Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider News NL200411 November 2004

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Frequently Used Acronyms

AVR	Automated Voice Response
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
CRF/DD	Community Residential Facility for the Developmentally Disabled
DFC	Division of Family and Children
DME	Durable Medical Equipment
EFT	Electronic Funds Transfer
EVS	Eligibility Verification Systems
FAQ	Frequently Asked Questions
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMS	Health Management Systems
IAC	Indiana Administrative Code
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IDOA	Indiana Department of Administration
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
LOC	Level of Care
LTC	Long-Term Care
MCO	Managed Care Organization
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCCM	Primary Care Case Management
PMP	Primary Medical Provider
RBRVS	Resource-Based Relative Value Scale
RHC	Rural Health Clinic

Provider News

Radioimmunotherapy Services Using Zevalin or Bexxar Effective January 1, 2004

The IHCP provides reimbursement of radioimmunotherapy services for refractory low-grade or CD20 positive B-cell Non-Hodgkin's Lymphoma. The August 2004 provider newsletter provides instructions for billing radioimmunotherapy services using Zevalin® effective May 1, 2003, to December 31, 2003. This article addresses billing of radioimmunotherapy services using Zevalin or Bexxar® effective January 1, 2004.

Outpatient facilities were instructed in 2003 to bill a single code for the procedure and radiopharmaceutical, G0273 and G0274, whereas physician office providers were also allowed separate reimbursement for the radiopharmaceutical using A9522 and A9523. There are several billing changes applicable to services provided on or after January 1, 2004. Radioimmunotherapy services using Zevalin or Bexxar provided in 2004 in an outpatient or physician office setting are both reimbursed using 78804 and 79403 for the procedure, plus C1080 and C1081 (Bexxar) or C1082 and C1083 (Zevalin). Additionally, J9310 and Q0084 for the infusion of Rituximab® (Zevalin regimen) beginning in 2003, or G3001 for the administration of tositumomab (Bexxar regimen) beginning in 2004, are separately reimbursable.

Radioimmunotherapy is used for the treatment of low-grade B-cell Non-Hodgkin's Lymphoma in patients who have not responded to or failed other chemotherapy treatments and should not be used for the first line of treatment. Zevalin and Bexxar are monoclonal antibodies that target lymphocytes, including malignant B-cells involved in disease. Radiation-carrying antibodies infused into a patient circulate throughout the body, bind to specific cells, and deliver cytotoxic radiation directly to cancerous cells. This treatment methodology may result in significant tumor shrinkage and avoidance of larger full body treatment doses of radiation. The patient's medical record must support the medical necessity of radioimmunotherapy as specified in this article.

The radioimmunotherapy regimen is administered in two separate steps. The first step is diagnostic to determine radiopharmaceutical biodistribution of radiolabeled antibodies. The second step is the therapeutic administration of targeted radiolabeled antibodies. The published criteria for determining appropriate biodistribution involve making a qualitative comparison of isotope uptake in several organ systems between the two scans. Therefore, these scans cannot be read in isolation and codes 78804 and 79403 must be reported only once no matter how many scans are performed during the treatment regimen. Facilities are not to use CPT codes 77750, 78800-78803, 78999, 79100, 79400, or 77990 when billing for radioimmunotherapy services using Zevalin or Bexxar.

The supply of the radiopharmaceutical imaging agent represents per dose. Codes C1080 (Bexxar) or C1082 (Zevalin) for diagnostic imaging agents and codes C1081 (Bexxar) or C1083 (Zevalin) for therapeutic imaging agents are to be reported once for diagnostic imaging and once for therapeutic imaging during the treatment regimen.

Currently radioimmunotherapy is not a repeated procedure. The codes for radioimmunotherapy services listed in this article are restricted as noted to one unit per code per lifetime. The IHCP will re-examine the issue if future research determines that additional sources of radioimmunotherapy would be appropriate.

Billing for Outpatient Setting

Table 1 provides information about billing for radioimmunotherapy services provided in an outpatient facility. The outpatient provider will bill on the UB-92 claim form or 837I electronic transaction for the technical component of the procedure, the radiopharmaceutical, and the appropriate revenue code. The physician will bill on a CMS-1500 claim form or 837P electronic transaction for the professional component of the procedure. The infusion of Rituximab prior to the administration of Zevalin or the infusion of tositumomab prior to the administration of Bexxar are separately reimbursable.

