PROVIDER BULLETIN

BT200804 JANUARY 15, 2008

To: All Providers

Subject: Updated Indiana *Care Select* and Prior Authorization and Restricted Card Changes

Overview

To improve the quality of care and health outcomes for its Indiana Health Coverage Programs (IHCP) members, the Indiana Family and Social Services Administration (IFSSA), announced a new program, *Care Select*, which will ultimately replace the *Medicaid Select* Program. Initially the implementation plan was divided into three phases, with the final phase concluding on June 1, 2008. Because of the success of the first phase implementation the next two phases will be combined and implemented on March 1, 2008.

The Indiana *Care Select* Program is designed to improve the member's health status; enhance quality of life; improve client safety, autonomy and adherence to treatment plans; and control fiscal growth. Through this program, the State will focus on the following objectives:

- Development of treatment regimens for chronic illnesses will conform to evidence-based guidelines.
- Primary medical providers (PMPs) will be able to incorporate knowledge of functional assessments, behavioral changes, self-care strategies, and methods of addressing emotional or social distress into overall patient care.
- Care will be less fragmented and more holistic (for example, care will address the physical and behavioral care needs as well as consider both medical and social needs), and communication will increase across settings and providers.
- Members will have greater involvement in their care management.

To accomplish these objectives, IFSSA has contracted with two Care Management Organizations (CMOs), MDwise, Inc. and ADVANTAGE Health Solutions, Inc.SM, to manage the care of eligible members and ultimately improve the quality of care and health outcomes for the members.

Additionally, on November 1, 2007, Prior Authorization (PA) transitioned from Health Care Excel (HCE) to the two CMOs. This change impacts all providers requesting PA. Details about this change are covered in the PA section of this bulletin.

The New Care Management Organizations

ADVANTAGE Health Solutions

ADVANTAGE Health Solutions, Inc.SM (ADVANTAGE) is a local health plan owned by four Catholic health care systems; Ancilla Systems, St. Vincent Health, Sisters of St. Francis of Perpetual Adoration, and Saint Joseph Regional Medical Center. ADVANTAGE has been providing healthcare

benefits and solutions to employers since May 2000. To learn more about ADVANTAGE, please visit their Web site at http://www.advantageplan.com/.

MDwise

MDwise, Inc. is a not-for-profit, managed care health plan created through a joint venture of Clarian Health Partners and the Health and Hospital Corporation of Marion County (Wishard Memorial Hospital). Since 1994, MDwise has been serving Hoosier Healthwise members as one of the State's MCOs. To learn more about MDwise, please visit their Web site at www.mdwise.org.

CMO Responsibilities

Through an agreement with the State, the CMOs will be responsible for providing to their members the following services:

- Care management of physical and behavioral health
- Coordination of transportation needs
- Care Coordination
- Utilization Management
- Prior Authorization
- Pharmacy utilization monitoring
- Enrollment and file maintenance of PMPs
- Provider network development, credentialing, and provider education
- Disease Management
- Member call center and member education
- Grievances and appeals
- Utilization and concurrent reviews
- Restricted Card Program Administration
- All items listed in *RFS 7-62 Attachment D: Statement of Work* which can be found on the following Web page http://www.indianamedicaid.com/ihcp/CareSelect/cs_index.asp

Member Eligibility

Providers must check eligibility each time services are provided to a member. Eligibility verification enables the provider to determine whether an IHCP member is eligible for *Care Select* or Traditional Medicaid. The following IHCP members are covered by the *Care Select* Program:

- Aged
- Blind
- Physically and mentally disabled
- Members receiving adoption assistance
- Members in the Waiver Program
- M. E. D. Works participants

Like other IHCP programs, eligibility and coverage is based on the member's aid category. The following IHCP members will **not** be covered by the *Care Select* Program:

