Monthly News

Indiana Health Coverage Programs

www.indianamedicaid.com

Provider News NL200409 September 2004

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Frequently Used Acronyms

ALS	Advanced Life Support
BDDS	Bureau of Developmental Disabilities Services
BLS	Basic Life Support
CAS	Commercial Ambulatory Service
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
DFC	Division of Family and Children
EVS	Eligibility Verification Systems
FQHC	Federally Qualified Health Center
HCBS	Home- and Community-Based Services
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
IAC	Indiana Administrative Code
IDOA	Indiana Department of Administration
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
MCO	Managed Care Organization
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCCM	Primary Care Case Management
PMP	Primary Medical Provider
RBMC	Risk-Based Managed Care
RHC	Rural Health Clinic

Provider News

Version 5.0 of the *IHCP Provider Manual* Now Available

EDS, along with the OMPP, HCE, ACS, and provider associations, has published version 5.0 of the *IHCP Provider Manual*. The manual was posted to the IHCP Web site on July 29, 2004. A CD-ROM version of the manual is being mailed to all billing providers' *Mail To* addresses. Mailing began in mid-August and continues for several weeks. Billing providers who do not receive a copy of the manual by **October 1, 2004**, may contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Web interChange Updates

Due to HIPAA security requirements and per provider community requests, Web interChange will be updated in the near future with new functionality titled *Membership*. *Membership* will allow an organization to assign one or more administrators. The administrator will have the ability to oversee the entire organization's use of the interChange Web site.

Membership offers the following advantages:

- The administrator will be able to assign specific access to individual users. For example, the front office staff can be set up to view eligibility but not to submit claims or access claim inquiry.
- Each user will have an individual user ID and password, which will assist with meeting security requirements.
- The administrator or the individual user will be able to perform password resets. The help desk will no longer need to be contacted for password resets.
- The administrator can create new users and remove users when necessary.
- Future enhancements to Web interChange will be available only to organizations using *Membership.*

Additional information about *Membership* and assigning an administrator will be available at the annual IHCP seminar on October 19, 20, and 21, 2004.

Hoosier Healthwise Program MCO Contract Procurement

The OMPP is currently procuring new MCO contracts for the Hoosier Healthwise Program. For a complete copy of the Request for Proposal (*RFP 4-79*), contact the IDOA at the following address:
Indiana Department of Administration
Procurement Personnel
402 West Washington Street
Room W468
Indianapolis, IN 46204

The following MCOs have submitted responses to the RFP:

- AmeriGroup
- CareSource
- Harmony Health Plan
- Managed Health Services
- MDwise
- Molina

IHCP providers may be contacted by any one or more of these companies, particularly if located in a mandatory MCO county. Names of the MCOs selected for contract negotiations will be posted on the IHCP Web site at www.indianamedicaid.com when the IDOA *Notification of Award* is issued. **The OMPP cannot release or discuss the RFP or the individual responses until the MCO contracts are signed.**

Summary of Milestones

Table 1 is an illustration of the MCO contract procurement process.

Table 1 – MCO Contract Procurement Process

Activity	Date
Proposal submission date	July 21, 2004
IDOA notifies selected MCO respondents*	September 13, 2004
Contract signed by MCO respondents*	September 24, 2004
MCOs may start signing PMP agreements	October 1, 2004
Signed PMP agreements are due to MCO to keep current members	November 1, 2004
MCO contract effective date	January 1, 2005

**Note: Due to the unpredictable nature of the evaluation period, these dates are subject to change.*

New Features

While the program has been successful in meeting its goals, the State is enhancing the Hoosier Healthwise program for this procurement. The State will be implementing new features, or modifying existing features of the program, including the following:

