice response system. Please press the pound sign.”	Press # on the telephone keypad.
Step 1 – Choose NPI or LPI	“Please press 1 to enter the National Provider Identifier or 2 to enter the Legacy Provider Identifier”	Press 1 on the telephone keypad to enter the National Provider Identifier (NPI). or Press 2 on the telephone keypad to enter the Legacy Provider Identifier (LPI).
Complete Steps 2a, 2b, and 2c if ‘1’ was pressed in Step 1.		
Step 2a – Enter NPI	“Please enter your National Provider Identifier, followed by the pound sign.”	Type the 10-digit NPI and press # on the telephone keypad.

Step	If the AVR System says the following complete the following
Step 2b – Enter Taxonomy Code	“Please enter your taxonomy code, followed by the pound sign. If your taxonomy code contains an alpha character, you may press 1, followed by the pound sign for instructions for entering an alpha character. “To bypass the taxonomy code entry, please press the pound sign.”	Type the taxonomy code that was reported to the IHCP with your NPI and press # on the telephone keypad. To receive instructions for entering an alpha character on the telephone keypad, press 1 on the telephone keypad. To bypass the taxonomy code entry, press # on the telephone keypad.
Step 2c – Enter ZIP Code	“Please enter your nine-digit service location ZIP Code, followed by the pound sign. To bypass the ZIP Code entry, please press the pound sign.”	Type the nine-digit ZIP Code for the provider’s service location and press # on the telephone keypad. To bypass the ZIP Code entry, press # on the telephone keypad. Proceed to Step 4.
Complete Steps 3a and 3b if ‘2’ was pressed in Step 1.		
Step 3a – Enter LPI	“Please enter your Legacy Provider Identifier followed by the pound sign.”	Type the LPI and press # on the telephone keypad.
Step 3b – Enter provider location code	“Please enter your provider location code followed by the pound sign.”	Type the provider location code and press # on the telephone keypad. Proceed to Step 4.
Step 4 – Validate NPI or LPI	“Please wait while your authorization is verified.”	Do not press any keys. The AVR System is checking the information to make sure it is valid.

NPI/LPI Validation

The logon validation sequence of the NPI differs from the logon validation sequence of the LPI. Table 3.19 contains the possible messages used for NPI and LPI validation.

Table 3.19 – Logon Validation Scenarios

NPI Validation Scenario	If the AVR System says the followingdo the following:
If the NPI is entered in Step 1 of Table 3.18 and the crosswalk returns multiple LPIs	“NPI has returned multiple legacy provider numbers. You will be returned to the logon process. You may wish to narrow the search by sending the taxonomy code and nine-digit ZIP Code. To end this call, please hang up.”	Return to Step 1 of Table 3.18 or To end the call, hang up.
If the NPI is entered in Step 1 of Table 3.18 and the crosswalk does not find a match	“NPI has not returned a legacy provider number. You will be returned to the logon process. To end this call, please hang up.”	Return to Step 1 of Table 3.18 or To end the call, hang up.
If the NPI is entered in Step 1 of Table 3.18 three times and the crosswalk does not find a match, the AVR System terminates the call.	“In order to service as many callers as possible, we must limit the number of input errors. Thank you for calling the Indiana Health Coverage Programs voice response system.”	Call is terminated.
LPI Validation Scenarios	If the AVR System says the followingdo the following:
If the LPI is entered in Step 1 of Table 3.18 and the LPI is not found	“LPI is not on file. You will be returned to the logon process. To end this call, please hang up.”	Return to Step 1 of Table 3.18 or To end the call, hang up.
If the LPI is entered in Step 1 of Table 3.18, and a match is not found after three attempts, the AVR System terminates the call.	“In order to service as many callers as possible, we must limit the number of input errors. Thank you for calling the Indiana Health Coverage Programs voice response system.”	Call is terminated.

For additional assistance with the AVR System, contact the HP Customer Assistance Help Desk at (317) 655-3240 in the Indianapolis area or toll-free at 1-800-577-1278.

Member Eligibility

The series of entries shown in Table 3.20 are related to verifying eligibility. Have the following information available when dialing in, because the system has time and attempt limits on data entry:

- RID, SSN, or Medicare number
- From date of service
- To date of service

Table 3.20 – AVR System – Verifying Member Eligibility

Step #	When the AVR System says this...	...you do this:
Step 5-0 – Enter a member identification option	“Please select one of the following member identification options followed by a pound sign.	Press the number that corresponds to the information about the member and press # .
	For Member number, press 1.	If 1 is entered, press # and continue at Step 5-1.
	For Social Security number, press 2.	If 2 is entered, press # and continue at Step 5-2.
	For Medicare number, press 3.”	If 3 is entered, press # and continue at Step 5-3.
Step 5-1 – Enter a member ID number	“Please enter a Member number followed by a pound sign.”	Enter the member number , and press # . Continue at Step 5-4.
Step 5-2 – Enter a member SSN	“Please enter a Social Security number followed by a pound sign.”	Enter the SSN, and press # . Continue at Step 5-4.
Step 5-3 – Enter a member Medicare number	“Please enter a Medicare number followed by a pound sign.”	Enter the Medicare number , and press # . Continue at Step 5-4.
Step 5-4 – Enter the “From” date-of-service	“Please enter the ‘From’ date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only for today’s date.”	Press # for today’s date, or enter the From date-of-service in MMDDCCYY format, and press # . <i>Example:</i> January 1, 2008, is entered as 01012008. Continue at Step 5-5.
Step 5-5 – Enter the “To” date-of-service	“Please enter the ‘To’ date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only if the ‘To’ date-of-service is the same as the ‘From’ date-of-service.”	Press # if the <i>To</i> date-of-service is the same as the <i>From</i> date-of-service previously entered, or enter the “ To ” date-of-service in MMDDCCYY format, and press # . <i>Example:</i> January 1, 2008, is entered as 01012008. Continue at Step 5-6.
Step 5-6 – Validate eligibility information	“Please wait while the requested information is retrieved.”	Do not press any keys. The AVR System is checking the information to make sure it is valid. Continue at Step 5-7.

Step #	When the AVR System finds this...	...you hear this message:
Step 5-7 – Eligibility response	Member does not exist on the AVR system records.	“Member number (RECIP-ID) is not on file. Please re-enter.” Return to Step 5-1.
		“Social Security number (RECIP-SSN) is not on file. Please re-enter.” Return to Step 5-2.
		“Medicare number (RECIP-MCARE-NO) is not on file. Please re-enter.” Return to Step 5-3.
	SSN or Medicare number to member ID information.	“Social Security number (RECIP-SSN) refers to member number (RECIP-ID).”
		“Medicare number (RECIP-MCARE-NO) refers to Member number (RECIP-ID).”
	(No eligibility) The member is not eligible for services.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is not eligible for services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-14.
	(Traditional Medicaid services) The member is eligible for Traditional Medicaid services during these dates.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Traditional Medicaid services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.
	(590 Program coverage) The member is eligible for 590 services during these dates.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for 590 services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.