Table 1 – Zevalin and Bexxar Therapy Provided in an Outpatient Facility Effective January 1, 2004

CPT Code	Revenue Code	Reimbursement	Description
78804* (outpatient provider)	341	$114.21 (max fee)	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
78804-26* (professional)	billed by physician	$40.15 (RBRVS)	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
79403* (outpatient provider)	340, 342	$111.85 (max fee)	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
79403-26* (professional)	billed by physician	$87.84 (RBRVS)	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
C1080* (Bexxar) or C1082* (Zevalin)	636	$1,719.48 (max fee)	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
C1081* (Bexxar) or C1083* (Zevalin)	636	$12,505.30 (max fee)	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose
G3001 (Bexxar Regimen)	333, 34x	$1,413.39 (max fee)	Administration and supply of tositumomab, 450 mg
J9310 **and** **Q0084 (Zevalin Regimen)**	636 335	$ 527.51 (January 1, 2004 – September 30, 2004) $548.68 (as of October 1, 2004) manual pricing	Rituximab, 100 mg Chemotherapy administration by infusion technique only, per visit

**Limited to one unit per lifetime*

Billing for Physician Office Setting

Table 2 provides information about billing radioimmunotherapy services provided in a physician office setting. The physician office provider must bill on a CMS-1500 claim form or 837P electronic transaction with the global scanning procedure code, the administration of the radiopharmaceutical, and the supply of the radiopharmaceutical. The infusion of Rituximab prior to the administration of Zevalin or the infusion of tositumomab prior to the administration of Bexxar are separately reimbursable.

Table 2 – Zevalin and Bexxar Therapy Provided in Physician Office Setting Effective January 1, 2004

CPT Code	Reimbursement	Description
78804*	$154.36 (RBRVS)	Radiopharmaceutical localization of tumor or distribution of radiopharmaceutical agent(s); whole body, requiring two or more days imaging
79403*	$199.69 (RBRVS)	Radiopharmaceutical therapy, radiolabeled monoclonal antibody by intravenous infusion
C1080* (Bexxar) or C1082* (Zevalin)	$1,719.48 (max fee)	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose
C1081* Bexxar) or C1083* (Zevalin)	$12,505.30 (max fee)	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose Supply of radiopharmaceutical therapeutic imaging agent, Yttrium 90 ibritumomab tiuxetan, per dose
G3001 (Bexxar Regimen)	$1,413.39 (max fee)	Administration and supply of tositumomab, 450 mg
J9310 **and** **Q0084 (Zevalin Regimen)**	$527.51 (January 1, 2004 – September 30, 2004) $548.68 (as of October 1, 2004) manual pricing	Rituximab, 100 mg Chemotherapy administration by infusion technique only, per visit

**Limited to one unit per lifetime*

Additional Information

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

IHCP Introduces File Exchange

Effective January 1, 2005, the IHCP will be offering *File Exchange*. *File Exchange* is a new application that supports secure file processing, storage, and transfer. It is designed to collect, store, manage, and distribute sensitive information between the IHCP and an organization using an Internet connection. Transmitting files in this manner has several advantages including increased speed and security. *File Exchange* also allows the IHCP and its trading partners to satisfy the data integrity, auditing, and privacy standards established by the HIPAA security and privacy rules. The IHCP Web site and software vendors will have additional information about *File Exchange* as it becomes available.

Provider Enrollment Forms

The IHCP provider enrollment applications and provider enrollment update forms were recently updated to better facilitate the provider enrollment process. Effective immediately, all provider enrollment applications and provider enrollment updates must be submitted on the updated forms.

Beginning December 15, 2004, EDS will return any enrollment or update request submitted to EDS Provider Enrollment on the old forms and request completion on the new forms. The new forms are available on the IHCP Web site at www.indianamedicaid.com, or by contacting EDS Provider Enrollment at 1-877-707-5750.

All new enrollments, including additional service locations, require a completed provider enrollment application. All file updates, including changes of name and address, set up of EFT accounts, and updates to rendering provider information, require a completed provider update form.

