

PARTICIPANT'S MANUAL



Children's Special Health Care Services



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Children's Special Health Care Services Program

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. See:

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

Terms and Definitions

Basic Dental Care

Basic dental care consists of examinations, prophylaxis (cleanings) and fluoride treatments every six (6) months, sealants, x-rays, fillings and crowns. The dentist or provider must be enrolled as a CSHCS Provider.

Basic Primary Care

Basic primary care consists of examinations, immunizations, sick and well child visits. The physician or provider must be enrolled as a CSHCS Provider.

Care Coordination

Care coordination is a process that links children with special health care needs and their families to services and resources in a coordinated effort to maximize the potential of the children and provide them with optimal health care.

Eligible Medical Condition

The diagnosis for which the participant was approved for the CSHCS program. This diagnosis must fall within the 23 categories of eligible conditions (see appendix A).

Exclusions

Those items or services not covered by the CSHCS program.

Explanation of Benefits (EOB)

A form issued by an insurance company showing that a claim is paid or denied. If the participant has any medical insurance, this form is needed by the provider for every service to be billed to CSHCS. The EOB must be submitted by a provider with a claim to CSHCS and is required for every claim before CSHCS will process the claim for payment.

Household Members

All persons who live in a household unit (house or apartment), whether they are related to each other or not, and who are living together as an economic unit.

Key Number

The six-digit computer generated CSHCS participant identification number.

Linked Provider

The primary care, specialty care or basic dental care provider from whom the participant receives care. Linkages must be established by the Medical Eligibility/Prior Authorization Unit before claims can be paid by CSHCS.

Medical Home

A medical home is a respectful partnership between a child, the child's family, and the child's primary health care setting. The medical home is family centered health care that is accessible, continuous, comprehensive, coordinated, compassionate and culturally competent.

Out-of-State Care

Treatment received outside of the State of Indiana. All out-of-state care must have a p rior authorization. Emergency room visits must be related to the eligible medical condition and must be reported to CSHCS within five (5) days of the visit.

The following contiguous areas are available for in-state service with an authorized linkage or prior authorization (PA): Louisville, KY; Cincinnati, OH; Harrison, OH; Hamilton, OH; Oxford, OH; Sturgis, MI; Watseka, IL; Danville, IL; and Owensboro, KY.

Payer of Last Resort

The Children’s Special Health Care Services program is the payer of last resort for authorized services. All other insurances must be billed first for services rendered and an EOB submitted to CSHCS.

Participant

The individual receiving services from the CSHCS program.

Primary Care Provider (PCP)

A primary care provider may be an individual doctor or clinic that sees the participant for regular visits (e.g., well child physicals) and immunizations. The PCP would also see the participant to treat minor illnesses (colds, flu, etc.). The CSHCS program pays for all office visits, lab work, X-rays or any prescription medications prescribed by the primary care provider.

Primary Dental Provider (PDP)

May be an individual dentist or clinic that sees the participant for the basic preventive dental care to keep teeth healthy. Some services covered for routine dental care include: examinations, prophylaxis (cleanings) and fluoride treatments every six (6) months, sealants, X-rays, fillings and some crowns.

Prior Authorization (PA)

An authorization statement issued by CSHCS for services related to the eligible medical condition not provided by a linked provider. CSHCS will pay the provider after insurance has been billed. Payment for authorized services will be made only if all CSHCS policy requirements are met.

Specialized Dental Care

Specialized dental services needed to treat an eligible medical diagnosis such as cleft lip and palate. A prior authorization (PA) is required before specialized dental work begins.

Specialized Medical Care

Specialized medical services needed to treat an eligible medical condition(s) (see Appendix A). A prior authorization (PA) is required before specialized care begins.

Specialty Care Provider

A specialty care provider may be an individual doctor or clinic that sees the participant for treatment of his/her **eligible medical condition(s)**. Sometimes the primary care doctors can also serve as the specialty care doctor. The CSHCS program pays for office visits, lab work, X-rays or any prescription medications prescribed by the specialty care provider. Some specialty services may require a prior authorization (i.e., therapy, durable medical equipment, surgeries, etc).

Transportation provider

A company or individual who transports an enrolled participant to and from authorized medical appointments. Family members may register with CSHCS as Travel Submitters (see Travel and Transportation, page 12).

Transition

The movement from one situation to another (e.g., hospital to home, home to school, school to college, college to living alone and from pediatric to adult medical care).

Important Information

The Children's Special Health Care Services program is the payer of last resort for authorized services. This means that your primary insurance or Hoosier Health Wise/Medicaid must always process the claim before billing the CSHCS program.

Before receiving your first service under the CSHCS program, call the **Medical Eligibility/Prior Authorization Unit at (317) 233-1351 or (800) 475-1355 (Option #3)** to have your child linked to their primary and specialty care providers. You should also review your medical insurance or Medicaid information with the nurse at that time to insure the information is documented accurately. Your assigned nurse will contact you upon program enrollment to assist you with identifying provider linkages, PAs or other questions you may have concerning this program.

Before CSHCS can pay any medical bills, your providers must be enrolled as "CSHCS providers and **all specialty services must be either linked or prior authorized**. Be sure to report any services that were received while your application was pending.