Step #	When the AVR System finds this...	...you hear this message:
<p>Step 5-7 – Eligibility response (Continued)</p>	<p>(Package A – Standard Coverage) The member is eligible for Package A – Standard Plan services during these dates.</p> <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p><i>Note: Care Select members also use the benefit package of Package A Standard.</i></p> </div>	<p>“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST NAME) is eligible for Package A – Standard Plan services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.</p>
	<p>(Package B – Pregnancy coverage) The member is eligible for Package B – Pregnancy coverage services during these dates.</p>	<p>“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Package B – Pregnancy Coverage services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.</p>
	<p>(Package C – Children’s Health Plan coverage) The member is eligible for Package C – Children’s Health Plan services during these dates.</p>	<p>“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Package C – Children’s Health Plan services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.</p>
	<p>(Package E – Emergency coverage) The member is eligible for Package E – Emergency Services during these dates.</p>	<p>“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Package E – Emergency Services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.</p>

Step #	When the AVR System finds this...	...you hear this message:
	(Package H – Healthy Indiana Plan) The member is eligible for Package H – Healthy Indiana Plan during these dates.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Package H – Healthy Indiana Plan from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.
	(Package P – Presumptive Eligibility) The member is eligible for Package P – Presumptive Eligibility during these dates.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is eligible for Package P – Presumptive Eligibility from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.
	(Multiple programs) If the member is eligible (or requires prior authorization) for multiple programs during these dates, the system speaks up to three different programs.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) (is eligible/requires prior authorization) for (ELIGIBILITY-TYPE) services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC) and (is eligible/requires prior authorization) for (ELIGIBILITY-TYPE) services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC) and (is eligible/requires prior authorization) for (ELIGIBILITY-TYPE) services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 5-8.

Service Restrictions

The next series of responses from the AVR system, shown in Table 3.21, address restrictions on member services, such as restriction to a specific hospital, pharmacy, or physician; restriction on coverage, such as a qualified Medicare beneficiary (QMB) and risk-based managed care (RBMC); or restriction on billing, such as spend-down and member liability.

Table 3.21 – AVR System – Service Restrictions

Step #	When the AVR System finds this...	...you hear this message:
<p>Step 5-8 – Service restriction responses</p>	<p>The member is restricted to a specific hospital.</p>	<p>“The member is restricted to a hospital. The hospital name is (LOCK-IN-HOSP-NAME).”</p>
	<p>The member is restricted to a specific physician.</p>	<p>“The member is restricted to a physician. The provider last name is (LOCK-IN-PROV-LNAME), and first name is (LOCK-N-PROV-FNAME).”</p>
	<p>The member is restricted to a specific pharmacy.</p>	<p>“The member is restricted to a pharmacy. The provider last name (LOCK-IN-PROV-LNAME), and first name is (LOCK-IN-PROV-FNAME).”</p>
	<p>The member must meet spend-down.</p>	<p>“The member met spend-down on (SPEND-DOWN-DATE).”</p> <p>“The member’s remaining obligation amount for this month is (SPEND-DOWN-AMOUNT). This amount is based on claims processed at the time of this eligibility verification. It is subject to change at any time following this eligibility verification as claims continue to process in the system. A provider may bill a member for the spend-down amount deducted from the adjudicated claim; however, with the exception of point of sale pharmacy claims, the member is not required to pay the provider until the member receives the monthly Medicaid Spend-down Summary Notice listing the amount applied to spend-down.</p>

Step #	When the AVR System finds this...	...you hear this message:
	<p>The member is a managed care member. <i>Care Select</i> members are currently identified as <i>Care Select</i>.</p>	<p>“The member is a Managed Care member. The type of managed care is <i>Care Select</i> from XX-XX-XXXX through XX-XX-XXXX. The managed care entity is (CMO NAME) and telephone number is (CMO PROVIDER SERVICES PHONE NUMBER). The Managed Care primary last name is (MANAGED-CARE-PROV-LNAME), and first name is (MANAGED CARE- PROV-FNAME). The provider’s telephone number is (PROV-PHONE-NUMBER).”</p>
<p>Step 5-8 – Service restriction responses (Continued)</p>	<p>The member has managed care with network information and multiple PMP assignments within a calendar month.</p>	<p>“The member is a Managed Care member. The type of managed care is Hoosier Healthwise risk-based managed care from XX-XX-XXXX through XX-XX-XXXX. The managed care entity is (MANAGED CARE ORGANIZATION) and telephone number is (MCO-PROVIDER SERVICES PHONE NUMBER). The member’s managed care network is (NETWORK NAME).”</p> <p>The Managed Care primary provider’s last name is (PROV-LNAME), and first name is (PROV-FNAME). The provider’s telephone number is (PROV-PHONE-NUMBER). There are (COUNT OF PMP ASSIGNMENTS) other managed care plans remaining. To hear information for the next managed care plan, please press the #.”</p> <p>AVR is restricted to provide only four PMP assignments. If there are four or more PMP assignments for a member, the following message will be stated: “AVR is able to provide a maximum of four PMP assignments. There are additional PMP assignments for this member that can be obtained through the Web interChange.”</p>

Step #	When the AVR System finds this...	...you hear this message:
	The member is a QMB.	“The member is a qualified Medicare beneficiary, and is eligible for coverage of Medicare deductible and coinsurance only.”
	The member is a nursing home (NH) resident for dates of service 10/01/2006 and later. The level of care (LOC) is within the LOC segment but is not an LOC ICF/MR.	“The member is a nursing home resident. The member’s liability amount is (LIAB-AMOUNT).”
	The member is an NH resident for dates of service 10/01/2006 and later. The LOC is outside the LOC segment.	“The member’s liability amount is (LIAB-AMOUNT).”
	The member is an NH resident for dates of service 10/01/2006 and later. The LOC is within the LOC segment and is ICF/MR.	“The member is an ICF/MR resident. The member’s liability amount is (LIAB-AMOUNT).”
The provider needs to contact Customer Assistance to verify the dates and type of waiver.	The member has waiver services during the dates of service requested.	“The member is a waiver resident. The member’s liability amount is (LIAB-AMOUNT).”
The provider needs to contact Customer Assistance to verify the dates and type of hospice service.	The member is a Hospice participant during the dates of service requested.	“The member is a Hospice resident. The member’s liability amount is (LIAB-AMOUNT).”
<i>Note: If there are multiple LOC segments available for the time period of the inquiry, these combinations could apply.</i>	The member has waiver services, and the member is an NH resident for dates of service 10/01/2006 and later. The LOC is within the LOC segment and is ICF/MR.	“The member is a waiver and ICF/MR resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a waiver and nursing home resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a waiver and hospice resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a waiver and rehabilitation resident. The member’s liability amount is (LIAB-AMOUNT).”

