Monthly News

Indiana Health Coverage Programs

www.indianamedicaid.com

Provider News NL200406 June 2004

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Frequently Used Acronyms

ASC	Ambulatory Surgery Center
CMS	Centers for Medicare & Medicaid Services
DFC	Division of Family and Children
DRG	Diagnosis Related Group
EOB	Explanation of Benefits
FDOS	From Date of Service
HCE	Health Care Excel
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HSPP	Health Services Provider in Psychology
LOC	Level of Care
LTC	Long Term Care
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCP	Primary Care Provider
PMP	Primary Medical Provider

Provider News

Check Related Documentation

IHCP providers must submit checks and associated documentation correctly for checks and check-related adjustments to process accurately and efficiently. Fifth Third bank scans check-related adjustments. For documentation to be imaged clearly, completely, and correctly, please observe the following guidelines:

- Do not highlight the member's name or other information on submitted documentation. When documentation is scanned, the scanned image appears in black and white only. Highlighted information appears blacked out on the scanned image and is not readable.
- Use an asterisk next to the claim to be adjusted rather than highlighting it. Other options include circling member information on the EOB or blacking out all information not related to that specific request.
- Do not staple the check to the documentation.
- Do not put adhesive notes on the documentation. When scanned, the note may cover up important information necessary to adjust the claim.
- When submitting more than one check and accompanying documentation, place the documentation for each check behind the check to which it relates. Include a cover sheet on the documentation to indicate the number of checks being submitted.
- Do not submit a stack of checks followed by documentation. This interferes with determining what check goes with what documentation.

Drug-Eluting Stent Coverage

Drug-eluting stents provide the same structural support to narrowed coronary arteries as uncoated stents. In addition, these stents slowly release a drug at the implantation site to reduce overgrowth of normal tissue that sometimes results in restenosis. This restores and maintains adequate blood flow through affected blood vessels. Overgrowth of normal tissue can be a cause of restenosis of the artery after stenting. Restenosis may also lead to another stent procedure or coronary artery bypass grafting.

Clinical studies have shown that drug-eluting stents can decrease potential restenosis of certain coronary arteries. Use of drug-eluting stents may avoid the costs of restenting or coronary artery bypass grafting for many patients. The FDA approved the first drug-eluting stent on April 24, 2003.

The IHCP will reimburse for drug-eluting stents when medically necessary and appropriate. The IHCP will reimburse for placement of additional types of drug-eluting stents as they become FDA approved.

Outpatient reimbursement for drug-eluting stents and all associated facility charges is made using revenue codes 36X – or 49X in combination with HCPCS codes G0290 – *Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* and G0291 – *Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel*. CPT codes 92980 and 92981 for placement of the stent(s) can be used on the CMS-1500 claim form.

A new outpatient surgery reimbursement category (or ASC assignment) of **G** has been created for these stents. Both G0290 and G0291 have been assigned to this new category and reimburse at 100 percent of $3,346.60 for the first stent and 50 percent of this rate for the second stent. Additional units of service will be denied. Refer to chapter 7 of the *IHCP Provider Manual* for complete details about outpatient surgery reimbursement.

No additional payment is made for the stent when the patient is in an inpatient hospital setting.

Direct questions about this information to the HCE Medical Policy Department at (317) 347-4500.

Hospital Provider Appeal Rights

Recent legislation (HB1320) amended *IC 12-15-13-3* to change the timeframe under which hospital providers may appeal overpayments. Effective July 1, 2004, hospital providers will no longer have 180 days to appeal overpayments. The amendment makes the appeal timeframe 60 days for all provider types. The 60-day

timeframe will be applied to any overpayments notifications sent to providers after July 1, 2004.

Billing Procedures for Nurse Practitioner and Physician Assistant Services

Proper billing procedures for billing nurse practitioner and physician assistant services are as follows:

- Nurse Practitioners - Independently practicing nurse practitioners are reimbursed at 75 percent of the rate on file. The nurse practitioner provider number is included in Locators 24K and 33 of the CMS-1500 claim form.
- Nurse practitioners, not individually enrolled in the IHCP, and clinical nurse specialists employed by physicians, in a physician directed group or clinic, bill services with the SA modifier and the physician number in locators 24K and 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
- Nurse practitioners, with an individual provider number, and employed by a physician(s) should bill using their provider number in locator 24K and the billing group number in locator 33 and are reimbursed at 100 percent of the Medicaid allowed amount.
- Nurse practitioner services in outpatient hospital settings are not separately billable and are included in the hospital outpatient reimbursement rate.
- Physician Assistants - Physician assistant services are billed with the HN, bachelors degree, or HO, masters degree, modifier applicable to the level of education of the physician assistant, the physician number in locators 24K and 33, and are reimbursed at 100 percent of the Medicaid allowed amount. Physician assistants are not separately enrolled in the IHCP. However, when a physician assistant provides assistant surgeon services, modifier AS should be used in lieu of the HN or HO modifier. For additional information about billing assistants with surgery claims, please refer to IHCP banner page *BR200218,* published April 30, 2002.