Services Provided

The CSHCS program helps pay for enrolled participants. Please make sure that all your providers are authorized through the Medical Eligibility/Prior Authorization Unit. The program may pay for medical services only after other health insurance (private or public—Hoosier Healthwise and Medicaid) has paid or denied coverage. The CSHCS program **will normally** pay for the following:

- Primary Care Visits: any sick or well-child visits to a primary care physician in his or her office or clinic.
- Specialty Care Visits: health care visits made to a specialty care physician or other provider for care related to the eligible medical diagnosis.
- Basic preventive Dental Care Visits: any visit to a dentist or dental health professional for routine/preventive dental care as defined by the program.
- Specialized Dental Care Services: dental service needed to treat the eligible medical conditions such as cleft lip or palate.
- Pharmacy Services: prescriptions for medications/supplies prescribed by your physician. Over the counter medications are not usually covered even if the doctor writes a prescription unless the medication is the prescribed treatment for the participant's eligible medical condition and has been prior authorized. Be sure to contact the Medical Eligibility/Prior Authorization Unit to ask if it can be covered.

Authorized Services

It is your responsibility to confirm that your provider is an enrolled CSHCS provider. This can be confirmed with the CSHCS Medical Eligibility/Prior Authorization Unit. If your preferred provider is not already a CSHCS provider you may ask the CSHCS Medical Eligibility/Prior Authorization Unit to contact your preferred provider to see if he/she is willing to enroll in the program. If you choose to obtain services from a provider who declines to become a CSHCS provider or without a linkage or authorization, **you will be responsible for the bills.**

Parents/guardians/family members are required to register with the CSHCS program if they wish to be reimbursed for authorized transportation required for the participant to access medical care.

Every participant on the CSHCS program is linked to a primary care provider, a dentist, and if appropriate to a specialty care provider. The linkage covers care provided in those providers' offices. The linkage remains in place until either the participant requests a change or leaves the CSHCS program, or the provider withdraws from the program.

Specialty care services (e.g., therapies, equipment, "supplies," emergency room visits) must be related to the participant's eligible medical condition and recommended by the participant's PCP. These services must have prior authorization from the program before those services are obtained and before reimbursement is made to the provider(s).

CSHCS will pay the Indiana Medicaid allowed rate for all authorized services. This means that, occasionally, the program may not pay the full amount that your provider bills. However, if CSHCS approves payment for a medical service, the provider must accept the CSHCS payment as final payment-in-full. You should not be billed for any balance. If you receive a bill for an authorized service, please contact the provider and ensure that he/she has billed the CSHCS program. If this does not resolve the issue, please contact **(317) 233-1351 or (800) 475-1355 (Option #3, Medical Eligibility/Prior Authorization Unit)**.

All providers and participants/guardians who submit claims for payment to the State must agree to be reimbursed by electronic funds transfer. This means that anyone who wishes to be reimbursed for travel by CSHCS must set up a **direct deposit account** (please see the Transportation and Travel Section for more detail).

Linkages and Prior Authorizations (PA)

A Linkage is a way to establish an authorized relationship between the enrolled participant and the medical professional.

A prior authorization (PA) is another way of saying "ask before obtaining services." A prior authorization must be requested by the medical professional and confirms medical necessity and the relationship of the service to an eligible medical diagnosis. **If you do not ensure that services are authorized, bills for those services may not be paid.** A prior authorization is needed for most of the specialty services the participant requires. Prior authorizations remain in place for a specific time period which is normally no longer than six (6) months.

If a prior authorization is not obtained before receiving services, the resulting bills will be the responsibility of the participant. If the participant is referred to another provider, the family/participant must ensure that the new provider has authorization to provide those services. Below is a list of some services that require a PA.

- Inpatient services (hospitalizations)
- Equipment and supplies
- Surgery
- Specialized dental care
- Therapy (occupational, physical, speech)
- Home health care items
- Primary care received from other than the participant's primary care provider
- Specialty care received from other than the participant's linked specialty care provider

- Basic dental care received from other than the participant's primary dental provider
- **Emergency room services** - the participant **must notify** the CSHCS program of **emergency care** and unscheduled hospitalizations within five (5) working days of the visit, not including Saturdays, Sundays or legal holidays. An authorization for payment may be written only after the Medical Eligibility/Prior Authorization Unit receives the discharge summary or medical notes from the emergency room visit. The **participant is responsible** for seeing that these documents are mailed or faxed to CSHCS. Only services related to the eligible medical condition(s) will be authorized for payment (contact information in Appendix E).

If you are in doubt about whether or not a service is covered, call the CSHCS Medical Eligibility/Prior Authorization Unit at (317) 233-1351 or (800) 475-1355 (Option #3).

Exclusions (Services Not Covered)

There are some services, supplies, equipment and medications that CSHCS f qgu not cover. These exclusions are listed below. **This list is not all inclusive. You may confirm that a specific item or service is covered, by calling (317) 233-1351 or (800) 475-1355 (Option #3, Medical Eligibility/Prior Authorization Unit).**

- Over-the-counter drugs (e.g., Tylenol, cough syrup, vitamins, etc.) even with a doctor's prescription
- Over-the-counter supplies (e.g., diapers, non-sterile gloves, alcohol, tape, bleach, Band-aids, egg crate mattress covers, etc.)
- Therapy: physical, speech, behavioral or occupational (except as related to eligible medical condition and with a prior authorization)
- Mental health services, 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 reasons not related to the eligible diagnosis
- Organ transplant surgery
- Eyeglasses, if not related to the eligible diagnosis
- Items provided by a participant's Individual Education Plan (IEP)

Care Coordination Services

The CSHCS program offers Care Coordination services to participants and their families. CSHCS participants with chronic illnesses or disabilities, often have complex medical, educational, social and vocational needs that require a wide range of services. The number of providers and agencies involved can be overwhelming to the participant/family. CSHCS Care Coordination staff will be available to assist participants/families in their efforts to understand the medical home concept and to ensure that the participant/family receives appropriate, comprehensive family-centered care.

