Monthly News

Indiana Health Coverage Programs

www.indianamedicaid.com

Provider News NL200401 January 2004

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Frequently Used Acronyms

CMS	Centers for Medicare and Medicaid Services
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
MCO	Managed Care Organization
OMPP	Office of Medicaid Policy and Planning

Provider News

Monthly Newsletters

This is the first edition of a monthly provider newsletter that will be sent to all providers. Its purpose is to present program information in an easy-to-read format that is distributed on a regular basis as well as to eliminate the need for multiple provider bulletins. The newsletter will be printed and mailed by the 15th of each month, and providers should expect to receive copies shortly thereafter. While the newsletter will not completely replace the provider bulletins, it will significantly reduce the number of bulletins printed each year. Providers will continue to receive bulletins on topics such as the annual HCPCS code updates, the annual diagnosis-related group (DRG) updates, quarterly drug utilization review (DUR) publications, and surveillance and utilization review (SUR) issues. Occasionally, bulletins associated with policy changes that do not fall into the time constraints of the monthly newsletter may also be sent separately to providers. Providers are encouraged to share the provider newsletters with their staff. Send comments about this publication to EDS at INXIXElectronicSolution@eds.com, subject: provider newsletter.

Indiana Health Coverage Programs Overview

This article gives an overview of the IHCP and associated benefits. The OMPP and Children's Health Insurance Program (CHIP) have categorized all covered benefits in the following four distinct programs:

- 590 Program
- Traditional fee-for-service Medicaid
- Hoosier Healthwise
- *Medicaid Select*

590 Program

The 590 Program is for processing and payment of claims with a total billed amount of $150 or more for services provided off-site to residents of State-owned facilities under the direction of the IFSSA Division of Mental Health, and the Indiana State Department of Health.

Individuals enrolled in the 590 Program are eligible for all benefits covered under the IHCP except transportation services. Eligibility for the 590 Program should be verified using the Eligibility Verification System (EVS).

Traditional Fee-for-Service Medicaid

The Traditional Medicaid program provides services to members not enrolled in 590 or the managed care programs.

Traditional fee-for-service Medicaid reimburses the provider on a per service basis. Providers bill services rendered to members directly to EDS for processing and payment.

Managed Care

The majority of Medicaid members are enrolled in one of the managed care programs: Hoosier Healthwise or *Medicaid Select*. The following are generally exclusions from a managed care program:

- Individuals in nursing homes and other institutions, such as intermediate care facilities for the mentally retarded
- Undocumented individuals
- Individuals receiving waiver or hospice services
- Individuals with spend-down liability

Wards and foster children can voluntarily enroll in Hoosier Healthwise

Hoosier Healthwise

The Hoosier Healthwise program provides managed care services to children, pregnant women, and low-income families in one of the following three member eligibility packages:

- Package A – standard plan
- Package B – pregnancy coverage only
- Package C – children's health plan

Hoosier Healthwise has two delivery system models: primary care case management (PCCM) and risk-based managed care (RBMC).

- PCCM is like Traditional Medicaid because payments are made on a fee-for-service basis by EDS plus a per member per month administration fee paid to the primary medical provider (PMP). Members have a PMP who provides or arranges for most medical care. Program providers contract directly with the state of Indiana by an addendum to the IHCP agreement. The Hoosier Healthwise PCCM plan is called Prime*Step*.
- RBMC requires the PMP to enroll in an MCO. The state of Indiana pays a capitation fee for each member enrolled in an MCO. The capitation fee covers the costs of care for most covered services

incurred by members enrolled in the MCO. Each MCO maintains its own provider and member services units, claims payment, and prior authorization responsibilities. Providers should contact the MCO for specific claims payment and prior authorization policies and guidelines. Indiana currently has three MCOs: Harmony Health Plan, Managed Health Services (MHS), and MDwise. Contact information for the MCOs can be found on the quick reference sheet attached to this newsletter.

Medicaid Select

Beginning January 1, 2003, Medicaid eligible aged, blind, and disabled residents of the State began to receive medical services through a new program called *Medicaid Select*.

Medicaid Select is similar to Hoosier Healthwise in that the member is connected with a PMP. The member goes to the PMP for most medical care including prescriptions and specialist referrals.

Currently, *Medicaid Select* PMPs are in the PCCM delivery system which is similar to the description given for the Hoosier Healthwise PCCM Prime*Step* program.