- All selected MCOs will have equal opportunity to contract with PMPs because current MCO PMP contracts terminate December 31, 2004. In addition, to allow time for PMP recruitment activities, the MCOs will not execute any PMP contract for this procurement before October 1, 2004. PMPs with current MCO contracts must have new contracts signed and returned to the MCO by November 1, 2004, to keep their members after December 31, 2004.
- MCO contracts resulting from this procurement will be effective January 1, 2005, and will authorize the MCOs to operate statewide. Selected MCOs must immediately initiate network development activities in all mandatory RBMC counties. The following counties are mandatory RBMC counties:
  - Allen
  - Delaware
  - Elkhart
  - Grant
  - Howard
  - Johnson
  - Lake
  - LaPorte
  - Madison
  - Marion
  - Morgan
  - Porter
  - St. Joseph
- The State plans to continue to add to the list of mandatory RBMC counties, but no timeframe or schedule has been established at this time. The following counties currently meet the established criteria for consideration:
  - Clark
  - Floyd
  - Monroe
  - Vanderburgh
  - Vigo
- The State will monitor each participating MCO's member enrollment in the mandatory RBMC counties on a county-by-county basis and may limit auto assignment for MCOs approaching a pre-determined number of members per county to ensure sufficient member choice among the MCOs participating in that county.
- Additional MCO network requirements are listed below for PMPs, specialists, and ancillary providers.

PMP Requirements

In counties where both PCCM and RBMC are available, the Hoosier Healthwise PMP may participate as a PMP in only one delivery system, for example, either PCCM or RBMC. This does not prohibit the PMP from maintaining fee-for-service or PCCM enrollment for non-Hoosier Healthwise members (for example, Traditional Medicaid or *Medicaid Select*

members). When the physician elects, or as in the mandatory RBMC counties is required to participate in the RBMC delivery system, the physician may contract as a PMP with only one MCO. However, an MCO PMP may participate as a specialist in any other Hoosier Healthwise managed care plan.

Specialist, Hospital, and Ancillary Provider Network Requirements

Specialty providers participating in Hoosier Healthwise may contract with both the Prime*Step* program and the MCO. Unlike PMPs, specialist, hospital and ancillary providers are not limited to serve in only one MCO network. In addition, physicians contracted as a PMP with one MCO may contract as a specialist with the other Hoosier Healthwise plans.

The MCO must include a minimum of two specialists and ancillary providers of each type identified in Table 2 for each mandatory MCO county, or meet other access standards established by the OMPP.

Considering the nature of the services some ancillary providers render, the OMPP requires that MCOs maintain different network access standards, as follows, for DME, home health, and pharmacy providers.

- Two durable medical equipment providers and two home health providers must be available to provide services to the MCO's members in each of the mandatory RBMC counties.
- Two pharmacy providers must be within 30 miles or 30 minutes from a member's residence in each of the mandatory RBMC counties.

FQHCs and RHCs

Because FQHCs and RHCs are essential community providers, the State strongly encourages the MCO to contract with FQHCs and RHCs, particularly in the mandatory RBMC counties.

Benefits and Services

The MCOs may provide additional enhanced services (for example, prenatal care education programs), but the basic Hoosier Healthwise program benefits and services remain the same.

The following sections summarize self-referral, carve-out, and excluded services.

Carve-Out Services

IHCP members enrolled in a Hoosier Healthwise MCO are eligible to receive some services that are not the financial responsibility of the MCO. These are referred to as *carved-out* services and are adjudicated by the IHCP according to fee-for-service guidelines. MCO members can obtain covered IHCP carved-out services from any IHCP provider qualified to render the care. Providers of these services submit their claims directly to EDS and are reimbursed on a fee-for-service basis whether or not their services are rendered within a member's MCO network. The carved-out services bypass the managed care edits 2017 and 2018 when rendered by the provider types and specialties identified in Table 3.

If the services are not carved out, claims submitted to EDS for reimbursement of services rendered to MCO members are systematically denied with edit 2017 or 2018, dependent upon the claim type. These edits state that the member is enrolled in an RBMC plan with the Hoosier Healthwise Program, and the member must seek care from the appropriate MCO.