Care Coordinators will be contacting all new participants/families to discuss the needs and priorities of the participant/family and attempt to link families with appropriate community resources, providers/agencies to assist them. Referrals outside medical needs might include referrals to food pantries, housing, school related services, as well as information on support groups and connections to other family support organizations within Indiana.

To speak with a CSHCS Care Coordinator call **(317) 233-1351 or (800) 475-1355 (Option #7)**.

Insurance

For the CSHCS program to consider payment for a specific service, you must follow the rules for your primary insurance coverage. To utilize CSHCS benefits, the participant must:

1. Learn about the benefits of your primary insurance company. CSHCS will not pay for a service that the insurance company has denied because the participant did not follow the rules. For example, claims that are denied by your insurance company because the service was provided out of network will also be denied by CSHCS. Payment for these services may be the responsibility of the participant.
2. Upon receipt of this packet, call the **Medical Eligibility/Prior Authorization Unit (317) 233-1351 or (800) 475-1355 (Option #3)** regarding your primary insurance/Medicaid to insure that the information is documented accurately. Report all changes regarding your insurance coverage to providers and the CSHCS program as soon as they occur. Failure to disclose insurance benefits may result in individual claims being denied or the participant being removed from the CSHCS program.
3. Inform your providers to bill all other medical insurance first. This includes Hoosier Healthwise, Medicaid, and Medicare in addition to private insurance. CSHCS should then be billed with an EOB (explanation of benefits) attached to the claim.
4. If your other insurance requires a prior authorization for a service, it is the responsibility of the participant to get that PA before the service is rendered. If the insurance denies a service because the participant did not get prior authorization, CSHCS will also deny the claim and the bill will remain the responsibility of the participant.
5. CSHCS may ask you to appeal denials by your insurance company. It may be that the insurance company requires more information. Please cooperate with any request made

by your insurance company for further information. CSHCS will not approve any claim that is still pending with your insurance company or a claim that was denied by your insurance company due to incomplete information.

6. CSHCS will cover all or part of the participant's deductible and/or co-payments (up to the total reimbursement limit) for each instance of a service authorized by CSHCS.

Remember, it is important to seek services from CSHCS providers. These providers should not bill you for authorized services rendered. CSHCS will only pay the providers and will not reimburse the participant for deductibles, co-payments or balances that the participant pays. **It is the responsibility of the participant to inform providers that bills must be sent to CSHCS within one (1) year of the date of the service.** There are exceptions, but without appropriate documentation CSHCS will not pay claims that are submitted late. The participant may be responsible for any unpaid bill.

Participant's Responsibility

You **must** notify the **Medical Eligibility/Prior Authorization Unit** if any of the following occur:

- Address or name changes
- Change of phone number
- Changes of household income or occupants
- Changes to an enrolled participant's marital status
- An enrolled participant's legal emancipation
- A participant's enrollment in a residential institution
- Changes in insurance coverage (change of company, Hoosier Healthwise/Medicaid, service coverage or termination)
- Requested changes of providers
- Change of guardianship
- Parent/guardian name change (e.g., as a result of marriage or divorce)
- Emergency room visits within five (5) days of the visit
- Hospital admission within five (5) days of the admission
- The death of a participant
- You must always confirm with your provider that an authorization for services has been received. You must inform your provider of your primary, secondary, Medicaid, any changes or billing issues before services are rendered.

What to Do if You Receive a Bill

If you receive a bill, never assume that the provider sent you the bill by mistake. Contact the provider immediately to see why you received the bill. Make sure that the provider knows to bill your insurance company or Hoosier Healthwise/Medicaid coverage first, and then the CSHCS program. Be sure the provider has the correct mailing address for CSHCS:

Indiana State Department of Health
CSHCS – Section 7B
2 North Meridian Street
Indianapolis IN 46204

If the provider says that the participant is responsible for the balance of a bill paid by CSHCS, contact the Claims Unit at (317) 233-1351 or (800) 475-1355 (Option #5) immediately. CSHCS may not be able to help you if the bill has gone to a collection agency. Services that have been denied as a non-covered service by the CSHCS program are the participant's responsibility. There are also some services that CSHCS will not cover. Those exclusions are listed on page 9.

Transportation and Travel Reimbursement

Effective July 1, 2010, the Children's Special Health Care Services program has discontinued travel reimbursement for participants dually enrolled in both CSHCS and Medicaid/Hoosier Healthwise (HHW). Dually enrolled participants will need to contact their Medicaid/HHW assigned health plan to arrange transportation.

The cost of traveling to and from a network provider for approved services may be reimbursed to the parent, foster parent or legal guardian of a participant if the following conditions are met.

1. Reimbursement (money paid back to you) will be made at 50 percent of the rate established by the Department of Administration and approved by the Agency.
2. Effective July 1, 2009, the first 49 miles one-way or round trip will not be reimbursed. Only mileage that exceeds 49 miles one-way or round trip will be reimbursed.
3. Mileage will not be approved for trips in excess of 2,500 miles round trip.
4. All mileage is based on the city-to-city calculation from the Indiana State Mileage Chart and **not the odometer reading from your vehicle.**
5. All signatures submitted on the Travel Voucher must be original.
6. All sections of the Travel Voucher must be completed legibly.
7. A maximum of three (3) travel dates may be submitted per one Travel Voucher.
8. Anyone requesting Travel Reimbursement must have filed (one time only) a completed Indiana Vendor Information Form.

9. The CSHCS program will not reimburse for transportation to visit a hospitalized participant, parking, meals or lodging.