Modifiers are placed in locator 24D, under the modifier heading on the CMS-1500 claim form.

Mental Health Billing Modifiers

The IHCP identified the following modifiers for billing of mental health services rendered by a mid-level practitioner under the supervision of a physician, psychiatrist, or HSPP as indicated in field 24K of the CMS-1500 claim form. These modifiers must be used with the appropriate procedure code and are as follows:

AH – Services provided by a clinical psychologist

AJ – Services provided by a clinical social worker

HE in conjunction with SA – Services provided by a nurse practitioner or clinical nurse specialist

HE – Services provided by any other mid-level practitioner as addressed in *405 IAC 5-25*

Claims billed for mid-level practitioner services and billed with the modifiers noted above will reimburse 75 percent of the IHCP allowed amount for the procedure code identified. Claims previously billed for mid-level practitioner services without a modifier and paid at 100 percent of the fee schedule must be adjusted to add the applicable modifiers. Community Mental Health Centers must continue to use the HW modifier to denote MRO services in addition to the modifiers listed above that identify the qualifications of the individual rendering the service. Modifiers are placed in locator 24D, under the modifier heading on the CMS-1500 claim form.

Tables 1 and 2 list additional billing requirements.

Table 1 – Nurse Practitioner Billing Information

Provider Type	Modifier	Billing Requirements
Nurse Practitioner Clinical Nurse Specialist Working for physician or group/clinic.	SA – Nurse Practitioner rendering services in collaboration with a physician.	Physicians bill with their individual provider numbers in field locator 24K, and the group or individual physician number in field locator 33 of the CMS-1500 claim form. Claims are reimbursed at 100 percent of the IHCP fee schedule.
Independently enrolled Nurse Practitioner	None	The nurse practitioners who independently practice bill their provider number in field locators 24K and 33 of the CMS-1500 claim form. Claims are reimbursed at 75 percent of the IHCP fee schedule.

Table 2 – Mid-Level Practitioner Billing Information

Provider Type	Modifier(s)	Billing Requirements
Nurse Practitioners (Advanced Practice Nurses) credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center Licensed psychiatric and mental health clinical nurse specialist	HE – Mental Health Program in combination with modifier SA-Nurse Practitioner rendering services in collaboration with a physician. Both modifiers should be billed on the CMS-1500 claim form, for example HE and SA.	Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner in field locator 24K and the billing provider number of the outpatient mental health clinic or facility in field locator 33 of the CMS-1500 claim form. Claims are reimbursed at 75 percent of the IHCP fee schedule.
Certified Clinical Social Worker (CCSW) or Licensed Clinical Social Worker (LCSW)	AJ – Clinical Social Worker	Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner in field locator 24K and the billing provider number of the outpatient mental health clinic or facility in field locator 33 of the CMS-1500 claim form. Claims are reimbursed at 75 percent of the IHCP fee schedule.
Clinical Psychologist	AH – Clinical Psychologist	Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner in field locator 24K and the billing provider number of the outpatient mental health clinic or facility in field locator 33 of the CMS-1500 claim form. Claims are reimbursed at 75 percent of the IHCP fee schedule.

2004 Third Quarter Workshops for Medicaid and Hospice Providers

The OMPP, Children's Health Insurance Program (CHIP), and EDS offer IHCP 2004 third quarter workshops free of charge. Sessions are offered at several locations in Indiana. Table 3 lists the time, name, and description of each session. The schedule allows for a lunch period from noon until 1:30 p.m.; however, lunch is not provided. **Seating is limited in all locations**. **Registrations are processed in the order received and registration does not guarantee a spot at the workshop**. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the seating capacity has been reached for that workshop.

