Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider Monthly Newsletter

NL200502 **February 2005**

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Frequently Used Acronyms

AVR	Automated Voice Response
CMS	Centers for Medicare & Medicaid Services
CPT®	Current Procedural Terminology
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EVS	Eligibility Verification Systems
FDA	Food and Drug Administration
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
IAC	Indiana Administrative Code
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
MRO	Medicaid Rehabilitation Option
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PCCM	Primary Care Case Management
PHI	Protected Health Information
PMP	Primary Medical Provider
RA	Remittance Advice
RBMC	Risk-Based Managed Care
TPL	Third Party Liability

Provider News

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 1 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**.

EDS processes registrations in the order received and registration does not guarantee a spot at the workshop. EDS sends confirmation letters upon receipt of registrations. If a confirmation letter is not received, the seating capacity has been reached for that workshop.

Table 1 – 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 use 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 enables 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 are effective January 1, 2005. A question and answer session will immediately follow the individual MCO presentations. **This session is specific to RBMC.**

Table 2 lists the dates and Indiana locations for each workshop.

Table 2 – 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 and 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 14 of this newsletter. Please print or type the information requested on the registration form. List one registrant per form.

Joint Injection Policy

The IHCP currently limits the reimbursement of joint injections to three injections per joint site, per provider, per month. As standard courses of treatment may require more frequent injections, the IHCP has modified the policy to allow up to four injections per joint site, per provider, per month as medically necessary, effective April 1, 2003. Claims submitted for more than four joint injections for the same member in a one-month period must have supporting documentation attached to indicate that the injections involve different joint sites and that no more than four injections were administered to a single joint. Table 3 lists CPT codes affected by this change in policy.

Providers may resubmit previously denied claims with supporting documentation for the fourth joint injection per joint site, per provider, per month. For claims that are past the one-year filing limit, a copy of this article may be used as supporting documentation to waive the filing limit. Direct questions about this article to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Table 3 – CPT Codes

Code	Description
20600	Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605	Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Billing Members for Covered Services

The OMPP reminds providers of the conditions under which IHCP members can be billed.

Note: An addition has been made to the policy (indicated in italics).

This article contains the balanced billing policy in its entirety.

An IHCP provider may bill an IHCP member only under the following conditions:

- The service must be an IHCP non-covered service or a covered service for which the member has exceeded the program limitations for the particular service. The provider must inform the IHCP member before receiving the service that the service is not covered under the IHCP and that the member is responsible for the charges.
- A provider may bill the member if the member failed to inform the provider of eligibility. The provider must maintain documentation to show that the provider billed the IHCP member or that the provider requested the information within the one year filing limit.
- A provider may bill a member for any charges incurred before the date the spend-down is met. Spend-down members must incur medical expenses in the amount of their excess income each month before becoming eligible for the IHCP.
- A provider may bill a member for any outstanding copayments, yet providers may not deny services to an eligible individual due to the individual's inability to pay the copayment amount on the date of service.
- *A hospital may bill an IHCP member for services if the hospital's utilization review (UR) committee established under* 42 CFR 482.30 *makes a determination that a continued stay is not medically necessary. The determination must comply with the requirements of* 42 CFR 482.30(d). *The determination that a continued stay is not medically necessary:*

    I. May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified in § 482.12 (c), *concur with the determination or fail to present their views when afforded the opportunity; and*

II. Must be made by at least two members of the UR committee in all other cases.

- *Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in* § 482.12(c), *and afford the practitioner or practitioners the opportunity to present their views.*
- *If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than two (2) days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in* § 482.12(c).
- *Prior to billing the patient, the provider must notify the patient or his or her health care representative in writing that the patient will be responsible for the cost of services provided after the date of the notice.*
- *If a provider has any questions concerning its responsibilities in the UR process, it should consult with its attorney or other advisor.*

Direct questions about this article to Heath Care Excel, Program Integrity at (317) 347-4500, ext. 237 in the Indianapolis area or 1-800-457-4515.

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 4 lists the scheduled transition dates, by county, from PCCM to an RBMC MCO.

