Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider News NL200412 December 2004

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Frequently Used Acronyms

BDDS	Bureau of Developmental Disabilities
CMS	Centers for Medicare & Medicaid Services
DD	Developmental Disabilities
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EFT	Electronic Funds Transfer
E/M	Evaluation and Management
EVS	Eligibility Verification Systems
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCBS	Home and Community-Based Services
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
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
ISDH	Indiana State Department of Health
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
POC	Plan of Care
RA	Remittance Advice
RHC	Rural Health Clinic
RHS	Residential Habilitation and Support

Provider News

Hoosier Healthwise Mandatory MCO Transition

The OMPP will implement Hoosier Healthwise mandatory RBMC enrollment in 13 additional Indiana counties in 2005. This will transition current PrimeStep Hoosier Healthwise managed care members from PCCM into enrollment with a local MCO in the RBMC delivery system. This article contains information for physicians, FQHCs/RHCs, hospitals, and ancillary providers.

Mandatory MCO Enrollment

The OMPP has submitted a request for federal approval for modification of Indiana's 1915(b) waiver to the CMS. The State anticipates that these counties will be approved for mandatory MCO enrollment in the near future. Table 1 lists the scheduled transition dates, by county, from PCCM to an RBMC MCO.

Table 1 – Counties for Mandatory MCO Transition and Key Dates

County	PMP Signed Contracts Sent to MCOs	Final Transition Date
Gibson	February 1, 2005	April 1, 2005
Knox	February 1, 2005	April 1, 2005
Posey	February 1, 2005	April 1, 2005
Sullivan	February 1, 2005	April 1, 2005
Vanderburgh	February 1, 2005	April 1, 2005
Vigo	February 1, 2005	April 1, 2005
Warrick	February 1, 2005	April 1, 2005
Clark	May 1, 2005	July 1, 2005
Floyd	May 1, 2005	July 1, 2005
Lawrence	May 1, 2005	July 1, 2005
Monroe	May 1, 2005	July 1, 2005
Washington	May 1, 2005	July 1, 2005
Harrison	May 1, 2005	July 1, 2005

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

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

Mandatory MCO Enrollment Information for PMPs

PMPs who render services to members in the affected counties should review the following to determine the impact of the upcoming changes:

- PMPs in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs or disenroll as a PrimeStep Hoosier Healthwise PMP. PrimeStep PMPs who complete the switch to one of the MCOs before the final transition date will retain their current Hoosier Healthwise members. PMPs can also choose to remain an IHCP provider limited to non-Hoosier Healthwise managed care members or provide services upon referral.
- MCOs can provide additional services to members complementing services provided by the PMPs. Examples include 24-hour nurse telephone services, enhanced transportation arrangements, and case management services. Contact the MCOs to discuss what benefits are available.

Mandatory MCO Enrollment Information for Other Providers

- **Do I need to sign a contract with a MCO to provide services?** Specialists, hospitals, and ancillary providers have various MCO arrangements. Some of the MCO networks are currently open, meaning that any IHCP provider can render services to the MCO members. However, some are closed, such as transportation and pharmacy networks. With closed networks, MCO-contracted providers usually render the services. In-network providers are paid according to their contract with the MCO. Out-of-network providers are paid at 100 percent of the Medicaid rate. With the exception of some self-referral services, the MCO can require members to access services from MCO-contracted providers.
- **How does this affect carve-out services?** The carve-out services are dental and behavioral health services. Generally, behavioral health services, which are not rendered in an acute care setting or the PMP's office, are not the responsibility of the MCO. Individual education plan (IEP) services are also carved-out. Mandatory MCO changes will not affect providers rendering care to MCO members for carved-out services. The November 2004 IHCP provider newsletter (*NL200411*) provides more information about this topic.
- **How does this affect self-referral services?** Changes affect self-referral providers such as podiatrists, vision care, and chiropractors. MCOs are responsible for payment of the self-referral services for their members. Claims for these services must be sent to the appropriate MCO for payment.
- **Can a FQHC or RHC contract with an MCO?** An FQHC or RHC can participate with an MCO. MCO provider contracts must specify the contractual arrangements to ensure that FQHCs and RHCs are reimbursed for services. The OMPP endorses the following types of contractual arrangements between MCOs and FQHCs/RHCs:
  - The FQHC or RHC accepts full capitation for primary, specialty, or hospital services.
  - The FQHC or RHC accepts a partial capitation or other method of payment at less than full risk for patient care, such as primary care capitation only, or fee-for-service.

