Children's Special Health Care Services Provider Manual

Indiana
Department of Health

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INTRODUCTION

Children's Special Health Care Services Program (CSHCS)

Mission Statement

The mission of the Children's Special Health Care Services (CSHCS) Program is to provide financial assistance for medically necessary treatment of Children and Youth with Special Health Care Needs (CYSHCN), and Care Coordination to facilitate and promote family-centered, community-based, comprehensive, coordinated care that promotes successful systems of care for the CYSHCN and their families in Indiana.

Vision Statement

To promote the health and well-being of Children and Youth with Special Health Care Needs (CYSHCN)

The statutory authority for the CSHCS Program can be found in Indiana Code (IC) 16-35-2 and Indiana Administrative Code (IAC) 410 3.2.

Visit: https://www.in.gov/legislative/iac/iac_title?iact=410&iaca=3.2

Dear Provider:

Thank you for your interest in serving as a provider for the Children's Special Health Care Services (CSHCS) Program. The CSHCS Program provides medical coverage for financially eligible participants who have been diagnosed in any of 23 eligible medical conditions/categories; it does not cover all medical conditions. This manual provides information regarding the services supported by this program.

If you have questions about any of the topics in this manual, please call the CSHCS Program at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana). These numbers will provide you the following list of options. Please press the option number that best addresses your questions or concerns:

1 = For Spanish callers (voice mail)
2 = Eligibility (new application or re-evaluations)
3 = Prior authorization (request for approval of medical services)
4 = Travel claims (reimbursement for mileage for trips greater than 50 miles)
5 = Claims and Provider Relations (claims billing, provider enrollment, provider changes/terminations)
    1 = EDI (electronic claims) / Provider Web Portal assistance
    2 = Claim inquiries/problems
    3 = Provider Agreement / direct deposit / National Provider Identifier / updates and inquiries
6 = Care coordination (resource referrals or parent support organization referrals)
7=Repeat Options

The CSHCS Program looks forward to working with you.

Sincerely,

Children's Special Health Care Services
Provider Relations

TERMS & DEFINITIONS

BAA – Business Associate's Agreement

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

CSHCN – Children with Special Health Care Needs

CSHCS – Children's Special Health Care Services

CYSHCN – Children and Youth with Special Health Care Needs

EDI – Electronic Data Interchange

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

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

HIPAA – Health Insurance Portability and Accountability Act of 1996

Linked Provider – The primary care, specialty care, or basic/routine dental care provider from whom the participant receives care.

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

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

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

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

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

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

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

Provider Web Portal – A secure website where CSHCS participant eligibility, primary insurance/Medicaid coverage, claims status, and payment information is displayed for authorized users.

MEDICAL HOME OVERVIEW

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

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

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

Accessible

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

Family-Centered

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

Continuous

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

Comprehensive

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

Coordinated

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

Compassionate

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

Culturally Competent

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

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

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

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

For more information regarding Medical Home, contact:

Madeline Wilks, BS
Integrated Community Services Program
Children's Special Health Care Services
Indiana Department of Health
317-234-7991
MWilks@health.in.gov

PROVIDER ENROLLMENT REQUIREMENTS

General Information

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

Provider Agreement

- Before CSHCS can process any medical bills, the provider must be enrolled and sign a provider agreement through the CSHCS Provider Relations section. A primary component of the provider agreement is the provider's commitment to accept payment from the CSHCS Program as final and complete payment for any approved claim. Providers may also sign up to submit claims via Electronic Data Interchange (EDI) and real-time pharmacy claims submission. A provider agreement packet can be obtained by calling 1-317-233-1351 (local or out of state providers), or 1-800-475-1355 (Indiana) and select option 5, or by visiting the Provider Relations page on the CSHCS website at https://www.in.gov/health/cshcs/provider-relations/.
- All providers submitting claims for payment to the Indiana CSHCS Program must agree to be reimbursed by electronic funds transfer (EFT).
- Vendor and EFT information is provided to the State Auditor's Office to allow processing of payment. The CSHCS Provider Relations section is available to assist with coordination with the Auditor's Office.