- Members on spend-down
- Members eligible for both Medicare and Medicaid
- Individuals with Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB) only (not in combination with another aid category)
- Persons in nursing homes, intermediate care facilities for the mentally retarded (ICF/MR), and State operated facilities
- Members in the Hospice Program
- Undocumented aliens
- AID to Recipient in County Homes (ARCH) members
- Members enrolled in the 590 Program
- Members enrolled in the Breast and Cervical Cancer Treatment Services Program

Waiver Program

The *Care Select* Program will include members enrolled in the Waiver Program. Waiver services rendered to waiver members will continue to require approval from their Waiver Case Manager and members must follow the Waiver Plan of Care. These services will not require a referral from their *Care Select* PMP. Claims submitted for non-Waiver services rendered by non-Waiver providers will require a referral from their *Care Select* PMP, unless the service rendered is a self-referral service for the *Care Select* Program.

Waiver providers and Waiver Case Managers will work together closely to identify and authorize waiver services for the *Care Select* Member. The prior authorization process that is currently in place for the Waiver program will be used. However, the State expects that strong communications between the Waiver Case Manager and the *Care Select* PMP will exist in order to ensure uninterrupted care.

EVS

Once the member has been assigned to a *Care Select* PMP and CMO, the Eligibility Verification Systems (EVS) provides the following information:

- The Member is eligible for the *Care Select* Program
- The member's *Care Select* PMP and the PMP contact phone number
- The CMO the member is assigned to and the CMO contact information.

Providers must contact the member's CMO regarding prior authorization and restricted card.

Revised Implementation Schedule

BT200723 outlined a three phase implementation schedule for *Care Select*. Because of the success of the implementation in the central region, the State has elected to combine the next two phases of the implementation plan. *Care Select* will be phased into other regions beginning on March 1, 2008. For additional information about the geographic regions, please see *Attachment 2 – CMO Implementation Schedule Map*.

All provider locations in out-of-state cities will be implemented along with the Indiana region that borders the applicable out-of-state city.

The implementation includes the following tasks:

- The CMOs will enroll contracted PMPs into their health plans
  - All Medicaid enrolled providers are encouraged to contact ADVANTAGE and/or MDwise to obtain a *Care Select* addendum. To ensure enrollment prior to implementation, please sign and return the *Care Select* addendum prior to February 15, 2007.

Table 1 – CMO Provider Enrollment Contact Information

Plan	Telephone Number
ADVANTAGE Health Solutions, Inc.SM	1-800-784-3981
MDwise, Inc.	1-866-440-2449

  - If a provider is not a Medicaid provider, contact EDS Provider Enrollment at 1-877-707-5750 to request a provider enrollment package or download the forms from http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp.
  - Existing *Medicaid Select* (MS) service locations will be end-dated on February 29, 2008.

- Assign *Care Select* members to a PMP through the following steps:
  - Members enrolled in *Medicaid Select*, whose PMP is enrolled in *Care Select*, will be systematically converted to *Care Select and assigned to the same PMP*.
  - For members that do not have an existing *Care Select* PMP relationship, the enrollment broker will contact the member and assist with the selection of a PMP.
  - Remaining members, who have not selected a PMP by June 1, 2008 will be auto-assigned to a PMP.
  - All members, regardless of region, who are dually eligible for Medicare and Medicaid were converted from *Medicaid Select* to Fee-For-Service on November 1, 2007.

Enrollment Broker

MAXIMUS Administrative Services, Inc. (MAXIMUS) was recently selected as the State's enrollment broker. The enrollment broker contacts members who are eligible for the *Care Select* Program and provides choice counseling to assist them with choosing a PMP that best meets their needs. The enrollment broker is an unbiased source for member counseling and education about the *Care Select* Program. MAXIMUS facilitates initial member enrollment in the program and performs member-initiated PMP changes. CMOs also provide education to their members after enrollment. The *Care Select* enrollment broker can be reached at 1-866-963-7383.

Primary Medical Provider

Physicians from the following specialties are eligible to enroll as PMPs and will receive auto assignments:

- Family Practitioner
- General Practitioner
- General Internal Medicine
- General Pediatrics
- OB/GYN

For the *Care Select* program, all other physician specialties may enroll as PMPs. However, specialist PMPs will not receive members by auto-assignment. Specialist PMPs will receive members only if the member actively chooses that physician as a PMP.