Step #	When the AVR System finds this...	...you hear this message:
Step 5-8 – Service restriction responses (Continued)	The member has waiver services and the member is an NH resident for dates of service 10/01/2006 and later. The LOC is within the LOC segment and the member is in a skilled level of care.	“The member is a waiver and intermediate resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a waiver and skilled resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a hospice and ICF/MR resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a hospice and nursing home resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a hospice and rehabilitation resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a hospice and intermediate resident. The member’s liability amount is (LIAB-AMOUNT).”
		“The member is a hospice and skilled resident. The member’s liability amount is (LIAB-AMOUNT).”

Other Insurance Information

The AVR system continues by providing information on up to seven third-party insurance carriers, as shown in Table 3.22. The system determines how many carriers are on file for the member for which the date of service falls within the other insurance policy coverage period. The AVR system then responds with the company’s name or code and up to nine coverage types. [Chapter 5](#) gives more information about the nine coverage types.

For company names and codes, use the following contact information:

HP Customer Assistance
(317) 655-3240 in the Indianapolis local area or
1-800-577-1278

Table 3.22 – AVR System – Other Insurance Information

Step #	When the AVR System finds this...	...you hear this message:
Step 5-9 – Other insurance information responses	The member has no other insurance carrier liable on the dates of service.	“The member does not have other insurance coverage.” Continue at Step 5-13.
	The member has one other insurance carrier liable on the dates of service.	Continue at Step 5-10.
	The member has more than one other insurance carrier liable on the dates of service.	“The member has other insurance with (NUM-OI-CARRIERS) carriers.” Continue at Step 5-10.
Step 5-10 – Other insurance carrier response	If the insurance company’s name is on the list of the 100 most frequently used carrier names, the system speaks the recorded company name. If the insurance company name is not on the list, the system speaks the company code.	“The member has other insurance with (RECIP-OI-COMPANY-NM).”
	Other insurance policy number and type of coverage. The AVR system provides up to nine coverage types.	“The member has other insurance with (RECIP-OI-COMPANY-CD).” “The insurance policy number is (RECIP-OI-INSURANCE-NO), with coverage type/types (COV-TYPE1, COV-TYPE2, ...etc).” Continue at Step 5-11.
Step 5-11 – Determine next step	More other insurance carrier liability information is available.	Continue at Step 5-12.
	No other insurance carrier liability information is available.	Continue at Step 5-13.
Step #	When the AVR System says this...	...you do this:
Step 5-12 – Select other insurance or Medicare option	“There are (NUM-OI-REMAINING) other insurance carrier/carriers remaining. To hear information for the next insurance carrier, press the pound sign. To verify Medicare Part A or Part B coverage, press 1 followed by the pound sign.”	Press # to hear more other insurance information concerning a different carrier, or Press 1 and # to hear Medicare information. Continue at Step 5-13. If # is pressed, return to Step 5-10.
Step #	When the AVR System finds this...	...you hear this message:
Step 5-13 – Medicare coverage information	(No Medicare coverage) The member does not have Medicare coverage.	“The member does not have Medicare Part A or Part B coverage.” Continue at Step 5-14.
	(Medicare Part A coverage) The member has Medicare Part A coverage.	“The member has Medicare Part A coverage. The Medicare ID number is (MEDICARE-ID-NUMBER).” Continue at Step 5-14.

	(Medicare Parts A and B coverage) The member has Medicare Part A and Part B coverage.	“The member has Medicare Part A and Part B coverage. The Medicare ID number is (MEDICARE-ID-NUMBER).” Continue at Step 5-14.
	(Medicare Parts D coverage) The member has Medicare Part D coverage.	“The member has Medicare Part D coverage. The Medicare ID number is (MEDICARE-ID-NUMBER).” Continue at Step 5-14.
Step 5-13A – Dental cap total dollars spent	The member has had dental services that count toward the \$600 annual dental cap. Information available for dental providers only.	“Dental cap dollars spent is 0 – \$600.” Continue at Step 5-14.
Step 5-13B – Dental sealants – tooth numbers sealed	The member has had teeth sealed. (Teeth identified by number for each sealed tooth available for dental providers only.)	“Tooth numbers sealed (Up to all 16 teeth available for sealing)” Continue at Step 5-14.
Step 5-13C – Incontinence supplies total spent	The member has had incontinence supply purchases for the rolling calendar year within the prior 12 months of the date included in the eligibility request. (Dollars spent is available for DME providers only).	“Supplies Total Dollar spent is 0-\$1,950” Continue at Step 5-14.
At this point, the system has completed all the eligibility response information. The AVR system gives a verification number for the transactions requested.		
Step #	When the AVR System says this...	...you do this:
Step 5-14 – Eligibility transaction verification number	“Eligibility verification number for this inquiry is (VERIF-NUMBER).”	Write down this number for future reference. Continue at Step 5-15.
Step #	When the AVR System says this...	...you do this:
Step 5-15 – Enter a menu option	“To obtain benefit limit information on this member, press 1 followed by the pound sign. To verify eligibility for the same member with different dates of service, press 2 followed by the pound sign. To verify eligibility for a different member, press 3 followed by the pound sign. To return to the main menu, press the pound sign. If this concludes your call, please hang up.”	Press the number that corresponds to the information to be obtained, and press # .
		If 1 is entered, press # and continue at Step 6-7 .
		If 2 is entered, press # and return to Step 5-4.
		If 3 is entered, press # and return to Step 5-0.
		If # is entered, return to Step 1.

Benefit Limits

For key entry in the benefits area, one of the following identification numbers and one of the dates of service are needed:

- RID
- SSN
- Medicare number
- *To* date of service
- *From* date of service

Benefit limits reflect only claims processed and paid in IndianaAIM. The specific benefit limitation information received is determined by the provider's type and primary specialty. A provider only receives benefit limitation information pertinent to its provider type and primary specialty. Table 3.23 shows the Benefit Limits steps.

Verify that the provider number is correct. Use the billing provider number to obtain benefit limitation information for most services. For medical office visits, use the rendering provider number to cross-reference limitation information.