What is New

- Providers have only two forms:
  - *Provider Enrollment Application* - For providers new to the IHCP and for billing providers adding new service locations.
  - *Provider Enrollment Update form* - For providers needing to make changes to their enrollment information, including the enrollment of new rendering providers or the addition of an IHCP-enrolled rendering provider to a group.
- Enhanced Ownership and Disclosure schedules were created to comply with the rule change stated in *405 IAC 1-19*.
- EFT is now required for all billing providers new to the IHCP.
- The process for enrolling group members has been simplified.

Web interChange Membership

Web interChange has been enhanced with a new functionality titled *Membership*. *Membership* allows organizations to assign one or more administrators to oversee their members' use of the interChange Web site. An administrator can assign specific access to individual users. For example, the front office staff can be set up to view eligibility only, but not submit claims. Also, under *Membership* each user is assigned a unique user ID and password and can reset their own password when necessary. With this functionality an individual user cannot disable a password for an entire organization. To set up an administrator for an organization, fill out and mail the *Administrator Request Form* found under *How to Obtain an ID* on the interChange Web site.

Membership also enforces HIPAA security regulations for password usage. All new Web interChange passwords must follow the HIPAA compliant format. All passwords are now case sensitive. Entering passwords not in the proper case or format can cause the password to be disabled. Detailed information about the valid format of Web interChange passwords can be found in the FAQ link on the interChange Web site.

Direct questions about *Membership* and administrator access to the EDI Solutions Help Desk at (317) 488-5160 – option 3 in the Indianapolis area or 1-877-877-5182. Questions can also be e-mailed to inxixElectronicSolution@eds.com.

DME Services

Automatic External Defibrillators and Wearable Cardioverter Defibrillators

The IHCP covers two types of automatic external defibrillators (AEDs) with PA for individual use. The IHCP will cover the automatic external defibrillator (AED), *E0617 – External defibrillator with integrated electrocardiogram analysis,* effective November 15, 2004. The second type of AED is the wearable cardioverter defibrillator (WCD), *K0606 – Automatic external defibrillator, with integrated electrocardiogram analysis, garment type*. The WCD (K0606) became covered effective January 1, 2004.

The AED (E0617) is similar to a manual defibrillator except the AED detects and analyzes heart rhythms automatically. There are various manufacturers of the AED devices. Each device uses a battery pack and electrode defibrillator pads and the initial supplies are usually included with the device.

The WCD consists of a vest-like or garment-like device worn under a patient's clothing that holds a monitor, electrodes, a battery, and a small alarm module. The monitor is designed to automatically sense abnormal heart rhythms and deliver electrical therapy through the electrodes after alerting the patient to avoid improper defibrillation. Non-wearable components include a battery charger, a computer modem, a modem cable, a computer cable, WCDNET, and the diagnostic test. WCDNET is a secure Web-based data storage and retrieval system that allows the physician to access the patient's electrocardiogram (ECG) data stored by the WCD monitor. The diagnostic tester is used by the physician to program the WCD to identify specific heart rates and rhythms for data storage. Additional components included with the WCD are a second battery to be used when the first is charging and an extra garment for use when the first is cleaned.

The AED (E0617) and the WCD (K0606) are indicated for members who normally are candidates for an implanted cardioverter defibrillator (ICD), but for whom an ICD is contraindicated, or needs to be removed. The average time of use is approximately two to three months, although some members awaiting transplant have used the device for more than one year.

The IHCP will cover either an AED (E0617) or a WCD (K0606) based on the physician's clinical assessment of the member's medical needs. Table 3 lists examples of factors that may be considered when choosing which defibrillator is most appropriate for the member.

Table 3 – Defibrillator Factors

Factors for Choosing E0617	Factors for Choosing K0606
Inability to wear a WCD vest due to obesity	Lack of assistant who can operate an AED
Skin irritation from wearing electrodes 24 hours per day	Frequency that the member is away from home
Limited or lack of mobility	Mobility of the member
Availability of an assistant to operate the AED	Frequently unstable heart rhythms

Coding and Reimbursement

The HCPCS code, description, and pricing for the WCD, AED, and accessories are listed in Tables 4 and 5. The WCD and the AED are capped rental items. K0607 and K0608 are inexpensive and routinely purchased items.