Table 4 – 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. Providers must send claims for these services 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 5 lists active MCOs in Indiana along with phone numbers and Web sites.

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 5 or AmeriChoice at 1-800-889-9949, Option 3.

Table 5 – 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

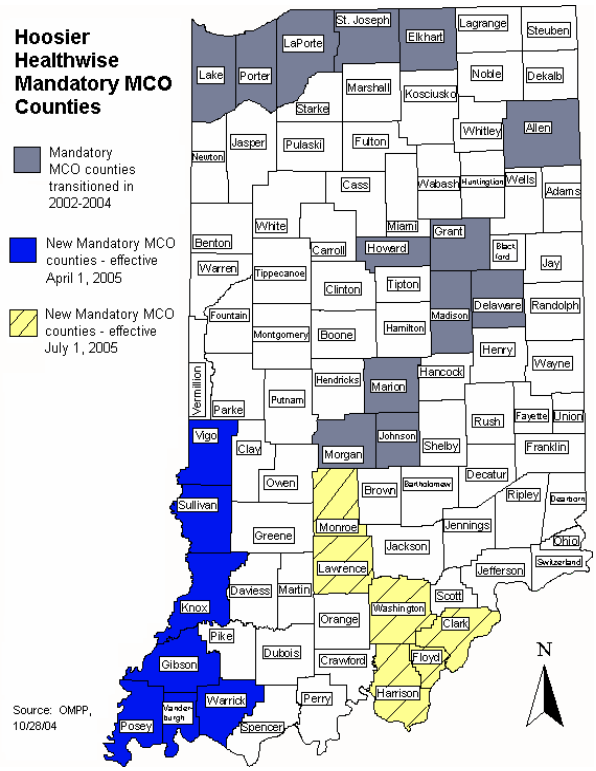

Figure 1 – Map of Mandatory MCO Counties

Web InterChange Password Updates

HIPAA security regulations require Web interChange users to change passwords every 90 days. New passwords must be compliant with HIPAA password standards.

The 90-day requirement occurs February 14, 2005, for many Web interChange users. Users may change passwords any time before this date.

HIPAA Password Standards

HIPAA-compliant passwords must meet the following criteria:

- Must be seven to 10 characters in length
- Must contain at least three of the following items:
  - At least one number (0 - 9)
  - At least one upper-case letter (A - Z)
  - At least one lower-case letter (a - z)
  - At least one special character. Special characters are defined as the following:

    ! " # $ % & ' ( ) * + , - . / : ; < = > ? @ [\ ] ^ _ ` { | }
- Must be case sensitive
- Cannot contain the user ID
- Cannot be the same as any of the six previous passwords.

Direct questions about Web interChange to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

HIPAA Compliance Updates

Effective April 1, 2005, the IHCP will no longer accept electronic claim transactions not compliant with HIPAA requirements. HIPAA requires that electronic claims for medical services be billed in a standardized X12N format. This requirement includes claims submission, eligibility verification, managed care enrollments, and other transactions. HIPAA specifications for these transactions are documented in implementation guides (IGs)

available from the Washington Publishing Company Web site at www.wpc-edi.com.

The OMPP recognizes that compliance is a significant undertaking for many providers. Therefore every effort has been made and will continue to be made to assist providers with becoming compliant. In April 2004 there were 1132 providers sending claims in non-compliant format. In December 2004 there were 101 providers using the non-compliant format. EDS will continue to contact the remaining providers and assist in their effort to become HIPAA compliant before the deadline.

Providers may also use the IHCP Web interChange as an alternative method of claims submission. Web interChange can be accessed from the IHCP Web site.

Direct questions about the claims submission process to the Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

File Exchange Updates

The current direct connect dial-up method of transmission used by trading partners to exchange data electronically in batch mode with the IHCP does not meet the HIPAA security rule standard, which goes into affect April 20, 2005. This direct connect dial-up method of data exchange contains the potential for unauthorized access to electronic PHI.

To meet the HIPAA security requirement and to ensure the security of PHI, the direct connect dial-up method of transmission will be replaced with an Internet application titled *File Exchange*. *File Exchange* is provided by the IHCP for secure file processing, storage, and transfer. It is designed to safely and securely collect, store, manage, and distribute sensitive information between the IHCP and provider organizations.