Table 3.23 – AVR System – Benefit Limits

Step #	When the AVR System says this...	...you do this:
Step 6-0 – Enter a member identification option	“Please select one of the following member identification options followed by a pound sign:	Press the number that corresponds to the information about the member, and press #.
	For member number, press 1.	If 1 is entered, press # and continue at Step 6-1.
	For Social Security number, press 2.	If 2 is entered, press # and continue at Step 6-2.
	For Medicare number, press 3.”	If 3 is entered, press # and continue at Step 6-3.
Step 6-1 – Enter a Member ID number	“Please enter a member number followed by a pound sign.”	Enter the Member ID number , and press #. Continue at Step 6-4.
Step 6-2 – Enter a member SSN	“Please enter a Social Security number followed by a pound sign.”	Enter the SSN , and press #. Continue at Step 6-4.
Step 6-3 – Enter a member Medicare number	“Please enter a Medicare number followed by a pound sign.”	Enter the Medicare number , and press #. Continue at Step 6-4.
Step 6-4 – Enter the <i>From</i> date-of-service	“Please enter the ‘From’ date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only for today’s date.”	Press # for today’s date, or enter the <i>From</i> date-of-service in MMDDCCYY format, and press #. Continue at Step 6-5.

Step 6-5 – Enter the <i>To</i> date-of-service	“Please enter the ‘To’ date-of-service in a month, day, century, year format followed by a pound sign, or enter a pound sign only if the ‘To’ date-of-service is the same as the ‘From’ date-of-service.”	Press # if the <i>To</i> date-of-service is the same as the <i>From</i> date-of service already entered, or enter the <i>To</i> date-of-service in MMDDCCYY format, and press #. Continue at Step 6-6.
Step 6-6 – Validate benefit limit information	“Please wait while the requested information is retrieved.”	Do not press any keys. The AVR system is checking the information to make sure it is valid. Continue at Step 6-7.
Step #	When the AVR System finds this...	...you hear this message:
Step 6-7 – Benefit limit response	Member does not exist in the AVR system records.	“Member number (RECIP-ID) is not on file. Please re-enter.” Return to Step 6-1.
		“Social Security number (RECIP-SSN) is not on file. Please re-enter.” Return to Step 6-2.
		“Medicare number (RECIP-MCARE-NO) is not on file. Please re-enter.” Return to Step 6-3.
	SSN or Medicare number also provides RID information.	“Social Security number (RECIP-SSN) refers to member number (RECIP-ID).”
		“Medicare number (RECIP-MCARE-NO) refers to member number (RECIP-ID).”
	(No eligibility) The member is not eligible for services.	“Member number (RECIP-ID), member last name (RECIP-LAST-NAME), member first name (RECIP-FIRST-NAME) is not eligible for services from (FROM-DATE-OF-SVC) through (TO-DATE-OF-SVC).” Continue at Step 6-10.
Step #	When the AVR System says this...	...you do this:
Step 6-7 – Benefit limit response	“Member number (RECIP-ID) has not exhausted benefit limits based on paid claims as of (CYCLE-TIME) on (CYCLE-DATE).”	Continue at Step 6-10.
	“Member number (RECIP-ID) has exhausted limits for (NUM-SERV-LIMITS) benefit(s).”	Continue at Step 6-8.
Step 6-8 – Benefit limit exhausted response	“The member has exhausted a benefit limit for transportation services. The limit is 20 per rolling 12-month period.”	To return to the main menu, press #. If this concludes the call, please hang up.

	<p>“The member has exhausted a benefit limit for optometry services. The limit for lenses is two per year for 18 and under.”</p> <p>“The member has exhausted a benefit limit for optometry services. The limit for lenses is two every two years for over 18.”</p> <p>“The member has exhausted a benefit limit for optometry services. The limit for frames is one unit per year for 18 and under.”</p>	
Step #	When the AVR System says this...	...you do this:
<p>Step 6-8 – Benefit limit exhausted response (Continued)</p>	<p>“The member has exhausted a benefit limit for optometry services. The limit for frames is one unit every two years for over 18.”</p>	<p>To return to the main menu, press #. If this concludes the call, please hang up.</p>
	<p>“The member has exhausted a benefit limit for optometry services. The limit for exams is one per year for 18 and under.”</p>	
	<p>“The member has exhausted a benefit limit for optometry services. The limit for exams is one every two years for over 18.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for X-rays is one unit every three years.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for oral evaluations is one unit every six months.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for prophylaxis for 20 and under is one unit every six months.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for prophylaxis for 21 and over is one unit every 12 months.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for prophylaxis for members in a State institution is two units every six months.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for fluoride treatments is one unit every six months for 20 and under.”</p>	

Step #	When the AVR System says this...	...you do this:
<p>Step 6-8 – Benefit limit exhausted response (Continued)</p>	<p>“The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for 20 and under is four units every two years.”</p>	<p>To return to the main menu, press #. If this concludes the call, please hang up.</p>
	<p>“The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for over 20 is four units per lifetime.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The limit for root planing and scaling for members in a State institution is four units every two years.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The total amount spent for the annual Dental cap is \$600.”</p>	
	<p>“The member has exhausted a benefit limit for dental services. The total lifetime sealant limit of this tooth has been reached.” (This message is heard only once, but applies to all of the teeth identified as having been sealed earlier in the Eligibility response.)</p>	
	<p>“The member has exhausted a benefit limit for therapy services. The limit for physical evaluations is one unit every 12 months.”</p>	
	<p>“The member has exhausted a benefit limit for therapy services. The limit for physical treatments is 50 units per calendar year.”</p>	
	<p>“The member has exhausted a benefit limit for therapy services. The limit for speech evaluations is one unit every 12 months.”</p>	
	<p>“The member has exhausted a benefit limit for therapy services. The limit for speech treatments is 50 units per calendar year.”</p>	

Step #	When the AVR System says this...	...you do this:
<p>Step 6-8 – Benefit limit exhausted response (Continued)</p>	<p>“The member has exhausted a benefit limit for therapy services. The limit for occupational evaluations is one unit every 12 months.”</p>	<p>To return to the main menu, press #. If this concludes the call, please hang up.</p>
	<p>“The member has exhausted a benefit limit for therapy services. The limit for occupational treatments is 50 units per calendar year.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. The limit for new patient office visits is one unit per lifetime.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. The limit for office visits is five per year.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. The limit for chiropractic medical treatments is 50 per year.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. The limit for chiropractic medical treatments is 14 per calendar year without PA.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. Treatments 15 through 50 require PA.”</p>	
	<p>“The member has exhausted a benefit limit for chiropractic services. The limit for X-rays is one per year.”</p>	
	<p>“The member has exhausted a benefit limit for podiatry services. The limit for foot care is six units every 12 months.”</p>	
	<p>“The member has exhausted a benefit limit for podiatry services. The limit for office visits is one per year.”</p>	

