

Presumptive Eligibility

Medical Provider Frequently Asked Questions

This document provides basic information on the Medicaid Presumptive Eligibility (PE) program. Information herein is subject to change. Any changes will be provided in an update to this document. You may also visit www.indianamedicaid.com for more information about PE.

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A. General Program Information

- 1. What is presumptive eligibility for pregnant women?**
Presumptive eligibility (PE) is a program that allows pregnant women to receive ambulatory (outpatient) prenatal services while their application for Medicaid is pending and being reviewed for eligibility by the Division of Family Resources (DFR). Women determined eligible for PE may begin receiving pregnancy-related services on the day they are determined PE eligible.
- 2. When does the program begin?**
PE begins on July 1, 2009.

B. Covered Services

- 1. The PE Bulletin states that covered services include ambulatory prenatal care. What does this include?**
PE covered services include outpatient pregnancy related services and services to treat conditions that might complicate the pregnancy.

Pregnancy-related outpatient services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant are covered with PE. Outpatient services for other conditions that might complicate the pregnancy are covered including those for diagnoses, illnesses, or medical conditions that might threaten the safe delivery of the fetus.

2. **What services are not covered under PE?**
Services not covered for PE members include inpatient services, hospice, long term care, labor and delivery services, abortion services, postpartum services, services not related to the pregnancy or birth outcome. These services may be covered if the client is determined eligible for ongoing Medicaid eligibility.
3. **Does PE cover prescription drugs?**
Yes. Unless provided in an inpatient setting, all drugs are covered.
4. **Is there a list of covered services for PE?**
Covered diagnosis codes will be published in an IHCP Provider Manual update. Except for the non-covered services listed in Question B-2, PE essentially covers the services in Hoosier Healthwise Package B.
5. **Are services for a pregnancy complication covered? (For example, if a pregnant woman requires an additional prenatal visit due to gestational diabetes.)**
Yes.
6. **Are there co-pays for services received during PE?**
PE members will not have co-pays, even for brand name drugs.

C. Member Eligibility

1. **Who is eligible for PE?**
To be eligible for PE a woman must meet the following requirements:
 - Have a medically verified pregnancy
 - Currently reside in Indiana
 - Be a U.S. citizen or qualified Non-Citizen
 - Have gross family income at or below 200% of the federal poverty level
2. **Who is not eligible for PE?**
 - Inmates of public institutions
 - Women already enrolled in a Medicaid program,
 - Women who had been previously granted PE coverage for the current pregnancy
3. **What is 200% of the federal poverty level?**
The federal poverty level (FPL) is a federal guideline used to determine eligibility for many state and federal programs. The FPL sets an income threshold for each family based on family size.

PE eligibility is set at two times, or 200%, of the federal poverty level. 200% FPL is shown in the following table.

Family Size	Monthly Income (\$)	Annual Income (\$)
2	\$2,429	\$29,148
3	\$3,052	\$36,624
4	\$3,675	\$44,100
5	\$4,299	\$51,588
6	\$4,922	\$59,064
7	\$5,545	\$66,540
8	\$6,169	\$74,028
For each additional person add:	\$624	\$7,476

Table 1 – Gross Family Income Requirements for Presumptive Eligibility for Pregnant Women (Effective March 1, 2009)

4. How is gross family income determined?

Gross income, before taxes and other deductions, is totaled for each person living with the pregnant woman who is counted in the family size determination (as explained in answer to next question) and the result is gross family income. Earned or employment related income for children under 18 who are not parents is not counted.

5. How is family size determined?

Family size is the number that represents the pregnant woman and her family members **that live with her**. Family members that should be counted in determining family size include:

- a. The pregnant woman and each of her unborn children
- b. The pregnant woman's spouse
- c. The pregnant woman's children under age 18 and those of her spouse.
- d. If the pregnant woman is under 18 and not married, the parents of the applicant and the parents' children under age 18.

6. What types of income are counted for PE?

Income includes: wages and salaries, tips, self-employment, dividends, interest, child support (if paid for the pregnant women's support), alimony, Social Security, veteran's benefits, unemployment compensation, worker's compensation, sick benefits, retirement benefits, pensions, rental income, cash contributions.