New Processing Method for Non-pharmacy Paper Claims

This article announces a new processing method for non-pharmacy paper claims. Paper claims are currently entered manually into the Indiana*AIM* system. The new process scans claims to create an electronic image. This process will decrease the time it takes for paper claims to process, and leave a smaller margin for error.

To improve the accuracy and processing speed of the new system, providers are encouraged to implement the following best practices for medical claims processing:

- Use red claim forms, instead of the black-lined forms. Red forms will receive priority status and facilitate processing without human intervention.

Note:	*The software cannot read handwriting. All information should be typed or hand-printed in block letters.*

- Ensure information is in the appropriate boxes on the form, and aligned correctly in those boxes.
- Place the **billing provider number and location code** in the first area of box 33, labeled PIN#.
- Do not enter commas or dashes. Diagnosis pointers on the detail lines should read 1234.
- Do not write or type any information, other than the appropriate address, on the claim form above the red line box.
- Do not put stray marks or Xs on the claim form.
- Minimize or eliminate information hand printed on medical claim forms. When hand printed information is necessary, please print using block letters and numbers within the boxes provided on the form.
- Submit attachments on regular 8½ X 11 paper.
- Do not paper clip or staple claim forms and additional documentation.
- Add data within the boxes on the form. Data outside the boxes can cause errors and delay processing.

Providers implementing these guidelines will have claims processed in an accurate and timely manner.

Crossover Claims on CMS-1500 Claim Forms

This is a reminder for billing Medicare Part B claims. Crossover claims received on the CMS-1500 claim form must have the combined total of the Medicare coinsurance, the deductible, and the psychiatric reduction reported on the left-hand side of field 22 under the Medicaid resubmission code heading. The Medicare paid amount (the actual dollar amount received from Medicare) must be submitted in field 22 on the right-hand side under the heading *Original Ref No*. CMS-1500 crossover claims received without the information in field 22 will be returned to the provider. If this process changes, providers will receive advanced notification.

Attachments for Electronic Claims Submission

When supporting documentation is submitted for electronic claims received, a **unique** attachment control number (ACN) should be written at the top of each page for each attachment. **Use the ACN only once.** If a claim is resubmitted for any reason, a different ACN should be used. Complete an attachment control cover sheet for each claim submitted. Access a copy of the cover sheet on the IHCP Web site at www.indianamedicaid.com and click **Forms/Claim Forms (non-pharmacy)/Attachment cover sheet**. Select either the Adobe® Acrobat or Word version. Detailed instructions can be found on the form.

Medicaid Select (Medicaid Managed Care for Aged, Blind, and Disabled)

In January 2003, at the General Assembly's direction, the OMPP began implementation of a program to provide managed care services to the State's aged, blind, and disabled population. The program was implemented in regional phases during 2003 and will complete the statewide enrollment in 2004.

Eligibility

In general, the *Medicaid Select* program covers the following IHCP members:

- Children receiving adoptive services
- Aged
- Blind
- Physically and mentally disabled
- Individuals receiving room and board assistance
- Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs) *in combination with* another aid category
- MedWorks participants

As with other IHCP programs, eligibility and coverage is based on the member's aid category.

In general, the *Medicaid Select* program will not cover the following IHCP members:

- Breast and Cervical Cancer Group
- Individuals with QMB or SLMB only (not in combination with another aid category)
- Wards
- Foster children
- Persons in nursing homes, intermediate care facilities for the mentally retarded (ICF/MRs), and state operated facilities
- Persons on home and community-based waivers
- Persons receiving hospice services
- Persons with spend-down liability
- Undocumented persons

PMP Information

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

In addition, other physician specialties may enroll as PMPs for *Medicaid Select*. Specialist PMPs will not receive auto-assignments. They will receive members only if the member actively chooses that physician as a PMP.