Self-Referral Services

Hoosier Healthwise members can seek care from any IHCP-enrolled provider qualified to render self-referral services, and without obtaining authorization from their PMP. An MCO may encourage its members to obtain care within its network, but it retains financial responsibility for self-referral services whether or not they are rendered within their network. In the absence of an agreement to the contrary, the MCO must reimburse out-of-network providers at the minimum amount listed on the IHCP Fee Schedule. Prime*Step* PCCM members are not required to obtain certification from their PMP for self-referral services. Regardless of whether the member is part of an MCO or Prime*Step* PCCM, certain services provided by a self-referral provider may require PA. Providers can refer to the *IAC* and the *IHCP Provider Manual* for further information. In the case of MCO members, the provider must contact the MCO to obtain PA when required.

Table 2 – Mandatory MCO County Provider Network

Physician Specialties	Self-referral Practitioners	Ancillary Providers
• Cardiologist • Orthopedic Surgeon • Otologist or Otolaryngologist • Urologist	• Chiropractor • Family Planning Practitioner • Ophthalmologist or Optometrist • Podiatrist	• DME • Home Health • Pharmacy

Table 3 – Summary of Carve-Out and Self-Referral Services by Hoosier Healthwise Delivery System

Services	MCO (RBMC) members	PrimeStep (PCCM) members
Chiropractic Services Services provided by IHCP-enrolled provider specialty 150	Self-referral* Claims go to MCO	Self-referral Claims go to EDS
Dental Services Services provided by IHCP-enrolled provider specialty 270-277	Carve-out and Self-referral Claims go to EDS	Self-referral Claims go to EDS
Diabetes Self Management Training Services Services for procedure codes G0108 – Diabetes outpatient self-management training services, individual, per ½ hour, and G0109 – Diabetes self-management training services, group session, (2 or more) per ½ hour, are available on a self-referral basis from any IHCP-enrolled chiropractor, podiatrist, optometrist, or psychiatrist who has had specialized training in the management of diabetes	Self-referral Claims go to MCO MCOs can require that diabetes self-management training services from other qualified health care professionals be provided within the MCO network. MCOs also can require members to obtain prior approval for payment to out-of-network providers.	Self-referral Claims go to EDS
Emergency Services Services rendered for the treatment of a true emergency or prudent layperson emergency	Self-referral Claims go to MCO Does not include non-emergency services that must receive PA from the MCO to be paid	Self-referral Claims go to EDS
Family Planning Services Procedures and diagnosis codes, as defined in the *IHCP Provider Manual*	Self-referral Claims go to MCO	Self-referral Claims go to EDS
HIV/AIDS targeted case management services Procedure code G9012 – Other specified case management service not elsewhere classified, ¼ hour	Self-referral Claims go to MCO	Self-referral Claims go to EDS

(Continued)

Table 3 – Summary of Carve-Out and Self-Referral Services by Hoosier Healthwise Delivery System

Services	MCO (RBMC) members	PrimeStep (PCCM) members
Individualized Education Plan (IEP) Services provided by a school corporation, IHCP-enrolled provider specialty 120, as part of a student's IEP	Carve-out Claims go to EDS	Self-referral Claims go to EDS
Behavioral Health Services Services provided by IHCP-enrolled provider specialties 011, 110-117, and 339	Carve-out and Self-referral Claims go to EDS	Self-referral Claims go to EDS
Pharmacy Services provided by IHCP-enrolled provider specialty 240	Use MCO network Claims go to MCO	Self-referral Claims go to EDS
Podiatric Services Services provided by IHCP-enrolled provider specialty 140	Self-referral* Claims go to MCO	Self-referral Claims go to EDS
Transportation Services provided by IHCP-enrolled provider specialties 260-266	Use MCO network Claims go to MCO	Self-referral Claims go to EDS
Vision care (except surgery) Services provided by IHCP-enrolled provider specialties 180 and 190	Self-referral* Claims go to MCO	Self-referral Claims go to EDS

**Note: Self-referral providers indicated with an asterisk must seek PA before rendering certain self-referral services. Refer to the* IHCP Provider Manual *and the* IAC *for further information.*

Excluded Services

The Hoosier Healthwise program excludes some benefits from coverage under managed care. These excluded benefits are available under traditional Medicaid or other waiver programs and include long-term care, home and community-based waiver, and hospice services. Therefore, a Hoosier Healthwise member who is or will be receiving these excluded services must be disenrolled from Hoosier Healthwise to be eligible for the services.