All trading partners who connect directly with the IHCP using modem dial - up will be required to exchange data using *File Exchange* during the next few months. Providers who send transactions through a clearinghouse will not be required to make any changes to the way they submit to the clearinghouse. Providers are encouraged to contact their clearinghouse to make sure they are aware of this conversion to *File Exchange*.

Additionally, this change does not apply to providers who send interactive transactions, use Web interChange to submit claims, or use the OMNI eligibility system. EDS will be contacting providers and software vendors to assist them with this transition. Updated communications guides, updates to the IHCP Web site, provider newsletters, and banner page articles will be published. A detailed *How To* document containing Internet connection options for providers will be available for additional assistance.

Direct questions about *File Exchange* to the EDS Electronic Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182. Questions can also be sent by e-mail to inxixTradingPartner@eds.com

Hospice Services

Hospice Reimbursements

This article provides clarification to hospice and nursing facility providers about reimbursement guidelines for hospice members residing in nursing facilities. This includes information about hospice discharge, payment for room and board under the hospice benefit when a hospice member is physically discharged alive from the nursing home, and payment for room and board under the hospice benefit for the date of death of a hospice member residing in a nursing facility. This article also provides information about recent hospice claims completion procedures for claims where a hospice member residing in a nursing facility has died. In addition to these issues, this article addresses reimbursement guidelines for nursing facility bed hold days when a member is admitted to the hospital.

Discharge by Hospice Provider

Hospice discharge is a process initiated by the hospice provider. A hospice must discharge a member for the following reasons:

- Member dies
- Member prognosis is determined to be greater than six months
- Member moves out of the hospice service area
- Member safety or hospice staff safety is compromised

The following program guidelines must be followed relating to the Medicaid hospice discharge form and subsequent reimbursement by hospice and nursing facility providers:

- The hospice provider may fax this form to the HCE PA Unit at (317) 347-4537 as long as all the hospice benefit periods preceding the hospice discharge date have been previously authorized.
- For hospice members residing in a nursing facility, hospice providers are encouraged to provide a copy of the IHCP hospice discharge form to the appropriate staff in the nursing facility to ensure the form is included in the hospice member's nursing facility clinical record. These coordination procedures ensure that the nursing facility staff is aware of the exact date that the hospice provider discharged the member from hospice care. To ensure better communication about reimbursement issues between the hospice and nursing facility, the hospice must also provide a copy of this form to the appropriate staff in the nursing facility billing department.
- The hospice must bill the IHCP for the hospice per diem for nursing facility room and board for the date of the hospice discharge. The reason for this reimbursement guideline is that the individual is still under hospice care on that day.
- The nursing facility can resume billing the IHCP directly for nursing facility care for the date of service after the hospice discharge date after the hospice provider has provided a copy of the PA decision form reflecting that the claims processing system has been updated with the hospice discharge date.
- Hospice providers are reminded that it is a violation of medical records standard to predate the hospice discharge. Hospice discharge mirrors hospice revocation in that the date the discharge is to be effective cannot be earlier than the date the hospice discharge occurred.

Reimbursement for Room and Board for a Hospice Member's Date of Death and Date of Physical Discharge

Current IHCP regulations for nursing facility reimbursement state that the IHCP does not pay the nursing facility for the date that a nursing facility resident is physically discharged from the nursing facility. For reimbursement purposes, a nursing facility resident's date of death is equivalent to nonpayment for the date of the nursing facility resident's physical discharge from the nursing facility. The election of hospice care by a nursing facility resident does not rescind the current nursing facility reimbursement regulations for nursing facility room and board.

Current IHCP hospice regulations mirror the Medicare hospice benefit. Therefore the hospice may still bill the IHCP for the hospice per diem **only** for the date when a nursing facility resident receiving hospice care is physically discharged

from the nursing facility or dies in the nursing facility.