Step #	When the AVR System says this...	...you do this:
<p>Step 6-8 – Benefit limit exhausted response (Continued)</p>	<p>“The member has exhausted a benefit limit for audiological services. The limit for assessments is one every 36 months.”</p>	<p>To return to the main menu, press #. If this concludes the call, please hang up.</p>
	<p>“The member has exhausted a benefit limit for medical office visits. The limit is 30 per year.”</p>	
	<p>“The member has exhausted a limit for DME services. The limit is \$2,000 per calendar year.”</p>	
	<p>“The member has exhausted a limit for DME services. The limit is \$5,000 per lifetime.”</p>	
	<p>“The member has exhausted a benefit limit for DME services. The limit for supplies is \$1,950 per rolling 12-month period.”</p>	
	<p>“The member has exhausted a benefit limit for outpatient services. The limit for office visits is 30 per year without PA.”</p>	
	<p>“The member has exhausted a benefit limit for outpatient services. The limit for office visits is 50 per year with PA.”</p>	
	<p>“The member has exhausted a benefit limit for inpatient rehab services. The limit is 50 days of inpatient rehab services per year.”</p>	
<p>If the AVR system has provided information for the last (or only) benefit limit, the system continues the call flow at Step 6-10. If information for another benefit limit is available, the system pauses to give the user a chance to record the information from the last response and continues at Step 6-9.</p>		
<p>Step 6-9 – Benefit limit continuation option</p>	<p>“There are (NUM-SERV-REMAINING) benefit limit(s) remaining. To hear the next benefit limit, press the pound sign. To skip the remaining benefit limit information, press 1 followed by the pound sign.”</p>	<p>Choose the response to hear the rest of the benefit limit information or skip it. If # is entered, return to Step 6-7. If 1 is entered, continue at Step 6-10.</p>

Step 6-10 – Benefit limit transaction verification number	“Benefit limit verification number for this inquiry is (VERIF-NUMBER).”	Write down this number for future reference. Continue at Step 6-11.
Step #	When the AVR System says this...	...you do this:
Step 6-11 – Benefit limit continuation menu option	“To obtain benefit limit information on another member, press 1 followed by a pound sign. To return to the main menu, press the pound sign. If this concludes your call, please hang up.”	Press the number that corresponds to the information to be obtained, and press # . If 1 is entered, press # and return to Step 6-0. If # is entered, return to Step 1.

Note: AVR reflects only the services paid to date through IndianaAIM. Benefit limitation information is provided as a service to the provider. Verifying benefit limits does not reserve services for the provider or guarantee payment.

Check Write

When the AVR system verifies the NPI or LPI and location code in Step 1-2, it obtains check write information to help reduce the number of host transactions. Whenever the Check Write option is selected, the system begins at Step 5-0 and responds with the retrieved information, as shown in Table 3.24.

Note: Information depends on whether an NPI or LPI is entered. The NPI must contain 10 digits, or the LPI must contain nine digits and the correct provider location code.

Table 3.24 – AVR System – Check Write Option

Step #	When the AVR System finds this...	...you hear this message:
Step 7-0 – Check write response	Check information is available for the provider number and location code entered.	“For provider number (PROVIDER-NO), the most recent check was issued on (CHECK-ISSUE-DATE) for (CHECK-AMT).” Continue at Step 7-1.
	Check information is not available for the provider number and location code entered.	“For provider number (PROVIDER-NO), no checks have been issued.” Continue at Step 7-1.
Step 7-1 – Claims pending response	There are claims pending for the provider number and location code entered.	“There are (PND-CLM-CNT) claim/claims pending for a total billed amount of (TOT-BILL-AMT).” Continue at Step 7-2.

Step #	When the AVR System says this...	...you do this:
Step 7-2 – Check write continuation option #	“To perform another check write inquiry, press 1 followed by the pound sign. To return to the main menu, press the pound sign. If this concludes your call, please hang up.”	Press the number that corresponds to the action to be followed, and press #. If 1 is entered, press # and continue at Step 7-3. If # is entered, return to Step 1.
Step 7-3 – Enter provider number	“Please enter your provider number followed by a pound sign.”	Enter the provider number and press #. Continue at Step 7-4 (if using LPI only).
Step 7-4 – Enter provider location code	“Please enter your provider location code followed by a pound sign.”	Enter the provider location code and press #. Continue at Step 7-5.
Step 7-5 – Validate provider information	“Please wait while the requested information is retrieved.”	Don’t press any keys. The AVR system is checking the information to make sure it is valid. Continue at Step 7-6.
Step #	When the AVR System finds this...	...you hear this message:
Step 7-6 – Provider response	The provider number entered does not exist on the AVR system records.	“Provider number (PROVIDER-NO) is not on file. Please re-enter.” Return to Step 7-3.
	The location code entered for the provider number entered does not exist on the AVR system records.	“The provider’s location code (PROV-LOC-CODE) is not on file. Please re-enter.” Return to Step 7-4.
	The provider number and location code entered exists on the AVR system records.	Return to Step 7-0.

Prior Authorization

The next series of prompts from the AVR system and entries made by the provider have to do with prior authorization, as shown in Table 3.25. The following information should be available when dialing in because the system has time and attempt limits on data entry:

- RID, SSN, or Medicare number
- PA number

Table 3.25 – AVR System – Prior Authorization

Step #	When the AVR System says this...	...you do this:
Step 8-0 – Enter a PA identification option	“Please select one of the following prior authorization identification options followed by a pound sign: For PA number, press 1. For Member number, press 2.”	Press the number that corresponds to the information about the PA request and press #. If 1 is entered, press # and continue at Step 8-1. If 2 is entered, press # and continue at Step 8-8.

Assignment Codes

PA information contains an **assignment code** to assist the AVR system with sorting data. The assignment codes are shown in Table 3.26.

Table 3.26 – AVR System Assignment Codes

Code	Description
01	Home health care (includes home health, private duty)
02	Hospital (includes inpatient and outpatient)
03	Physician (includes physician, optometric, and podiatric services)
04	Transportation
05	Mental health
06	Therapies (includes audiology, speech, occupational, physical, and respiratory therapies)
07	Dental
08	Chiropractic
09	Pharmaceutical
10	Other (includes rehabilitation services, rural health clinics, and durable medical equipment)

Prior Authorization Inquiry Using Prior Authorization Number

To inquire about PA, the provider must have the PA number available. The PA steps are shown in Table 3.27.