Audiology and Hearing Aid Services

Code Set Notification

Effective October 1, 2004, claims submitted by audiologists and hearing aid dealers will be subject to edit 1012 – *Procedure billed not payable for this provider specialty*. The development of the *Hearing Services Code Set* does not involve any policy change, but instead identifies procedure codes that are appropriate for reimbursement by audiologists and hearing aid dealers. Providers must ensure that they are enrolled under the correct provider specialty or specialties with the IHCP. For questions about provider enrollment, refer to Chapter 4 of the *IHCP Provider Manual*, contact a provider field representative, or call the EDS Provider Enrollment Unit at 1-877-707-5750. Enrolled providers billing within current guidelines should not experience difficulty with claim adjudication associated with the implementation of the *Hearing Services Code Set.*

For example, it is not appropriate for an audiologist to receive reimbursement for oral surgery, but it would be appropriate for an audiologist to receive reimbursement for a hearing test. Additionally, it is appropriate for a hearing aid dealer (or audiologist) to receive reimbursement for hearing aids and associated miscellaneous services relating to the provision of hearing aids.

A copy of the *Hearing Services Code Set* is available on the IHCP Web site at www.indianamedicaid.com. This code set is subject to change and will be updated accordingly based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the *Hearing Services Code Set*. Reimbursement will continue to be subject to current applicable policies, edits, or audits. Direct questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Chiropractic Services

Chiropractic ICD-9-CM Diagnosis Codes

The list of diagnostic codes billable by chiropractors has been expanded to allow appropriate payment for services rendered to members covered by Package B. This includes chiropractic services that are medically necessary for pregnancy. For chiropractors to receive reimbursement for services to Package B members, the claim must be submitted with one of the following pregnancy diagnosis codes as the primary diagnosis, followed by the appropriate chiropractic diagnosis code and chiropractic procedure code.

Table 4 lists the ICD-9-CM diagnosis codes that have been added to the chiropractic code set to reimburse for services to Package B members effective retroactive to July 1, 2003.

Direct questions about this information to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

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Table 4 – ICD-9-CM Diagnosis Codes for Chiropractic Services, Package B Members

Diagnosis Codes	Description
646.93	Unspecified complication of pregnancy – antepartum condition or complication
648.73	Bone and joint disorders of the back, pelvis, and lower limbs – antepartum condition or complication
648.93	Other current conditions classified elsewhere – antepartum condition or complication

HCBS Waiver Services

Service Definitions and Documentation Reminders

Table 5 contains the requirements for HCBS Waiver Services documentation.

Table 5 – Documentation References

Source	Covered Information
405 IAC 1-5-1	Medical Records; Contents and Retention
460 IAC 6	Supported Living Services and Supports Rule
BT200305	Changes to the HCBS Waiver Review Process
BT200315	Respite Care Services, Spend-down CHOICE, and the Rounding of Units
BT200371	Documentation Standards for HCBS Waiver Programs
IHCP Provider Manual	IHCP Policy and Procedures
BDDS Bulletins	BDDS Policy and Procedures
IHCP Banner Pages	IHCP Policy and Procedures

General Documentation Reminders

The documentation of services as rendered must match the units as billed. Entries must include a complete (mm/dd/yy) date, time (including a.m. or p.m. notations), and a staff/caregiver signature for **each** date of service or member encounter. Staff signatures must include a title where appropriate; for example RN, LPN, QMRP, and so forth. Service documentation must also include the following:

- The payer source; for example Medicare, Medicaid PA, CHOICE, or Medicaid Waiver.
- The name of the service rendered; for example attendant care, residential habilitation and support, and so forth.

Employee records, such as timecards or staffing schedules, do **not** constitute acceptable documentation of services.

Respite Services

(*460 IAC 6-3-49)* defines respite as "…services provided to individuals unable to care for themselves that are furnished on a short-term basis because of the absences or need for relief of those persons normally providing care."

The following guidelines also apply to respite services:

- Respite is **not** to be used to provide day care while the caregiver is at work or to provide services to members who do not have a primary caregiver.
- Respite/HHA is **not** to be used in place of traditional home health services available through Medicaid State Plan PA services.
- Respite/Nursing is **not** to be used for the purpose of providing skilled services, monitoring or assessments, as these skilled services are also available through traditional home health PA.