According to banner pages *BR200424* published June 15, 2004, *BR200425* published June 22, 2004, and *BR200426* published June 29, 2004, hospice providers must change the way they billed for the date of death effective July 1, 2004. When billing a date of service that is the same as the date of death (for those members residing in a nursing facility), hospice providers bill occurrence code 51 in field 32a on the UB-92 claim form, along with the date of death. The system no longer pays the date of death; the system only pays for hospice services for the date of death for revenue codes 653 and 654. Without occurrence code 51, providers receive explanation of benefits (EOB) *9069 – Room and board not paid on date of death/discharge*, when they bill revenue codes 653 and 654. Without occurrence code 51, the system denies revenue code 659 if it is the same date as the date of death. Providers receive EOB *4233 – Date of death/discharge not covered*, when they bill revenue code 659 for date of death.

Table 6 describes these reimbursement rules for hospice discharge.

Table 6 – Hospice Discharge Reimbursement Rules

Discharge Status	Hospice Per Diem	Room and Board Per Diem
Hospice Discharge Date Alive	Yes (billed by hospice through hospice per diem)	Yes (billed by hospice through hospice per diem)
Billing for Dates of Service After Hospice Discharge Date	No - Hospice no longer caring for patient	Yes - Nursing facility bills IHCP directly at 100 percent rate
Hospice Member Discharged Alive by Nursing Facility	Yes	No
Hospice Member Date of Death in Nursing Facility	Yes (see instructions above)	No

Billing for Nursing Facility Bed Hold Days under the IHCP Hospice Benefit

The IHCP reminds hospice and nursing facility providers that in states with a Medicaid hospice benefit, the nursing facility resident must elect hospice under both the Medicare and Medicaid hospice benefits because Medicaid pays for the room and board only. For this reason, the hospice may bill the IHCP for bed hold days under hospice revenue codes 183, 185, and 180 when the resident is receiving hospice care under the Medicare or Medicaid hospice benefits.

Table 7 describes hospice revenue codes 183, 185, and 180.

Table 7 – Hospice Revenue Codes

Revenue Code	Description for Revenue Code	Detailed Explanation of Revenue Code
183	Nursing facility bed hold for hospice therapeutic days	The hospice provider receives 50 percent of the nursing facility case mix rate to cover the nursing facility room and board associated with therapeutic leave absence days. A total of 18 therapeutic leave of absence days are allowed per patient per calendar year. Hospice providers should not bill the IHCP using this revenue code when the nursing facility occupancy rate is less than 90 percent pursuant to *405 IAC 5-34-12(e).*
185	Nursing facility bed hold policy for hospitalization for services unrelated to the terminal illness of the hospice member	The hospice provider receives 50 percent of the 95 percent of the nursing facility case mix rate to cover the room and board associated with each hospitalization up to 15 days per occurrence. After the 15th day, the member is considered discharged from the nursing facility. Hospice providers should not bill the IHCP using this revenue code when the nursing facility occupancy rate is less than 90 percent pursuant to *405 IAC 5-34-12(e).*
180	Nursing Facility Bed hold Non-Paid Revenue Code	When the nursing facility occupancy is less than 90 percent, the hospice agency should use revenue code 180 to bill the IHCP for leave days. Revenue code 180 is a revenue code used to charge a resident or legal guardian for nonreimbursed bed hold days.

The following provider bulletins provide additional information about bed hold days:

- *BT200146 – Nursing Facility Bed Hold Days*
- *BT200204 – Changes to Nursing Facility Rules and Clarification of Bed Hold and Crossover Information*

Procedures for Billing When a Hospice Member is Admitted to a Hospital

When a dually-eligible hospice member residing in a nursing facility is admitted to a hospital for a Medicare hospice qualifying stay for treatment of a non-terminal condition, the nursing facility may bill Medicare directly when the individual's admission meets Medicare's criteria for billing under condition code 7. Hospices and contracted nursing facilities should contact their respective Medicare fiscal intermediary with questions about billing guidelines for condition code 7 claims. Additional information is available in provider bulletin *BT199924 – Treatment for Non-Terminal Conditions for Hospice Recipients Admitted to a Nursing Facility After a Hospital Stay*.