Table 3.27 – PA Inquiry Using PA Number

Step #	When the AVR System says this...	...you do this:
Step 8-1 – Enter a PA number	Please enter a PA number followed by a pound sign.”	Enter the PA number , press #. Continue at Step 8-2.
Step #	When the AVR System says this...	...you do this:
Step 8-2 – Validate PA information	“Please wait while the requested information is retrieved.”	Do not press any keys. The AVR system is checking the information to make sure it is valid. Continue at Step 8-3
Step #	When the AVR System finds this...	...you hear this message:
Step 8-3 – PA response	PA request does not exist on the AVR System records.	“PA number (PA-NUMBER) is not on file. Please re-enter.” Return to Step 8-1.
	PA request is in evaluation.	“For member number (RECIP-ID), PA number (PA-NUMBER) is in evaluation.” Continue at Step 8-20.
	PA request has been finalized.	Continue at Step 8-4.

Step 8-4 – Finalized PA response	PA request line item has been approved.	“For member number (RECIP-ID), PA number (PA-NUMBER) is approved for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/(PRN-CODE) for (PA-UNITS-AUTH) unit/units. (PA-UNITS-AVAIL) unit/units are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).”
		“For member number (RECIP-ID), PA number (PA-NUMBER) is approved for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/(PRN-CODE) for (PA-DOLLARS-AUTH) dollar(s). (PA-DOLLARS-AVAIL) dollar(s) are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-5.
Step #	When the AVR System finds this...	...you hear this message:
Step 8-4 – Finalized PA response (Continued)	PA request line item has been modified.	“For member number (RECIP-ID), PA number (PA-NUMBER) is modified for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/(PRN-CODE) for (PA-UNITS-AUTH) unit/units. (PA-UNITS-AVAIL) unit/units are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).”
	PA request line item has been modified.	“For member number (RECIP-ID), PA number (PA-NUMBER) is modified for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/(PRN-CODE) for (PA-DOLLARS-AUTH) dollar(s). (PA-DOLLARS-AVAIL) dollar(s) are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-5.
	PA request line item has been denied.	“For member number (RECIP-ID), PA number (PA-NUMBER) is denied.” Continue at Step 8-5.

	PA request line item is not assigned.	“For member number (RECIP-ID), PA number (PA-NUMBER) is not assigned – request does not require PA.” Continue at Step 8-5.
	PA request line item is pending.	“For member number (RECIP-ID), PA number (PA-NUMBER) is pending written documentation.” Continue at Step 8-5.
	PA request line item has been rejected.	“For member number (RECIP-ID), PA number (PA-NUMBER) is rejected.” Continue at Step 8-5.
When PA information is requested using a PA number, the AVR system provides information for up to six PA request line items per inquiry.		
Step #	When the AVR System finds this...	...you hear this message:
Step 8-5 – Determine next step	More PA request line item information available.	Continue at Step 8-6.
	No more PA request line item information available.	Continue at Step 8-7.
Step #	When the AVR System says this...	...you do this:
Step 8-6 – More PA information	“More PA requests exist. Please press the pound sign.”	Press # to hear the next PA request line item information or go to the next step. If # is pressed, return to Step 8-4; otherwise, continue at Step 8-7.
After all PA information is given, the AVR system notifies the provider of any other PA request line items on the AVR system records.		
Step #	When the AVR System finds this...	...you hear this message:
Step 8-7 – Final PA message	More PA request line items exist.	“More PA requests exist for PA number (PA-NUMBER). Please call Customer Assistance at (PSU-PHONE-NO) for assistance.” Continue at Step 8-20.
	No more PA request line items exist.	“No PA requests remain for PA number (PA-NUMBER).” Continue at Step 8-20.
	No more PA request line items exist.	“No PA requests remain for PA number (PA-NUMBER).” Continue at Step 8-20.

Prior Authorization Inquiry Using Member Identification Number

For a PA inquiry, the following information must be available for entry using a touch-tone telephone keypad:

- RID
- Assignment code
- Start date (if known)

The steps to access PA information using a RID are shown in Table 3.29. PA information contains an AVR assignment code to assist the AVR system with sorting data.

Assignment Code

PA information contains an assignment code. The assignment codes are shown in Table 3.28.

Table 3.28 – AVR System PA Assignment Codes

Code	Description
01	Home health care (includes home health, private duty)
02	Hospital (includes inpatient and outpatient)
03	Physician (includes physician, optometric, and podiatric services)
04	Transportation
05	Mental health
06	Therapies (includes audiology, speech, occupational, physical, and respiratory therapies)
07	Dental
08	Chiropractic
09	Pharmaceutical
10	Other (includes rehabilitation services, rural health clinics, and durable medical equipment)

Table 3.29 – PA Inquiry Using Member Identification Number

Step #	When the AVR System says this...	...you do this:
Step 8-8 – Enter a member ID number	“Please enter a member number followed by a pound sign.”	Enter the member ID number and press #. Continue at Step 8-9.
Step 8-9 – Enter the assignment code	“Please enter the assignment code followed by a pound sign.”	Enter the assignment code and press #. Continue at Step 8-10.
Step 8-10 – Select a start date option	“If the start date is known, press 1 followed by a pound sign. If the start date is not known, press 2 followed by a pound sign.”	Enter the number that corresponds to the information about the PA request and press #. If 1 is entered, press # and continue at Step 8-11. If 2 is entered, press # and continue at Step 8-12.

Step #	When the AVR System says this...	...you do this:
Step 8-11 – Enter the start date	“Please enter the start date in a month, day, century, year format followed by a pound sign.”	Press # for today’s date or enter the <i>Start Date</i> for the PA request in MMDDCCYY format, and press #. Continue at Step 8-12.
Step 8-12 – Validate PA information	“Please wait while the requested information is retrieved.”	Do not press any keys. The AVR system is checking the information to make sure it is valid. Continue at Step 8-13.
Step 8-13 – PA response	Member does not exist on the AVR system records.	“Member number (RECIP-ID) is not on file. Please re-enter.” Continue at Step 8-8.
	Valid response for a PA inquiry without a start date.	Continue at Step 8-14.
	Valid response for a PA inquiry with a start date.	Continue at Step 8-15.
When PA information is requested using a RID, an assignment code, and no start date, the AVR system provides information for the most recent PA request line item.		
Step 8-14 – PA Response – No Start Date	No PA requests found for the member ID and assignment code on the AVR system records.	“For member number (RECIP-ID) and assignment code entered, there are no PA requests.” Continue at Step 8-20.
	Most recent PA request is in evaluation.	“For member number (RECIP-ID), the most current PA request in process is PA number (PA-NUMBER), which is in evaluation.” Continue at Step 8-20.
	Most recent PA request line item has been approved.	“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is approved for assignment code (ASN-CODE) procedure/revenue/NDC code/PA Drug Program/ (PRN-CODE) for (PA-UNITS-AUTH) unit/units. (PA-UNITS-AVAIL) unit/units are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).”