The documentation of respite (all levels) **must** include the following required elements:

- The type of respite; for example Respite/ATTC, Respite/Nursing, and so forth
- The location where the respite was rendered
- The reason for the respite

HIV Care Coordination Services

Code Set Notification

Effective October 1, 2004, claims submitted by HIV care coordinators will be subject to edit 1012 – *Procedure billed not payable for this provider specialty*. The development of the *HIV Care Coordinator Code Set* does not involve any policy change, but instead identifies codes that are appropriate for reimbursement by HIV care coordinators. The only code included in the code set is G9012, *Other specified case management service not elsewhere classified*. Providers must ensure that they are enrolled as the correct provider specialty or specialties with the IHCP. For questions about provider enrollment, refer to Chapter 4 of the *IHCP Provider Manual*, contact a provider field representative, or call the EDS Provider Enrollment Unit at 1-877-707-5750. Enrolled providers billing within current guidelines should not experience difficulty associated with the implementation of the *HIV Care Coordinator Code Set.*

A copy of the *HIV Care Coordinator Code Set* is available on the IHCP Web site at www.indianamedicaid.com. This code set is subject to change and will be updated accordingly on the IHCP Web site based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the *HIV Care Coordinator Code Set*. Reimbursement will continue to be subject to current applicable policies, edits, or audits. Direct questions to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Optometry and Optical Services

Code Set Notification

Effective October 1, 2004, claims submitted by optometrists and opticians will be subject to edit 1012 – *Procedure billed not payable for this provider specialty*. The development of the *Vision Services Code Set* does not involve any policy change, but instead identifies procedure codes that are appropriate for reimbursement by optometrists and opticians. Providers must ensure that they are enrolled under the correct provider specialty or specialties with the IHCP. For questions about provider enrollment, refer to Chapter 4 of the *IHCP Provider Manual*, contact a provider field representative, or call the EDS Provider Enrollment Unit at 1-877-707-5750. Enrolled providers billing within current guidelines should not experience difficulty with claim adjudication associated with the *Vision Services Code Set*.

For example, it is not appropriate for an optometrist to receive reimbursement for oral surgery, but it would be appropriate for an optometrist to receive reimbursement for an eye exam. Additionally, it is appropriate for an optician (or optometrist) to receive reimbursement for eyeglass frames, lenses, and associated miscellaneous services relating to the provision of eyeglasses.

A copy of the *Vision Services Code Set* is available on the IHCP Web site at www.indianamedicaid.com. This code set is subject to change and will be updated accordingly based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the *Vision Services Code Set*. Reimbursement will continue to be subject to current applicable policies, edits, or audits. Direct questions about this information to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Transportation Services

Transportation Code Set Clarifications

This article clarifies questions about the *Transportation Code Set* published in the IHCP May provider newsletter, *NL200405*. Table 8 contains the updated version of the code set.

Elimination of Coverage of Codes

Table 6 outlines the changes that were effective July 1, 2004. Mileage code, S0215 *Non-emergency transportation; mileage, per mile* was made non-covered effective July 1, 2004. Instead of S0215, providers must use A0425 *Ground mileage, per statute mile* with the appropriate modifier as outlined in Table 6. Additionally, modifiers have been removed from codes T2001 TK, T2003 U9, and T2004 TT because the modifiers were redundant of the code description.

Table 6 – Transportation Services Coding Changes

End-Dated Code	Description	Replacement Code	Description
S0215	Non-emergency transportation; mileage, per mile	**A0425 U1**	ALS ground mileage, per statute mile
		A0425 U2	BLS ground mileage, per statute mile
		A0425 U3	CAS ground mileage, per statute mile
		A0425 U4	NAS ground mileage, per statute mile
T2001 TK	Non-emergency transportation; patient attendant/ escort, TK = extra patient or passenger, non-ambulance	**T2001**	Non-emergency transportation; patient attendant escort
T2003 U9	Non-emergency transportation; encounter/trip, U9 = base rate	**T2003**	Non-emergency transportation; encounter/trip*
T2004 TT	Non-emergency transport; commercial carrier, multi-pass, TT = individualized service provided to more than one patient in one setting	**T2004**	Non-emergency transport; commercial carrier, multi-pass

*Only applicable to CAS providers.