Table 3 – Third Quarter Workshop Session Times, Name, and Description

Time	Session	Description
9 a.m. to noon	Medicaid 101	This session provides an overview of the IHCP, eligibility verification methods, the restricted card program, managed care programs, and more. This session is ideal for new IHCP billers or those needing an IHCP refresher course.
Noon to 1:30 p.m.	Lunch Break	Lunch is not provided.
1:30 p.m. to 3:30 p.m.	Code Sets and Provider Enrollment – What Are They and How Do They Affect Me?	This session educates providers about code sets and the implementation process. This session also reviews how setting up provider enrollment files affects billing and reimbursement. This session primarily affects providers who bill on the CMS-1500 claim form, but also reviews provider enrollment issues. Education about enrollment forms is included such as which ones to complete and when. Provider types and specialties are reviewed as well.

Table 4 lists the dates and Indiana locations for each workshop.

Table 4 – Third Quarter Workshop Dates, Deadlines, and Locations

Workshop Date	Registration Deadline	Location
July 19, 2004	July 12, 2004	St. Mary's Hospital, Evansville Manor Auditorium 3700 Washington Ave.
July 23, 2004	July 16, 2004	St. Catherine's Hospital, East Chicago Birthing Center 4321 Fir St.
August 11, 2004	August 4, 2004	Central Indiana Orthopedics, Anderson Conference Room 2610 Enterprise Drive
August 18, 2004	August 11, 2004	Clark Memorial Hospital, Jeffersonville Conference Center – Lower Level 1220 Missouri Avenue
August 24, 2004	August 17, 2004	Unity Health Care, Lafayette 1345 Unity Place Room D
August 24, 2004	August 17, 2004	Union Hospital, Terre Haute ISU School of Nursing 1606 N. 7th St.
August 31, 2004	August 24, 2004	St. Joseph Regional Medical Center, South Bend Educational Center 801 E. LaSalle Ave.
September 1, 2004	August 25, 2004	Lutheran Hospital, Fort Wayne Kachmann Auditorium 7950 W. Jefferson Blvd.
September 2, 2004	August 26, 2004	Wishard Hospital, Indianapolis Myers Auditorium 1001 W. 10th St.

All workshops begin promptly at 9 a.m. local time. General directions to workshop locations are available on the IHCP Web site at www.indianamedicaid.com. To access directions on the Web site click **Provider Services/Education Opportunities/Provider Workshops**. Consult a map or other location tool for specific directions to the exact location.

Workshops are presented free of charge to providers and seating for the workshops is limited to two registrants per provider number. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop. A letter or fax confirming registration will be sent before the workshop. Direct questions about the workshop to a field consultant at (317) 488-5072.

For comfort, business casual attire is recommended. Consider bringing a sweater or jacket due to the possible room temperature variations.

The *Provider Workshop Registration* form can be found on page 16 of this newsletter. Please print or type the information requested on the registration form. List one registrant per form.

Hospice and Nursing Facility Services

Patient Status Code Required for Hospice Providers

Effective August 1, 2004, hospice providers must complete the patient status code in box 22 on the UB-92 claim form. Table 5 lists valid patient status codes and descriptions for each code. Indiana*AIM* uses patient status code information to close the nursing facility LOC segment for hospice members residing in nursing facilities. This process is known as *Autoclosure of the Recipient LOC Screen* and has been in place for LTC providers since January 1998. The purpose of capturing discharge information from the UB-92 claim form is to prohibit inappropriate payment of the nursing facility per diem for the date of discharge. The hospice provider is required to continue to submit appropriate hospice discharge paperwork to HCE to ensure that the hospice LOC segment is closed.

IHCP provider bulletin *BT200011*, published February 25, 2000, addressed date of death issues and discharge of a nursing facility resident who elected the hospice benefit. The following sections contain excerpts from *BT200011* as a reminder to hospice providers of the significance of these issues and are included to emphasize the OMPP's decision to require hospice providers to complete the patient status code on the UB-92 claim form.

Date of Death

Hospice providers are not consistently notifying the IHCP of a hospice member's date of death by sending in the *IHCP (Medicaid) Hospice Discharge* form as required by *405 IAC 5-34 2(h)(1)*. In December 1999, HCE reviewed hospice members enrolled in the IHCP hospice benefit since the date of program implementation. HCE identified approximately 500 members for whom hospice providers had not notified the IHCP of the member's date of death.

If Indiana*AIM* indicates a date of death on the recipient eligibility screen, the HCE hospice analyst enters the date of death at the time of initial hospice certification. This can also occur when hospice recertifications are processed if the forms have been properly completed. The local DFC caseworker provides the date of death.