- Do not count employment related income for children other than the pregnant woman or her spouse
- Count child support for the pregnant woman only if she receives it from her parents for her own support
- Do not count child support if it is paid for the support of the pregnant woman's children

7. **Are the family size and family income considerations for PE the same as other State assistance programs?**

The income and family size requirements for PE are the same as for Hoosier Healthwise for Pregnant Women. FSSA follows state and federal rules regarding whose income counts in the eligibility determination and who is counted in the family size.

8. **Can a woman enrolled in the Healthy Indiana Plan (HIP) apply for PE?**

A woman cannot simultaneously participate in the Healthy Indiana Plan (HIP) and PE. She must follow the procedure outlined for HIP women to transfer to Hoosier Healthwise Package B. HIP women have coverage for pregnancy related services during the transition from HIP to Medicaid.

D. Application Process

1. **What is the process for a woman to gain PE benefits?**

A Qualified Provider must determine that the woman meets PE eligibility requirements. The QP does this using Web-interChange to submit an application for PE on behalf of the woman. If approved, the woman must immediately contact the enrollment broker to select a Primary Medical Provider (PMP) and a Managed Care Organization (MCO) to have PE activated.

2. **How long does it take Web interChange to process a PE decision?**

Once submitted, the application will be processed within seconds. A determination notice of either approval or denial must be printed by the Qualified Provider.

3. **How soon after PE determination will pregnant women have coverage for services?**

Services will be covered beginning the day the PE is approved; however, updating the eligibility systems will take between three and five days. This will result in a woman having coverage beginning the day that PE eligibility was approved while her coverage will not appear on IHCP eligibility verification systems for three to five days.

4. **How does the woman obtain an identification card for PE?**

There is no identification card for PE. The PE approval notice serves as the woman's identification of PE. The woman will also receive a PE member welcome letter that will include the member's RID and PMP/MCO information.

5. **How does a PE woman's eligibility get activated?**

The woman's PE is activated when she calls the enrollment broker and selects a PMP and an MCO. If there are no PMPs available in her geographic area, the enrollment broker will activate the woman's PE eligibility and the member will be considered fee-for-service until a selection can be made. Claims for PE women who are fee-for-service must be submitted to IHCP for reimbursement.

6. **What if the PE woman doesn't contact the enrollment broker, MAXIMUS on the date of her PE determination?**
If she fails to contact the enrollment broker to select a PMP and MCO, her PE coverage will not be activated and services will not be covered.
7. **What are the hours of the PE Web interChange system?**
The PE web-tool used to apply for PE benefits will be available Monday through Friday from 8 a.m. to 6 p.m. and from 8 a.m. to 12 p.m. (Eastern Time) on Saturday. MAXIMUS, the enrollment broker, will be available 8 a.m. to 7 p.m. Monday through Friday and 8 a.m. to 1 p.m. on Saturday.
8. **What is the expectation of accuracy with regard to gross income on the PE application?**
Applicants must provide the most accurate information possible.
9. **What if the applicant is under 18 years of age and doesn't know her parents' income?**
If an applicant under age 18 cannot state her parents' income, she will need to either have a parent come back with her to apply or ask her parent for the information and bring this information to the QPs office.
10. **What if the income amount provided by the applicant is found to be different from the amount that DFR verifies when processing the woman's Medicaid application?**
If the amount stated by the applicant for the PE application is less than the amount indicated in the documentation provided to DFR, she will be denied Medicaid if it is above the PE income threshold and her PE will end. If the income indicated in DFR documentation, although higher than what was reported to the QP, is below the PE income threshold, she will be approved for Medicaid and her PE will end.
11. **Can the PE application be started, stopped, and restarted?**
No.
12. **What if the application is started, but the applicant discovers she doesn't know all the required information?**
The QP will need to exit the PE application in this situation. When the woman returns to the QP office with complete information, a new PE application can be started. It is recommended that the applicant be asked if she knows her family income before starting the PE application.
13. **What happens when a woman who is approved for Medicaid switches from PE to Medicaid?**
The day after EDS receives notice of the woman's Medicaid approval from DFR, her PE eligibility will be terminated and she will be enrolled in either Medicaid Package A, B or C. She will be assigned to the last MCO with which she was enrolled during her PE. After a PE member gains Medicaid eligibility, she is assigned a traditional Medicaid RID, and the "550" RID is linked to the new RID.

