Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider Monthly Newsletter

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Frequently Used Acronyms

CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
DME	Durable Medical Equipment
FQHC	Federally Qualified Health Centers
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
IAC	Indiana Administrative Code
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
ISP	Internet Service Provider
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
PHI	Protected Health Information
PMP	Primary Medical Provider
RA	Remittance Advice
RBMC	Risk-Based Managed Care
RHC	Rural Health Clinics
RID	Recipient (Member) Identification Number
TPL	Third Party Liability

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Provider News

Payment Error Rate Measurement Demonstration

Overview

The OMPP is participating in a national quality improvement demonstration sponsored by the CMS. The demonstration, called the Payment Error Rate Measurement or PERM, will measure and report on the error rate of claim payments by examining supporting documentation for selected claims. This year is the OMPP's third year of participation and the final year of the federal demonstration. PERM is scheduled to become a national CMS requirement for State Medicaid programs in October 2005. The OMPP contracted with Myers and Stauffer, LC for assistance with this study.

Requested Documentation

The purpose of this article is to inform all enrolled IHCP providers that the OMPP and Myers and Stauffer will be requesting information for certain selected claims to study the error rate of Traditional Medicaid and Hoosier Healthwise payments. The sample size for the demonstration is modest and many providers will not be asked to participate, though some providers will be asked to submit medical and claim documentation for review.

The demonstration will examine both paid and denied claims from October 1, 2004, to December 31, 2004. For each claim selected, any or all of the following information may be requested:

- Medical charts
- Billing information
- Patient notes
- Test orders and results
- Service authorization forms
- Prescriptions
- Provider charge information
- Third party payor information
- Encounter logs
- Any other patient information, as deemed necessary by the OMPP to support the amount, scope, and duration of services provided.

Please be advised that under the terms of your provider agreement and participation in the IHCP, providers are required to submit requested documentation. Any submitted information will not be returned. Therefore, it is suggested that copies, rather than original documents, be submitted.

Services that are undocumented, or are not sufficiently documented will be considered as an "error" by CMS; therefore, complete and expedient participation when medical and claim documentation is requested is very important to the success of the demonstration.

Note: Neither the OMPP nor Myers and Stauffer will reimburse providers for copies of any requested documentation. Information collected for this study will be held in strict confidence in compliance with all applicable policies, requirements, regulations and statutes. By virtue of their contract and Business Associate Agreement with the OMPP, Myers and Stauffer is authorized to have access to protected health information.

Additional Information

Provider cooperation is greatly appreciated. Providers should direct questions about the PERM project or requested documentation to the following address:

Nedra Moran, R.N.
Supervisor, Acute Care Services
Myers and Stauffer LC
9265 Counselors Row, Suite 200
Indianapolis, IN 46240-6419

Nedra Moran can also be reached by telephone at (317) 846-9521 or 1-800-877-6927.

Coordination of Benefit Claims Updates

This article provides updated crossover claim information to educate providers about 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 *Crossover/TPL Claims* section of the IHCP Web site at www.indianamedicaid.com:

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

Electronic submission of crossover claims decreases the need to submit paper claims, allows for adjudication of claims in a more efficient and timely manner, and eliminates potential 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 837 Billing of Crossover Claims to Medicare link on the IHCP Web site for additional information.

How to Resubmit an IHCP Denied Crossover Claim via web interChange

Web interChange allows providers to access IHCP denied claims and to use the *Copy This Claim* function, which allows providers to make necessary corrections for resubmission of new claims. This function eliminates the need for rekeying the entire claim. Monitor the monthly provider newsletter as well as the IHCP Web site for future updates about submitting crossover claims using Web interChange. Direct questions about this information to the EDI Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182, or by e-mail at INXIXTradingPartner@eds.com.

Reporting Personal Injury Claims

Providers are asked to notify the EDS TPL Casualty Department if a request for medical records is received from an IHCP member's attorney about a personal injury claim, or if information is available about a personal injury claim being pursued by an IHCP member. When notifying the TPL Casualty Department, include the IHCP member's name, RID, date of injury, insurance carrier information, and attorney name, phone number, and address, if available.