The HCE hospice analyst returns the paperwork with a hospice return letter requesting that the hospice provider retroactively submit the *IHCP (Medicaid) Hospice Discharge* form to HCE. This information must be submitted by mail rather than by fax. Hospice discharge forms must also include either a copy of the hospice return letter or documentation from the hospice provider indicating that the discharge form has been returned to HCE to file in the member's records.

If the date of death entered by the HCE hospice analyst does not coincide with the date of death recorded by the hospice provider, the hospice provider must coordinate with the local DFC caseworker to correct this discrepancy. After correcting the discrepancy, the hospice provider may request a correction of the hospice LOC from HCE. The local DFC caseworker requires the death certificate to correct this. Hospice providers are encouraged to review current procedures to ensure that hospice staff does not incorrectly submit IHCP hospice discharge forms for members not enrolled in the IHCP hospice benefit.

Hospice Claims

Some hospice providers are incorrectly coding box 22 *STAT* of the UB-92 claim form. When the member is deceased, the hospice provider must use code 20 for *expired*.

IHCP-enrolled hospice providers are reminded that it is their responsibility to return any IHCP reimbursement for dates of service past the hospice member's date of death to the IHCP by completing the appropriate adjustment form.

Any IHCP payment to the hospice provider for services past the date of death are considered an IHCP overpayment and must be returned as an IHCP claims adjustment. Failure to do this is considered program misuse and subjects the IHCP provider to recoupment of the IHCP overpayment.

Any IHCP payment for nursing facility room and board services for the date of death of a nursing

facility resident who has elected hospice is considered an IHCP overpayment and must be returned as an IHCP claims adjustment. The IHCP does not pay a nursing facility provider for the date of death or the date of discharge of a nursing facility resident eligible for nursing facility covered services. This policy also applies to reimbursement of nursing facility room and board services for a nursing facility resident who has elected hospice.

Table 5 – Patient Status Codes

Patient Status Codes	Code Description
01	Discharged to home or self-care, routine discharge
02	Discharged or transferred to another short-term general hospital for inpatient care
03	Discharged or transferred to SNF
04	Discharged or transferred to an ICF
05	Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution
06	Discharged or transferred to home under care of organized home health service organization
07	Left against medical advice or discontinued care
08	Discharged or transferred to home under care of a home intravenous provider
20	Expired
30	Still a patient

Long Term Care Services

Autoclosure of Recipient LOC Segment

If a LTC provider experiences a claim denial for *EOB 2008 – Recipient not eligible for this LOC* for dates of service when the provider has an approved *Form 450B* with the correct provider number, the provider must contact the EDS LTC Review Unit at (317) 488-5094 for resolution. The provider must submit the member name, RID number, dates of service affected by the claim denial, and explanation of the member's status (for example, the member went to the hospital for these dates and was inadvertently discharged because the incorrect patient status code was indicated on the UB-92 claim form). An EDS LTC review analyst will review provider requests during the third full week of each month to determine if the LOC segment can be restored. The LTC review analyst may contact the provider to verify the member's status and restore the LOC segment when applicable or provide further instruction to the LTC provider so that future reimbursement issues can be prevented.

For all retro-rate adjustments processed on or after August 1, 2004, EDS will de-activate the autoclosure process. This change will prevent claim denial and the creation of unnecessary accounts receivables for LOC segments that have previously been manually restored by EDS following notification that the provider billed the incorrect patient status code.

Wheelchair Reimbursements

Standard wheelchairs are included in the per diem rate per *405 IAC-5-13-3-4* and *405-IAC 5-13-3-7*. A request for a custom wheelchair for a LTC member can be submitted to HCE only if there is medical necessity for the custom wheelchair. For example, if the member's diagnosis requires sitting in a particular upright position due to a breathing difficulty, there may be a need for a customized wheelchair. The normal PA process must be followed, using IHCP PA and medical clearance forms.

LTC members receive 24-hour care in a nursing facility. This care includes safety, propulsion, evaluation of the member for skin breakdown, and following an active plan of care to prevent and treat decubitus ulcers. Therefore, custom wheelchairs should not be requested for the sole purpose of providing safety, preventing decubitus ulcers, allowing self-propulsion, or providing restraint.

Managed Care Services

Revenue Codes That Bypass PMP Certification Code Requirements

IHCP provider bulletin *BT200262*, published December 31, 2002, states that effective January 15, 2003, outpatient laboratory, pathology, radiology, and therapy services performed in a hospital setting no longer require the two-digit PMP certification code for PrimeStep and *Medicaid Select* members. The bypass of these outpatient hospital services is based on the revenue code being billed. Table 6 lists revenue codes and descriptions that bypass the two-digit PMP certification code requirement.