Ambulances Billing for Commercial Ambulatory Services (CAS) or Non-Ambulatory Services (NAS)

Table 7 lists the new codes for non-emergency transportation by ambulance providers.

Table 7 – CAS or NAS Services Billed by Ambulances

Code	Description	Explanation
A0426 U3	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1) (CAS)	Scheduled transport of a patient in a non-emergency situation using an ALS vehicle but providing a level of service of a commercial ambulatory (CAS) provider.
A0426 U5	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1) (NAS)	Scheduled transport of a patient in a non-emergency situation using an ALS vehicle but providing a level of service of a non-ambulatory service (NAS) provider, or wheelchair van provider.
A0428 U3	Ambulance service, basic life support, non-emergency transport (BLS) (CAS)	Scheduled transport of patient in a non-emergency situation using a BLS vehicle, but providing a level of service of a commercial ambulatory service (CAS) provider.
A0428 U5	Ambulance service, basic life support, non-emergency transport (BLS) (NAS)	Scheduled transport of patient in a non-emergency situation using a BLS vehicle, but providing a level of service of a non-ambulatory service (NAS) provider, or wheelchair van provider.

Codes in Table 7 are to be used for scheduled transportation. For example, if an IHCP member calls an ambulance company for transportation to a doctor's appointment, but does not need a level of service that a BLS or ALS ambulance would provide, the appropriate modifier should be used. Payment will be equivalent to the reimbursement of a CAS or NAS, because the level of service provided was not that of an ambulance. Ambulance providers have been instructed to continue billing mileage according to vehicle type, ALS or BLS, using A0425 U1 or A0425 U2 listed in Table 6.

Providers are reminded that the least expensive form of transportation that meets the medical need of the member should always be provided. The codes in Table 7 are subject to the audit 6803 – *Transportation: one-way trips in excess of 20 [trips] requires prior authorization* and edit 3012 – *Transportation exceeding fifty miles requires prior authorization.*

Taxi Providers

The May provider newsletter, *NL200405*, incorrectly listed the following codes as valid for taxi providers, A0425 U3, A0425 U5, T2001, T2003, T2004, T2007 U3, and T2007 U5.

Revised Transportation Code Set

Table 8 contains an updated transportation code set. The code set is arranged by provider specialty.

Table 8 – Transportation Code Set (Revised)

260 Ambulance Provider			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0225	No	Yes	Ambulance service, neonatal transport, base rate, emergency transport, one-way
A0420 U1	No	No	Ambulance waiting time ALS, one-half (1/2) hour increments
A0420 U2	No	No	Ambulance waiting time BLS, one-half (1/2) hour increments
A0422	No	No	Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation
A0424	No	No	Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)
A0425 U1	No	No	Ground mileage, per statute mile; ALS
A0425 U2	No	No	Ground mileage, per statute mile; BLS
A0426	No	No	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1)
A0426 U3	No	Yes	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); CAS
A0426 U5	No	Yes	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS1); NAS
A0427	No	No	Ambulance service, advanced life support, emergency, level 1 (ALS1-emergency)
A0428	No	No	Ambulance service, basic life support, non-emergency transport; BLS
A0428 U3	No	Yes	Ambulance service, basic life support, non-emergency transport; CAS
A0428 U5	No	Yes	Ambulance service, basic life support, non-emergency transport; NAS
A0429	No	No	Ambulance service, basic life support, emergency transport, (BLS-emergency)
A0433	No	No	Advanced ALS (Level 2)
A0999	Yes	Yes	Unlisted ambulance service

Table 8 – Transportation Code Set (Revised)