All banner pages and bulletins referred to in this article are available at the IHCP Web site at www.indianamedicaid.com.

IHCP Provider Field Consultants Effective February 3, 2005

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	Natalie Snow	(317) 488-5388	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	Jessica Ferguson (temp)	(317) 488-5197	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	Mona Green	(317) 488-5326
Kentucky	Louisville/Owensboro	Jessica Ferguson (temp)	(317) 488-5197
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

Member and Provider Relations Leaders

Title	Name	Telephone
Director of Member and Provider Relations	Marcia Meece-Bagwell	(317) 488-5345
Supervisor	Phyllis Salyers (temp)	(317) 488-5154

Note: For a map of provider representative territories or for updated information about the provider field consultants, visit the IHCP Web site at www.indianamedicaid.com.

Indiana Health Coverage Programs Quick Reference Effective February 3, 2005

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization			
AVR System **(including eligibility verification)** (317) 692-0819 or 1-800-738-6770	**EDS Administrative Review** Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	**EDS Customer Assistance** (317) 655-3240 or 1-800-577-1278	**EDS Electronic Solutions Help Desk** (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@eds.com
EDS Forms Requests P.O. Box 7263 Indianapolis, IN 46207-7263	**EDS Member Hotline** (317) 713-9627 or 1-800-457-4584	**EDS Provider Written Correspondence** P.O. Box 7263 Indianapolis, IN 46207-7263	**EDS Provider Enrollment/Waiver** P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750
EDS Third Party Liability (TPL) (317) 488-5046 or 1-800-457-4510 Fax (317) 488-5217	**HCE Medical Policy Department** P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	**HCE Prior Authorization Department** P.O. Box 531520 Indianapolis, IN 46253-1520 (317) 347-4511 or 1-800-457-4518	**HCE SUR Department** P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515
HCE Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 or 1-800-457-4515		**IHCP Web Site** www.indianamedicaid.com	
Pharmacy Benefit Manager			
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	**ACS PBM Call Center for Pharmacy Services/POS/ProDUR** 1-866-645-8344 or Indiana.ProviderRelations@acs-inc.com	**ACS Preferred Drug List Clinical Call Center** 1-866-879-0106	**Indiana DUR Board** INXIXDURQuestions@acs-inc.com
Indiana Pharmacy Claims/Adjustments c/o ACS P. O. Box 502327 Atlanta, GA 31150	**Indiana Administrative Review/Pharmacy Claims** c/o ACS P.O. Box 502327 Atlanta, GA 31150	**PA For ProDUR and Indiana Rational Drug Program – ACS Clinical Call Center** 1-866-879-0106 or Fax 1-866-780-2198	**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			
CareSource **Claims** 1-866-930-0017 **Member Services** 1-800-488-0134 **PA** 1-866-930-0017 **Provider Services** 1-866-930-0017	**Harmony Health Plan** www.harmonyhmi.com **Claims** 1-800-504-2766 **Member Services** 1-800-608-8158; TTY: 1-877-650-0952 **PA/Medical Management** 1-800-504-2766 **Provider Services** 1-800-504-2766 **Pharmacy** 1-800-608-8158	**Managed Health Services (MHS)** www.managedhealthservices.com **Claims** 1-800-414-9475 **Member Services** 1-800-414-5946 **PA/Medical Management** 1-800-464-0991 **Provider Services** 1-800-414-9475 **Nursewise** 1-800-414-5946 **ScripSolutions (PBM)** 1-800-555-8513	**MDwise** www.mdwise.org **Claims** 1-800-356-1204 or (317) 630-2831 **Member Services** 1-800-356-1204 or (317) 630-2831 **PA/Medical Management** 1-800-356-1204 or (317) 630-2831 **Provider Services** 1-800-356-1204 or (317) 630-2831 **Pharmacy** (317) 630-2831 or 1-800-356-1204
Molina **www.molinahealthcare.com** **Claims** 1-800-642-4509 **Member Services** 1-800-642-4509 **PA** 1-800-642-4509 **Provider Services** 1-800-642-4509	**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 **PA** 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
EDS 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: _____