Table 4 – Wearable Cardioverter Defibrillator

HCPCS Code	Description	Pricing
K0606	Automatic external defibrillator with integrated electrocardiogram analysis, garment type	$1,866.67 - RR $28,000.00 - NU
K0607*	Replacement battery for AED, garment type only	$19.84 - RR $198.31 - NU
K0608	Replacement garment for use with AED garment type only, each	$12.39 - RR $123.76 - NU
K0609*	Replacement electrodes for use with AED, garment type only	$823.02 (Supply)

**These codes are used for both the automatic external defibrillator and wearable cardioverter defibrillator.*

Table 5 – Automatic External Defibrillator

HCPCS Code	Description	Pricing
E0617	External defibrillator with integrated electrocardiogram analysis	$310.44 - RR $4,656.60 - NU
K0607*	Replacement battery for AED, garment type only	$19.84 - RR $198.31 - NU
K0609*	Replacement electrodes for use with AED, garment type only	$823.02 (Supply)

**These codes are used for both the automatic external defibrillator and wearable cardioverter defibrillator.*

Prior Authorization Criteria

The IHCP covers the AED (E0617) and the WCD (K0606) under the same PA criteria. The AED or the WCD is covered for members in two circumstances as described in Table 6.

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Table 6 – Prior Authorization Criteria

Members must meet either (1) both criteria A and B; or (2) criterion C	
Criteria	**Description**
A	The member has **one** of the following conditions (**1-5)**
	1. A documented episode of cardiac arrest due to ventricular fibrillation, not due to a transient or reversible cause [1] (*ICD-9 427.41, 427.42, 427.5*)
	2. A sustained, lasting 30 seconds or longer, ventricular tachyarrhythmia, either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction[2], and not due to a transient or reversible cause (*ICD-9 427.1*)
	3. Familial or inherited conditions with a high risk of life-threatening ventricular tachyarrhythmias such as long QT syndrome (*ICD-9 426.89*) or hypertrophic cardiomyopathy (*ICD-9 425.1*)
	4. Coronary artery disease with a documented prior myocardial infarction, (*ICD-9 410.0-0-410.92*) with a measured left ventricular ejection fraction[2] less than or equal to 0.35, and inducible, sustained ventricular tachycardia (VT) or ventricular fibrillation (VF) during an EP study. To meet this criterion both (a) and (b) below must occur:
	a) The myocardial infarction must have occurred more than four weeks prior to the external defibrillator prescription; **and**,
	b) The EP test must have been performed more than four weeks after the qualifying myocardial infarction.
	5. Documented prior myocardial infarction (*ICD-9 410.00-410.92*) and a measured left ventricular ejection fraction less than or equal to 0.30 and a QRS duration of greater than 120 milliseconds. Patients must not have the following:
	a) New York Heart Association classification IV; **or**
	b) Cardiogenic shock or symptomatic hypotension while in a stable baseline rhythm; **or**
	c) Had a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months; **or**
	d) Had an enzyme-positive MI within the past month; **or**
	e) Clinical symptoms or findings that would make them a candidate for coronary revascularization; **or**
	f) Irreversible brain damage from preexisting cerebral disease; **or**
	g) Any disease, other than cardiac disease (for example, cancer, uremia, liver failure), associated with a likelihood of survival less than one year.
B	Implantation surgery is contraindicated.
C	A previously implanted defibrillator now requires removal.

[1] Transient or reversible causes include conditions such as drug toxicity, severe hypoxia, acidosis, hypocalcemia, hyperkalemia, systemic infections, and myocarditis (not all-inclusive).

[2] Myocardial infarctions must be documented by elevated cardiac enzymes or Q-waves on an electrocardiogram. Ejection fractions must be measured by angiography, radionuclide scanning, or echocardiography.

Claims for defibrillators for other indications will be denied as not medically necessary. The IHCP will not purchase both an AED and WCD for one member, nor rent an AED and a WCD simultaneously for one member.

Prior Authorization Criteria for Accessories K0607 – K0609

PA criteria for accessories are based on the estimated average life expectancies of the accessories. The accessories replacement batteries, K0607, and replacement electrodes, K0609, are used for both the AED (E0617) and WCD (K0606).

K0607 – Replacement Battery

1. The member must currently be renting or have purchased an AED (E0617) or WCD (K0606 with integrated electrocardiogram analysis, garment type).
2. The battery being replaced must be at least 11 months old or completely discharged.