Other PMP information about *Medicaid Select* is as follows:

- PMPs receive a $4 per member per month administrative fee.
- Claims are submitted to and adjudicated as fee-for-service by EDS.
- PMPs can have a panel size between 50 and 1000 members. Smaller panel sizes are available on a case-by-case basis. *Medicaid Select* and Hoosier Healthwise panel sizes are maintained separately.
- When members become eligible for *Medicaid Select*, they may continue to see their current doctor only if their doctor becomes a PMP, or their doctor receives a referral from the member's new PMP.
- Members are given 60 days, versus 30 days for Hoosier Healthwise, to choose a *Medicaid Select* PMP. Auto-assignment, a federal requirement, begins after 60 days.
- Covered services for members do not change under the *Medicaid Select* program. Some services are self-referral and do not require PMP authorization. These include chiropractic, mental health, dental, family planning, and pharmacy.
- Members can access services at the same hospitals that they visit now, but non-emergency services require PMP authorization.
- Members can fill prescriptions at the same pharmacies that they currently use.
- Members retain the same IHCP member ID number and use the same Hoosier Health card that they had before entering *Medicaid Select*.
- When a referral to another health care professional is necessary, PMPs are required to authorize the referral by phone or in writing. PMPs give the specialist their provider ID number and a two-digit certification code, which allows the specialist to bill and receive reimbursement. For PCCM providers in both Hoosier Healthwise

and *Medicaid Select*, the quarterly certification code is the same for both programs.

- The prior authorization (PA) process is the same as that used for Traditional Medicaid and Hoosier Healthwise PCCM programs. Health Care Excel (HCE) administers PA.

Medicaid Select Advisory Committee

The OMPP has formed an advisory committee to assist with policy and issues for *Medicaid Select* with members from the following categories:

- One PMP and one specialist
- Two IHCP members or family representatives
- One advocate for the aged
- One advocate for mental health
- One advocate for the physically disabled
- One advocate for children with special needs
- One Medicare representative
- One office management or billing representative

This committee meets at least quarterly. The schedule of meetings and previous meeting minutes is available at www.state.in.us/fssa/healthcare/select.

Further Information

Please direct questions about this article to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. IHCP providers requesting more information about becoming a PMP in the *Medicaid Select* program should contact the *Medicaid Select* Helpline at 1-877-633-7353, option 3, or on the Web site at www.medicaidselect.com.

Local Codes Expire January 1, 2004

The 1996 Administration Simplification Requirements of HIPAA mandate that covered entities no longer use local codes or local code modifiers in transactions effective January 1, 2004, except for anesthesia changes that were effective October 16, 2003. The HCPCS local level III codes are alphanumeric codes starting with letters W, X, Y, or Z followed by four numbers. The range of local codes is W0000 through Z9999. Effective January 1, 2004, replacement level I Current Procedural Terminology (CPT) or level II (national) codes must be used instead of local level III codes. Claims submitted with dates of service on or after January 1, 2004, with local codes and local code modifiers, will deny. IHCP provider bulletin, *BT200353*, provides a comprehensive crosswalk of the code changes. Providers should use the tables in IHCP provider bulletin, *BT200353,* as a guide. Locate the code currently used in the first column and follow across to find the new code(s) and modifier(s), if applicable. Please note that some codes were previously replaced during the annual HCPCS review process. This information was released in IHCP provider bulletin, *BT200313*.

Third Party Liability Information Accepted on Electronic Mail

The Third Party Liability (TPL) Casualty Department is now accepting accident and trauma information from IHCP providers through e-mail. The e-mail address is INXIXTPLCasualty@eds.com.

Providers are asked to notify the TPL Casualty Department if a request for medical records is received from a member's attorney because of a personal injury claim or if the provider becomes aware of accident related claims by any other means. When notifying the TPL Casualty Department please include the IHCP member's name, member identification number, date of loss or injury, any other information about other insurance carriers, and attorney name, phone number, and address, if available. This information can be sent to the TPL Casualty Department by e-mail at the address listed above, by facsimile at (317) 488-5217, by telephone at (317) 488-5046 in the Indianapolis local area or 1-800-457-4510, or U.S. mail at the following address:

EDS TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7762

Mailing Address Changes for Non-Pharmacy and TPL Refunds

Effective February 1, 2004, addresses for non-pharmacy refunds and TPL refunds will change. Please remit non-pharmacy refund checks to correct billing errors, to settle casualty cases, and to satisfy accounts receivable to the following address:

EDS Refunds
P. O. Box 2303
Dept. 130
Indianapolis, IN 46206-2303

All refund checks as a result of TPL billing to insurance companies should be remitted to the following address:

EDS TPL (HMS) Checks
P. O. Box 2303
Dept. 132
Indianapolis, IN 46206-2303

The following address to return any non-cashed IHCP checks remains unchanged:

EDS Finance Department
950 N. Meridian Street
Suite 1150
Indianapolis, IN 46204-4288

Electronic Funds Transfer

Providers currently receiving a physical check from the IHCP each week should consider signing up for electronic funds transfer (EFT) today.