State law now requires any person and/or entity who submit claims for payment by the State to be reimbursed by electronic funds transfer. This means that if you wish to be reimbursed for family travel by the CSHCS program, you must submit information to set up direct deposit.

Information on the direct deposit process and forms required are located in Appendix D.

Vouchers must be submitted within one (1) year of the date of travel. For example, if you traveled to the doctor on May 1 of 2009, we must have received your travel vouchers in our office prior to May 1, 2010. **Blank travel vouchers and the Vendor Information form can be obtained from our website or by contacting us directly at (317) 233-1351 or (800) 475-1355 (Option #4).**

Properly signed and completed travel vouchers must be mailed to the CSHCS office:

Indiana State Department of Health
CSHCS – Section 7B
2 North Meridian Street
Indianapolis IN 46204

Re-Evaluations

Once a year from the date of initial application, participants are re-evaluated to determine if there have been changes in their eligibility status. The re-evaluation is required to maintain active status on the program. CSHCS will notify you by mail when you are required to submit information for your annual re-evaluation.

During the re-evaluation you will be asked to provide information on all household members income (earned and unearned) by submitting a copy of all household members latest **federal tax form 1040** or other documents that can verify income. If household members do not file federal taxes, submit written documentation of all household income received (i.e., last three consecutive check stubs and a statement listing all other household income received or a statement declaring that no other income is received).

If income has changed drastically from the time taxes were filed, submit the latest tax form along with written documentation of current income (i.e., the last three consecutive check stubs or a written statement from your employer on the company's letterhead) indicating salary. Remember, even though there will be an annual re-evaluation; parent/guardian/participant is still responsible for informing the CSHCS program of any changes in financial information that occur during the year.

When you receive notification of the re-evaluation, you must return the information requested by the due date in the letter. Failure to return the updated information could result in the participant being removed from the CSHCS program. If you have any questions please call the **CSHCS Eligibility Unit at (317) 233-1351 or (800) 475-1355 (Option #2).**

Case Closures: Removal from the CSHCS Program

The participant may be removed from the CSHCS program for various reasons. Some of the reasons the participant's enrollment may be terminated:

- Failure to complete and return the annual re-evaluation packet within the required time
- Failure to provide updated income information
- Failure to utilize health insurance benefits and/or provide updated health insurance information
- Failure to provide current address information
- Failure to apply for Medicaid/Hoosier Healthwise
- Loss of state residency – participant is no longer an Indiana resident (moves out of state)
- Death of participant
- The participant has turned 21 years of age. Participant with CF is not subject to age limitation, but must remain financially eligible

Transition

Transition is the movement from one situation to another (e.g., hospital to home, home to school, school to college, pediatric care to adult medical care and/or from family living to living independently as an adult). It is important to know the tools and resources available to transition youth with special health care needs. Some of the systems that families understand well in the pediatric world have different rules in adult life. For example, individuals with disabilities may or may not meet eligibility for Supplemental Security Income (SSI) benefits when they turn 18. Prior to age 18, family income is considered in financial eligibility. After 18, only individual's income is considered.

When your child reaches adulthood, he or she will transition out of the range of school services guaranteed under the Individual with Disabilities Education Act (IDEA). Beginning at age 14, a transition plan should be developed and updated annually for those children with an Individual Educational Program (IEP).

Youths must be ready to speak for themselves as they turn 18. Regardless of the level of disability, an individual automatically becomes his or her own legal guardian or decision-maker upon turning 18 unless legal guardianship is pursued. While most young adults with special health care needs continue to look for recommendations and support from their families, once 18, the person is able to sign legal documents and contracts. The person becomes responsible for medical care such as making own appointments, getting medicines, requesting equipment.

Transition is the natural progression through life. There are many transitions that occur in the life of any child. Each change has some potential to be scary and bring up many questions. In

busy lives, it is sometimes difficult to stop and plan for the future. However, planning today for tomorrow's goals is very important to actually achieving those goals.

The CSHCS program has identified some state and national websites for your information. The websites listed below include health care, educational, employment and recreational information. It is our hope that these sites will help in all phases of transitioning from childhood to adulthood.

State and National Transition Resources

Center for Youth and Adults with Conditions of Childhood (CYACC): <http://iuhealth.org/riley/community-pediatrics/transition-clinic/the-cyacc-team/> – Provides consultation for youth and adults preparing to transition from pediatric to adult health care as well as all related issues for a successful transition to adulthood. Phone: (866) 551-0093.

DisabilityInfo.gov: www.disability.gov - This federal website links to information of interest to people with disabilities and their families. Topics include employment, education, housing, transportation, health, income support, technology, community life, and civil rights.

GovBenefits.gov: www.benefits.gov - A partnership of federal agencies and organizations with enhance access to government assistance programs. There is a confidential online screening tool that can help individuals find out which federal government programs and benefits they may be eligible to receive. Toll-Free Phone: (800) 333-4636.

Got Transition: www.gottransition.org - This site contains transition-related information, tools, resources and links to many transition-related websites. Phone: (603) 228-8111.

National Center on Secondary Education & Transition: www.ncset.org - Includes resources related to education, training, independent living and work for youth with disabilities.

Social Security: www.ssa.gov/disability - Site contains information about eligibility and applications for SSI and SSDI. Toll-Free Phone: (800) 772-1213 or (800) 325-0778 (TTY).

The Arc of Indiana: www.arcind.org - This site provides valuable information concerning transition and other services, including guardianship information. Toll-Free Phone: (800) 382-9100.

Build Your Own Care Notebook: www.medicalhomeinfo.org/tools/care_notebook.html - Site provides access to several different care notebooks.

