Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider News NL200407 July 2004

Table of Contents

Provider News

2004 Third Quarter Workshops for Medicaid Providers 2

Long Term Care Services

Nursing Facility Updates 4

Managed Care Services

Hoosier Healthwise Managed Care Claims Appeals Procedures 4

Transportation Services

Transportation Procedure Code Updates 7

IHCP Provider Field Consultants 8

IHCP Telephone and Address Quick Reference 9

IHCP Provider Workshop Registration Form 10

Frequently Used Acronyms

CMS	Centers for Medicare & Medicaid Services
DFC	Division of Family and Children
HCE	Health Care Excel
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
LTC	Long Term Care
MCO	Managed Care Organization
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCP	Primary Care Provider
PMP	Primary Medical Provider

Provider News

2004 Third Quarter Workshops for Medicaid 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 1 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 1 – 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 2 lists the dates and Indiana locations for each workshop.

Table 2 – 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 10 of this newsletter. Please print or type the information requested on the registration form. List one registrant per form.

Long Term Care Services

Nursing Facility Updates

When a nursing facility resident elects Medicare benefits for room and board at the beginning of the month, liability is collected at the beginning of the month, as if the resident were not using Medicare days. If the resident uses Medicare room and board benefits for the entire month, the liability collected at the beginning of the month is placed into the resident's personal needs allowance account. If the resident is using Medicare benefits for room and board for several months, this could put the resident over personal resources. In this case, the county caseworker must be notified. The resident could be taken off Medicaid until personal resources are exhausted. The resident could then re-apply for Medicaid, and a new *Form 450B* would have to be completed. If the resident uses only a portion of the month for Medicare room and board benefits, the liability collected by the nursing facility is only for the days that Medicaid paid the nursing facility room and board. The remaining liability is placed in the resident's personal needs allowance account. If the dollar amount in the personal needs allowance account exceeds the limit allowed, the caseworker must be notified.

Managed Care Services

Hoosier Healthwise Managed Care Claims Appeals Procedures

In Indiana's Hoosier Healthwise Program, the State requires that MCO claims resolution procedures apply to all providers who are not under contract within the plan, for example, out-of-network providers. The State-mandated out-of-network claims dispute resolution procedures ensure a minimum level of due process for providers who are not under contract to provide services to the MCO's members. The State requires two levels of claims dispute resolution procedures for out-of-network providers, informal and formal. The informal process must be completed before beginning the formal process.

Note:	*MCOs have the right to negotiate different **in-network** claims dispute resolution procedures. Review the contract or contact the MCO for additional information.*

Informal Process – Verbal or Written Request

A provider may initially inquire or seek an informal resolution through verbal contact with the MCO. If this is not desired or satisfactory, a provider may submit an informal claims resolution dispute in writing to the MCO. When submitting a written appeal, attach a description of the nature of the dispute and identify a contact person. The informal process must be completed before initiating the formal process. Key points to consider are as follows:

- The MCO must notify the provider of the claims determination (paid, denied, or suspended) within 30 days of receipt of the claim.
- If the MCO has the claim for 30 days and the provider has not received a claims determination, or the provider wishes to appeal the claims determination decision, the provider has 60 days from either of these events to initiate the informal claims resolution process.
- The MCO must deliver a response to the provider's informal complaint within 30 days of receipt.

Formal Process – Written Notice of Formal Claims Dispute

If the dispute is not resolved informally, the provider has 60 days from the date of the MCO's response to submit a formal appeal **in writing** to the MCO. When submitting a written appeal, attach a description of the nature of the dispute and identify a contact person.

- The formal appeal must be reviewed by a panel of one or more individuals chosen by the MCO, who are knowledgeable about the policy, legal, and clinical issues presented in the matter, and who were not involved in the

original denial decision. The MCO medical director, or another licensed physician, must be consulted about any questions of medical necessity or medical appropriateness. The provider must be allowed to appear in person or otherwise question the panel, and submit any documentation the provider feels is relevant to the appeal.

- The panel must deliver to the provider a detailed written determination within 45 days. Failure to deliver a formal appeal determination within 45 days is considered a denial.

Binding Arbitration

The State also requires that binding arbitration is made available to an out-of-network provider who wishes to appeal the formal claims resolution decision, unless the provider and the MCO mutually agree to some other binding resolution process. The provider has 60 days from receipt of the formal denial decision to initiate the binding arbitration process.