In order for the PMP to participate in *Care Select*, the CMOs will complete the following tasks:

- Credential the PMP according to credentialing guidelines approved by the State
- Obtain a signed *Care Select* addendum
- Obtain demographic, scope of practice, and panel size information from the PMP
- Electronically enroll the PMP in IndianaAIM via the secure Web InterChange

> *Note: Physicians must be enrolled as a Medicaid provider to be eligible to participate in the Care Select Program.*

PMPs are required to notify their affiliated CMOs of any changes to their PMP information.

PMPs will receive a $15 administrative fee per member, per month. PMPs have flexibility to determine their panel size. *Care Select* and Hoosier Healthwise panels are maintained separately.

PMPs have the option to enroll in one CMO or both.

When members become eligible for *Care Select*, they may continue to see their current doctor only if their doctor becomes a *Care Select* PMP, or their doctor receives a referral from the member's new *Care Select* PMP.

Hospitals, specialists, and ancillary providers are not required to have a signed *Care Select* addendum with either of the CMOs at this time. Members can access services at hospitals and pharmacies they are currently using as long as the provider is enrolled in the IHCP. Members use the same IHCP member ID number (RID) and Hoosier Health card.

Prior Authorization (PA) will be submitted to the CMO to which the member is assigned on the date of request. A service that requires PA should be submitted to that member's CMO only and not to other IHCP vendors such as Hoosier Healthwise MCO, EDS, or Health Care Excel. Refer to the *Prior Authorization* section of this bulletin for detailed information regarding PA.

PMPs enrolled in both *Medicaid Select* and *Care Select* will be issued one certification code per quarter to be used for both programs. PMPs will continue to receive a letter each quarter that lists their new certification code. Providers who do not receive a certification code letter should contact EDS customer service at (317) 655-3240 or toll free at 1-800-577-1278.

When a referral to another healthcare professional is necessary, PMPs are required to authorize the referral by phone or in writing. PMPs give the specialist their provider ID number and the two-digit certification code so the specialist can bill and receive reimbursement.

Self Referral Services

Some services will be self referral and will not require PMP authorization, including podiatry, chiropractic, mental health, dental, vision, family planning, HIV/AIDS targeted case management, immunizations, diabetes self-management, and pharmacy.

> *Note: A complete list of provider types and specialties, including descriptions and enrollment criteria is listed in Chapter 4 of the IHCP Provider Manual.*

The following ancillary services are allowed as self referral and do not require *Care Select* PMP referral.

- Emergency Services as indicated by the primary diagnosis code on the claim
- Lab - Provider Specialties 280 and 281
- Radiology – Provider Specialties 290 and 291
- Anesthesia – Provider Specialty 311
- Transportation – Provider Specialties 260 through 266
- Durable Medical Equipment (DME) and Home Medical Equipment (HME) providers
- Home health services – provider specialty 050

The following outpatient therapy services are also considered as self referral:

- Physical – provider specialty 170
- Occupational – provider specialty 171
- Respiratory – provider specialty 172
- Speech – provider specialty 173

The following Provider Type and IHCP Programs are also considered as self referral:

- School Corporations
- First Steps
- Medical Review Team (MRT)
- Pre-Admission Screening/Resident Review (PASRR)

> *Note: Although the two-digit PMP certification code is not required for the non-emergency outpatient hospital services, the eight-digit PMP license number is required for claim reimbursement. These services include outpatient non-emergency ER visits, as well as radiology, pathology, and laboratory, when performed in an outpatient hospital setting. The PMP license number should be provided on the UB-04 claim form when submitting claims for such services on behalf of Care Select Providers. Details regarding completion of the UB-04 claim form can be found in Chapter 8 of the IHCP Provider Manual.*

Covered Services

Covered services for members will not change under the *Care Select* Program. Please see *RFS 7-62 Attachment E: Care Select Program Description and Covered Benefits* for more information. This document is available at the following Web address: http://www.indianamedicaid.com/ihcp/CareSelect/content/documents/62atte.pdf

One additional covered service is available to *Care Select* PMPs. The CMO will coordinate with the *Care Select* PMPs to perform care coordination conferences to review a member's progress and care management plan. The PMPs are eligible to be reimbursed for their time at these case conferences.

