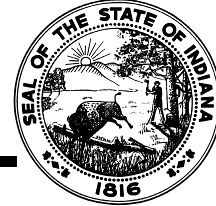
Indiana Medicaid Transition Newsletter



Distributed to All Indiana Medicaid Providers **T98-06, December 11, 1998**

TO: **ALL INDIANA MEDICAID PROVIDERS**

SUBJECTS:
- **HEALTH CARE EXCEL (HCE) CONTACT ADDRESSES AND TELEPHONE NUMBERS**
- **HEALTH CARE EXCEL (HCE) AND EDS' UPDATE ON USER ACCEPTANCE AND OPERATIONS READINESS TESTING**
- **POINT OF SALE (POS) TELEPHONE NUMBER ADDITION**
- **PRIOR AUTHORIZATION FORM WITH NEW HCE MAILING ADDRESS**

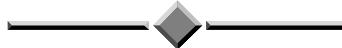
What's New?

✓ Health Care Excel (HCE) contact addresses and telephone numbers beginning January 1, 1999.

✓ Health Care Excel (HCE) and EDS' update on User Acceptance and Operations Readiness Testing.

✓ Point of Sale has a new telephone number beginning January 1, 1999.

✓ The Prior Authorization (PA) form has a new mailing address beginning January 1, 1999



✓ Health Care Excel (HCE) Contact Addresses and Telephone Numbers Beginning January 1, 1999

Beginning January 1, 1999, Health Care Excel (HCE) will assume operations responsibility for: (1) medical policy; (2) review of requests for prior authorization (PA); and (3) surveillance and utilization review (SUR). (Refer to Transition Newsletter T98-01 for additional background information.)

In this month's newsletter we have included the HCE address, PA and SUR P.O. Box addresses and telephone numbers (see page 3 of this newsletter). Providers will be pleased to learn that many of the numbers will remain the same to support a seamless transition from EDS to HCE. The following paragraphs provide further clarification regarding the PA and SUR departments.

Prior Authorization. HCE will assume the current PA toll-free number (800) 457-4518, effective January 1, 1999. **For those facilities previously faxing PA requests, notification regarding HCE's PA fax number will be provided under a separate cover.** EDS will cease PA review at the close of business Wednesday, December 30, 1998. **In order to transition current prior authorizations to HCE, EDS will not be accepting PA phone calls on Thursday, December 31, 1998 and Friday, January 1, 1999.** The offices of EDS and HCE will be closed on Friday, January 1, 1999 in observance of the holiday.

HCE will be closed Friday, January 1 through Sunday, January 3, 1999. Providers may continue to mail and fax Prior Authorization requests to HCE during this closed period to ensure a smooth transition on Monday, January 4, 1999. As in the past, telephone requests will be processed commencing the next business day following the weekend, Monday, January 4, 1999. (See page 3 for HCE Prior Authorization Department contact information.)

Emergency services delivered between December 31, 1998 and January 3, 1999 should be reported on January 4, 1999. At this time, the same standards for prior authorization will be applied as would have been applied if the authorization had been requested before the service was delivered.

Surveillance and Utilization Review. HCE also will be assuming the current SUR toll-free number (800) 457-4515, effective January 1, 1999. An additional toll-free number will be available to providers and recipients to report potential fraud and/or abuse and should not be confused with the EDS Provider Assistance number. (See page 3 for HCE contact information.)

✓ Health Care Excel (HCE) and EDS' Update on User Acceptance and Operations Readiness Testing

As part of the Transition Phase, the State contracted with KPMG Peat Marwick LLP to conduct User Acceptance Testing (UAT) and Operational Readiness Testing (ORT). These tests are separate but related processes focused on determining a contractor's ability to perform work at levels of quality and efficiency acceptable to the State.

The User Acceptance Testing is an independent analysis, which validates that EDS' upgrades and modifications to the Indiana*AIM* System are working to specification.

The Operational Readiness Test is conducted to assess the preparedness of HCE in relation to operating the Medical Policy, Prior Authorization and Surveillance Utilization business functions. Operational Readiness Test activities are also conducted to assess new EDS processes and procedures and to validate coordination efforts between HCE and EDS prior to January 1, 1999.

The UAT and ORT will be complete the middle of December in preparation for operations.