The provider may also initiate binding arbitration proceedings if the MCO fails to deliver a formal appeal determination within the required 45-day period. Arbitration is conducted in compliance with the rules and regulations of the American Health Lawyers Association (AHLA). Arbitration fees and expenses should be borne by the non-prevailing party. A single arbitration matter may include multiple formal procedures. Table 3 lists steps in the appeal process and Table 4 lists appeals contact information.

Table 3 – General Checklist

Step	General Checklist	Process Level
1	Provider sends claim to MCO.	
2	MCO sends claim determination to provider within 30 days of receipt of claim.	Informal
3	Provider verbally contacts MCO or files a written informal claims appeal request with MCO within 60 days of step 2 or within 60 days after MCO has failed to complete step 2. For example, 90 days after the MCO has received the claim.	Informal
4	MCO determination of request is sent to provider within 30 days of step 3.	Informal
5	If not resolved informally, provider can file written notice of formal claims dispute within 60 days of step 4.	Formal
6	MCO Review Panel completes review and sends determination to provider within 45 days of step 5. Failure of the MCO Review Panel to deliver a determination within 45 days has the effect of a denial.	Formal
7	Provider submits request for binding arbitration within 60 days of Review Panel decision.	Formal

Table 4 – Claims Appeal Contact Information

Harmony Health Plan of Indiana	Managed Health Services (MHS)	MDwise
Harmony Health Plan Attn: Claims Appeals Coordinator 125 South Wacker Drive Suite 2600 Chicago, IL 60606-4402	Managed Health Services P.O. Box 3000 Farmington, MO 63640-3802 PH: 1-800-414-9475	MDwise – Appeals P.O. Box 441423-1423 Indianapolis, IN 46244-1423 PH: 1-800-356-1204

Frequently Asked Questions

1. What are some of the common reasons for claims denial?

Some common reasons for claims denial include provider ID missing from the claim, member not eligible on the date of service, member not enrolled in the plan (for example, member enrolled in different Hoosier Healthwise plan), additional information necessary to process claim, duplication of paid claim, and no authorization on file.

2. What are the referral and PA requirements?

In general, referrals to non-contracted specialists (excluding self-referral services) require a referral or PA from the MCO.

3. Is there a list of procedures requiring referrals or PAs?

Contact the MCO for information.

4. Who should the provider contact for PA?

The phone numbers are listed in the quick reference information on page 9 of this newsletter.

5. What is the PMP's responsibility?

The PMP is responsible for giving the referral and monitoring the member's medical needs. If the PMP refers to a non-contracted specialist, the MCO must be contacted for PA.

6. What is the specialist's responsibility in-network and out-of-network?

PMPs may refer to in-network or out-of-network specialists. If out-of-network, the specialist must verify with the referring PMP that the MCO was notified of the referral so the claim will pay. However, the specialist must contact the MCO to confirm the referral prior to rendering services. Specialists must not inform the member to contact the MCO to obtain the referral.

7. What documentation is needed for a claims appeal?

When submitting a written appeal send a copy of the claim, attach a description of the nature of the dispute, and identify a contact person.

8. What documentation is needed for prudent layperson determination for emergency room claims?

There is no established national format, but the medical record usually contains the necessary information. However, discharge notes are generally not sufficient.

9. Where can I send a claims dispute or appeal?

See Table 4.

Transportation Services

Transportation Procedure Code Updates

Transportation claims submitted with procedure code A0130 TT – *Non-emergency transportation; wheelchair van, individualized service provided to more than one patient in same setting* (multiple passenger), for dates of service starting January 1, 2004, may have paid incorrectly up to $20 per unit. Procedure code A0130 TT, which is the replacement for local code Y9201, should be reimbursed at $10 per unit.

The reimbursement rate was changed from $20 to $10 on June 18, 2004, and the $10 rate will be made retroactive to January 1, 2004. The rate was incorrectly reported in IHCP provider bulletin *BT200353* published August 15, 2003. The IHCP will systematically mass adjust all affected claims in the near future and providers will be notified in advance. Most providers will notice only one RA affected by this mass adjustment process. However, some providers may be notified in advance if the process will require additional time.

IHCP Provider Field Consultants Effective June 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	Jessica Ferguson	(317) 488-5197	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	(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 June 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: _____