Reimbursement for the *Care Select* Care Coordination Conference service requires that the service be performed by the PMP assigned to the member or a nurse practitioner in the same group as the *Care Select* PMP. If a provider other than the member's *Care Select* PMP or nurse practitioner in the same group as the *Care Select* PMP bills for the service, the claim will deny for Explanation of Benefit code,

1050 – *The recipient is enrolled in the Care Select Program. Care Management service must be billed by the member's assigned Care Select PMP or nurse practitioner in the same group as the Care Select PMP.*

Each *Care Select* PMP is limited to two one-hour care coordination conferences per 12 rolling month period, for each *Care Select* member.

Services must be billed using HCPCS code 99211 SC – *Office or other outpatient visit for the evaluation and management of an established patient, SC-Medically Necessary Service or Supply. Care Select* PMPs are reimbursed $40 for each care coordination conference.

Claims for *Care Select* Care Coordination Conference services that exceed the program limitation will be denied with Explanation of Benefit code, 6925 – *Care Select Care Coordination service is limited to 2 units of service per member, per rolling 12 months*.

Prior Authorization

Each CMO is responsible for processing medical service PA requests and updates for members assigned to their organization at the time of the request.

Additionally, ADVANTAGE Health Solutions [SM] FFS will be responsible for processing the following;

- PA requests and updates for all Traditional Medicaid fee-for-service (FFS) members
- PA requests for risk-based managed care (RBMC) carve-out services
- PA request for *Medicaid Select* services for members who have not yet transitioned to a *Care Select* program

ACS will continue to serve as the pharmacy PA contractor. For pharmacy PA information, contact 1-866-879-0106.

Contact Information

Contact information for the PA requests is located in Attachment 1: Indiana Health Coverage Programs Quick Reference.

Prior Authorization Form

Each CMO will continue to use the same PA and Medical Necessity forms that are currently used. The CMOs prefer to receive the completed PA forms by fax. However, paper PA requests will continue to be accepted. The CMO's fax numbers are provided in Attachment 1: Indiana Health Coverage Programs Quick Reference.

Providers will notice the following modifications to the PA forms.

- The address for submitting a PA request or update has been removed.
- A link is available on the form for providers to access address information for the organizations performing PA.
- A change to the member information section allows a provider to select the program to which the member is assigned, based on the information provided in the EVS.
- A new field has been added to the forms in the requesting provider field to indicate the Mail To provider ID and service location.

- If you are the requesting provider, but do not have a service location associated with your requesting provider ID, complete both the Requesting and the Mail To provider ID fields. Entering a Mail To provider ID ensures that the system generates a provider mailing address for the PA decision letter.
- Failure to complete the Mail To field when a requesting provider does not have a service location will prevent the production of a PA decision letter. When both the requesting and Mail To provider ID and service location fields contain data, the mailing provider ID information is used as the mailing address for the PA decision letter.
- These forms can be found on the IHCP Web site at www.indianamedicaid.com/ihcp/Publications/forms.asp.

EDS has established a new link in the provider services section of the content Web site of www.indianamedicaid.com for providers to easily access the organizations that are performing PA and their contact information such as phone numbers and mailing addresses. It is important for providers to know that this information will always be retrieved from real-time data available in Indiana*AIM*. Therefore, this information may be more current than information available in the IHCP Quick Reference Guide.