The following is a list of benefits providers enjoy through EFT:

- Significantly reduces the amount of time for receiving payment for IHCP services because monies are available in your account on Wednesdays.
- Efficient and cost-effective means of enhancing practice management accounts receivable.
- Eliminates mailing time from EDS to the provider, manual deposit at the bank, and delays in crediting the funds to the provider's account that may be imposed by banking institutions.
- Eliminates the chance the check will get mailed to or cashed by another provider; or, if the provider has forgotten to update the *pay to* address in the system, the remittance advice (RA), but not the returned check, will be mailed to the old address until an update is made.
- Eliminates lost, misplaced, voided, and stale-dated checks.
- Help improve cash flow.

The EFT application is available for download from the IHCP Web site at www.indianamedicaid.com or to request a form by U.S. mail, call the Provider Enrollment Unit at 1-877-707-5750.

Written Correspondence Inquiries for Non-pharmacy Claims

Inquiries about non-pharmacy claims can most often be addressed by contacting the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. However, EDS recognizes that some inquiries are complex and better addressed by written correspondence. The Written Correspondence Unit is available to research claims and denials for providers experiencing difficulty in receiving claim payment.

Written inquiries submitted on the *Written Inquiry Request* form ensures the written correspondence analyst has all the information necessary to research the inquiry. Please limit requests to one per form, including the necessary information on the form for research by EDS.

For tracking purposes, responses to inquiries are assigned a letter control number (LCN) or Research Project Tracking System (RPTS) number on receipt. The LCN or RPTS number, located at the bottom of the return to provider letter, should be referenced in any subsequent correspondence with the IHCP about the inquiry.

How to Obtain Forms

A copy of the *Indiana Health Coverage Programs Inquiry* form is included in this newsletter on page 11 and can be copied for use. The form is also available for print or download from the IHCP Web site at www.indianamedicaid.com. This form should accompany all written inquiries.

How to Submit the IHCP Inquiry Form

Copies of claims and attachments submitted for payment should be included with the written inquiry. Prior authorization numbers or copies of prior authorization decision forms, as well as copies of RA statements should be included. Incomplete *Written Inquiry Request* forms significantly slow the ability of the Written Correspondence Unit to research problems. When complete information is provided on a written inquiry form with a clearly stated **Reason for Inquiry**, the written correspondence analyst is able to completely research the issue and provide appropriate avenues of resolution.

All completed written inquiry forms should be mailed to the following address:

EDS Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263

Providers should not submit claims for processing to the Written Correspondence Unit unless specifically directed to do so. The Written Correspondence Unit is available to perform specific claim research and determine the best resolution. Claim status is accessible through the Automated Voice Response (AVR) system at (317) 692-0819 in the Indianapolis area or 1-800-738-6770. Providers can also obtain claim status through Web interChange at https://interchange.indianamedicaid.com. Both systems provide access 24 hours a day, seven days a week. Claim status is generally available 30 days

after a paper submission and 21 days after an electronic claim submission.

Written correspondence for pharmacy claims can be directed to ACS at the following address:

Indiana Administrative
Review/Pharmacy Claims
c/o ACS
P. O. Box 502327
Atlanta, GA 31150

SUR Methodology and Procedure for Conducting Audits at the Provider Facility

As a result of recent changes in privacy regulations and an increased emphasis on provider accountability for record security, the Surveillance Utilization Review (SUR) Department is aware of provider concerns about record confidentiality. Specifically, providers voiced concerns about the security of original medical records when a provider's office staff is not present for the review of those records during a SUR on-site audit. SUR will modify its procedures to allow a representative of the provider's office to be present during the on-site audit of the records.

The following conditions will apply to this change in procedure:

- Provider office staff can remain with the audit team only to ensure security and physical integrity of the records. This is an option for providers, not a requirement.
- Provider office staff can serve as a resource to the audit team by answering questions raised by the audit team or by retrieving missing documentation, when requested.
- Provider office staff will not be involved in the audit process and should not attempt to interfere with the record review process.
- Providers are reminded that audit findings at the point of record review are preliminary and, therefore, no argument or challenges are appropriate.