INDIANA MEDICAID MEDICAL POLICY,
PRIOR AUTHORIZATION, AND
SURVEILLANCE AND UTILIZATION REVIEW SERVICES

Health Care Excel, Incorporated

⇨ General Administrative and Medical Policy Information

Hours: 8:00 a.m. to 5:00 p.m. (EST—Indianapolis local time)
Monday through Friday (except holidays)

Address: P.O. Box 53380
Indianapolis, IN 46253-0380

Phone: (317) 347-4500

⇨ Prior Authorization (PA) Department – *beginning January 1, 1999*

Hours: 7:30 a.m. to 6:00 p.m. (EST—Indianapolis local time)
Monday through Friday (except holidays)

Address: P.O. Box 531520
Indianapolis, IN 46253-1520

Phone: Local: (317) 347-4511 (Marion County)
Toll-free: (800) 457-4518

⇨ Surveillance and Utilization Review (SUR) Department – *beginning January 1, 1999*

Hours: 8:00 a.m. to 5:00 p.m. (EST—Indianapolis local time)
Monday through Friday (except holidays)

Address: P.O. Box 531700
Indianapolis, IN 46253-1700

Phone: Local: (317) 347-4527 (Marion County)
Toll-free: (800) 457-4515

⇨ Provider and Recipient Concern Line (Fraud and Abuse)– *beginning January 1, 1999*

Hours: 8:00 a.m. to 5:00 p.m. (EST—Indianapolis local time)
Monday through Friday (except holidays)

Phone: Local: (317) 347-4527 (Marion County)
Toll-free: (800) 216-5938

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✓ Pharmacy Services Point of Sale and ProDUR Help Desk Have a New Telephone Number

⇨ Pharmacy Services POS & ProDUR Help Desk *beginning January 1, 1999*

877-877-5182
(317) 488-5069, locally
7:30 a.m. to 6:00 p.m. (EST—Indianapolis local time)
Monday through Friday (except holidays)

✓ The Prior Authorization (PA) Form with New HCE Mailing Address *beginning January 1, 1999*

As Prior Authorization responsibility transitions to Health Care Excel (HCE), the most obvious change to the providers will be the new address information printed on the Prior Authorization (PA) forms. Included in this newsletter are copies of the Prior Authorization and the Dental Prior Authorization forms. You will begin using these forms on January 1, 1999.

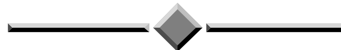
1. You may order new forms by sending a request to the following address:

   EDS Forms Request
   P.O. Box 68420
   Indianapolis, IN 46268-0760

2. If you have a supply of the old forms, you can continue using them on or after January 1, 1999 by changing the address or making sure to mail them to:

   Health Care Excel
   Prior Authorization Department
   P.O. Box 531520
   Indianapolis, IN 46253-1520

3. Or, you can photocopy the Prior Authorization forms included with this newsletter.



If you have any questions regarding the contents of this bulletin, please contact EDS Provider Assistance at 1-800-577-1278, or locally at 317-655-3240.

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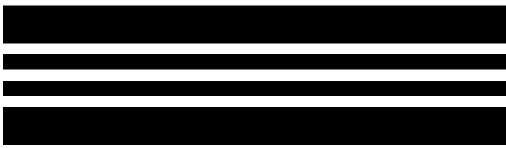

INDIANA PRIOR REVIEW AND AUTHORIZATION REQUEST

(# REQUIRED IF MEDICAID PROVIDER) PMP ( )

Requesting
Provider # ____________________ Phone ____________

Name ____

Address ____

City/State/Zip _____________________________________

INTERNAL USE ONLY

(1) HOME HEALTH
(2-3) HOSP., OUT PT
(4) PHYSICIAN
(5) REHAB.
(6) TRANSPLANT
(7) TRANSPORTATION
(8) AUDIOLOGY
(9) SPEECH
(10) MENTAL HEALTH SERVICES
(11) DURABLE MEDICAL EQUIPMENT
(12) OCCUPATIONAL THERAPY (O.T.)
(13) PHYSICAL THERAPY (P.T.)
(14) RESPIRATORY THERAPY (R.T.)
(15) DENTAL SERVICES
(16) OPTOMETRIC SERVICES (O.D.)
(17) PODIATRY SERVICES
(18) CHIROPRACTIC SERVICES
(19) PHARMACEUTICAL SERVICES