Table 2 lists active MCOs in Indiana along with phone numbers and Web sites.

Table 2 – Managed Care Organizations

Organization	Provider Service Phone Number	Web site
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

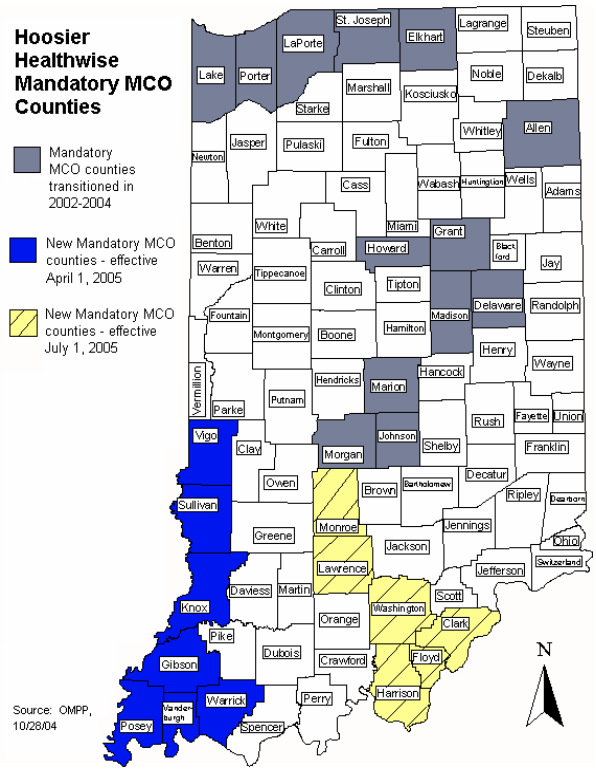

Figure 1 – Map of Mandatory MCO Counties

Additional Information

Additional information, including MCO network summaries, is available from the IHCP Web site at www.indianamedicaid.com. Questions about the information in this article should be directed to the appropriate MCO listed in Table 2 or AmeriChoice at 1-800-889-9949, Option 3.

The OMPP will hold a series of public meetings about the transition to mandatory RBMC in southern Indiana. The details of the next scheduled public meeting on the transition to mandatory RBMC are as follows:

- Clark/Floyd Counties Area Public Meeting: The meeting will be held from 12 noon to 1 p.m. on December 7, 2004, at Floyd Memorial Hospital, 1850 State Street, New Albany. The agenda will include a brief presentation from the OMPP and all the MCOs will be available to answer questions.

Medical Abortion by Oral Ingestion of Medication

This article informs providers about IHCP coverage of medical abortion by oral ingestion of medication. Effective January 1, 2005, the IHCP will reimburse mifepristone and misoprostol for use in medical abortion procedures based on the same coverage criteria applicable to surgical abortions. Submission of claims for these medications must follow the instructions in this article. Direct questions about coverage of this service to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Coverage and Reimbursement of Medical Abortion by Oral Ingestion of Medication

Mifepristone is also known as RU-486. By blocking progesterone, which is necessary to establish and maintain placental attachment, mifepristone disrupts the attachment of a fertilized egg to the uterus. Mifepristone was approved by the FDA in 2000 for use in medical

abortions. Danco Laboratories, LLC (Danco) is responsible for manufacturing, marketing, distributing, and monitoring FDA compliance in the use of mifepristone in the United States.

Danco requires each physician ordering mifepristone to sign a provider agreement about their responsibilities in providing this medication. This agreement requires that physicians report complications related to the administration of mifepristone to Danco; Danco then submits the information to the FDA. In addition, Danco requires the patient to sign a patient agreement that will be maintained in the medical record.