If a provider's record security procedures would preclude SUR auditors from reviewing original records without provider staff present, the provider may exercise one of the following options when notified of an upcoming SUR audit:

- Appoint a staff member to remain present during the on-site audit of records to ensure the security of original medical records.
- Provide copies of the medical record to be reviewed during the on-site audit, with original medical records being available for SUR audit staff to review as requested.

The provider is not required to exercise one of these options. Providers may continue to allow SUR auditors to review the original medical records. Any copies can be made at the time of the audit.

As an alternative to an on-site audit, SUR may conduct a medical record audit by requesting copies of records be sent to HCE.

Chiropractic Services

Nutritional Supplements

Nutritional supplements are not covered when provided by a chiropractor. A chiropractor intending to supply or provide some type of vitamin, herb, or other form of nutritional supplement, must maintain documentation to substantiate that the member understands he or she is receiving a noncovered IHCP service before the service is given. The member can be billed for this noncovered service only when the appropriate documentation procedure is followed. This procedure can be found in the *IHCP Provider Manual*, Chapter 8.

Dental Services

Supernumerary Tooth Extractions

Effective December 17, 2001, claims for supernumerary tooth extractions must be billed with procedure code *D7999 – Unspecified Oral Surgery Procedure by Report.* A note of explanation is always required when billing D7999. The attachment should indicate whether an erupted or impacted tooth was extracted.

An impacted tooth extraction must be documented to include the degree of impaction: soft tissue, partially bony, or completely bony and any unusual complications should be listed.

This is a manually priced code. Providers are required to bill usual and customary fees. Claims submitted without an attachment will deny for explanation of benefits (EOB) *4019 – Attachment Required for Services Rendered.*

> *Note: When billing for supernumerary tooth extractions, tooth numbers should not be used on the claim form.*

American Dental Association 1999/2000 Version Claim Form

The American Dental Association (ADA) 1999/2000 version claim form is the only claim form the IHCP will accept for claim processing received on or after November 14, 2003. Detailed instructions for completing the ADA 1999/2000 version claim form were published in IHCP provider bulletin, *BT200364*, dated September 30, 2003. The form accepts as many as eight service lines. If the number of service lines exceeds eight, an additional claim form must be completed. The billing provider number and service location must be included in field 44. If dental claims are received by the IHCP on any form other than the ADA 1999/2000 version claim form or the billing provider number is omitted from field 44, the claim will be returned to the provider for correction.

Pharmacy Services

Pharmacy Point-of-Sale Suspense Function

Effective November 10, 2003, the IHCP added a suspense function to its pharmacy claims processing for compound claims more than $275 and claims requiring attachments.

Compound Claims

All compound pharmacy claims submitted by point-of-sale (POS) with a submitted charge greater than $275 will suspend with a POS message stating, "Claim suspended for ACS review." These claims are reviewed for pricing and will adjudicate within 21 days of suspension. With the addition of the suspense function, all compound claims can be submitted by POS.

Claims Requiring an Attachment

While all claims can now be submitted electronically, some transactions may require additional documentation to process the claim, for example

spend-down claims. Claims submitted by POS requiring additional documentation will suspend and the provider will receive a POS response with instructions to send the supporting documentation to ACS. This documentation is submitted as a paper attachment. The provider must send a completed *Pharmacy Claims Attachment Cover Sheet* for each attachment. A copy of the *Pharmacy Claims Attachment Cover Sheet* as well as submission methods can be found on the IHCP Web site at: www.indianamedicaid.com under **Forms/Pharmacy Claims**.

Additional Information

For more information, refer to IHCP provider bulletin, *BT200369,* or direct questions about suspended claims to the ACS Point-Of-Sale Help Desk at 1-866-645-8344 or in writing to the following address:

Indiana Administrative Review/Pharmacy Claims
c/o ACS
P. O. Box 502327
Atlanta, GA 31150

Physicians, FQHC and RHC, Hospitals, and Ancillary Providers

Hoosier Healthwise Mandatory MCO Transition

The OMPP is continuing its transition to mandatory managed care organizations (MCOs) in select Indiana counties. Johnson and Morgan will be transitioned in March 2004. In July 2004, Delaware, Grant, Howard, and Madison will become mandatory MCO counties. Table 1 lists the transition dates, by county, from PCCM to an MCO.