K0608 – Replacement Garment (only for WCD)

1. The member must currently be renting or have purchased a WCD with integrated electrocardiogram analysis, garment type (K0606).
2. The garment must be damaged or worn beyond repair and have been in use at least five months.

K0609 – Replacement Electrodes

1. The member must currently be renting or have purchased an AED (E0617) or the WCD with integrated electrocardiogram analysis, garment type (K0606).
2. The electrodes being replaced must have been used for at least 22 months, or it must be proven that the equipment is broken or damaged beyond repair.

Hospice Services

Medicaid Rates Effective October 1, 2004

Each year on October 1, the CMS releases new hospice rates to state Medicaid agencies for Medicaid-enrolled hospice providers.

This article provides the following information about the new IHCP hospice rates:

- A brief explanation of the method of calculation used by Myers and Stauffer, LC, the IHCP long term care rate-setting contractor, to establish the IHCP hospice rates.
- A brief summary of how EDS, the IHCP fiscal agent contractor, updated Indiana*AIM*, to reflect the new hospice rates, and the date the claims mass adjustments are to be completed.
- A table listing the new IHCP hospice rates, effective October 1, 2004, as prepared by Myers and Stauffer, LC.

Method of Calculation

Reimbursement for the IHCP hospice benefit follows the methodology and level established by the CMS for the administration of the federal Medicare program. Therefore the IHCP hospice rates, based on Medicare reimbursement rates and methodology, are adjusted to disregard offsets resulting from Medicare premium amounts. The rates are adjusted in wages using listings from the CMS.

The total per diem amounts reimbursed to an IHCP-enrolled hospice provider are calculated according to the IHCP hospice member's location of care. Hospice providers are reimbursed at one of the hospice LOCs. A member's hospice LOC is covered in one of the following situations:

- Routine home hospice LOC in the private home - IHCP hospice per diem only
- Routine home hospice LOC in the nursing home - IHCP hospice per diem plus room and board per diem
- Continuous home hospice LOC - IHCP hospice per diem only
- Continuous home hospice LOC in the nursing home - IHCP hospice per diem plus room and board per diem
- Inpatient respite care for the private home members or nursing facility members - IHCP hospice per diem only - There is no additional room and board per diem for this service
- General inpatient care for the private home members or nursing facility members - IHCP hospice per diem only - There is no additional room and board per diem for this service

Hospice providers are reminded that the Balanced Budget Act (BBA) of 1997 changed the reimbursement methodology so that the hospice per diem for routine and continuous home hospice LOC is paid using the wage index listing of the city or county where the member resides. The BBA of 1997 did specify that when a hospice bills for inpatient hospice care that the hospice rate would continue to be paid using the wage index listing of the city or county where the hospice is located. Indiana*AIM* pays IHCP hospice claims consistent with the BBA of 1997.

Payment of Hospice Claims

The new hospice rates were loaded into Indiana*AIM* on October 7, 2004, and are listed in Table 7. There will be no mass claims adjustments as the system was updated with the new hospice rates prior to November 1, 2004, when hospices would start billing for October 2004 hospice service dates.