14. Is there still three months of retro coverage for pregnant women that are eligible?

Yes. If she is eligible for coverage prior to the PE determination date, there will be a period of retroactive coverage added to the system. The retroactive coverage period that is prior to the PE determination date will be billed as fee-for-service to EDS.

15. If a pregnant woman qualifies for PE today and the provider prescribes prenatal vitamins and other legend drugs, how should the member obtain those medications?

When possible, the QP should instruct the woman to wait 3-5 days before filling a prescription at the pharmacy. This will allow for eligibility information to be passed to the MCO's pharmacy benefit management (PBM) system.

If a prescription is needed prior to the passage of 3-5 days, the QP, member, or pharmacy may contact the MCO to request assistance. The MCO will have eligibility information the day following PE determination and may be able to facilitate passing of the data to the PBM manually. Providers and members are encouraged to be patient during the first 3-5 days of PE and contact the MCO of record with any questions.

If a pharmacy provider has difficulty processing a claim for a woman with eligibility information in EVS, they should contact the MCO of record. All three MCOs have indicated they will be able to communicate with the PBM to resolve any delays of eligibility information.

16. When does the presumptively eligible woman apply for Medicaid?

The application for Medicaid is completed at the same time as the PE. The Web interChange system populates the Hoosier Healthwise application for Medicaid based on information entered on the PE application. The pregnant woman must review the Hoosier Healthwise application, add a few additional details, and sign. The QP must fax the signed application from the QP site to the Division of Family Resources (DFR).

17. How long does it take for a PE eligible woman to receive a decision with regards to her eligibility for Medicaid?

DFR strives to make eligibility determinations within 45 days.

18. What if a woman's Medicaid application takes longer than 45 days for DFR to review and render a decision?

To remain eligible for PE, the woman's Medicaid application must show as pending with DFR before the end of the month following the month in which she was approved for PE. She must comply with any requests for information from the DFR. As long as the woman is complying with requests from DFR for additional information and her application is pending, she will remain on PE until DFR makes a decision on her Medicaid application.

- 19. How long will PE coverage last?**
PE coverage starts on the day the client is determined eligible for the PE program and will last until a determination is made on her Medicaid application or until her pregnancy ends.
- 20. What if the woman does not complete the Hoosier Healthwise application or fails to submit documentation to DFR?**
If the woman does not have a pending Medicaid application in the DFR system by the last day of the month following the month in which she was approved for PE her PE will be terminated. She will not be able to re-apply for PE.
- 21. Why might a woman be denied PE?**
PE will be denied if the woman:
- (1) has income greater than the PE income threshold,
 - (2) does not meet citizenship requirements,
 - (3) is not an Indiana resident,
 - (4) is incarcerated
 - (5) is already covered by Medicaid, or
 - (6) was previously granted PE coverage for the current pregnancy.
- 22. Can women denied for PE still apply for Medicaid?**
Yes. Women denied for PE can still apply for Medicaid
- 23. Can women appeal a PE application that was denied?**
No. Medicaid denials can be appealed but PE denials cannot be appealed.
- 24. How does open enrollment fit into PE?**
PE women will not be subject to open enrollment rules until after Medicaid is approved. After Medicaid is approved, the pregnant women will have a 90-day free change period to change MCOs until she selects and remains with one MCO in excess of 90-days.
- 25. What if there are no PMPs available in the pregnant woman's area?**
The enrollment broker will activate the woman as eligible for PE benefits when there are no PMPs available in her geographic area. Please note: The EVS will report the member eligible for Package P and there will not be managed care PMP/MCO information listed. The member will be considered fee-for-service and PE claims must be submitted to IHCP for reimbursement.
- 26. Can a PE member be auto-assigned?**
Auto-assignment does not occur for PE women. PE women must select a PMP and MCO on the date of PE determination to have the PE coverage activated or if there are PMP access issues in the woman's area, the process described in the answer to question D-25 will apply.