Misoprostol is a prostaglandin which softens the cervix and creates uterine contractions to release the fetus. Misoprostol has FDA approval for treatment of ulcers and is commonly used in labor induction to thin, relax, and open the cervix. Misoprostol, when used in combination with mifepristone, must be administered orally in the physician's office.

The IHCP will only reimburse the FDA-approved regimen for medically induced abortions using orally administered mifepristone and misoprostol. The IHCP will not reimburse what is commonly known as the *evidence based* regimen for medical abortion with mifepristone and misoprostol, which includes at-home or vaginal administration of misoprostol.

The FDA approved regimen for these medications is as follows:

- Recommended gestational age – 49 days from last menstrual period (LMP)
- Mifepristone dose – 600 mg orally administered on day one office visit
- Misoprostol dose – 400 mcg orally administered on day three office visit
- Misoprostol timing – 48 hours after receiving mifepristone

Billing

Mifepristone must be billed using HCPCS code *S0190–Mifepristone, oral, 200mg,* and misoprostol must be billed using *S0191–Misoprostol, oral, 200 mcg.* HCPCS code S0190 will be reimbursed at $90 per unit (tablet) and S0191 will be reimbursed at $0.86 per unit (tablet).

Medical abortion by oral ingestion of mifepristone and misoprostol requires three separate office visits to complete the procedure. The information below shows the billing guidelines for these office visits and the medications provided during the office visits. All claims for medical abortion by oral ingestion of mifepristone and misoprostol must be billed on the CMS-1500 claim form or 837P electronic transaction.

- Day one:
  - Member reviews and signs the *Patient Agreement*
  - Provider orally administers three 200 mg tablets of mifepristone
  - Provider bills HCPCS code *S0190–Mifepristone, oral, 200 mg*, three units
  - Provider bills the appropriate E/M code for the office visit
- Day three:
  - Provider checks pregnancy status with clinical examination or ultrasound exam
  - If an ultrasound is performed, provider bills the appropriate code for the service provided
  - Provider orally administers two 200 mcg tablets of misoprostol
  - Provider bills HCPCS code *S0191–Misoprostol, oral, 200 mcg*, two units
  - Provider bills appropriate E/M code for the office visit
- Day 14:
  - Provider verifies pregnancy termination with clinical examination or ultrasound exam
  - Provider bills appropriate E/M code for the office visit
  - If an ultrasound is performed, the provider bills the appropriate code for the service provided

Confirmation of pregnancy status must occur prior to the day one office visit. The day one office visit must occur after the 18 hour counseling and waiting period required by *IC 16-34-2-1.1*.

Claims for day one and day three office visits will be suspended pending submission of required documentation. Providers are required to submit all necessary documentation with claims for these office visits to be reimbursed for services.

The physician must specify in writing the physical condition of the member leading to the

professional judgment that the abortion was one of the following:

- Medically necessary because the pregnancy creates a serious risk of substantial and irreversible impairment of a major bodily function
- Necessary to preserve the life of the pregnant woman
- Due to rape or incest

The documentation must contain the name and address of the member, dates of service, physician's name, and physician's signature. In addition, medical abortion by oral ingestion of mifepristone and misoprostol requires submission of the signed *Prescriber's Agreement* and *Patient Agreement*. These agreements are available from Danco and use of them is also required by Danco. Documentation must be attached to paper claim forms, or sent separately as an attachment to the electronic claim transaction. Failure to submit this documentation will result in denial of claims.

Crossover Claims Updates

This article provides updated crossover claim information to advise providers about the options available for submitting crossover claims for dually eligible members or for members covered by private insurance.

The following additional information is available on the IHCP Web site at www.indianamedicaid.com under **Crossover**, **TPL Claims**:

- Billing of Crossover Claims to Medicare
- Billing of Crossover Claims Directly to the IHCP
- Billing of TPL Claims

Electronic submission of crossover claims has the following benefits:

- Decreases the need to submit paper claims
- Allows for adjudication of claims in a more efficient and timely manner
- Eliminates the potential for keying errors

To increase the volume of electronic claims that automatically cross over from Medicare, the IHCP requests that providers include information needed by the IHCP for adjudication when submitting the 837 electronic transactions to Medicare. Refer to the Billing of Crossover Claims to Medicare link on the IHCP Web site for additional information.