Table 7 – Hospice Wage Adjusted Rates Effective October 1, 2004

County Name	County Code	Wage Index	Routine Home Care	Continuous Home Care Full Rate 24 hours	Continuous Home Care Hourly Rate	Inpatient Respite Care	General Inpatient Care
Bloomington:							
Monroe	53	0.9232	115.69	674.62	28.11	127.30	515.94
Cincinnati:							
Dearborn	15	1.0033	122.42	713.81	29.74	133.06	543.76
Ohio	58	1.0033	122.42	713.81	29.74	133.06	543.76
Elkhart-Goshen:							
Elkhart	20	1.0427	125.72	733.10	30.55	135.89	557.44
Evansville:							
Posey	65	0.8984	113.61	662.48	27.60	125.51	507.32
Vanderburgh	82	0.8984	113.61	662.48	27.60	125.51	507.32
Warrick	87	0.8984	113.61	662.48	27.60	125.51	507.32
Fort Wayne:							
Adams	1	1.0216	123.95	722.77	30.12	134.37	550.11
Allen	2	1.0216	123.95	722.77	30.12	134.37	550.11
De Kalb	17	1.0216	123.95	722.77	30.12	134.37	550.11
Huntington	35	1.0216	123.95	722.77	30.12	134.37	550.11
Wells	90	1.0216	123.95	722.77	30.12	134.37	550.11
Whitley	92	1.0216	123.95	722.77	30.12	134.37	550.11
Gary:							
Lake	45	1.0029	122.38	713.62	29.73	133.03	543.62
Porter	64	1.0029	122.38	713.62	29.73	133.03	543.62
Indianapolis:							
Boone	6	1.0569	126.92	740.04	30.84	136.91	562.37
Hamilton	29	1.0569	126.92	740.04	30.84	136.91	562.37
Hancock	30	1.0569	126.92	740.04	30.84	136.91	562.37
Hendricks	32	1.0569	126.92	740.04	30.84	136.91	562.37
Johnson	41	1.0569	126.92	740.04	30.84	136.91	562.37
Madison	48	1.0569	126.92	740.04	30.84	136.91	562.37
Marion	49	1.0569	126.92	740.04	30.84	136.91	562.37
Morgan	55	1.0569	126.92	740.04	30.84	136.91	562.37
Shelby	73	1.0569	126.92	740.04	30.84	136.91	562.37

(Continued)

Table 7 – Hospice Wage Adjusted Rates Effective October 1, 2004

County Name	County Code	Wage Index	Routine Home Care	Continuous Home Care Full Rate 24 hours	Continuous Home Care Hourly Rate	Inpatient Respite Care	General Inpatient Care
Kokomo:							
Howard	34	0.964	119.12	694.58	28.94	130.23	530.11
Tipton	80	0.964	119.12	694.58	28.94	130.23	530.11
Lafayette:							
Clinton	12	0.9631	119.04	694.14	28.92	130.17	529.79
Tippecanoe	79	0.9631	119.04	694.14	28.92	130.17	529.79
Louisville:							
Clark	10	0.985	120.88	704.86	29.37	131.74	537.40
Floyd	22	0.985	120.88	704.86	29.37	131.74	537.40
Harrison	31	0.985	120.88	704.86	29.37	131.74	537.40
Scott	72	0.985	120.88	704.86	29.37	131.74	537.40
Muncie:							
Delaware	18	0.9353	116.71	680.54	28.36	128.17	520.14
South Bend:							
St. Joseph	71	1.0467	126.06	735.05	30.63	136.18	558.83
Terre Haute:							
Clay	11	0.8873	112.68	657.05	27.38	124.72	503.47
Vermillion	83	0.8873	112.68	657.05	27.38	124.72	503.47
Vigo	84	0.8873	112.68	657.05	27.38	124.72	503.47
Non-urban Areas:							
Bartholomew	3	0.9405	117.15	683.08	28.46	128.54	521.94
Benton	4	0.9405	117.15	683.08	28.46	128.54	521.94
Blackford	5	0.9405	117.15	683.08	28.46	128.54	521.94
Brown	7	0.9405	117.15	683.08	28.46	128.54	521.94
Carroll	8	0.9405	117.15	683.08	28.46	128.54	521.94
Cass	9	0.9405	117.15	683.08	28.46	128.54	521.94
Crawford	13	0.9405	117.15	683.08	28.46	128.54	521.94
Daviess	14	0.9405	117.15	683.08	28.46	128.54	521.94
Decatur	16	0.9405	117.15	683.08	28.46	128.54	521.94
Dubois	19	0.9405	117.15	683.08	28.46	128.54	521.94
Fayette	21	0.9405	117.15	683.08	28.46	128.54	521.94
Fountain	23	0.9405	117.15	683.08	28.46	128.54	521.94

(Continued)