Table 1 – List of Counties for Mandatory MCO Transition and Key Dates

County	PMP Signed Contracts Sent to MCOs	Final Transition Date
Johnson	January 1, 2004	March 1, 2004
Morgan	January 1, 2004	March 1, 2004
Delaware	May 1, 2004	July 1, 2004
Grant	May 1, 2004	July 1, 2004
Howard	May 1, 2004	July 1, 2004
Madison	May 1, 2004	July 1, 2004

Providers rendering services to members in the affected counties should review this article to determine the impact of these upcoming changes:

- Mandatory MCO enrollment does not apply to *Medicaid Select* members. These members continue PCCM coverage.
- Mandatory MCO enrollment does not apply to IHCP members who have spend-down, or have a level of care designation for nursing home, waiver, or hospice. These members continue the traditional fee-for-service IHCP coverage.

Mandatory MCO Enrollment Information for PMPs

PMPs rendering services to members in the affected counties should review the following items to determine the impact of these upcoming changes:

- PMPs in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs or disenroll as a Hoosier Healthwise PMP. Members who remain eligible for IHCP and who meet the PMP's scope of practice criteria will remain with their PMP through the transition if the Prime*Step* PMP contracts with an MCO before the final transition date. To ensure enrollment with an MCO will be effective by the transition date, PMPs must have their signed contracts submitted to the MCO at least 60 days before the transition date. PMPs can also choose to remain as an IHCP provider limited to non-Hoosier Healthwise managed care members or provide services upon referral.
- MCOs can provide additional services to members complementing services provided by the PMPs. Some examples of additional services are 24-hour nurse telephone services, enhanced transportation arrangements, and case management services. Contact the MCOs to discuss what benefits are available.

Mandatory MCO Enrollment Information for Other Providers

Following are frequently asked questions and responses:

Q. Do I need to sign a contract with an MCO to provide services?

A. Specialists, hospitals, and ancillary providers have various MCO arrangements. Some of the MCO networks are open, meaning that any IHCP provider can render services to the MCO

members. However, some are closed such as transportation and pharmacy networks. With closed networks, MCO-contracted providers usually render the services. In-network (MCO-contracted) providers are paid according to the contract with the MCO. Out-of-network (non-contracted) providers are paid at 100 percent of the IHCP rate. With the exception of some self-referral services, the MCO can require members to access services from MCO-contracted providers.

Q. How does this mandatory enrollment affect carved-out services?

A. The carved-out services are Individual Education Plan (IEP) billed by an enrolled school corporation, dental services, and behavioral health services. Generally, behavioral health services not rendered in an acute care setting or the PMP's office are not the responsibility of the MCO.

Mandatory MCO changes will not affect providers rendering care to MCO members for carved-out services. Claims for those services continue to be processed by EDS.

Self-referral services, such as family planning, vision, chiropractic, and podiatry, are different from carve-out services in that self-referral services do not require PMP or plan referral and are paid by the MCO for MCO members.

However, claims related to carve-out services such as pharmacy services related to a dental visit or for family planning services, are the responsibility of the MCO. The October 1, 2003, IHCP provider bulletin, *BT200362,* provides more information on this topic.

Q. How does this affect self-referral services?

A. Changes that affect self-referral providers are podiatric, vision care, chiropractic, and family planning services. MCOs are responsible for payment of the self-referral services for their members. Claims for these services must be sent to the appropriate MCO for payment.

Q. Can an FQHC or RHC contract with an MCO?

A. An FQHC or RHC can participate with an MCO. The MCO provider contract must specify the contractual arrangements to ensure that FQHCs and RHCs are reimbursed for services. The OMPP endorses the following types of contractual arrangements between MCOs and FQHCs or RHCs:

- The FQHC or RHC accepts full capitation for primary, specialty, or hospital services.
- The FQHC or RHC accepts a partial capitation or other method of payment at less than full risk for patient care, such as primary care capitation only, or fee-for-service.