Assigning Participant to Providers (Provider Linkages)

- Every participant in the CSHCS Program is linked to a primary care provider (PCP), a dental care provider (DCP), and based on need, a specialty care provider (SCP). A linkage will cover every routine service provided in the office. Surgery, supply items, orthodontia and therapy are examples of non-routine services that would require a specific prior authorization. This linkage remains in place until the participant requests a change or leaves the CSHCS Program, or the provider withdraws from the program. When the PCP also provides the necessary specialty care, a separate SCP need not be assigned.
- All specialty care must have prior authorization or be performed in the office of a linked provider.
- The DCP is a dentist or clinic that provides routine dental care to keep the participant's teeth and gums healthy. CSHCS has a specific list of covered routine dental codes. The program may also authorize specialty dental care to treat a participant's eligible medical condition, such as cleft lip and palate.

Reporting Updates to Provider Information

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

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

CSHCS Provider Web Portal

- The CSHCS Program provides access to program information via an internet web portal. The CSHCS Provider Web Portal allows providers to check participant enrollment status, claims status and history, warrant information, and enables providers to print an explanation of payment (EOP) for all denied/approved completed claims. Please note you will not be able to view EOP/EFT information for one to two business days after a deposit is made to an account.
- Providers must enroll in the CSHCS Provider Web Portal to access all claim processing/warrant inquiry information as this information is not provided over the telephone, by fax, or by email. Billing companies/clearinghouses may also obtain access if requested by the provider. If you have not already done so, please visit the Provider Relations page on the CSHCS website at https://www.in.gov/health/cshcs/provider-relations/ to obtain a copy of the CSHCS Web Portal Enrollment and Change Request form.

CSHCS Provider Relations Section Contact Information

1-317-233-1351 (local or out of state)
1-800-475-1355 (Indiana) and select option 5
Fax: 1-317-233-1342

Indiana Department of Health
CSHCS Provider Relations
2 North Meridian Street, Section 5C
Indianapolis, IN 46204

REIMBURSEMENT CONSIDERATIONS

Calculation of Payments

CSHCS will pay based on the lesser of these three calculations:

- Charge amount (usual and customary), less other insurance payment,
- Program allowed amount, less other insurance payment or
- Co-payment amount billed.

Coordination with Other Insurance

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

Billing Participants

- Providers may not bill the participant for any service covered by the CSHCS Program.
- If CSHCS approves the billing for any medical services, the provider must accept the Indiana Medicaid allowed rate paid by any primary payers and/or the CSHCS Program as payment-in-full. CSHCS participants may not be billed for any balance on a claim approved by CSHCS.
- If you have any questions about a participant's information related to the eligible diagnosis or covered services, please call the CSHCS Program at 1-317-233-1351 (local or out of state providers) or 1-800-475-1355 (Indiana) and select option 3.

CLAIMS SUBMISSION

Forms and Coding

- CSHCS utilizes the same billing forms and coding classifications used by Indiana Medicaid. Claim forms accepted are as follows:

    1. UB-04 (CMS-1450) Institutional Claim Form
    2. CMS-1500 Professional Claim Form, version 02-12
    3. ADA Dental Claim Form, version 2012
    4. Indiana Medicaid Drug Claim Form, version 08-10-17
    5. Indiana Medicaid Compounded Prescription Claim Form, version 10-15-17

- CSHCS utilizes national code sets, including HCPCs for medical or supply claims, revenue codes for inpatient, outpatient or home health claims, National Drug Codes (NDC) for pharmacy claims and ICD-10-CM (ICD-9 prior to 10/2015) for diagnoses. Providers must utilize the most appropriate code when billing. Documentation in the medical records maintained by providers must substantiate the medical necessity and coding for the billed service.

Adjustments

- Providers may request adjustments of previously denied or incorrectly paid claims within one year of the claim processing date. Providers may submit a copy of the Explanation of Payment (EOP) that is available on the CSHCS Provider Web Portal, denoting the claim in question and the reason for the adjustment. The request may be mailed or faxed to 1-317-233-1342. If you have questions, please call the CSHCS Program at 1-317-233-1351 (local or out of state providers) or 1-800-475-1355 (Indiana) and select option 5.