Medicaid/Hoosier Healthwise: www.in.gov/fssa - A public health insurance for children to age 19 and those with disabilities. Toll-Free Phone: (800) 889-9949.

Indiana Family Helpline: www.in.gov/isdh/21047.htm - A statewide health information and referral service. Toll-Free Phone: (855) 435-7178 or (855) HELP-1ST.

Mental Health America of Indiana: www.mentalhealthassociation.com - Resource for services to address mental health needs. Toll-Free Phone: (800) 555-6424.

Indiana Institute on Disability & Community: www.iidc.indiana.edu - This center on transition provides resources and technical assistance to families and professionals. Toll-Free Phone: (800) 433-0746.

Division of Aging and Rehabilitative Services: www.in.gov/fssa/2328.htm - Provides services for Developmental Disability, Vocational Rehabilitation, Visual and Hearing Impaired and Aging and In-Home Services. Toll-Free Phone: (800) 545-7763.

Indiana Council on Independent Living (ICOIL): www.icoil.org - Provides information and peer support to individuals with disabilities regarding independent living services. Toll-Free Phone: (317) 232-7770.

Indiana Governor's Planning Council: www.in.gov/gpcpd - Advances independence, productivity, and inclusion of people with disabilities in all aspects of society. Phone: (317) 232-7770

Special Education: www.doe.in.gov/exceptional/speced/welcome.html - Special education programs for eligible children who qualify from the ages of 3 through 21. Toll-Free Phone: (877) 851-4106.

Indiana Protection and Advocacy Services: www.in.gov/ipas/ - Provides information and support about the rights of children and adults with disabilities. Toll-Free Phone: (800) 622-4845.

Indiana Justice Center: www.indianajustice.org/Home/PublicWeb - Provides civil legal assistance to eligible low-income people throughout Indiana. Toll-Free Phone: (800) 869-0212.

About Special Kids (ASK): www.aboutspecialkids.org - Provides information, peer support to families of youth and young adults with special needs. Toll-Free Phone: (800) 964-4746.

IN*SOURCE: www.insource.org - Provides information, peer support to families of youth and young adults with special needs. Toll-Free Phone: (800) 332-4433.

Appendices

A. List of Eligible Medical Conditions

There are multiple diagnoses associated with the conditions listed below. Please contact the Medical Eligibility/Prior Authorization Unit for clarifications at (317) 233-1351 or (800) 475-1355 (Option #3).

- Apnea
- Arthritis
- Asthma – Severe, two medications daily
- Autism
- Cerebral Palsy
- Chronic Anemia (e.g., Sickle Cell)
- Chromosomal Disorders
- Chronic Pulmonary Disease
- Cleft Lip and/or Palate
- Congenital or Acquired Developmental Deformities
- Congenital Heart Disease or Arrhythmias
- Cystic Fibrosis (life time medical eligibility)
- Endocrine Deficiencies (e.g., Diabetes)
- Hydrocephalus
- Inflammatory Bowel Disease
- Inborn Errors of Metabolism (e.g., PKU)
- Myelodysplasia or Spinal Cord Dysfunction (e.g., Spina Bifida)
- Neuromuscular Dysfunction (e.g., Cerebral Palsy)
- Oncologic Disorders (e.g., Cancer)
- Profound Hearing Loss – Bilateral
- Renal Disease
- Seizure Disorder
- Severe Hemophilia

B. Summary of Important Information

1. The Children's Special Health Care Services (CSHCS) program pays for all authorized care as well as specialty care related to the participant's eligible medical condition. It is your responsibility to confirm that your provider has received authorization for services provided.
2. You **must** contact the CSHCS **Medical Eligibility/Prior Authorization Unit (317) 233-1351 or (800) 475-1355 (Option #3)** or the **TTY Number (866) 275-1274** upon receiving your approval letter for enrollment in order to link the participant with services. **Payment for services will not be processed until this is done.** Be sure to talk to the Medical Eligibility/Prior Authorization Unit nurse about any services received since your application was submitted to see if they are covered.
3. The program may pay for emergency care received outside the primary care physician's office only if the treatment is related to the participant's eligible diagnosis. You **must** call the CSHCS program at the **(317) 233-1351 or (800) 475-1355 (Option #3)** or the TTY number within 5 (five) working days of receiving such emergency care.
4. Payment may be made for certain equipment related to the participant's eligible condition with a prior authorization. Contact the PA/CC section for specific guidance.
5. Please contact CSHCS **Medical Eligibility/Prior Authorization Unit (317) 233-1351 or (800) 475-1355 (Option #3)** with any changes to your current medical condition or any additional complications that have been documented by your physician.
6. If you have other health insurance for your child, you are required to provide that information to the CSHCS program. Your insurance provider will be the primary payer. **This means that your insurance company must be billed first for any services rendered.** You may need to submit a claim to your insurance provider yourself for some medical care, equipment or prescription drugs. If you belong to a HMO, PPO or, if your care is managed through Medicaid, you must follow their guidelines for coverage.
7. You must send any money you receive directly from your insurance company to CSHCS as reimbursement of money paid to the providers for services provided for the CSHCS participant. Failure to do so will result in your case being closed and coverage terminated.
8. **All providers and participants/guardians** who submit claims for payment to the State must agree to be reimbursed by electronic funds transfer. This means that anyone who wishes to be reimbursed for travel by CSHCS must set up a **direct deposit account**.

C. **NOTICE OF PRIVACY PRACTICES** Effective April 14, 2006 - Version 2.0

**INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN WITH SPECIAL HEALTH CARE SERVICES**

Para Recibir Este Documento En Espanol Por Favor Contactar Al Indiana Family Helpline (Linea De Ayuda Para Las Familias De Indiana) Al (855) 435-7178.