PA Submission on Web interChange

The following provider types can submit PA requests via Web interChange:

- Chiropractor
- Dentist
- Doctor of Medicine
- Doctor of Osteopathy
- Home Health Agency (authorized agent)
- Hospice
- Hospital (authorized agent)
- Optometrist
- Podiatrist
- Psychologist endorsed as Health Service Provider in Psychology (HSPP)
- Transportation Provider (authorized agent)

Additional information regarding submission of prior authorization requests via Web interChange can be found on the IHCP website at www.indianamedicaid.com.

PA Process

The review of PA requests will remain consistent across the CMO and FFS organizations. PA determinations will serve as a utilization management measure, allowing payment only for those treatments and/or services that are medically necessary, appropriate, and cost-effective.

The *Care Select* Program will emulate the PA requirements that have been established for the Traditional Medicaid FFS and *Medicaid Select* population.

Since there will be multiple vendors performing PA, providers must verify member eligibility to determine the program to which the member belongs. The various methods available to verify member eligibility provide specific information regarding the member's assignment to a PMP and a CMO. PA requests must be submitted to the CMO to which the member is assigned on the date of the request.

This also applies to PA updates that are submitted for review. For example, if the member is assigned to MDwise at the time the PA was originally submitted, but has since moved from *Care Select* to Traditional Medicaid, fee-for-service, then the PA update should be submitted to ADVANTAGE Health Solutions SM -FFS for review.

Rejected PA Requests

In the event that a provider submits a paper or faxed PA request to the incorrect organization, the provider will receive a PA decision letter informing them that the PA was rejected. When providers receive notification that the submitted PA request has been rejected, a new PA or a PA update request must be submitted to the member's correct CMO or FFS organization.

However, for PA requests that are submitted via Web interChange, the system determines which CMO/FFS vendor needs to receive the information and forwards the request to the correct vendor.

For PA requests submitted to the incorrect CMO via the 278 PA Request and Response transaction, the PA request will be rejected regardless of the certification type with reason code 78 – *Subscriber/ Insured not in Group/Plan identified and a PA decision form will not be generated.* When providers receive notification that the submitted PA request has been rejected, a new PA or a PA update request must be submitted to the member's correct CMO or FFS organization.

Suspension of PA Requests for Additional Information

For the PA reviewer to determine if a service or procedure is medically reasonable and necessary, the PA vendor may request more information from the provider. The IHCP must receive the requested information within 30 days of the request or the PA request will be systematically denied.

In the event that a PA is in suspense and the member is re-assigned between the *Care Select* Programs and/or the Traditional Medicaid FFS program, the additional requested information that has been submitted for review will be forwarded to the appropriate PA vendor for review and approval.

Outstanding Prior Authorizations

If a member changes programs between Traditional Medicaid (FFS), *Medicaid Select*, or *Care Select*, PAs that are approved by either of the two *Care Select* vendors or the FFS vendor will be available in Indiana*AIM* for claims processing by EDS and will not necessitate a new request.,

If a member changes programs from Hoosier Healthwise to Traditional Medicaid (FFS), *Medicaid Select*, or *Care Select;* all existing PAs are honored for 30 days. The IHCP honors the PA for 30 days or for the remainder of the PA dates of service, whichever occurs first. Requiring a duplicate authorization request from the new plan places an additional burden on the provider and can result in delayed or inappropriately denied treatments or services to the member. The PAs may be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home healthcare.

When a provider requests a PA from a Hoosier Healthwise MCO and receives approval from that MCO and then the member becomes eligible for *Care Select*, it is important for the provider to fax a copy of the PA approval notification to the CMO the member is enrolled with on that date of service so the PA can be entered into the IndianaAIM System and the provider can be reimbursed for the service.

The entity that issued the original prior authorization provides the new program with the following:

- Member identification number (RID)
- IHCP provider number
- Procedure codes
- Duration and frequency of authorized services

- Other information pertinent to the determination

This information can be provided in spreadsheet format, computer screen prints, authorization form copies, or any other mutually agreed upon format.

The reverse is also true. If a member is eligible for *Care Select* and the provider receives approval from one of the CMOs and the member becomes eligible for Hoosier Healthwise, it is important for the provider to fax a copy of the PA approval notification to the Hoosier Healthwise MCO the member is enrolled with on that date of service so the PA can be entered into the MCO's claims processing system and the provider can be reimbursed for the service.