Table 7 – Hospice Wage Adjusted Rates Effective October 1, 2004

County Name	County Code	Wage Index	Routine Home Care	Continuous Home Care Full Rate 24 hours	Continuous Home Care Hourly Rate	Inpatient Respite Care	General Inpatient Care
Franklin	24	0.9405	117.15	683.08	28.46	128.54	521.94
Fulton	25	0.9405	117.15	683.08	28.46	128.54	521.94
Gibson	26	0.9405	117.15	683.08	28.46	128.54	521.94
Grant	27	0.9405	117.15	683.08	28.46	128.54	521.94
Greene	28	0.9405	117.15	683.08	28.46	128.54	521.94
Henry	33	0.9405	117.15	683.08	28.46	128.54	521.94
Jackson	36	0.9405	117.15	683.08	28.46	128.54	521.94
Jasper	37	0.9405	117.15	683.08	28.46	128.54	521.94
Jay	38	0.9405	117.15	683.08	28.46	128.54	521.94
Jefferson	39	0.9405	117.15	683.08	28.46	128.54	521.94
Jennings	40	0.9405	117.15	683.08	28.46	128.54	521.94
Knox	42	0.9405	117.15	683.08	28.46	128.54	521.94
Kosciusko	43	0.9405	117.15	683.08	28.46	128.54	521.94
Lagrange	44	0.9405	117.15	683.08	28.46	128.54	521.94
La Porte	46	0.9405	117.15	683.08	28.46	128.54	521.94
Lawrence	47	0.9405	117.15	683.08	28.46	128.54	521.94
Marshall	50	0.9405	117.15	683.08	28.46	128.54	521.94
Martin	51	0.9405	117.15	683.08	28.46	128.54	521.94
Miami	52	0.9405	117.15	683.08	28.46	128.54	521.94
Montgomery	54	0.9405	117.15	683.08	28.46	128.54	521.94
Newton	56	0.9405	117.15	683.08	28.46	128.54	521.94
Noble	57	0.9405	117.15	683.08	28.46	128.54	521.94
Orange	59	0.9405	117.15	683.08	28.46	128.54	521.94
Owen	60	0.9405	117.15	683.08	28.46	128.54	521.94
Parke	61	0.9405	117.15	683.08	28.46	128.54	521.94
Perry	62	0.9405	117.15	683.08	28.46	128.54	521.94
Pike	63	0.9405	117.15	683.08	28.46	128.54	521.94
Pulaski	66	0.9405	117.15	683.08	28.46	128.54	521.94
Putnam	67	0.9405	117.15	683.08	28.46	128.54	521.94
Randolph	68	0.9405	117.15	683.08	28.46	128.54	521.94
Ripley	69	0.9405	117.15	683.08	28.46	128.54	521.94
Rush	70	0.9405	117.15	683.08	28.46	128.54	521.94

(Continued)

Table 7 – Hospice Wage Adjusted Rates Effective October 1, 2004

County Name	County Code	Wage Index	Routine Home Care	Continuous Home Care Full Rate 24 hours	Continuous Home Care Hourly Rate	Inpatient Respite Care	General Inpatient Care
Spencer	74	0.9405	117.15	683.08	28.46	128.54	521.94
Starke	75	0.9405	117.15	683.08	28.46	128.54	521.94
Steuben	76	0.9405	117.15	683.08	28.46	128.54	521.94
Sullivan	77	0.9405	117.15	683.08	28.46	128.54	521.94
Switzerland	78	0.9405	117.15	683.08	28.46	128.54	521.94
Union	81	0.9405	117.15	683.08	28.46	128.54	521.94
Wabash	85	0.9405	117.15	683.08	28.46	128.54	521.94
Warren	86	0.9405	117.15	683.08	28.46	128.54	521.94
Washington	88	0.9405	117.15	683.08	28.46	128.54	521.94
Wayne	89	0.9405	117.15	683.08	28.46	128.54	521.94
White	91	0.9405	117.15	683.08	28.46	128.54	521.94

Long Term Care Services

LTC Facility Liability for Hoosier Healthwise Members Pending LOC Determination

Providers must verify health care coverage before providing services to a patient. IHCP member eligibility can be verified using one of the EVS including AVR, OMNI swipe card, or Web interChange. These sources of eligibility data reflect whether the patient is enrolled in an IHCP managed care program such as Hoosier Healthwise or *Medicaid Select*, and who the provider must contact about care and reimbursement.

Refer to Chapter 3 of the *IHCP Provider Manual* for more information about the EVS.

The LTC facility, nursing facility, CRF/DD, or ICF/MR where an IHCP member is treated must verify the patient's IHCP eligibility and health care program when the patient is admitted or screened, to determine whether the individual is currently enrolled in a managed care program. Because LTC services are excluded from the managed care program, managed care members must be disenrolled from the managed care program to become eligible for long term LOC.