The TPL Casualty Department has prepared a form to use when submitting this information; however, use of this form is not required. A copy of this form, titled *Provider TPL Referral Form*, is on page 19 of this newsletter and is also available on the IHCP Web site at www.indianamedicaid.com under *Publications*, *Forms*, *TPL Forms*.

Send this form to the TPL Casualty Department by e-mail at INXIXTPLCasualty@eds.com, by facsimile at (317) 488-5217, or by U.S. mail to the following address:

EDS TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7762

File Exchange Updates

The current EDS direct connection 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. This method of data exchange contains the potential for unauthorized access to electronic PHI.

To ensure the security of PHI and enhance data exchange performance, the current EDS direct connection dial-up method of data exchange will be eliminated and replaced with a solution that will require access to the Internet through a local ISP. This solution is called *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 connecting directly with the IHCP to exchange data will be required to transition to using *File Exchange* during the next few months. Testing with trading partners and vendors will begin in early April 2005.

Advantages of File Exchange

- Ensures secure data transfer between trading partners.

- Faster uploads and downloads – Dependent upon the chosen method of connection.
- Possible cost savings – Eliminates long distance charges for direct connection dial-up.
- Provides capability to send files 24 hours a day, seven days a week.
- Incoming files can be compressed.
- Maintains outgoing files in the trading partner's home directory for 30 days.

> ***Note:*** *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 ensure they are aware of the 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.*

The IHCP is dedicated to making this an efficient transition for all trading partners.

Trading partners and software vendors will be contacted to assist them with this transition. A detailed *How To* document will be available to provide step-by-step assistance to trading partners through the process of switching from the current direct connection dial-up method to data exchange using *File Exchange*. In addition, an updated communications guide, updates to the IHCP Web site, provider newsletters, and banner page articles will be published.

Direct questions about *File Exchange* to the EDS EDI 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

Provider Profile Now Available in Web InterChange

Providers can now view their profiles through Web interChange. Accessing *Provider Profile* allows providers to view information on file with the IHCP, including name, current addresses and phone numbers, and type and specialties. Groups are also able to view all of the rendering providers associated with their practice. In addition, copies of the *Provider Profile* can be printed directly from Web interChange.

Please check with the Web interChange administrator to obtain the capability to view a *Provider Profile*. Additional information about becoming an administrator can be found at Web Membership FAQs.

Provider Search Now Available on the IHCP Web Site

A new feature is available at the IHCP Web site that allows users to search for enrolled IHCP providers. A *Provider Search* option is available from the *Provider Services Menu.*

Once selected, the *Provider Search* Web page displays. Within this page, users may search for IHCP providers by type, specialty, name, city, state, county, or ZIP Code. The *Helpful Hints* can be used to maximize the search potential. The IHCP *Provider Search* Web page is available at http://www.indianamedicaid.com/ihcp/ProviderServices/ProviderSearch.asp.

Search results display provider name, street address, city, state, ZIP code, phone number, county, provider type, all active specialties, and programs or networks. In addition, each provider listed will have the option to view the provider's location on a map through Mapquest®.

Visit the IHCP Web site at www.indianamedicaid.com for additional information.

TPL Credit Balance Project

Beginning the first quarter of 2005, HMS will partner with EDS to collect credit balances owed to the IHCP. HMS will mail letters and credit balance worksheets to select providers each quarter, and the due date for refunding credit balances will be 60 days from the date of the letter. A copy of the worksheet and instructions are attached to this newsletter on pages 20 and 21. Adjustments will be processed on a weekly basis for providers who wish to have credit balances subtracted from future Medicaid payments. Though only selected providers will receive a letter and credit balance worksheet each quarter, all providers may use this credit balance process to return any type of overpayments. Providers should contact HMS Provider Relations at 1-877-264-4854 with questions about this credit balance collection process or requests for copies of the credit balance worksheet and instructions. The credit

balance worksheet and instructions are also available on the IHCP Web site at www.indianamedicaid.com.