Hearings, Appeals, and Administrative Reviews

Hearings and appeals, and administrative reviews, will be completed by the PA vendor who denied the request. (In the event that the hearing, appeal or administrative review is submitted to the incorrect CMO or FFS organization, the request will be returned to the provider for submission to the appropriate organization for review.) If the member has been assigned to a different program since the request for PA was denied, providers can either appeal to the PA vendor that denied the request or submit a new PA request for review to the current CMO/FFS PA vendor for review.

The policies and procedures regarding hearings and appeals or the administrative review process will remain the same as currently published. This information is distributed to the provider and member upon the generation of the PA decision letter or PA update letter. Further information regarding the hearings, appeals and the administrative review process can be found in the IHCP Provider Manual, *Chapter 6, Prior Authorization.*

Restricted Card Program

Member utilization review identifies members who use IHCP services more extensively than their peers. The Restricted Card Program (RCP) is designed to monitor member utilization and, when appropriate, implement restrictions for those members who would benefit from increased care coordination.

Members in the RCP will transition to the CMOs. Traditional FFS Medicaid members in the RCP will be assigned to ADVANTAGE as the Traditional Medicaid PA vendor.

Since there will be multiple vendors performing RCP, providers must verify member eligibility to determine to which CMO the member belongs. The EVS options that are available to the provider community provide specific information regarding the member's CMO and PMP assignment. Please refer to Attachment 1: Indiana Health Coverage Programs Quick Reference.

You should continue the same process you use today for RCP care and referrals.

Additional information regarding the RCP and how it affects providers and members can be found in the IHCP Provider Manual, *Chapter 13, Member Utilization Review Process*.

Claims Processing

EDS will process claims for *Care Select* members. However, the CMO to which the member is assigned is responsible for reviewing claims that suspend for medical policy audits directly related to the *Care Select* programs. ADVANTAGE FFS is responsible for reviewing claims that suspend for medical policy related audits for services rendered to members in FFS.

Care Select claims submitted with missing or invalid certification codes that require PMP referral will be subject to the following *Care Select* Edits and will systematically deny:

- 1047 – *The Certification Code is Missing- Care Select. Please verify and resubmit*
- 1048 – *The Certification Code is Invalid- Care Select. Please verify and resubmit*
- 1049 – *The recipient is enrolled in the Care Select Program. Claim must have recipient's primary medical provider information. Please provide information and resubmit*

Contact Information

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278. Additional contact information is located in Attachment 1: Indiana Health Coverage Programs Quick Reference.

For questions or additional information on *Care Select* services provided by each CMO please contact the CMO or visit the CMO website.

If you need additional copies of this bulletin, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

Attachment 1: Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization

AVR System (including eligibility verification) (317) 692-0819 1-800-738-6770	EDS Administrative Review Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Customer Assistance (317) 655-3240 1-800-577-1278 Opt 1 = Pharmacy, Opt 2 = First Steps	EDS Electronic Solutions Help Desk (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@eds.com
EDS Forms Requests P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Member Hotline (317) 713-9627 1-800-457-4584 Opt 1 = First Steps, Opt 2 = Pharmacy	EDS Omni Help Desk (317) 488-5051 1-800-284-3548	EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
EDS Provider Enrollment and Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	EDS TPL (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	ADVANTAGE Health Solutions Prior Authorization – FFS P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720 Fax: 1-800-689-2759	HCE Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 1-800-457-4515
HCE SUR Department P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515	IHCP Web Site http://www.indianamedicaid.com		

Pharmacy Services Contact Information

ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	EDS Pharmacy Services Help Desk for POS Claims Processing (317) 655-3240 1-800-577-1278 or INXIXPharmacy@EDS.com	EDS Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268	EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265
Pharmacy Benefit Management Inquiries PDL@fssa.state.in.us	Indiana Administrative Review/ Pharmacy Claims EDS Pharmacy Claims Admin. Review P.O. Box 7263 Indianapolis, IN 46207-7263	PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center 1-866-879-0106 Fax: 1-866-780-2198	To make refunds to IHCP for pharmacy claims send check to: EDS Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303