CSHCS Processing/Response to Claims

- Access to claims status, claim payment and Explanation of Payment (EOP) information is only available on the CSHCS Provider Web Portal at https://cshcsclaims.isdh.in.gov. The EOP details processing information such as provider name, participant name, claim number, warrant number, amount paid, reason for denial and other processing details.
- If you do not already have access to the CSHCS Provider Web Portal, please visit the Provider Relations page on the CSHCS website at https://www.in.gov/health/cshcs/provider-relations/ to obtain a copy of the CSHCS Web Portal Enrollment and Change Request form.

Code Updates

- The CSHCS Program makes every effort to enter code and pricing changes into the claims processing system as quickly as possible. However, there may be occasions when a provider bills for a service for which the new or revised code has not yet been loaded into the CSHCS claim processing system. This might result in a claim denial for an “invalid code.” Additionally, the claim payment amount could be affected if a pricing update applicable to the claim’s date of service has not been entered into the CSHCS claim processing system by the time the claim is processed. Should either of these situations arise, providers should contact the CSHCS Program at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 5 to request reconsideration of the claim.

- In the area of pharmaceutical services, revisions in pricing and coding are based upon information from a drug-pricing vendor, currently Elsevier. The CSHCS Program receives an electronic update near the first of every month that provides changes to National Drug Codes (NDC) and/or pricing that occurred during the previous month. When the CSHCS Program receives a pharmacy claim for an NDC that is not found in our system, the claim's final adjudication is delayed. The CSHCS Program manually checks information to determine whether the drug code is valid and processes the claim accordingly.

  Updates in NDC pricing that were not applied to a claim, due to the delay in system updating, will not be identified by CSHCS. Therefore, it is the provider's responsibility to submit an adjustment request for any claims believed to be paid inaccurately. For pharmacy pricing adjustment requests, providers should also submit verification from Medicaid that their allowance is different. This request can be mailed to our billing address or faxed to us at 1-317-233-1342.

Filing Limit and Waivers

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

Electronic Billing

- The CSHCS Program is committed to conducting its business transactions with the health care provider community as efficiently as possible. Therefore, CSHCS invites all participating providers to utilize electronic data interchange (EDI) to submit claims electronically as appropriate and practical.
- All providers wishing to begin submitting claims electronically must complete an EDI trading partner agreement and EDI trading partner profile. Providers may contact our EDI office at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 5, then option 1 to inquire further about electronic filing.

Pharmacy/Real-time Claims

- The CSHCS Program offers real-time pharmacy claims processing in the NCPDP D.0 format. This allows providers to verify patient eligibility and to receive prompt and accurate claims payments. If a claim is rejected due to improper submission, providers will receive immediate feedback to allow them to correct and resubmit the claim.
- The CSHCS Program requires that the provider service address and/or pay-to-address used for billing match the service address and/or pay-to-address that was submitted on the CSHCS Provider Agreement. The payee provider NPI submitted on the claim must also match the payee NPI submitted on the Provider Agreement.

ELECTRONIC DATA INTERCHANGE AND TRADING PARTNERS

Electronic Data Interchange (EDI)

- To assist providers who wish to bill electronically, the EDI Trading Partner Agreement form 51402 and the EDI Trading Partner Profile forms (51441-Clearinghouse/Software Vendor and 51401-Provider) are available on the CSHCS website at https://www.in.gov/health/cshcs/provider-relations/.
- The EDI office will advise if the provider's claims will route through single or dual clearinghouse(s) and whether a clearinghouse requires the provider to enroll through the clearinghouse's website.
- The EDI office will also advise if testing is needed with the provider, software vendor, or clearinghouse before the provider submits live transactions. Testing may be required for initial certification or industry-standard change releases of EDI X12 or NCPDP formats.
- Please review, complete, and return the EDI forms to IDOH. If appropriate, please have your billing service or clearinghouse complete and return the EDI forms on your behalf.
- Only providers who wish to exchange data electronically directly with IDOH are required to become an Indiana Department of Health (IDOH) trading partner. Please read the following descriptions to determine the scenario that best fits your situation.