Rendering
Provider # ____________________ Phone ____________

Name ____

Address ____

City/State/Zip _____________________________________

PCCM ( ) MCO ( ) 590 ( )

RID No. __________________________ DOB ___________

Name ____

Address ____

City/State/Zip _____________________________________

MEDICAL DIAGNOSIS: (USE OF ICD-9-CM DIAGNOSTIC CODE REQUIRED)

Primary ____

Secondary ____

Is this a request for continuing service? Yes ____ No ____ (No gap in certification)

Will DME be Purchased: ____ Rented: ____ Repaired: ____ Length of time DME required: ____________________

Has service or medical supply been previously provided? Yes ____ Date _____________ No ____

WARNING: ANY AUTHORIZATION IS VALID ONLY IF RECIPIENT IS ELIGIBLE ON THE DATE WHICH SERVICE WAS PROVIDED.

DATES OF SERVICE START CCYYMMDD	DATES OF SERVICE STOP CCYYMMDD	SERVICE CODE REQUIRED	REQUESTED SERVICE	PLACE OF SERVICE	UNITS	DOLLARS

Clinical Summary: (Include Prognosis and Rehabilitation Potential) A current plan of treatment and progress notes as to the necessity, effectiveness and goals of therapy services (PT, OT, RT, SP, Audiology, Psychotherapy, Home Health, and Transportation) must be attached.

Signature of
Requesting Provider ____ Date _______________________

(original signature required) The above sections must be completed or the request will be rejected.

FORWARD TO: Health Care Excel
Prior Authorization Department
P.O. Box 531520
Indianapolis, IN 46253-1520

Date of Submission ______________________________

EDS-8-10-94 / PAU-8001

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INDIANA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

Provider # __________________ Phone _________________ RID NO.________________________ DOB _____________
Name: ____ Name: ____
Address: ____ Address: ____
City/State/Zip ____ City/State/Zip ____

DATES OF SERVICE START MMDDCCYY	STOP MMDDCCYY	SERVICE CODE REQUIRED	REQUESTED SERVICE	PLACE OF SERVICE	UNITS	DOLLARS

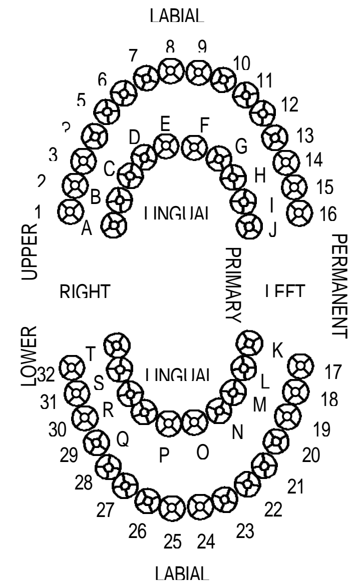
Caseworker__________________________ Phone_______________ 590 Program ( )
Is Recipient Employed? YES _____ NO _____ Circumstances (Place/Type):______________________________
Is Recipient in Job Training? YES _____ NO _____ Type of Job Training___________________________________
Dental Treatment Plan

1. Endodontics – Indicate on diagram below the tooth/teeth to be treated by root canal therapy.

   1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
   32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

2. Periodontics – Evaluate the periodontal condition _______________________________
   ____
3. Partial dentures (use chart to right to indicate teeth involved)
   A. Date or dates of extractions of missing teeth. ______________________________
      ____
   B. Which teeth (use tooth number) are to be extracted? _______________________
   C. Which teeth (use tooth number) are to be replaced? _______________________
   D. Brief description of materials and design of partial. ________________________
      ____
   E. Is patient wearing partials now? YES ___ NO ___ Age of present partials ______
4. Dentures (check one or both): Full upper denture _______ Full lower denture _______
   A. How long edentulous ____
   B. Is patient wearing dentures now? YES __ NO __ Age of present dentures _____
5. Describe treatment if different from above: ___________________________________
   ____
   ____

Does the Recipient have missing teeth? YES___ NO___
If YES please indicate missing teeth with an X.



Brief Dental/Medical History: ____
____
____

Signature of Requesting Dentist ______________________________ Date of Submission: ______________________
(original signature required) The above sections must be completed or the request will be rejected.

Health Care Excel
Prior Authorization Department
P.O. Box 531520
Indianapolis, IN 46253-1520

EDS-9-06-94 / PAU-8002