261 Air Ambulance Provider			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0140	Yes	Yes	Non-emergency transportation and air travel (private or commercial), intra or interstate
A0420 U1	No	No	Ambulance waiting time ALS, one-half (1/2) hour increments
A0420 U2	No	No	Ambulance waiting time BLS, one-half (1/2) hour increments
A0422	No	No	Ambulance (ALS and BLS) oxygen and oxygen supplies, life-sustaining situation
A0424	No	No	Extra ambulance attendant, ground (ALS or BLS) or air (rotary and fixed wing)
A0430	Yes	No	Ambulance service, conventional air service, transport, one way (fixed wing)
A0431	Yes	No	Ambulance service, conventional air service, transport, one way (rotary wing)
A0999	Yes	Yes	Unlisted ambulance service

Table 8 – Transportation Code Set (Revised)

262 Bus Provider			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0110	Yes	Yes	Non-emergency transportation and bus, intra or interstate carrier

Table 8 – Transportation Code Set (Revised)

263 Taxi Provider			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0100 UA	No	Yes	Taxi, rates non-regulated, 0-5 miles
A0100 UB	No	Yes	Taxi, rates non-regulated, 6-10 miles
A0100 UC	No	Yes	Taxi, rates non-regulated, 11 or more miles

(Continued)

Table 8 – Transportation Code Set (Revised)

263 Taxi Provider			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0100 TK UA	No	No	Taxi, rates non-regulated, 0-5 miles for accompanying parent/attendant
A0100 TK UB	No	No	Taxi, rates non-regulated, 6-10 miles for accompanying parent/attendant
A0100 TK UC	No	No	Taxi, rates non-regulated, 11 or more miles for accompanying parent/attendant
A0100 TT UA	No	Yes	Taxi, rates non-regulated, 0-5 miles for multiple passengers
A0100 TT UB	No	Yes	Taxi, rates non-regulated, 6-10 miles for multiple passengers
A0100 TT UC	No	Yes	Taxi, rates non-regulated, 11 or more miles for multiple passengers
A0100 U4	No	Yes	Non-emergency transportation; taxi, suburban territory

Table 8 – Transportation Code Set (Revised)

264 Common Carrier-Ambulatory			
Procedure Code	**Prior Authorization?**	**20 One-Way Trip Limitation?**	**Description**
A0425 U3	No	No	Ground mileage, per statute mile; CAS
T2001	No	No	Non-emergency transportation, patient attendant/escort
T2003	No	Yes	Non-emergency transportation, encounter/trip
T2004	No	Yes	Non-emergency transportation, commercial carrier, multi-pass
T2007 U3	No	No	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; CAS

Table 8 – Transportation Code Set (Revised)

265 Common Carrier-Non Ambulatory			
Procedure Code	**Prior Authorization?**	**Twenty One-Way Trip Limitation?**	**Description**
A0130	No	No	Non-emergency transportation, wheel chair van base rate
A0130 TK	No	No	Non-emergency transportation, wheel chair van base rate; extra patient or passenger, non-ambulance
A0130 TT	No	No	Non-emergency transportation, wheel chair van base rate; individualized service provided to more than one patient in same setting
A0425 U5	No	No	Ground mileage, per statute mile; NAS
T2007 U5	No	No	Transportation waiting time, air ambulance and non-emergency vehicle, one-half (1/2) hour increments; NAS

Table 8 – Transportation Code Set (Revised)

266 Family Member Provider			
Procedure Code	**PA?**	**20 Trip Limit?**	**Description**
A0090	No	No	Non-emergency transportation, per mile-vehicle provided by individual (family member, self, neighbor) with vested interest

Providers experiencing difficulty with the implementation of the code set should contact EDS Customer Assistance, a provider representative, or EDS Provider Enrollment. Telephone numbers are located on pages 17 and 18 of this newsletter.

IHCP Provider Field Consultants Effective August 14, 2004

Territory Number	Provider Consultant	Telephone	Counties Served
1	Sharon Page	(317) 488-5071	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	Jessica Ferguson (temp)	(317) 488-5197	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Laura Merkel (temp)	(317) 488-5356	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 Consultants for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/Watseka	Sharon Page	(317) 488-5071
	Danville	Jessica Ferguson (temp)	(317) 488-5197
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) 488-5197.

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 August 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	