27. **Can a PE member change MCOs during her PE eligibility?**
PE members may change MCOs during the PE period. To make a PMP or MCO change, PE members must contact the enrollment broker, MAXIMUS at 1-800-889-9949. The same procedures that apply to Hoosier Healthwise members, apply to PE members.
28. **Can a PE member make a pre-birth PMP selection for her child or children?**
Yes. The member may select a PMP for her child when she selects her PMP with the Enrollment Broker (MAXIMUS).
29. **How will the MCOs be notified that a PE member has been enrolled with a particular plan?**
A daily file of PE eligible members will be made available to the MCOs.
30. **If an individual's Hoosier Healthwise application is approved and her PE segment is converted to Package A or Package B, will the eligibility be made retroactive to the date of the application or possibly retroactive to a date prior to the PE application?**
Yes. The start dates of Hoosier Healthwise coverage is the date that DFR receives a complete Hoosier Healthwise application. It is important that QPs assist the woman by faxing the complete Hoosier Healthwise application to DFR on the same date that PE is determined. Some women may also be eligible for coverage prior to the day that PE began if the woman met eligibility requirements during the time period prior to the PE application.
31. **If the member provides the QP with documentation such as pay stubs or proof of citizenship, what is the procedure for submitting these to DFR? Should the pages be labeled with the member name, SSN other identifying information?**
The provider should fax the documentation to the DFR office with the woman's Medicaid application. A cover sheet should be used to identify how many pages are included in the fax.
32. **If the individual's PE is denied, is it still necessary to fax the Hoosier Healthwise application? If the individual wants to apply for Medicaid, the HHW application must be faxed.**
There are some income disregards that are allowed on the Medicaid application but not part of the PE application. These disregards may be enough to make someone eligible for Medicaid despite being ineligible for PE.
33. **How will a provider identify individuals for which they should complete the PE process? Is a QP expected to provide a PE intake for all patients, only those patients with no insurance, only those patients who specifically request a PE intake, etc?**
It is up to the QP to determine how to manage identification of PE members. Providers may want to screen women over the phone during the scheduling process. A provider who signs up to be a QP must complete a PE application for any pregnant woman who asks to apply.

34. **Does OMPP have any objection to a provider implementing a PE screening process which would be less cumbersome and more efficient for their staff?**
OMPP will not prescribe internal QP processes that have been carefully designed by the QP office staff to meet the program requirements in an efficient manner. A screening process is acceptable as long as it does not in any way serve as a barrier to the application process. A provider who signs up to be a QP must complete a PE application for any pregnant woman who asks to apply.
35. **Many patients already well into a pregnancy may qualify for this program after July 1, 2009. If a provider has a patient whom they have been seeing for prenatal care will they be required to perform another pregnancy test on the individual to be submitted with the PE application (since the test in the records may be 6 or 8 months old)?**
No. As long as the patient's medical record substantiates that the pregnancy is ongoing, a new test would not be required. A professionally administered test must have been administered and be documented in the patient record at some point during treatment.
36. **If a patient has applied for PE and been denied because her income did not meet the stated requirements but she subsequently has a change in her job or living status that changes her income, can she re-apply for PE?**
Yes.
37. **Can the provider charge the patient a fee for "completing paperwork" to perform QP functions?**
No. Providers are performing QP activities voluntarily and cannot charge for services.