The eight-digit PMP license number continues to be required for claim reimbursement of these outpatient hospital services.

Table 6 – Revenue Codes and Descriptions

Revenue Code	Revenue Code Description
300	Laboratory
301	Lab Chemistry
302	Lab/Immunology
303	Lab/Rental Home
304	Lab/Non-routine Dialysis
305	Hematology Lab
306	Bacteriology Lab
307	Urology Lab
309	Lab/Other
310	Pathology Lab
311	Pathology/Cytology
312	Pathology/Histology
314	Pathology/Biopsy
319	Pathology/Other
320	Diagnostic X-ray
321	Diagnostic X-ray
322	Diagnostic X-ray/Angiocardiography
323	Diagnostic X-ray/Arteriography
324	Diagnostic X-ray/Chest
329	Diagnostic X-ray/Other
330	Therapeutic X-ray
331	Chemotherapy/Injected
332	Chemotherapy/Oral

(Continued)

Table 6 – Revenue Codes and Descriptions

Revenue Code	Revenue Code Description
333	Radiation Therapy
335	Chemotherapy/IV
339	Therapeutic X-ray/Other
340	Nuclear Medicine
341	Nuclear Medicine/Diagnosis
342	Nuclear Medicine/Therapeutic
349	Nuclear Medicine/Other
350	CT Scan
351	CT Scan/Head
352	CT Scan/Body
359	CT Scan/Other
400	Image Services
401	Mammography
402	Ultrasound
403	Screening Mammography
404	Positron Emission Tomography (PET)
409	Other Imaging Services
410	Respiratory Service
412	Inhalation Services
413	Hyperbaric Oxygen Therapy
419	Other Respiratory Services
420	Physical Therapy
421	Physical Therapy/Visit
422	Physical Therapy/Hour
423	Physical Therapy/Group
424	Physical Therapy/Evaluation/Re-evaluation
429	Physical Therapy/Other
430	Occupational Therapy
431	Occupational Therapy/Visit
432	Occupational Therapy/Hour
433	Occupational Therapy/Group
434	Occupational Therapy/Evaluation/Re-evaluation
439	Occupational Therapy/Other
440	Speech Pathology
441	Speech Pathology/Visit
442	Speech Pathology/Hour

(Continued)

Table 6 – Revenue Codes and Descriptions

Revenue Code	Revenue Code Description
443	Speech Pathology/Group
444	Speech Pathology/Evaluation/Re-evaluation
449	Speech Pathology/Other
460	Pulmonary Function
469	Pulmonary Function/Other
610	Magnetic Resonance Imaging
611	MRI/Brain
612	MRI/Spine
619	MRI/Other
920	Other Diagnostic Services
921	Peripheral Vascular Lab
922	Electromyogram
929	Additional Diagnostic Services

Waiver Services

Rounding Units of Service

The IHCP eliminated the use of local codes effective January 1, 2004, in accordance with HIPAA requirements. Because of this, some procedure codes previously billed in one-hour units of service were replaced with procedure codes with 15-minute units of service. For example, *Z5606 – Respite/Attendant Care/Personal Assistance Services (1 hour = 1 unit)* was changed to *S5150 – U7 (Waiver); UA-(Agency) Provider; UC – Personal Care – Unskilled Respite Care, not hospice each 15 minutes*.

Partial units cannot be billed. If a fractional unit of service is rendered, units of service must accrue to the **end of the day** when services were rendered. At the **end of the day**, units can be rounded when calculating reimbursement using the following guidelines:

- 15-minute units of service:
  - Any partial unit of service eight minutes or more is rounded up to a 15-minute unit of service.
  - Any partial unit of service seven minutes or less must not be rounded up and therefore should not be billed.

Attendant Care vs. Homemaker Clarification

Table 7 lists revised requirements for attendant care documentation.