The following submission options are available to providers for claims denied by Medicare or for claims that do not cross over electronically to the IHCP:

- Web interChange
- EDI vendor or clearinghouse. Refer to the Billing of Crossover Claims Directly to the IHCP link on the IHCP Web site for additional information.

Web interChange allows providers to access denied claims and to use the *Copy This Claim* function that allows providers to make necessary corrections for resubmission of new claims. **This function eliminates the need for re-keying the entire claim.**

Direct questions about this information to the EDI Help Desk at (317) 488-5160 in the Indianapolis local area or 877-877-5182 or by e-mail at INXIXTradingPartner@eds.com.

2005 First Quarter Workshops for Medicaid Providers

The OMPP, Children's Health Insurance Program (CHIP), and EDS offer IHCP 2005 first quarter workshops free of charge. Sessions are offered at several locations in Indiana. Table 3 lists the time, name, and description of each session. The schedule allows for a lunch period from noon until 1 p.m.; however, lunch is not provided. **Seating is limited in all locations**. **Registrations are processed in the order received and registration does not guarantee a spot at the workshop**. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the seating capacity has been reached for that workshop.

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

Time	Session	Description
8 a.m. – 10:30 a.m.	Web interChange	This session provides information about usage of the member eligibility, check write, claim inquiry, and claim submission features available through Web interChange. It also covers instructions for the administrator function that will enable providers to assign access to their office staff, change passwords, and create, maintain, and delete users and user groups.
10:45 a.m. – noon	HIPAA Updates	This session provides an overview of recent updates and information about the next phase of the HIPAA implementation including updates about electronic RAs and PA requests. This session is designed for providers, vendors, and clearinghouses.
Noon – 1 p.m.	Lunch Break	Lunch is not provided.
1 p.m. – 2: 45 p.m.	Voids and Replacements	This session provides education to providers about voids and replacements (adjustments) that can be completed electronically. The session will cover the new language, how the process will work, and the increased efficiency of the new process.
3 p.m. – 4: 30 p.m.	Managed Care Roundtable	This session includes brief presentations by all current and new MCOs. New Hoosier Healthwise MCO contracts will be effective January 1, 2005. A question and answer session will immediately follow the individual MCO presentations. **This session is specific to RBMC.**

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

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

Workshop Date	Registration Deadline	Location
February 15, 2005	February 8, 2005	Ball Memorial Hospital, Muncie Auditorium 2401 University Avenue
February 23, 2005	February 16, 2005	Unity Health Care, Lafayette 1345 Unity Place Room D
February 24, 2005	February 17, 2005	Bloomington Hospital, Bloomington Wegmiller Auditorium 601 W. 2nd St.
March 1, 2005	February 22, 2005	Wishard Hospital, Indianapolis Myers Auditorium 1001 W. 10th St.
March 3, 2005	February 25, 2005	Union Hospital, Terre Haute Landsbaum Center for Health Education 1433 N. 6 ½ St.
March 9, 2005	March 2, 2005	St. Catherine's Hospital, East Chicago Birthing Center 4321 Fir St.
March 16, 2005	March 9, 2005	Deaconess Hospital, Evansville Bernard Schnacke Auditorium 600 Mary St.
March 22, 2005	March 15, 2005	Holiday Inn, Clarksville Shakespeare Room 505 Marriott Drive
March 22, 2005	March 15, 2005	St. Joseph Regional Medical Center, South Bend Educational Center 801 E. LaSalle Ave.
March 24, 2005	March 17, 2005	Lutheran Hospital, Fort Wayne Kachmann Auditorium 7950 W. Jefferson Blvd.

All workshops begin promptly at 8 a.m. local time. General directions to workshop locations are available on the IHCP Web site at www.indianamedicaid.com. To access directions on the Web site click **Provider Services/Education Opportunities/Provider Workshops**. Consult a map or other location tool for specific directions to the exact location.

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

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

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

DME Services

PA Clarification for Non-Heated and Heated Humidifiers

This policy is a clarification of the PA criteria for non-heated humidifiers (E0561) and heated humidifiers (E0562). The initial publication in the May 15, 2004, edition of the provider monthly newsletter indicated that these devices are covered for use with non-invasive respiratory assistive devices (RADs), when ordered by a physician, based on medical necessity, subject to PA. The codes listed as RADs were E0601, K0532, and K0533.