This Notice Describes How Medical Information About You May Be Used And Disclosed And How You Can Get Access To This Information. Please Review It Carefully. This notice explains your rights to control your health information. Your health information will not be shared without your written authorization except as described in this notice, or when required or permitted by law. We reserve the right to revise our privacy practices and make new privacy provisions for medical information we maintain. Should changes to the terms of this notice be made, an updated notice will be made available to you.

YOU NEED NOT DO ANYTHING AS A RESULT OF THIS NOTICE

Our Responsibilities and Commitment to You: We understand that your health care information is personal. We take our responsibility to keep your personal health information private very seriously. We are committed to following all state and federal laws that protect your health information. We are required to do the following:

- Protect your health information
- Give you this notice to explain our responsibilities and the ways we use and share your health information
- Tell you about your rights to your health information

Your Rights: You have the following rights:

- You have the right to request a paper copy of this notice at any time, even if you agree to receive it electronically (by e-mail).
- You have the right to see and get a copy of your personal health information. You will be charged a copy fee per page. We may deny your request to see and get a copy of your health information under limited circumstances under state laws. If you feel access to your medical information has been wrongly denied you may file an appeal with the Privacy Officer or file a civil lawsuit in the courts in the county where the denial occurred. Prior to filing a lawsuit, a person may contact the Office of the Public Access Counselor for an informal response or to file a formal complaint. If an appeal is filed with the Privacy Officer, an individual who did not participate in the decision to deny will review the appeal.

- You have the right to ask that we change health information that you feel is incorrect or incomplete. Your request may be denied if the information was not created by us, is not part of the information you are allowed to review or copy, or if we decide the personal health information is accurate and complete.
- You have the right to request a list showing each time we released your personal health information. This list will not include personal health information that was released to provide treatment to you, to obtain payment for services, or for administrative or operational purposes. This list will not include information released to you that you requested in writing, information released to others with your written approval, information released to persons who are involved in your care, or information released before April 14, 2003.
- You have the right to request that we not release your personal health information, release only part of your information, or release it for reasons you request. We may not be legally required to honor your request.
- You have the right to request that we contact you about your personal health matters in a certain way or at a certain location. For example, you can request that we only contact you at work or by e-mail. We will review and accommodate reasonable requests. To request a special way or location for us to contact you about your personal health information, you must call or write to the Privacy Office at the address or phone number in the contact information at the end of this notice.

Use and Disclosure of Your Health Information: We do not create health records. We receive health information to determine eligibility for this program. Information is also received as a claim for payment from the health care practitioners who provide services to you. We may use your health information to pay for services provided to you by your health care provider, for administrative and operational purposes and to evaluate the quality of services you receive. Uses of your medical information not mentioned in this Notice will not be made without your written authorization. If you sign an authorization it may be revoked by giving written notice of the revocation. While we cannot describe all cases related to the legal use of your health information, the following are some common examples of how we use your personal health information:

- We may use your health information to determine if treatment is medically necessary or that you are provided proper treatment.
- Physicians, hospitals and other health care practitioners that provide services to you submit health information to us in the form of a claim for payment. This payment request includes information that identifies you, the diagnosis, and procedures. We use this health information to pay for the services, in accordance with Program rules and regulations. We may also share your information with other programs, such as Medicaid, or private insurance companies to coordinate benefits and payments.
- Members of our staff may use your health information to review the care and outcome of your treatment and to compare the outcomes of other recipients who received the same or similar treatment.
- We may disclose your health information to the workforce involved in the administration of this Program. We may also disclose your health information to contractors so they can

perform the jobs we ask them to do, such as authorizing services for you or reviewing payments made to health care practitioners. To protect your health information we require contractors to follow rules to protect your information.

- We may use and disclose your health information to provide appointment reminders, tell you about possible treatment options, alternative treatments, and for other health-related benefits.
- We may disclose or share your health information with other government agencies that may provide public benefits or services to you, such as, First Steps.
- We may use or disclose your health information in compliance with the law and as required by law in response to a court order. If your health information involves a communicable disease, that information, with limited exceptions, will not be disclosed without your written authorization.

Filing a Complaint: If you believe that we have violated your rights or our health information practices, you may file a complaint with our Privacy Officer or the U.S. Department of Health and Human Services. You can contact us regarding a complaint by using the following address or phone number:

**Privacy Officer
Office of HIPAA Compliance
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
(317) 233-7655**

You also can file a complaint with the Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services. If the alleged violation took place in Indiana, use the OCR Region V address or telephone number below:

**Office for Civil Rights
Department of Health & Human Services
233 N. Michigan Ave. – Suite 240
Chicago, IL 60601
(312) 886-2359**

We will never retaliate against you for filing a complaint and it will in no way impact the health care services provided to you.

D. Travel Reimbursement Documents

There are two documents that a parent, guardian or participant must complete before travel reimbursement can occur and this process may take several weeks to complete. The forms that need to be completed and submitted are: a Vendor Information Form and a Family Travel Voucher. These forms are included in this Appendix.

These forms may also be obtained by going to the following State of Indiana websites and printing them off or by calling the CSHCS office, (317) 233-1351 or (800) 475-1355 (Option #4), and asking to have them mailed to you.

Vendor Information Form http://www.in.gov/isdh/files/Vendor_Information_Form.pdf
Reimbursement for Travel <http://www.in.gov/isdh/23658.htm>

Whenever there is a change in address or banking information, the parent, guardian or participant is required to complete and submit a new Vendor Information Form. Failure to do this will result in a delay of reimbursement payments.