Providers who ARE required to become an IDOH Trading Partner

- Billing providers who have purchased vendor software to electronically bill IDOH must become an IDOH trading partner by completing the following steps:

    1. Intermediary initially completes or updates the EDI Trading Partner Agreement form 51402.
    2. Intermediary initially completes or updates the EDI Trading Partner Profile - Clearinghouse/Software Vendor form 51441.
    3. Provider initially completes or updates the EDI Trading Partner Profile - Provider form 51401.

- Providers creating their own software to send or receive electronic transactions must follow the same testing and approval process as a software vendor. The provider must become an IDOH trading partner by completing the following steps:

    1. Provider initially completes or updates the EDI Trading Partner Agreement form 51402.
    2. Provider initially completes or updates the EDI Trading Partner Profile - Provider form 51401.

Providers who are NOT required to become an IDOH Trading Partner

- Billing providers who exchange electronic data via a billing service or clearinghouse do NOT need to submit an EDI Trading Partner Agreement form 51402. The billing service or clearinghouse is the trading partner and will need to submit the EDI Trading Partner Agreement form 51402 and the EDI Trading Partner Profile - Clearinghouse/Software Vendor form 51441.
- The provider must always complete the EDI Trading Partner Profile - Provider form 51401. If the provider wants to receive an outbound transaction (example: the 835-Remittance Advice) via a billing service or clearinghouse, it is the provider's responsibility to send the EDI Trading Partner Profile - Provider form 51401 to IDOH as authorization for IDOH to release the provider's data to the billing service or clearinghouse.

Completing the EDI Trading Partner Agreement

- The EDI Trading Partner Agreement form 51402 is a contract between parties who have chosen to become electronic business partners. The EDI Trading Partner Agreement form 51402 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 EDI Trading Partner Agreement form 51402 is required.
- If a billing provider is submitting transactions through a clearinghouse or billing service, the clearinghouse or billing service is the trading partner, and a trading partner agreement is not required from the individual provider. Please forward the EDI Trading Partner Agreement form 51402 and the EDI Trading Partner Profile – Clearinghouse/Software Vendor form 51441 to your intermediary for them to complete and return to IDOH.

Completing the EDI Trading Partner Profile(s)

- IDOH requires all providers exchanging electronic data directly or through an intermediary with IDOH to complete and submit the EDI Trading Partner Profile - Provider form 51401 and/or the EDI Trading Partner Profile - Clearinghouse/Software Vendor form 51441. The EDI Trading Partner Profile form is the tool that the provider or its intermediary must use to notify IDOH about the types of transactions they will exchange and the protocols they will use. After the initial setup, the EDI Trading Partner Profile Form will be used to inform IDOH of any changes to the vendor software, billing service, or clearinghouse selection.
- The provider must always complete the EDI Trading Partner Profile - Provider form 51401. If the provider wants to receive an outbound transaction (example: the 835-Remittance Advice) via a billing service or clearinghouse, it is the provider's responsibility to send the EDI Trading Partner Profile - Provider form 51401 to IDOH as authorization for IDOH to release the provider's data to the billing service or clearinghouse.

Submitting the EDI Trading Partner Agreement and EDI Trading Partner Profile(s)

- The EDI Trading Partner Agreement and EDI Trading Partner Profile(s) must be signed and submitted by the billing provider or its intermediary via email, fax, or U.S. mail to:

Indiana Department of Health
Attn: OTC/EDI Department
2 North Meridian Street, Section 3K
Indianapolis, IN 46204
Fax: 1-317-233-8199
Email: edimail@health.in.gov

- Upon receiving the signed EDI Trading Partner Agreement and the signed EDI Trading Partner Profile(s), the billing provider's system and procedures will be evaluated for exchanging production data. The trading partner will receive notification of approval via secure email. For initial trading partner certifications, the trading partner will also receive the trading partner ID, login ID, password, and other communication information via secure, encrypted email.