HCPCS code *E0601–Continuous airway pressure device (CPAP),* was included in the list of respiratory devices that could be used in conjunction with a humidifier. It is the intent of the IHCP to cover both non-heated and heated humidifiers for use with CPAPs, based on medical necessity, subject to PA.

Codes K0532 and K0533 for RADs, published in the May newsletter, were cross walked to *E0470–Respiratory assist device, bi-level pressure capacity, without backup rate feature, used with noninvasive interface* and *E0471–Respiratory assist device, bi-level pressure capacity, with backup rate feature, used with noninvasive interface*, respectively.

The non-heated and heated humidifier policy clarification is as follows:

- A non-heated (E0561) or a heated (E0562) humidifier will be covered for use with a non-invasive RAD (E0470 and E0471) or a CPAP (E0601), when ordered by a physician, based on medical necessity, subject to PA.
- Documentation of medical necessity for humidifiers E0561 and E0562 must indicate that the member is suffering from nosebleeds, extreme dryness of the upper airways, or other conditions that interfere with compliance or use of the RAD or CPAP, and that the humidifier could improve this condition.
- E0561 and E0562 are single patient use devices, categorized as inexpensive and routinely purchased items, available for purchase only for Traditional Medicaid members. Rental is temporarily available for crossover claims only. A rental trial is no longer required before purchase of a non-heated or heated humidifier.

HCBS Waiver Services

HCBS Waiver Documentation Standards

This article clarifies documentation standards for HCBS Waiver Programs providers rendering services described in IHCP provider bulletin *BT200305* dated January 15, 2003, and *BT200371* dated December 19, 2003.

For all services that contain the following documentation requirements; "data record documenting the date of service and the number of units of service delivered that day", or "data record documenting the complete date and time entry (including a.m. or p.m.) and the number of units of service delivered that day" – the intent of the documentation requirement is to record the complete date (mm/dd/yy) and the time-in as well as time-out. Time-in and time-out must reflect a.m. and p.m. as appropriate, unless the agency chooses to use 24-hour clock time notations. Time must be recorded consistently regardless of methodology, either standard time or 24-hour time notation.

To summarize this clarification, all time-bound HCBS waiver services detailed in the bulletins referenced above must be documented clearly, reflecting the complete date (mm/dd/yy) as well as the time-in and time-out, using either a.m. and p.m. or the 24-hour clock time notation. All documentation entries must have the signature of the staff member making the entry, including at minimum the first initial and last name of the individual along with certification or title, as applicable.

The above noted procedures are to be implemented immediately.

Documentation entries not meeting the above stated criteria will be recouped for dates of service starting January 1, 2005.

During recent HCBS waiver audits and at the October IHCP seminar in Indianapolis, the following issues were raised for clarification:

- It is not allowable to bill for a different service if units of the actual service have been exhausted; for example, billing CHP – Group (T2021 U7 HQ) if units of CHP – Individual (T2021 U7) have been exhausted. The service code billed to the IHCP for reimbursement must match the documentation of the service as rendered and must be in accordance with the service definition and parameters as previously published.
- As stated in the July 2004 IHCP monthly provider newsletter, the only HCBS waiver service that can be rendered to and reimbursed for a member in an institutional setting (for example, hospitalized or incarcerated) is case management. Reimbursement for other services including, but not limited to, respite, RHS, and behavior management is prohibited.
- For those service providers using electronic signatures for documentation, refer to *DD Bulletin 34* published by the BDDS which describes the requirements for electronic signature use.
- Several providers have contacted the EDS Waiver Unit with questions about Title XX services. EDS is the fiscal agent for the IHCP (Medicaid) and all Title XX questions must be addressed with the BDDS.
- The INsite help desk may be reached by telephone at (317) 232-7858 or by e-mail at INsitehelp@fssa.state.in.us.

Home Health Services

Traditional Medicaid PA Clarification for Home Health Services

The HCE PA Unit has received questions about two home health agencies providing home health services to an IHCP member.