Q. How can I enroll with an MCO?

A. Table 2 lists active managed care organizations in Indiana, active regions in the State, and telephone numbers.

Table 2 – Managed Care Organizations

Organization and Web site	Contract Region	Provider Service Phone Number
Harmony Health Plan www.harmonyhmi.com	North and Central	1-800-504-2766
Managed Health Services (MHS) www.managedhealthservices.com	Statewide	1-800-414-9475
MDwise www.mdwise.org	Statewide	1-800-356-1204 or (317) 630-2831

Q. How are prior authorizations handled for members changing networks or plans?

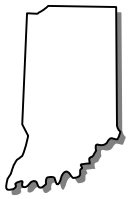
A. Any time members enter or change a Hoosier Healthwise managed care network they may have already received authorizations for services and procedures not completed on the effective date of the enrollment in the new network. The PAs might be for a specific procedure, such as surgery, or for ongoing procedures authorized for a specified duration, such as physical therapy or home health care.

Hoosier Healthwise Prime*Step* and MCOs must honor outstanding PAs for services for the first 30 days of a member's effective date in the new network. This authorization extends to any service or procedure previously authorized in the Hoosier Healthwise program, including but not limited to, surgeries, therapies, pharmacy, home health care, and physician services. MCOs could be required to reimburse out-of-network providers during the 30-day transition period. This enables PAs to be established in the new network while providing continuity of care. If the member has or will have an outstanding PA on the transition date, the provider should contact the new MCO to request a new PA.

Additional Information

Additional information, including MCO network summaries, is available on the IHCP Web site at www.indianamedicaid.com. Direct questions about the information in this article to the appropriate MCO listed in Table 2 or to the Hoosier Healthwise Helpline at 1-800-889-9949, option 3 (Provider Services).

Indiana Health Coverage Programs



INDIANA HEALTH COVERAGE PROGRAMS NON-PHARMACY INQUIRY

Date _____ **For EDS Internal Use** **CCN#**_____

Provider name _____ **Provider number** _____

Provider address _____

_____

_____

Member name _____ **Member identification number (RID)** _____

Date of service _____ **Total amount of charges** _____

Date billed _____ **ICN from previous bills** _____

Date paid/denied _____

Reason for inquiry _____

_____

_____

_____

_____

_____

_____

_____

Signature

For EDS Internal Use **Response**

_____

_____

_____

_____

_____

_____

_____

Signature of analyst

Retain a copy for your records and send the original to:

Provider Written Correspondence
EDS
P. O. Box 7263
Indianapolis, IN 46207-7263

IHCP Provider Field Consultants

Territory Number	Provider Representative	Telephone	Counties Served
1	Randy Miller	(317) 488-5388	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, and Starke
2	Virginia Hudson	(317) 488-5071	Allen, Dekalb, Elkhart, Fulton, Huntington, Kosciusko, Lagrange, Marshall, Miami, Noble, St. Joseph, Steuben, Wabash, and Whitley
3	Chris Kern	(317) 488-5326	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Hendricks, Howard, Montgomery, Parke, Putnam, Tippecanoe, Tipton, Vermillion, Warren, and White
4	Debbie Williams	(317) 488-5080	Adams, Blackford, Delaware, Grant, Hancock, Henry, Jay, Madison, Randolph, Wayne, and Wells
5	Relia Manns	(317) 488-5187	Marion
6	Tina King	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, and Washington
7	Phyllis Salyers	(317) 488-5148	Clay, Greene, Johnson, Lawrence, Monroe, Morgan, Orange, Owen, Sullivan, and Vigo
8	Pam Martin	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick
9	Mark Wheatley	(317) 488-5021	Out-of-State

Field Representatives for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/ Watseka	Randy Miller	(317) 488-5388
	Danville	Chris Kern	(317) 488-5326
Kentucky	Louisville/Owensboro	Pam Martin	(317) 488-5153
Michigan	Sturgis	Virginia Hudson	(317) 488-5071
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Tina King	(317) 488-5123

Out-of-state providers not located in these states, or those with a designated out-of-state billing office supporting multiple provider sites throughout Indiana should direct calls to (317) 488-5139.

Statewide Special Program Field Representatives

Special Program	Representative	Telephone
590	Charlene Schweikhart	(317) 488-5182
Dental	Pat Duncan	(317) 488-5101
Waiver	Mona Green	(317) 488-5152

Client Services Department Leaders

Title	Name	Telephone
Director	Darryl Wells	(317) 488-5013
Supervisor	Connie Pitner	(317) 488-5154

Note: For map showing the provider representative territories or for more updated information about the provider field representatives, visit the IHCP Web site at www.indianamedicaid.com.