CSHCS PROGRAM INFORMATION

Eligibility Information

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

Financial Criteria

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

Medical Criteria

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

Applying for Services

- To apply for services, a parent, legal guardian, or emancipated child shall complete a written application. The following persons may apply for a child to receive health care services through the CSHCS Program:
    1. A child's parent (regardless of parent's age).
    2. A child's legal guardian.
    3. An emancipated child.
    4. A county department if a child is a ward of the county.
    5. A licensed child placement agency if a child has been placed in their legal guardianship.
- All participants of the CSHCS Program are issued a participant's manual and a complete enrollment packet with pertinent participant and program information.
- If you have any questions about eligibility, please call the CSHCS Program at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 2.
- Note that the CSHCS Program serves as the payer of last resort for all approved services for CSHCS participants.

Re-evaluations

- CSHCS re-evaluates participants/families annually to maintain enrolled status. During re-evaluation, participants must update income status, insurance information, household members and notify us of any other changes that have occurred since the initial application or most recent re-evaluation. Primary Care Providers (PCPs) are also required to complete a Physician's Health Summary form to document that the participant's condition still exists and update or add any new conditions that exist.
- If a provider has any questions as to the enrollment status of a patient, he/she should visit the CSHCS Provider Web Portal at https://cshcsclaims.isdh.in.gov and access the Eligibility page or call the CSHCS Program at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 2.

CARE COORDINATION

Children with special health care needs often require more healthcare services than typically healthy children. Getting the necessary services to maintain your child's health can involve dealing with many different healthcare providers, state agencies and local community resources. Managing the healthcare system can sometimes be confusing and overwhelming for parents and caregivers who are trying to cope with their child's complex medical issues.

CSHCS Care coordinators can help parents and caregivers apply for the CSHCS program, answer questions about the program, provide information on other programs they may be eligible for, provide referrals and connect them to local resources.

Who might need our services?

- Any caregiver who is caring for a child or youth (0-21) with a special health need.

How can I access a Care Coordinator?

Call 1-317-233-1351 or Toll Free 1-800-475-1355, Option 6, or email at cshcscarecoordinatio@health.in.gov

AUTHORIZATION OF SERVICES

Prior Authorization

- All services, except pharmacy (legend drugs only), lab and x-ray, must be approved by either a prior authorization (PA) or by a linkage of the provider to the participant for services related to the participant's eligible medical condition. A PA confirms medical necessity and the relationship of the service to an eligible medical diagnosis. Most services provided by a linked provider in their office do not require PA.
- Providers are responsible for obtaining PA from CSHCS for covered services when necessary. Please visit the Prior Authorization page on the CSHCS website at https://www.in.gov/health/cshcs/prior-authorization/ to obtain a copy of the Request for Authorization form. Providers should contact the prior authorization section and fax a copy of the Prior Authorization Request Form along with their evaluation or consultant records from the patient's medical chart.
- The fax number for the CSHCS Program is 1-317-233-1342.
- The telephone number for Prior Authorization is 1-317-233-1351 (local or out of state providers) or 1-800-475-1355 (Indiana) and select option 3.
- If a service covered by CSHCS requires PA and authorization is not obtained before the service is rendered, the participant/family may not be billed unless the family consents to receiving the service before the PA decision is made. However, if the service is denied by PA or is not a covered service, the provider may bill the participant/family if the family decides to receive the service anyway.
- If a provider is unable to obtain a PA and the participant/family insists on having the unauthorized procedure/services, providers should consider having the participant/family sign a waiver stating they understand they are responsible for the cost of these services.
- Covered services include routine primary care, routine dental care, and specialty services as described in 410 IAC 3.2.-7-2 (basic services included in the health care service package) and 410 IAC 3.2-7-3 (limited health care services included in the health care service package). Specialty services must be for treatment of an eligible medical condition. Providers may bill families for specialty services provided to a participant for a non-covered medical condition.
- PA requests will be reviewed and, if approved, a PA number will be given over the phone. A letter stating whether or not the request is approved in whole, in part or denied is faxed to the provider and mailed to both the provider and the participant or their family. If additional medical information is needed to determine the PA decision, it is requested from the provider and must be reviewed before a decision can be rendered.

Below is a list of services that require either PA or an additional provider linkage to allow payment by CSHCS; however, this list is not all-inclusive.