The ISDH has mandatory home health licensure and all home health agencies are required to be licensed. There are three federal classifications as follows:

- Certified home health Medicare and Medicaid
- Certified Medicare only
- Certified Medicaid only

HHAs are to provide only the services that they have informed the ISDH that they provide and that have been entered into the SID computer system by the ISDH. Licensed HHAs that provide services within the state of Indiana and that are classified as State-only HHAs are only required to provide services for which they have been licensed by the ISDH. State-only agencies are not allowed to provide Traditional Medicaid services; however, they can provide Medicaid waiver services. The following examples illustrate different HHA scenarios:

- HHA #1 is a Medicare/Medicaid and State licensed HHA, and is licensed to provide skilled nursing services only.
- HHA #1 receives a referral for a patient that requires skilled nursing and home health aide services.
- HHA #1 must not accept the patient because the agency cannot provide the services that the physician has ordered for this patient.
- HHA #1 must refer the patient to HHA #2.
- HHA #2 is a Medicare/Medicaid and State licensed home health agency that can provide the skilled nursing services and the home health aide services under its license with ISDH.
- HHA #2 has the discretion to provide both skilled nursing and home health aide services directly through their employees or HHA #2 may enter into an agreement with another licensed agency (HHA #3) to provide the home health aide service.
- Under the agreement or arrangement, the following guidelines apply:
  - The home health agencies must specify if the agreement is for contracting the employee that requires the agency to follow regulatory language for contractual agreement found in *42 CFR484* and *410 IAC Article 17*.
  - *Example Contractual Agreement:* HHA #2 must provide skilled nursing services and home health aide services. HHA #2 enters a **written** agreement with HHA #3. HHA #2 requests HHA #3 to provide home health aide services for a Medicare beneficiary. HHA #2 must bill Medicare for **all services** including skilled nursing and home health aide services and then pay HHA #3 for the use of employees who provided home health aide services. This same scenario would apply to Medicaid-only members. **The written agreement must specify the regulatory requirements in both federal and state home health laws.**
- The following examples illustrate sharing a patient:
  - The HHA that shares in providing services with another HHA or waiver provider must demonstrate coordination of services. Services may not be duplicated.
  - The Medicare/Medicaid HHA provider or primary agency must demonstrate that they are providing all services that the Medicare/Medicaid beneficiary needs and that Medicare or Traditional Medicaid will pay for before additional payers of last resort may be used.
  - If another agency is providing the support services, the two agencies must coordinate efforts to ensure that all Medicare/Medicaid services are exhausted prior to providing support services or billing from other payer resources (insurance, Medicaid waivers, DD waivers, choice, or private pay).
  - The support services must not duplicate the services provided by Medicare and Traditional Medicaid services.

- The primary agency that provides skilled nursing must ensure that supportive services do not impede the patient's recovery and ensure that all services support the medical plan of care for the patient.
- The HHAs must document the other services on the POC, coordinate the services, determine who contacts the physician for medical needs, who educates the patient about their medical POC, supervision, how the agencies will communicate changes and when, who is billing for what services, and other issues that may arise when sharing patient services.
- Both HHAs must demonstrate that their efforts of coordination have occurred and that duplication of services does not occur.
- All personnel furnishing services must maintain communication to ensure that their efforts are coordinated effectively and support the objectives outlined in the POC, the clinical record, or minutes of case conferences.
- A written summary report for each patient is sent to the attending physician at least every 60-62 days.

PA for home health services may establish the following:

- Authorize more than one provider because the authorization of services is associated with the patient. However, PA must be able to determine the medical necessity for the service.

The IHCP informs IHCP home health providers that they must follow the guidelines below:

- Ensure compliance with State rules for home health agencies.
- Ensure compliance with the Medicare Conditions of Participation for home health agencies if they are a Medicare/Medicaid certified agency.
- An agency that cannot meet the full scope of services for the patient must not take the referral. The HHA must refer the patient to an agency that can meet the patient's needs.
- The IHCP recommends that providers who are licensed as either Medicare/Medicaid certified HHAs or Medicaid-only HHAs submit IHCP PA requests for those services that they can provide under their respective state license.