Table 7 – Attendant Care Documentation

Old Code	HIPAA Code Effective January 1, 2004	Description of Services and Documentation Requirements	Applicable Waivers
Z5604 Z5653	S5125 (Attendant care services, per 15 minutes)	Attendant Care – No Homemaker Services on the Plan of Care (POC) •Identified need in the POC/Cost Comparison Budget (CCB) •Data record of services provided, including date of service and number of units delivered •Each staff member providing direct care or supervision of care to the client makes at least one entry on each day of service, describing an issue or circumstance concerning the client. •Documentation should include the complete date and time, and at least the last name and first initial of the staff person making the entry. If the person providing the service is required to be a professional, the title of the individual must also be included. **•If direct care or supervision of care is not provided to the client and the documentation of services rendered for the units billed reflects homemaker duties, an entry must be made to indicate why the direct care was not provided for that day. If direct care or supervision of care is not provided for more than 30 days and the documentation of services rendered for the units billed reflects homemaker duties, the case manager must be contacted to amend the POC to a) add Homemaker Services and eliminate Attendant Care Services or b) reduce attendant care hours and replace with the appropriate number of hours of homemaker services.** Modifiers: U7 – Waiver, UA – Provider	AD, MFC, TBI

HCBS Waiver Member Services

The OMPP's policy is to discontinue reimbursement for HCBS waiver services to members temporarily placed in an institutional setting including the following:

- Hospital
- Correctional Facility
- Nursing Facility (for an approved waiver respite stay)

In accordance with this policy, the only HCBS waiver service allowed during a short-term placement in one of these facilities is case management.

The rate, per diem, or DRG paid to such facilities is all-inclusive. The provision of other HCBS waiver services including, but not limited to, respite (except for an approved waiver respite stay in a nursing facility as noted above), residential habilitation and support, and behavior management is prohibited.

IHCP Provider Field Consultants Effective May 14, 2004

Territory Number	Provider Consultant	Telephone	Counties Served
1	Randy Miller (temp)	(317) 488-5388	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, and Starke
2	Debbie Williams	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, and Whitley
3	Chris Kern	(317) 488-5326	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Randy Miller	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, 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, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, and Vigo
8	Pam Martin	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick
9	Pat Duncan (temp)	(317) 488-5101	Out-of-State

Field Consultant for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/ Watseka	Pat Duncan (temp)	(317) 488-5101
	Danville	Chris Kern	(317) 488-5326
Kentucky	Louisville/Owensboro	Pam Martin	(317) 488-5153
Michigan	Sturgis	Debbie Williams	(317) 488-5080
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 Consultants

Special Program	Consultant	Telephone
590	Laura Merkel (temp)	(317) 488-5356
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 a map of provider representative territories or for updated information about the provider field representatives, visit the IHCP Web site at www.indianamedicaid.com.

Indiana Health Coverage Programs Quick Reference Effective May 14, 2004

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 – ACS Clinical Call Center** 1-866-879-0106 fax 1-866-780-2198
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/Waiver 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

Hoosier Healthwise (Managed Care Organizations and PCCM) 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 **Pharmacy** 1-800-608-8158	**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 **Pharmacy** (317) 630-2831 1-800-356-1204	**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 **ScripSolutions (PBM)** 1-800-555-8513	**Prime*Step* (PCCM)** www.healthcareforhoosiers.com **Claims - 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 for PMPs** 1-800-889-9949, Option 3 **Pharmacy** – see ACS in Pharmacy Benefit Manager section above	***Medicaid Select*** www.medicaidselect.com **Claims - 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 for PMPs** 1-877-633-7353, Option 3 **Pharmacy** – see ACS in Pharmacy Benefit Manager section above

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 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	

Indiana Health Coverage Programs

PROVIDER WORKSHOP REGISTRATION

Please **print** or **type** the information below and fax to (317) 488-5376.

Medicaid 101

Please indicate the workshop you will be attending in Indiana:

☐ Evansville, July 19, 2004 ☐ East Chicago, July 23, 2004 ☐ Anderson, August 11, 2004
☐ Jeffersonville, August 18, 2004 ☐ Lafayette, August 24, 2004 ☐ Terre Haute, August 24, 2004
☐ South Bend, August 31, 2004 ☐ Ft. Wayne, September 1, 2004 ☐ Indianapolis, September 2, 2004

Code Sets and Provider Enrollment – What Are They and How Do They Affect Me?

Please indicate the workshop you will be attending in Indiana:

☐ Evansville, July 19, 2004 ☐ East Chicago, July 23, 2004 ☐ Anderson, August 11, 2004
☐ Jeffersonville, August 18, 2004 ☐ Lafayette, August 24, 2004 ☐ Terre Haute, August 24, 2004
☐ South Bend, August 31, 2004 ☐ Ft. Wayne, September 1, 2004 ☐ Indianapolis, September 2, 2004

Registrant Information

Name of Registrant: _____

Provider Number: _____

Provider Name: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Provider Telephone: _____ Provider Fax: _____

Provider E-Mail Address: _____