1. Inpatient services (hospitalizations)
2. Equipment and supplies
3. Surgery
4. Specialized dental care/orthodontia
5. Therapy (occupational, physical, speech, ABA)
6. Home health care
7. Emergency room services for covered conditions
8. Specialized medical care for covered conditions
9. Over-the-counter nutritional formulas or vitamins

Assistance with Payment of Diagnostic Tests

- Diagnostic examinations may be arranged upon establishing the possible existence of a program-covered medical condition and determining that the family is financially eligible for the program. Diagnostic examinations to establish the presence of a CSHCS covered condition will be reimbursed for children who have applied for the CSHCS Program who meet CSHCS financial criteria. Diagnostic examinations may also be reimbursed for a suspected but undiagnosed covered illness or condition of a patient already enrolled in the CSHCS Program.
- PA is not a guarantee of payment. Although the PA does confirm coverage of the service, the patient must be eligible on the date of service for the charges to be reimbursed. Additionally, the provider would need to submit a claim for the service on the appropriate claim form or electronically. All claims are subject to third party payment provisions as described in the Reimbursement Considerations section of this manual (p. 8).
- CSHCS will consider payment for over the counter (OTC) vitamins, nutritional supplements, and formula for treatment of an eligible diagnosis. These items require PA and must not be available through other programs, for example, the Special Supplemental Food Program for Women, Infants and Children (WIC).

Authorization for Emergency Services

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

Coverage Exclusions

There are some services, supplies, equipment, and medications that CSHCS will not cover at all. These exclusions are listed below. This list is not all-inclusive. You may confirm that a specific item or service is covered by calling 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 3.

- Over-the-counter drugs (e.g., Tylenol, cough syrup, etc.) even with a doctor's prescription
- Over-the-counter supplies (diapers, non-sterile gloves, alcohol, tape, bleach, Band-Aids, etc.)
- Services for mental health conditions, counseling, testing and substance abuse treatment
- Emergency room visits for reasons not related to the participant's eligible diagnosis (e.g., if the eligible diagnosis is Asthma, the CSHCS Program will not cover an emergency room visit for a broken arm)
- Hospitalization for reason not related to the eligible diagnosis
- Organ transplant surgery
- Eyeglasses, if not related to the eligible diagnosis
- Earplugs
- Supplies such as egg crate mattress covers, etc.

If you are in doubt about whether or not a service is covered, please call the CSHCS Program at 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 3.

Request for Review of Denied Prior Authorizations

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

Request for Review of Denied Claims

- A provider may request a reconsideration of a claim which is denied by the CSHCS Program. Request an informal review by calling 1-317-233-1351 (local or out of state) or 1-800-475-1355 (Indiana) and select option 5. Providers may also request reconsideration of a denied claim by sending a copy of the EOP, marking the claim in question, and indicating why the provider disagrees with the denial. Providers should also indicate a contact number, if necessary, to discuss the request. If the claim is approved, the provider will receive payment. If the denial is upheld, the provider will be notified.

Appeals

- Participants/families may appeal either eligibility or prior authorization decisions with which they disagree. Submit Appeal requests in writing to:

  The State of Indiana Office of Administrative Law Proceedings in one of the following ways:
  1) go online to https://www.in.gov/oalp/ and complete a Petition for Review (State Form 5691 (5-20));
  2) mail your request; or
  3) personally appear at the Office of Administrative Law Proceedings located at 402 W. Washington Street Rm. W161 / Indianapolis, IN 46204 to file a Petition for Review.

  You will need the Eligibility or Prior Authorization Letter that was sent to you to complete the request.

  Your appeal request must contain the following information:
  A. That you are the parent or legal guardian of the participant;
  B. That you are aggrieved or adversely affected by this decision; or
  C. That you are entitled to review under the applicable administrative law or under the administrative rules of the Children's Special Health Care Needs Program.

- Participants/families may either appeal immediately if they disagree with an eligibility or prior authorization decision and/or may request an informal review of the action. Please note, however, that all appeals must be filed within 18 days of the decision, which is being appealed, whether the family or the physician requests information review.