E. Qualified Providers

1. What is a Qualified Provider (QP)?

A QP is a provider who meets the following criteria:

1. Enrolled as a provider in the Indiana Health Coverage Programs (IHCP)
2. Capable of verifying pregnancy via a professionally administered pregnancy test (home administered tests do not meet this requirement)
3. Attended a Qualified Provider training session provided by the Family and Social Services Administration (FSSA) or designee
4. Currently providing outpatient hospital, rural health clinic or clinic services
5. Able to access Web interChange, printer and fax machine
6. Allows PE applicants to use an office phone to facilitate the PE and Hoosier Healthwise enrollment process

2. What type of providers should consider signing up to be a QP?

A QP may be one of the following provider types: a family or general practitioner; a pediatrician; an internist; an obstetrician or gynecologist; a certified nurse midwife; an advanced practice nurse practitioner; a federally-qualified health care center; a medical clinic; a rural health clinic; an outpatient hospital; a local health department; or a family planning clinic.

3. What are the responsibilities of a QP?

QPs help women enroll in the PE program by explaining PE and facilitating the joint PE and Medicaid application process. The application process can be summarized as follows:

- The Qualified Provider verifies the client's pregnancy. Tests performed by the QP or by other licensed practitioners are acceptable forms of verification. Home pregnancy tests are not acceptable forms of verification.
- The QP gathers information from the pregnant woman and enters this information into the Web interChange PE application system.
- If the woman meets all eligibility requirements, the system will respond with a determination notice of PE approval which the QP will provide to the pregnant woman.
- If the woman does not meet all eligibility requirements, the system will respond with a determination notice of PE denial which the QP will provide to the pregnant woman.
- The Qualified Provider will direct pregnant women approved for PE coverage to use the QP's phone to contact the Enrollment Broker to select a primary care provider and an MCO.
- The Enrollment Broker will activate the pregnant woman's PE once her PMP and MCO selections have been made.
- The QP will provide the Hoosier Healthwise application for the pregnant woman to review and sign.
- The QP will fax the Hoosier Healthwise application to DFR.
- To complete the process for determining if she is eligible for ongoing Medicaid coverage, DFR will contact the client at a later date and will direct her to schedule an interview and submit supporting documentation (e.g. proof of income, residency, etc.). If the woman does not respond to DFR requests within the timeframes provided by DFR, she will be denied ongoing Medicaid coverage and her PE coverage will end.

4. How can I become a Qualified Provider?

To become a Qualified Provider, you must be enrolled as an Indiana Health Coverage Programs (IHCP) provider, meet other basic requirements, pre-qualify as a Qualified Provider on Web interChange, and attend a training session provided by EDS.

5. How do I sign up for training?

First you must log onto Web interChange and pre-qualify as a QP at <https://interchange.indianamedicaid.com/Administrative/logon.aspx>. You can also contact the Provider Relations Field Representative for PE at (317) 488-5363. An EDS representative will contact you to enroll you in the training session in your area.

6. **What if training has already occurred in my area, but I missed the session?**
EDS Provider Relations staff can come to your office and provide one-on-one training for you and your office personnel. This option may not be available until after July 1, 2009 due to the number of QP training sessions being offered throughout the State. Please contact the PE Provider Relations Field Representatives at (317) 488-5363 if you have any questions.
7. **If a QP provider has 2 locations and sees patients at location A on Monday-Wednesday and sees patients at location B on Thursday-Saturday but the staff is the same, will the provider be required to have the same staff attend the training session twice, one for each location?**
No.
8. **How will a potentially pregnant woman know about this program to seek out a QP office?**
Pregnant women will hear of PE from healthcare providers, community centers, community health workers, and others. The FSSA Web site will also be updated to include PE information.
9. **Can Eligibility Assistance Companies perform QP functions for PE?**
Eligibility assistance companies may not perform QP functions for PE. Only employees of the Qualified Provider may perform QP functions. If there are questions about which staff can perform QP functions on behalf of the QP, the QP can submit questions by e-mail to Pehelp@fssa.in.gov.