State-Wide Hoosier Healthwise Mandatory MCO Transition

The OMPP will implement Hoosier Healthwise mandatory RBMC enrollment across all 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. 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 a level of care designation for nursing home, ICF/MR, waiver, or hospice. These members continue their traditional fee-for-service IHCP coverage.

This article contains information for physicians, FQHCs and 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, for the southern region of the state, Table 2 for the northern region of the state, and Table 3 for the central region of the state. The map in Figure 1 provides a graphic representation of the transition schedule. Table 4 provides MCO contact information.

Table 1 – Southern Region Counties for Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
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
Bartholomew	May 1, 2005	July 1, 2005
Brown	May 1, 2005	July 1, 2005
Clark	May 1, 2005	July 1, 2005
Clay	May 1, 2005	July 1, 2005
Crawford	May 1, 2005	July 1, 2005
Daviess	May 1, 2005	July 1, 2005
Dearborn	May 1, 2005	July 1, 2005
Decatur	May 1, 2005	July 1, 2005
Dubois	May 1, 2005	July 1, 2005
Floyd	May 1, 2005	July 1, 2005
Franklin	May 1, 2005	July 1, 2005
Greene	May 1, 2005	July 1, 2005
Harrison	May 1, 2005	July 1, 2005
Jackson	May 1, 2005	July 1, 2005

(Continued)

Table 1 – Southern Region Counties for Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
Jefferson	May 1, 2005	July 1, 2005
Jennings	May 1, 2005	July 1, 2005
Lawrence	May 1, 2005	July 1, 2005
Martin	May 1, 2005	July 1, 2005
Monroe	May 1, 2005	July 1, 2005
Ohio	May 1, 2005	July 1, 2005
Orange	May 1, 2005	July 1, 2005
Owen	May 1, 2005	July 1, 2005
Perry	May 1, 2005	July 1, 2005
Pike	May 1, 2005	July 1, 2005
Ripley	May 1, 2005	July 1, 2005
Scott	May 1, 2005	July 1, 2005
Spencer	May 1, 2005	July 1, 2005
Switzerland	May 1, 2005	July 1, 2005
Washington	May 1, 2005	July 1, 2005

Table 2 – Northern Region Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
Adams	July 1, 2005	September 1, 2005
Cass	July 1, 2005	September 1, 2005
Dekalb	July 1, 2005	September 1, 2005
Fulton	July 1, 2005	September 1, 2005
Huntington	July 1, 2005	September 1, 2005
Jasper	July 1, 2005	September 1, 2005
Kosciusko	July 1, 2005	September 1, 2005
LaGrange	July 1, 2005	September 1, 2005
Marshall	July 1, 2005	September 1, 2005
Miami	July 1, 2005	September 1, 2005
Newton	July 1, 2005	September 1, 2005
Noble	July 1, 2005	September 1, 2005
Pulaski	July 1, 2005	September 1, 2005
Starke	July 1, 2005	September 1, 2005
Steuben	July 1, 2005	September 1, 2005
Wabash	July 1, 2005	September 1, 2005
Wells	July 1, 2005	September 1, 2005
White	July 1, 2005	September 1, 2005
Whitely	July 1, 2005	September 1, 2005