The facility **must** contact the managed care plan responsible for the patient's care in the following situations:

- If eligibility information indicates the patient is enrolled in PCCM (PrimeStep or *Medicaid Select*), the provider must contact the PMP identified by the EVS.
- If the eligibility information indicates that the patient is enrolled in RBMC, the provider must contact the MCO identified by the EVS.

The provider **must** verify the patient's IHCP program eligibility, not only upon admission and screening, but also on the first and 15th of **every month thereafter** because the member may switch from fee-for-service Medicaid to Hoosier Healthwise or *Medicaid Select* managed care or may switch managed care plans, for example, from PCCM to an MCO.

If a managed care member is undergoing screening for admission to an IHCP-certified LTC or nursing facility, the facility must complete the LOC paperwork and submit it to the appropriate agency. During the time that the paperwork is being processed by the facility or the appropriate agency, the member may be auto-assigned to a PMP in a managed care plan. It is not until the LOC determination is entered into Indiana*AIM* that managed care enrollment is blocked. Details about this process can be found in Chapter 14, Section 2, of the *IHCP Provider Manual*. Chapter 14, Section 12, covers the managed care related issues.

If the facility determines that a patient is enrolled in a Hoosier Healthwise MCO, the provider **must** notify the MCO within 72 hours. **If the provider fails to verify an IHCP member's coverage or fails to contact the MCO within 72 hours of admission or on the first and 15th of every month, the provider will be responsible for any charges incurred until the Hoosier Healthwise member is disenrolled from the MCO.** When the provider notifies the MCO within 72 hours of admission, the MCO will be liable for charges up to 60 days. If the provider fails to complete the paperwork for the appropriate LOC determination and the member is still enrolled in Hoosier Healthwise after two months, the MCO is no longer liable for payment. However, as long as the patient is a member of the MCO, claims submitted to EDS will be denied payment.

Additional Information

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

Managed Care Services

Hoosier Healthwise Program MCO Contract Procurement

The OMPP is currently procuring new MCO contracts for the Hoosier Healthwise Program. A complete copy of the Request for Proposal (*RFP 4-79)* is available online at http://www.in.gov/fssa/hoosier_healthwise/rfp4-79.html or the IDOA can be contacted at the following address for a printed copy:

Indiana Department of Administration
Procurement Personnel
402 West Washington Street
Room W468
Indianapolis, IN 46204
Phone (317) 232-3053 / Fax (317) 232-7312

Table 8 lists MCOs that have submitted responses to the RFP and have been selected for contract negotiations with the OMPP.

Table 8 – Managed Care Organizations

Organization	Provider Service Phone Number	Web site
AmeriGroup	1-888-821-1108	www.amerigroupcorp.com
CareSource	1-866-930-0017	www.care-source.com
Harmony Health Plan	1-800-504-2766	www.harmonyhmi.com
Managed Health Services (MHS)	1-800-414-9475	www.managedhealthservices.com
MDwise	1-800-356-1204 or (317) 630-2831	www.mdwise.org
Molina Healthcare	1-800-642-4509	www.molinahealthcare.com

IHCP providers may be contacted by any one or more of these companies, particularly if located in a mandatory RBMC county. The OMPP cannot release or discuss the RFP or the individual responses until the MCO contracts are signed.

Summary of Milestones

Table 9 is an illustration of the MCO contract procurement process.

Table 9 – MCO Contract Procurement Process

Activity	Date
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

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 PMP enrollment or 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.
- Providers who contract with an MCO may negotiate contract provisions about reimbursement. PMP contracts are required to include a clause allowing the PMP to terminate the contract with no cause with a 90-day written notice.
- Non-contracted providers are paid at Indiana Medicaid rates and may request PA from the MCO to render services to an MCO member.
- 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, specialists, 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 10 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 DME 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 11.

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 provider must seek reimbursement 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 11 summarizes the self-referral services.

Table 10 – 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 11 – 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
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

(Continued)

Table 11 – Summary of Carve-Out and Self-Referral Services by Hoosier Healthwise Delivery System

Services	MCO (RBMC) members	PrimeStep (PCCM) members
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.

IHCP Provider Field Consultants Effective October 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	(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 October 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 (including eligibility verification) (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	