Hoosier Healthwise – Risk Based Managed Care (MCOs), *Care Select* (CMOs) and *Medicaid Select*

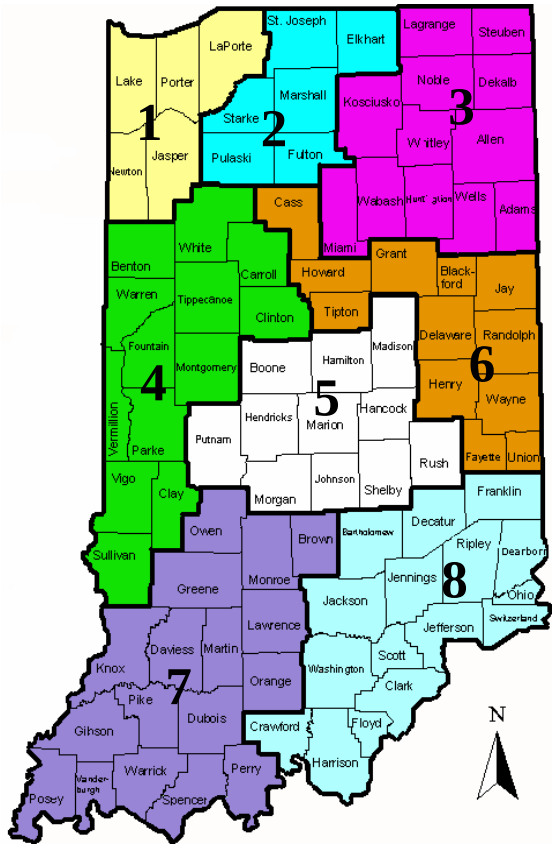
Managed Care Helplines	*Medicaid Select*	Managed Care Organizations (MCOs)	
AmeriChoice - Hoosier Healthwise http://www.healthcareforhoosiers.com 1-800-889-9949, Option 3 for Providers EDS - Hoosier Healthwise Package C Premium Collection Services Package C Payment Line 1-866-404-7113 Package C Payment Mailing Address Hoosier Healthwise P.O. Box 3127 Indianapolis, IN 46206-3127	http://www.medicaidselect.com Claims - EDS Customer Assistance (317) 655-3240 or 1-800-577-1278 Member Services 1-877-633-7353, Option 1 PA 1-800-269-5720 Provider Services for PMPs 1-877-633-7353, Option 3 Pharmacy See Pharmacy Services Contact Information located above	Anthem http://www.anthem.com Claims 1-888-232-9613 Member Services 1-866-408-6131 1-888-232-9613 (Prospective Member) TTY: 1-866-408-7188 Fax: 1-866-408-7087 PA 1-866-408-7187 Fax: 1-866-406-2803 Provider Services 1-866-408-6132 1-800-618-3141 (Prospective Provider) Fax: 1-866-408-7087 Transportation 1-800-508-7230 TTY: 1-866-910-1603 Fax: (317) 291-9446 Pharmacy 1-866-629-1608 TTY: 1-800-905-9821 PA Fax: 1-866-408-7103	Managed Health Services (MHS) http://www.managedhealthservices.com Claims, Member Services, PA/Medical Management, Provider Services, and Nursewise 1-877-MHS-4U4U or 1-877-647-4848 Pharmacy - US Script (PBM) 1-800-460-8988 Pharmacy PA 1-866-399-0928 Fax: 1-866-399-0929
			MDwise http://www.mdwise.org Claims, Member Services PA/Medical Management, Provider Services, and Pharmacy (317) 630-2831 or 1-800-356-1204
			CareSource http://www.caresource-indiana.com Claims and Provider Services 1-866-930-0017
		Harmony Health Plan http://www.harmonyhmi.com Claims and Provider Services (317) 423-3000 or 1-800-504-2766	Molina Healthcare http://www.molinahealthcare.com Claims and Provider Services 1-800-642-4509