Table 3 – Central Region Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
Benton	September 1, 2005	November 1, 2005
Blackford	September 1, 2005	November 1, 2005
Boone	September 1, 2005	November 1, 2005
Carroll	September 1, 2005	November 1, 2005
Clinton	September 1, 2005	November 1, 2005
Fayette	September 1, 2005	November 1, 2005
Fountain	September 1, 2005	November 1, 2005
Hamilton	September 1, 2005	November 1, 2005
Hancock	September 1, 2005	November 1, 2005
Hendricks	September 1, 2005	November 1, 2005
Henry	September 1, 2005	November 1, 2005
Jay	September 1, 2005	November 1, 2005
Montgomery	September 1, 2005	November 1, 2005
Parke	September 1, 2005	November 1, 2005
Putnam	September 1, 2005	November 1, 2005
Randolph	September 1, 2005	November 1, 2005
Rush	September 1, 2005	November 1, 2005
Shelby	September 1, 2005	November 1, 2005
Tippecanoe	September 1, 2005	November 1, 2005
Tipton	September 1, 2005	November 1, 2005
Union	September 1, 2005	November 1, 2005
Vermillion	September 1, 2005	November 1, 2005
Warren	September 1, 2005	November 1, 2005
Wayne	September 1, 2005	November 1, 2005

Figure 1 – Map of Mandatory MCO Counties

RBMC Public Meetings

The OMPP will hold a series of public meetings about the transition to mandatory RBMC for the Hoosier Healthwise program. The meeting's agenda will include an overview of the transition process, individual MCO presentations, and the opportunity to direct questions to the MCOs. The details of upcoming scheduled meetings on the transition to mandatory RBMC are as follows:

1. Bartholomew County Area Public Meeting: April 5, 2005, at the Columbus Regional Hospital Auditorium (2400 East 17th St., Columbus, Ind.). The meeting will be held from noon – 1 p.m.
2. Wayne County Area Public Meeting: May 10, 2005, at Reid Hospital Auditorium (1401 Chester Blvd., Richmond, Ind.). The meeting will be held from noon – 1 p.m.
3. Tippecanoe County Area Public Meeting: June 7, 2005, at the Kathryn Weil Center for Education (415 N. 26th St., Suite 400, Lafayette, Ind.). The meeting will be held from noon to 1 p.m.

Mandatory MCO Enrollment Information for Primary Medical Providers

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. PrimeStep PMPs who complete the switch to one of the MCOs before the final transition date will retain their current Hoosier Healthwise members.
- Disenroll as a Hoosier Healthwise PMP
- PMPs can also choose to disenroll as a PMP and remain an IHCP provider limited to non-Hoosier Healthwise managed care members and/or provide services to MCO members by referral as an *out-of-network* provider.
- An MCO may offer a variety of contracting options for their PMPs, including flexible reimbursement arrangements. Contracting with an MCO may result in the following:
  - Reduced office practice administrative processes
  - Access to distribution of MCO provider communications
  - MCO Provider Relations Representative

Please contact the MCOs to discuss what options are available for your practice.

MCO Member Benefits

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. Please contact the MCOs to discuss what additional members 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 may 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 MCOs have closed networks. With closed networks, MCO-contracted providers or in-network 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 when the MCO has the obligation to pay for the service. Such services include emergency care and self referral services. 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, individual education plan (IEP) 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. Mandatory MCO changes will not affect providers rendering care to MCO members for carved-out services. Claims for these carve out services continue to be processed by EDS. The November 2004 IHCP *Provider Monthly Newsletter*, *NL200411,* provides more information about coverage and payment of carve out services.
- **How does this affect self-referral services?** These changes affect where the self-referral providers such as podiatrists, vision care, and chiropractors will submit claims for services. 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 contract with an MCO. MCO provider contracts must specify the contractual arrangements to ensure that FQHCs and RHCs are reimbursed for services.

Table 4 lists active MCOs in Indiana along with phone numbers and Web sites.

Table 4 – Managed Care Organizations

Organization	Provider Service Phone Number	Web site
CareSource	1-866-930-0017	www.caresource-indiana.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

Additional Information

Additional information is available on the www.indianamedicaid.com Web site. Direct questions about the information in this article to the appropriate MCO listed in Table 4 or AmeriChoice at 1-800-889-9949, Option 3.