Step #	When the AVR System says this...	...you do this:
<p>Step 8-14 – PA Response – No Start Date (Continued)</p>	<p>Most recent PA request line item has been approved.</p>	<p>“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is approved for assignment code (ASN-CODE) procedure/revenue/NDC code/PA Drug Program/ (PRN-CODE) for (PA-DOLLARS-AUTH) dollar(s). (PA-DOLLARS-AVAIL) dollar(s) are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-20.</p>
	<p>Most recent PA request line item has been modified (dollars).</p>	<p>“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is modified for assignment code (ASN-CODE) procedure/revenue/NDC code/PA Drug Program/ (PRN-CODE) for (PA-DOLLARS-AUTH) dollar(s). (PA-DOLLARS-AVAIL) dollar(s) are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-20.</p>
	<p>Most recent PA request line item has been modified (units).</p>	<p>“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is modified for assignment code (ASN-CODE) procedure/revenue/NDC code/PA Drug Program/ (PRN-CODE) for (PA-UNITS-AUTH) dollar(s). (PA-UNITS-AVAIL) dollar(s) are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-20.</p>
	<p>PA request line item has been denied.</p>	<p>“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER) which is denied.” Continue at Step 8-20.</p>
	<p>Most recent PA request line item is not assigned.</p>	<p>“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is not assigned – request does not require PA.” Continue at Step 8-20.</p>

Step #	When the AVR System says this...	...you do this:
	Most recent PA request line item is pending.	“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is pending written documentation.” Continue at Step 8-20.
	Most recent PA request line item has been rejected.	“For member number (RECIP-ID), the most current finalized PA request is PA number (PA-NUMBER), which is rejected.” Continue at Step 8-20.
Step 8-15 – PA Response – with Start Date	No PA requests found for the member ID, assignment code, and start date on the AVR system records.	“For member number (RECIP-ID) and assignment code and date entered, there are no PA requests.” Continue at Step 8-20.
	PA requests returned from the AVR system are in evaluation.	“For member number (RECIP-ID) and assignment code and date entered, there are (PA-MATCH-COUNT) PA request/requests being processed.” Continue at Step 8-16.
	PA requests returned from the AVR system are finalized.	“For member number (RECIP-ID) and assignment code and date entered, there are (PA-MATCH-COUNT) PA request/requests finalized.” Continue at Step 8-16.
Step 8-16 – PA Request Line Item Response	PA request is in evaluation.	“PA number (PA-NUMBER) is in evaluation.” Continue at Step 8-17.
	PA request line item has been approved (units).	“PA number (PA-NUMBER) is approved for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/ (PRN-CODE) for (PA-UNITS-AUTH) unit/units. (PA-UNITS-AVAIL) unit/units are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-17.

Step #	When the AVR System says this...	...you do this:
Step 8-16 – PA Request Line Item Response (Continued)	PA request line item has been modified.	“PA number (PA-NUMBER) is modified for assignment code (ASN-CODE), procedure/revenue/NDC code/PA Drug Program/(PRN-CODE) for (PA-UNITS-AUTH) unit/units. (PA-UNITS-AVAIL) unit/units are still available. Authorized from (PA-START-DATE) through (PA-STOP-DATE).” Continue at Step 8-17.
	PA request line item has been denied.	“PA number (PA-NUMBER) is denied.” Continue at Step 8-17.
	PA request line item is not assigned.	“PA number (PA-NUMBER) is not assigned – request does not require PA.” Continue at Step 8-17.
	PA request line item is pending.	“PA number (PA-NUMBER) is pending written documentation.” Continue at Step 8-17.
	PA request line item has been rejected.	“PA number (PA-NUMBER) is rejected.” Continue at Step 8-17.
When PA information is requested using a member identification number, an assignment code, and a start date, the AVR system provides information for up to six request line items per inquiry.		
Step 8-17 – Determine next step	More PA request line item information available.	Continue at Step 8-18.
	No more PA request line item information available.	Continue at Step 8-19.
Step 8-18 – More PA information	“More PA requests exist. Please press the pound sign.”	Press # to hear the next PA request line item information or go on to the next step. If # is pressed, return to Step 8-16; otherwise, continue at Step 8-19.
After all PA information has been given, the AVR system notifies the provider if there are any more PA request line items in the AVR system records.		
Step #	When the AVR System finds this...	...you hear this message:
Step 8-19 – Final PA message	More PA request line items exist.	“More PA requests exist for member number (RECIP-ID) for the assignment code and date entered. Please call the Customer Service Unit at (PSU-PHONE-NO) for assistance.” Continue at Step 8-20.

Step #	When the AVR System says this...	...you do this:
	No more PA request line items exist.	“No PA requests remain for member number (RECIP-ID) for the assignment code and date entered.” Continue at Step 8-20.
Step #	When the AVR System says this...	...you do this:
Step 8-20 – PA continuation option	“To check a PA number, press 1 followed by a pound sign. To check PA using a member number, press 2 followed by a pound sign. To return to the main menu, press the pound sign. If this concludes your call, please hang up.”	Press the number that corresponds to the action desired, and press # . If 1 is entered, press # and return to Step 8-1. If 2 is entered, press # and return to Step 8-8. If # is entered, press # and return to Step 1.

Claim Status Inquiry

For the claim status portion of the call, the provider must have the following available:

- Internal control number (ICN)
- RID with dates of service and the total amount billed

The steps to access claim status information are shown in Table 3.30.

Table 3.30 – AVR System Claim Status Inquiry

Step #	When the AVR System says this...	...you do this:
Step 9-0 – Enter a claim status identification option	“Please select one of the following claim identification options followed by a pound sign:	Press the number that corresponds to the information about the claim status request and press # .
	For internal control number (ICN), press 1.	If 1 is entered, press # and continue at Step 9-1.
	For member number, press 2.”	If 2 is entered, press # and continue at Step 9-5.
Step 9-1 – Enter an ICN	“Please enter an ICN followed by a pound sign.”	Enter the 13-digit numeric ICN and press # . Continue at Step 9-2.
Step 9-2 – Validate ICN information	“Please wait while the requested information is retrieved.”	Do not press any keys. The system is checking the information to make sure it is valid. Continue at Step 9-3.
Step 9-3 – ICN response	“ICN (ICN) is not on file. Please re-enter.”	ICN request does not exist on the AVR system records. Continue at Step 9-4A.