E. Contact Information

Indiana State Department of Health
CSHCS – Section 7B
2 North Meridian Street
Indianapolis IN 46204
(317) 233-1351 or (800) 475-1355
<http://cshcs.isdh.in.gov/>

- | | |
|--|--|
| 1. Translation en Espanol | Options de Translation para todos los programas |
| 2. Eligibility | Eligibility criteria, status of pending applications and re-evaluation questions |
| 3. Medical Eligibility/ Prior Authorization | Linkages and PA service requests |
| 4. Family Travel | Questions regarding family travel reimbursement |
| 5. Claims | Billing questions and procedures |
| 6. Provider Relations | Questions regarding CSHCS provider enrollment |
| 7. Care Coordination | Resource and Referrals |
| 0. The Attendant | |

CSHCS Fax Number

(317) 233-1342

**VENDOR INFORMATION**

State Form 53788 (R2 / 10-09)
 Approved by Auditor of State, 2009
 Approved by State Board of Accounts, 2009

Name and telephone number of the person who completed this document must be provided.

Name: _____

Daytime telephone number: _____

Print or Type

Legal Name (Owner of the EIN or SSN as name appears on your tax return. Do not enter the business name of a sole proprietorship on this line.) _____

Trade Name (Doing Business as Name D/B/A) (Complete only if payment is to be made payable to the DBA name) _____

Remit Address (number and street, city, state, and ZIP code) _____

Purchase Order Address – Optional (number and street, city, state, and ZIP code) _____

Enter 9-digit Taxpayer Identification Number (TIN) of the legal name:
 (SSN=Social Security Number, EIN=Employer Identification Number)

(Individual's SSN) _____ - _____ - _____ or EIN _____ - _____

Check legal entity type (A box must be checked in this section. Check only one box.)

Individual Sole Proprietorship Partnership

Estate / Trust *Note: Show above, the name and number of the legal trust, or estate, not personal representatives*

Other [Limited Liability Company (LLC) (attach IRS Form 8832 if applicable), Joint Venture, Club, etc.]

Corporation Do you provide legal or medical services? Yes No

Government (or Government operated entity)

Organization Exempt from Tax under Section 501(a)

One box must be checked I am a U.S. Person (including a U.S. resident alien) I am not a U.S. Person (a W-8 must be filed with the Auditor of State)

Add Deposit Change Deposit **Indiana law (I.C. 4-13-2-14.8) requires that YOU receive PAYMENT(S) by means of electronic transfer of funds.**

SECTION 1: AUTHORIZATION

According to Indiana law, your signature below authorizes the transfer of electronic funds under the following terms:

Account Holder's Name: _____ Account Number: _____

Type of Account: Checking (Demand) Savings

Please check this box if your direct deposit will be automatically forwarded to a bank account in another country.

SECTION 2: FINANCIAL INSTITUTION'S APPROVAL (Attach a non-altered voided check or have your financial institution complete this section)

The financial institution identified below agrees to accept automated deposits under the terms set forth herein:

Name of Financial Institution: _____

Telephone: (_____) _____

Address: _____

Number and Street, and/or P.O. Box No. _____

City, State, and ZIP Code (00000-0000) _____

ABA Transit-Routing Number _____

Financial Institution's Authorized Signature _____

Title _____

_____, 20____

Date _____

ATTACH A NON-ALTERED VOIDED CHECK HERE

ATTACH A NON-ALTERED VOIDED CHECK HERE

SECTION 3: ELECTRONIC NOTIFICATION OF ELECTRONIC FUND TRANSFER (EFT) DEPOSITS
 (Complete this section only if you are requesting electronic notification. You may provide up to four email addresses.)

I hereby request that all future notices of EFT deposits to the bank account specified above be sent to the following email addresses:

I agree to the provisions contained on the reverse side of this form.

NAME (print or type) _____ TITLE _____

AUTHORIZED SIGNATURE _____ DATE _____ TELEPHONE NUMBER _____

REQUEST FOR VENDOR INFORMATION

THIS FORM APPLIES TO YOU, IF YOU ARE:

- 1) A U.S. person (including a U.S. resident alien); and
- 2) A person, business, or other entity who has or will receive a payment from the state; or
- 3) A state employee who has or will receive a payment, other than payroll, from the state.

PURPOSE OF FORM:

The Auditor of State of Indiana (Auditor) must have correct vendor information to make payments to vendors. This includes the vendor's legal name, doing business as name (if any), address, Taxpayer Identification Number (TIN), entity type, and banking information. This form allows you to provide your correct name, address, TIN, entity type, and banking information.

If you do not provide us with the information, your payments may be subject to federal income tax withholding. In addition, if you do not provide us with this information, you may be subject to a penalty imposed by the Internal Revenue Service per I.R.C. 6723.

Federal law on withholding preempts any state and local law remedies, such as any rights to a mechanic's lien. If you do not furnish a valid TIN, we are required to withhold a percentage of our payment to you. Withholding is not a failure to pay you. It is an advance tax payment. You should report all withholdings as a credit for taxes paid on your federal income tax return.