F. Billing Guidelines

1. **Are Qualified Providers reimbursed for paperwork completed as part of the PE process?**
No. Qualified Providers serve on a voluntary basis. QPs are not reimbursed for providing PE enrollment services. QPs are reimbursed for medical care provided to a woman on the day she is approved for PE.
2. **What if the PE determination notice is lost? How can a provider bill for services without the identification number for PE? Can the determination notice be reprinted?**
The determination notice for PE cannot be reprinted. However, the healthcare provider does not need the determination notice to bill for a service provided to a PE enrolled woman. A provider can use the woman's name and date of birth or SSN to look up her eligibility status using one of the IHCP eligibility verification methods. The eligibility response will note that the woman is eligible for Package P - Presumptive Eligibility if the woman is enrolled in PE.
 - Web interChange
 - <https://interchange.indianamedicaid.com>
 - Automated Voice Response system (AVR)
 - (317) 692-0819 or 1-800-738-6770
 - Omni Machine using either the swipe machine or by entering pertinent information about the member (provider, member, date of service) and receiving a display or printed confirmation.

3. **How will the MCOs process claims for services provided the same day that the PE determination is made? What if the QP is out-of-network for the MCO selected by the PE woman?**

MCOs will pay QPs for the initial services provided the same day that the QP made the PE determination. QPs will be paid regardless of their affiliation status with the MCO chosen by the PE member. MCOs will consider QP locations to be in-network providers when processing medical claims for services provided on the date the PE determination was made by the QP. Provider should make sure they are registered with each MCO so that claims can be processed in a timely manner. Providers should contact the MCOs to determine if they are registered. MCO provider services phone numbers:

Anthem 1-866-408-6232

Managed Health Services 1-877-647-4848

MDwise 1-800-356-1204

4. **How can I identify women on PE on the eligibility systems?**

PE is shown as Medicaid Package "P".

5. **If a provider's claim for a service is denied during the PE eligibility and the woman gains Medicaid eligibility covering the date of service for the claim, can the provider re-submit the claim for payment?**

Yes. Once a Medicaid RID has been assigned to the member, the provider must bill with the Medicaid RID, not the PE RID and must submit a new claim for a previously denied claim, not an adjustment.

6. **What actions can be taken to help ensure proper claims payment?**

- Providers should check IHCP eligibility verification methods before providing services.
 - Web interChange
 - <https://interchange.indianamedicaid.com>
 - Automated Voice Response System (AVR)
 - (317) 692-0819 or 1-800-738-6770
 - Omni Machine
- Providers should bill with the appropriate RID number for the date of service being billed—the "550" RID during the PE period and the Regular Medicaid RID during Medicaid eligibility. Once a Medicaid RID number has been assigned to the member, providers should no longer use the PE "550" RID number.
- When billing for pregnancy-related services, providers must indicate a diagnosis of pregnancy in any of the claim's diagnosis fields.

7. **If a PE member receives a service that is not covered under the PE Program, is the provider required to provide written notification to the individual that the service is not covered under PE?**

Yes. The same requirements that exist for current Medicaid members apply to PE members. The provider must inform the woman that the service is not covered under PE and the amount that she will be responsible for paying for the service.

8. **In the situation where an individual is determined eligible for PE late in the pregnancy and she delivers prior to her final eligibility determination, is the provider required to notify the member that the delivery is not covered by PE?**
Yes
9. **What is the MHS denial code for PE claims?**
The denial code is "XP".

G. Other

1. **Will notifications of pregnancy (NOP) be reimbursed for PE members?**
Yes. FSSA is also launching a new program to improve early identification of health risks associated with pregnant women. This initiative, Notification of Pregnancy (NOP), reimburses recognized providers for gathering health information for a pregnant patient and submitting this information to the Indiana Health Care Programs electronically by means of the NOP form. To learn more about NOP go to www.indianamedicaid.com. When performing NOP tasks for a woman determined eligible for Presumptive Eligibility who has been enrolled with one of the MCOs, the provider should print a blank NOP form and complete the required information gathered from the patient. On the day after the QP makes the PE determination, the provider may enter the PE member's NOP into Web interChange. Upon successful submission of the NOP for the member, the provider should submit a claim for completing the NOP. Providers will receive \$60 for submitting each valid NOP form.
2. **How is OMPP planning to communicate information about this program in communities?**
OMPP is developing a PE brochure which will be available to providers, community organizations and others for distribution to potential members.
3. **Will there be any TV or print media to notify the public that this program is available?**
There are no plans for a media campaign at this time. A member brochure is currently under development.