	“For ICN number (ICN), member number (RECIP-ID), this claim is currently in suspense as of (MM/DD/CCYY) (speaking today’s date). Please contact Customer Assistance for further information.”	ICN is in suspense. Continue at Step 9-4A.
Step #	When the AVR System finds this...	...you hear this message:
If the ICN has been paid or denied, continue at Step 9-4.		
Step 9-4 – Finalized ICN header-level information	ICN has been approved to pay.	“For ICN Number (ICN) and member number (RECIP-ID), for dates of service from (FROM-DATE) through (THROUGH-DATE) billed for (DOLLARS-BILLED), dollar(s) have been approved to be paid (DOLLARS-PAID) dollar(s) on (RA-DATE).” Continue at Step 9-4A.
	ICN has been denied.	Only Header explanation of benefits (EOB) are spoken. “For ICN number (ICN) and member number (RECIP-ID), dates of service from (FROM-DATE) through (THROUGH-DATE) billed for (DOLLARS-BILLED), dollar(s) were denied on Remittance Advice dated (RA-DATE) for (EOB Code). (EOB CODE) for EOB code definition, please refer to your Remittance Advice.” Continue at Step 9-4A.
	ICN has been denied on a line item.	“For ICN number (ICN) and member number (RECIP-ID), for dates of service from (FROM-DATE) through (THROUGH-DATE) billed for (DOLLARS-BILLED), dollar(s) have been denied on a line item on (MM/DD/CCYY) Remittance Advice. Please call Customer Assistance for further information.” Continue at Step 9-4A.

Step #	When the AVR System says this...	...you do this:
Step 9-4A – Finalized ICN response options	“To select another ICN, please press the pound sign.”	Press # to select another ICN. Return to Step 9-1.
	“To return to the main menu, please press the asterisk sign.”	Press * to return to the main menu. Return to Step 9-1.
Step 9-4B – Finalized member response options	“To select another member number, please press the pound sign.”	Press # to select another member number. Continue at Step 9-5.
	“To return to the main menu, please press the asterisk sign.”	Press * to return to the main menu. Return to Step 9-1.
Step 9-5 – Claim Status Member Inquiry (enter member ID number)	“Please enter a member number followed by a pound sign.”	Enter the 12-digit member number and press #. Continue at Step 9-6.
Step 9-6 – Enter the “From” date of service	“Please enter the from date of service in a month, day, century, year format followed by a pound sign.”	Enter the claim <i>From</i> date of service in MMDDCCYY format and press #. Continue at Step 9-7.
Step 9-7 – Enter the “To” date of service	“Please enter the through date of service in a month, day, century, year format followed by a pound sign.”	Press # for same date as from date of service or enter the claim <i>Through</i> date of service in MMDDCCYY format, and press #. Continue at Step 9-8.
Step 9-8 – Enter total billed amount	“Please enter total billed amount without a decimal point followed by a pound sign.”	Enter the total billed amount without decimal point and press #. Continue at Step 9-9.
Step 9-9 – Validate claim information	“Please wait while the requested information is retrieved.”	Don’t press any keys. The AVR system is checking the information to make sure it is valid. Continue at Step 9-10.
Step 9-10 – Claim status response	“Member number (RECIP-ID) is not on file. Please re-enter or press asterisk to return to the main menu.”	Member does not exist on the AVR system records. Return to Step 9-5.
<p>For a valid response of a claim inquiry for <i>From</i> date of service and <i>Through</i> date of service and billed amount, continue at Step 9-11 or 9-15, as appropriate.</p> <p>When claim status is requested using a RID and dates of service, but no claims are found that satisfy the entered criteria, the AVR system provides the following response.</p>		

Step #	When the AVR System finds this...	...you hear this message:
Step 9-11 – Claim status response (no claim for dates of service)	No claims found for the member ID, dates of service, and billed amount on the AVR system records.	“There are no claims on file for member number (RECIP-ID) for dates of service from (FROM-DATE) through (THROUGH-DATE) for billed amount (speak billed amount).” Return to Step 9-4B.
Step 9-12 – Claim status response – for dates of service, header-level information	A valid response has been found. Up to six claims.	“For member number (RECIP-ID), and dates of service from (FROM DATE) through (THROUGH-DATE) billed for (DOLLARS-BILLED) dollar(s), there were __ claim(s) found.” Continue at Step 9-12A.
Step 9-12A	Claim in suspense.	“For ICN number (ICN), claim is currently in suspense as of (MM/DD/CCYY). Please call Customer Assistance for further information.” Continue at Step 9-13.
	Claim has been approved to pay.	“For ICN number (ICN), a claim has been approved to be paid – (DOLLARS-PAID) dollar(s) on this date (RA-DATE).” Continue at Step 9-13.
	Claim has been paid.	“For ICN number (ICN), a claim was paid – (DOLLARS-PAID) dollar(s) on Remittance Advice dated (RA-DATE).” Continue at Step 9-13.
	Claim has been denied.	“For ICN number (ICN), a claim was denied on Remittance Advice date (RA-DATE). Please call Customer Assistance for further information.” Continue at Step 9-13.
Step #	When the AVR System finds this...	...you hear this message:
Step 9-12A (Continued)	Claim has been denied on a line item.	“For ICN number (ICN), a claim was denied on a line item on Remittance Advice dated (RA-DATE). Please call Customer Assistance for further information.” Continue at Step 9-13.
Step 9-13 – Determine next step	More claim information available.	Continue at Step 9-14.
	No more claim information available.	Continue at Step 9-16.

<p>Step 9-14 – More claim information</p>	<p>More claims exist, but six claims have been researched. Return to Step 9-4B.</p>	<p>“More claims exist for member number (RECIP-ID), but you have received the maximum allowed for this transaction. Please contact Customer Assistance for further information.”</p>
<p>Step 9-15 – Continuation option</p>	<p>Press * or hang up. Return to Step 1. No selection made. AVR automatically continues to Step 9-16.</p>	<p>“To return to the main menu, please press the asterisk sign. If this concludes your call, please hang up.”</p>
<p>Step 9-16 – Termination message</p>	<p>Call the AVR system again for additional information requests. The maximum number of transactions allowed per call has been reached.</p>	<p>“Thank you for calling the Indiana Health Coverage Programs voice response system.”</p>

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