The IHCP has received concerns from Medicaid HHAs that care for medically fragile children. These agencies typically provide skilled nursing services only and do not employ home health aides because they have assessed that most medically fragile children require skills beyond those of a home health aide and the services require skilled nursing services. These agencies have expressed difficulty in contracting home health aide services. PA may be granted by the IHCP for skilled services under the home health benefit; however, the HHA must bill the IHCP for services that were provided as described in the following examples:

- The skilled nurse renders home health aide services because the agency was unable to contract a home health aide.
- The agency must then document that the nurse rendered the home health aide service.
- The agency must bill the IHCP using the appropriate local code for home health aide services.
- If the post payment review identifies that the agency billed for skilled nursing services rather than home health aide services, the IHCP will recoup the overpayment.

The following sections provide the regulations for reference:

- Definitions that define Primary Home Health Agency are found under *42 CFR Chapter IV Part 484.2*. The Primary Home Health Agency is the agency responsible for the services furnished to patients and for implementation of the POC.
- Services under arrangement are found under *42 CFR Chapter IV Part 484.14 (h)* and are subject to a written contract conforming with the requirements specified in paragraph (f) of this section and with the requirements of S*ection 1861 (w) of the Act (42 U.S.C. 1495x(w))*.

Direct questions about the PA process to the HCE PA Unit at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518. Direct questions about the state licensing process for home health agencies to the ISDH Acute Care Unit at (317) 233-7742. Questions about Medicare billing procedures can be directed to the respective Medicare fiscal intermediary and

Medicaid billing questions may be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

IHCP Provider Field Consultants Effective November 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	Mona Green	(317) 488-5326	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Jessica Ferguson (temp)	(317) 488-5197	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, and Wells
5	Laura Merkel	(317) 488-5356	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

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 November 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	

Indiana Health Coverage Programs

PROVIDER WORKSHOP REGISTRATION

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

Web interChange		
Please indicate the workshop you will be attending in Indiana:		
☐ Muncie, February 15, 2005	☐ Lafayette, February 23, 2005	☐ Bloomington, February 24, 2005
☐ Indianapolis, March 1, 2005	☐ Terre Haute, March 3, 2005	☐ East Chicago, March 9, 2005
☐ Evansville, March 16, 2005	☐ Clarksville, March 22, 2005	☐ South Bend, March 22, 2005
☐ Fort Wayne, March 24, 2005		
HIPAA Updates		
Please indicate the workshop you will be attending in Indiana:		
☐ Muncie, February 15, 2005	☐ Lafayette, February 23, 2005	☐ Bloomington, February 24, 2005
☐ Indianapolis, March 1, 2005	☐ Terre Haute, March 3, 2005	☐ East Chicago, March 9, 2005
☐ Evansville, March 16, 2005	☐ Clarksville, March 22, 2005	☐ South Bend, March 22, 2005
☐ Fort Wayne, March 24, 2005		
Voids and Replacements		
Please indicate the workshop you will be attending in Indiana:		
☐ Muncie, February 15, 2005	☐ Lafayette, February 23, 2005	☐ Bloomington, February 24, 2005
☐ Indianapolis, March 1, 2005	☐ Terre Haute, March 3, 2005	☐ East Chicago, March 9, 2005
☐ Evansville, March 16, 2005	☐ Clarksville, March 22, 2005	☐ South Bend, March 22, 2005
☐ Fort Wayne, March 24, 2005		
Managed Care Roundtable		
Please indicate the workshop you will be attending in Indiana:		
☐ Muncie, February 15, 2005	☐ Lafayette, February 23, 2005	☐ Bloomington, February 24, 2005
☐ Indianapolis, March 1, 2005	☐ Terre Haute, March 3, 2005	☐ East Chicago, March 9, 2005
☐ Evansville, March 16, 2005	☐ Clarksville, March 22, 2005	☐ South Bend, March 22, 2005
☐ Fort Wayne, March 24, 2005		

Registrant Information

Name of Registrant: _____

Provider Number: _____

Provider Name: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Provider Telephone: _____ Provider Fax: _____

Provider E-Mail Address: _____