INSTRUCTIONS:

- 1) Enter your legal name on the designated line. Your legal name is the one that appears on your Social Security Card or, if you are a business, the Employer Identification Number (EIN) as it is in the IRS records. If you are a sole proprietor, then your legal name is the business owner's name. If you have a "doing business as" (d/b/a) name, enter this on the trade name line. Enter your remit address on the next line, and if you have a separate address for purchase orders, enter that address on the appropriate line.
- 2) Record the appropriate TIN in the space provided and check the box that corresponds to the correct organization type for your name. Note that individuals and sole proprietors are the only types that should record a social security number (SSN). a) If you are a corporation, you must indicate whether you provide legal or medical services. b) If you are a sole proprietor, you must show the business owner's name in the legal name box and you may show the business name in the trade name box. You cannot use only the business name. For a sole proprietor, you may use either the individual's SSN or the EIN of the business. However, we prefer you provide the SSN.
- 3) Check the appropriate box that indicates whether you are or are not a U.S. person.
- 4) Complete Section 1: Authorization
- 5) Have your financial institution complete Section 2: Financial Institution's Approval. Your financial institution should return the completed form to you. A voided check may be provided in lieu of having your financial institution complete this section. Attach only preprinted checks. Deposit slips, starter checks, or checks that have been altered will not be accepted.
- 6) Complete Section 3: Electronic Notification of Electronic Fund Transfer (EFT) Deposits, only if you choose to receive electronic EFT notifications by email. If this section is not completed, your notification will be sent by U.S. Mail to the remit address designated on the reverse side of this form.
- 7) Fax the completed form to (317) 234-1916 or mail to the Indiana Auditor of State, 240 Statehouse, 200 W. Washington St., Indianapolis, IN 46204.
- 8) Retain a copy of the completed form for your records.
- 9) Any form submitted without an authorized signature will be destroyed and will not be entered into the Auditor's vendor file.

BY SIGNING THIS FORM:

You represent that you understand and agree that:

- 1) You are authorized to provide this information on behalf of yourself or your organization.
- 2) The State of Indiana is authorized to initiate credits (deposits) in various amounts, by EFT through automated clearing house (ACH) processes, to the checking (demand) or savings account in the financial institution designated on the reverse side of this form.
- 3) If necessary, you will accept reversals from the State for any credit entries made in error to a bank account per National Automated Clearing House Association (NACHA) regulations.
- 4) You may only revoke this request and authorization by notifying the Auditor in writing, at the above address, at least fifteen (15) days before the effective date of revocation.
- 5) Any change to the account or to a new financial institution will require a new Vendor Information form be completed and submitted to the Auditor of State at the above address. Failure to provide timely notification to the Auditor that your account has changed will result in a delay in payment.
- 6) The State of Indiana and its entities are not liable for late payment penalties or interest if you fail to provide information necessary for an EFT transaction and/or you do not properly follow the Instructions above.
- 7) The email addresses provided in Section 3 for electronic EFT notification will allow for appropriate application of all payments.
- 8) You acknowledge that it will cause disruption to the notification process if the email addresses provided for electronic EFT notification are frequently changed or changed without promptly providing an updated email address to the Auditor.
- 9) You acknowledge that an email notification returned as undeliverable may be removed from the Auditor's email notification system and all future notices of EFT deposits to you will be provided by the Auditor via U.S. Mail to the remit address designated on the reverse side of this form until you have provided a valid email address to the Auditor.
- 10) You are responsible for contacting the Auditor if you are not receiving electronic notices of EFT deposits.



**REIMBURSEMENT FOR TRAVEL
TO/FROM APPROVED PROVIDER(S) FOR
50 MILES OR MORE ROUNDTrip**

State Form 50254 (R/12-03)
Form approved by State Board of Accounts, 2003

INSTRUCTIONS

1. All sections completed, printed, and legible.
2. Signatures must be original in ink.
3. Maximum of three (3) travel dates per form.
4. One year filing limit from date of travel.
5. Return to CSHCS.

**INDIANA STATE DEPARTMENT OF HEALTH
CHILDREN'S SPECIAL HEALTH CARE SERVICES
(CSHCS)
2 NORTH MERIDIAN STREET
INDIANAPOLIS, INDIANA 46204**

| PARTICIPANT INFORMATION | | COMPLETED BY PARENT/GUARDIAN |
|---|----------------------------------|-------------------------------------|
| Name of Child | Date of Birth (month, day, year) | CSHCS # |
| Street address of participant (number and street, city, state, ZIP code (spell city name completely)) | | |

| TRANSPORTATION INFORMATION | | COMPLETED BY PARENT/GUARDIAN/DRIVER |
|--|---|--|
| Date(s) of Travel (month, day, year & maximum of three per claim) | | |
| To (number and street, city, state, ZIP code (spell city name completely)) | | |
| Reason(s) for Visit(s) | | |
| Name of Driver | Driver's License # (provide copy if not Indiana) | |
| Driver's Date of Birth | Vehicle Plate # (provide copy of registration if not Indiana) | |

| MEDICAL PROVIDER INFORMATION | | COMPLETED BY MEDICAL PROVIDER |
|--|-------------------------|--------------------------------------|
| Name of Medical Provider (printed) | | |
| Signature of Medical Provider (must be in ink) | Date (month, day, year) | |

| PARENT/GUARDIAN INFORMATION | | COMPLETED BY PARENT/GUARDIAN |
|---|-------------------------|-------------------------------------|
| Mailing address of parent/guardian, if different from above (number and street, city, state, ZIP code (spell city name completely)) | | |
| Name of Parent/Guardian (printed) | | |
| Signature of Parent/Guardian (must be in ink) | Date (month, day, year) | |
| I hereby certify that the foregoing account is just and correct, that the amount claimed is legally due, after allowing all just credits, and that no part of the same has been paid. | | |



Indiana State Department of Health

Women's Special Health
Care Services

2 North Meridian Street
Section 7B
Indianapolis IN 46204
(317) 233-1351 or 1 (800) 475-1355
cshcs.in.gov