Care Management Organizations (CMOs)		
ADVANTAGE Health Solutions http://www.advantageplan.com/ Member Services 1-800-784-3981 Provider Services 1-866-504-6708 PA | PA Fax 1-800-784-3981 | 1-800-689-2759 P.O. Box 80068 Indianapolis, IN 46280	MDwise http://www.mdwise.org Member Services and Provider Services 1-866-440-2449 Member Services Fax: 1-877-822-7188 PA | PA Fax 1-866-440-2449 | 1-877-822-7186 P.O. Box 44214 Indianapolis, Indiana 46244-0214	
Claims - Customer Assistance (317) 655-3240 or 1-800-577-1278	Maximus 1-866-963-7383	Pharmacy See Pharmacy Benefit Manager section

Claim Filing

EDS 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	EDS Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	EDS CCFs P.O. Box 7266 Indianapolis, IN 46207-7266	EDS Dental Claims P.O. Box 7268 Indianapolis, IN 46207-7268	EDS CMS-1500 Claims P.O. Box 7269 Indianapolis, IN 46207-7269
EDS Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259	EDS Waiver Programs Claims P.O. Box 7269 Indianapolis, IN 46207-7269	EDS Medical Crossover Claims P.O. Box 7267 Indianapolis, IN 46207-7267	EDS Institutional Crossover/UB-92 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims P.O. Box 7271 Indianapolis, IN 46207-7271	

Check Submission (Non-Pharmacy)		Rate Setting	
To make refunds to IHCP: EDS Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	To Return Uncashed IHCP Checks: EDS Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	Myers and Stauffer, LC http://www.mslcindy.com 9265 Counselors Row, Suite 200 Indianapolis IN 46240	(317) 846–9521 1-800-877–6927 Fax (317) 571–8481 MDS Help Desk: (317) 816–4122



Implementation Schedule

Effective Date	Region
November 1, 2007	Central
March 1, 2008	East Central
	North Central
	Northeast
	Northwest
	West Central
	Southeast
	Southwest

Note: All Provider locations that reside in the Out-of-State Cities will be implemented along with the Indiana State region that borders the applicable Out-of-State city.

1	2	3	4	5	6	7	8	9
Northwest Region	**North Central Region**	**Northeast Region**	**West Central Region**	**Central Region**	**East Central Region**	**Southwest Region**	**Southeast Region**	**Out-of-State Cities***
Jasper	Elkhart	Adams	Benton	Boone	Blackford	Brown	Bartholomew	Louisville, Ky.
Lake	Fulton	Allen	Carroll	Hamilton	Cass	Daviess	Clark	Owensboro, Ky.
LaPorte	Marshall	Dekalb	Clay	Hancock	Delaware	Dubois	Crawford	Cincinnati, Ohio
Newton	Pulaski	Huntington	Clinton	Hendricks	Fayette	Gibson	Dearborn	Harrison, Ohio
Porter	Starke	Koscuisko	Fountain	Johnson	Grant	Greene	Decatur	Hamilton, Ohio
	St. Joseph	Lagrange	Montgomery	Madison	Henry	Knox	Floyd	Oxford, Ohio
		Miami	Parke	Marion	Howard	Lawrence	Franklin	Sturgis, Mich.
		Noble	Sullivan	Morgan	Jay	Martin	Harrison	Watseka, Ill.
		Steuben	Tippecanoe	Putnam	Randolph	Monroe	Jackson	Danville, Ill.
		Wabash	Vermillion	Rush	Tipton	Posey	Jefferson	
		Wells	Vigo	Shelby	Union	Orange	Jennings	
		Whitley	Warren		Wayne	Owen	Ohio	
			White			Perry	Ripley	
						Pike	Scott	
						Spencer	Switzerland	
						Vanderburgh	Washington	
						Warrick		