Indiana Health Coverage Programs Quick Reference Effective August 11, 2003

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization		Pharmacy Benefits Manager
EDS Customer Assistance (317) 655-3240 1-800-577-1278	**EDS Forms Requests** P.O. Box 7263 Indianapolis, IN 46207-7263	**Indiana Drug Utilization Review Board** INXIXDURQuestions@acs-inc.com
EDS Member Hotline (317) 713-9627 1-800-457-4584	**Indiana Health Coverage Programs Web Site** www.indianamedicaid.com	**ACS PBM Call Center for Pharmacy Services/POS/ProDUR** 1-866-645-8344 Indiana.ProviderRelations@acs-inc.com
EDS OMNI Help Desk 1-800-284-3548	**HCE Prior Authorization Department** P.O. Box 531520 Indianapolis, IN 46253-1520 (317) 347-4511 1-800-457-4518	**ACS Preferred Drug List Clinical Call Center** 1-866-879-0106
EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263		**PA For ProDUR and Indiana Rational Drug Program - HCE** (317) 347-4511 or 1-800-457-4518 Fax (317) 347-3593
AVR System (317) 692-0819 1-800-738-6770	**HCE Medical Policy Department** P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	**Indiana Pharmacy Claims/Adjustments** c/o ACS P. O. Box 502327 Atlanta, GA 31150
EDS Electronic Solutions Help Desk (317) 488-5160 1-877-877-5182 INXIXElectronicSolution@eds.com	**HCE Provider and Member Concern Line (Fraud and Abuse)** (317) 347-4527 1-800-457-4515	**Indiana Administrative Review/Pharmacy Claims** c/o ACS P.O. Box 502327 Atlanta, GA 31150
EDS Provider Enrollment P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	**HCE SUR Department** P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 1-800-457-4515	**Drug Rebate** ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332
EDS Third Party Liability (TPL) (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	**EDS Administrative Review** Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	**To make refunds to IHCP for pharmacy claims send check to:** ACS State Healthcare – Indiana P.O. Box 201376 Dallas, TX 75320-1376

IHCP Managed Care Organizations, Hoosier Healthwise, and *Medicaid Select*				
Harmony Health Plan www.harmonyhmi.com **Claims** 1-800-504-2766 **Member Services** 1-800-608-8158; TTY: 1-877-650-0952 **Prior Authorization/Medical Management** 1-800-504-2766 **Provider Services** 1-800-504-2766	**MDwise** www.mdwise.org **Claims** 1-800-356-1204 or (317) 630-2831 **Member Services** 1-800-356-1204 or (317) 630-2831 **Prior Authorization/Medical Management** 1-800-356-1204 or (317) 630-2831 **Provider Services** 1-800-356-1204 or (317) 630-2831	**Managed Health Services (MHS)** www.managedhealthservices.com **Claims** 1-800-414-9475 **Member Services** 1-800-414-5946 **Prior Authorization/Medical Management** 1-800-464-0991 **Provider Services** 1-800-414-9475 **Nursewise** 1-800-414-5946	**Prime*Step* (Hoosier Healthwise)** www.healthcareforhoosiers.com **Claims** Automated voice response 1-800-738-6770 or (317) 692-0819 **EDS Customer Assistance** 1-800-577-1278 or (317) 655-3240 **Member Services** 1-800-889-9949, Option 1 **Prior Authorization** HCE: 1-800-457-4518 or (317) 347-4511 **Provider Services** 1-800-889-9949, Option 3	***Medicaid Select*** www.medicaidselect.com **Claims** Automated voice response: 1-800-738-6770 or (317) 692-0819 **EDS Customer Assistance** 1-800-577-1278 or (317) 655-3240 **Member Services** 1-877-633-7353, Option 1 **Prior Authorization** HCE: 1-800-457-4518 or (317) 347-4511 **Provider Services** 1-877-633-7353, Option 3

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
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)		
To make refunds to IHCP: **EDS Refunds** P.O. Box 1937, Dept. 104 Indianapolis, IN 46206-1937	**To Return Uncashed IHCP Checks:** **EDS Finance Department** 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	**EDS TPL (HMS) Checks** P.O. Box 1937, Dept. 56 Indianapolis, IN 46206-1937