2005 Second Quarter Workshops for Medicaid Providers

The OMPP, CHIP, and EDS offer IHCP 2005 second quarter workshops free of charge. Sessions are offered at several locations in Indiana. Table 5 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 5 – Second Quarter Workshop Session Times, Name, and Description

Time	Session	Description
8:45 a.m. – 9:30 a.m.	Program Updates	This session provides an overview of recent updates and information about the Indiana Prescription Drug Program (also known as HoosierRx) and the next phase of the HIPAA implementation. This session is designed for providers, vendors, and clearinghouses.
9:30 a.m. – 10:30 a.m.	278 Transaction (HIPAA Transaction for Prior Authorization)	This session provides an overview of the 278 Transaction (electronic PA requests). This session is designed for providers, vendors, and clearinghouses.
10:45 a.m. – noon	Third Party Liability (TPL)	This is a comprehensive presentation for advanced billers that contains information about TPL claims identification, file updates, denial letters, the 90-day rule, attachments, and other helpful hints.
Noon – 1 p.m.	Lunch Break	Lunch is not provided.
1 p.m. – 2 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 6 lists the dates and Indiana locations for each workshop.

Table 6 – Second Quarter Workshop Dates, Deadlines, and Locations

Workshop Date	Registration Deadline	Location
May 19, 2005	May 12, 2005	Union Hospital Landsbaum Center for Health Education 1433 N. 6 ½ St. Terre Haute
May 25, 2005	May 18, 2005	St. Joseph Regional Medical Center Educational Center 801 E. LaSalle Ave. South Bend
June 3, 2005	May 27, 2005	St. Catherine's Hospital Birthing Center 4321 Fir St. East Chicago
June 7, 2005	May 31, 2005	Wishard Hospital Myers Auditorium 1001 W. 10th St. Indianapolis
June 15, 2005	June 8, 2005	Unity Health Care 1345 Unity Place Room D Lafayette
June 16, 2005	June 9, 2005	St. Mary's Medical Center Manor Auditorium 3700 Washington Avenue Evansville
June 21, 2005	June 14, 2005	Columbus Regional Hospital Kroot Auditorium 2400 E. 17th St. Columbus
June 23, 2005	June 16, 2005	Lutheran Hospital Kachmann Auditorium 7950 W. Jefferson Blvd. Fort Wayne
June 24, 2005	June 17, 2005	Reid Hospital Wallace Auditorium 1401 Chester Blvd Richmond

All workshops begin promptly at 8:45 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 possible room temperature variations. The *Provider Workshop Registration* form can be found on page 18 of this newsletter. Please print or type the information requested on the registration form. List one registrant per form.

Dental Services

Denture Billing Guidelines

At the annual IHCP Seminar in October 2004, several dental providers requested clarification of the policy for billing complete and partial dentures. This article addresses the questions raised at the seminar and provides clarification.

> *Note: Provider questions are shown in italics and the answer to those questions appear immediately following the question.*

When must dentures be billed to the IHCP? What is the date of service for dentures?

The service of providing dentures to any patient is not complete until the completed denture has been delivered to the patient. The date of the provision of the finished product is the date of service that must be used for claims filing and must be supported by record documentation. The provider must bill the IHCP according to when the services are rendered. The IHCP requires that provider records be maintained in accordance with *405 IAC 1-5-1*. Per *405 IAC 1-5-1(b)(4),* the medical record must contain the date when the service was rendered. In addition, according to *405 IAC 1-1-4,* denial of claim payment can occur if the services claimed are not documented in accordance with *405 IAC 1-5-1*.

What if the member becomes ineligible after dentures have been completed? Can the member be charged for the dentures?

If the member is no longer eligible, the former member can be charged for the dentures. The IHCP policy for charging members for non-covered services does not apply if the member is no longer eligible; therefore, a non-covered services waiver is not required.

Providers are responsible for verifying member eligibility prior to rendering services. Providers are urged to advise members that if their eligibility is terminated prior to the dentures being completed, the cost of the dentures will be the member's responsibility. If the provider has verified that the member is no longer eligible, the provider can charge the member according to the provider's usual practices for other customers not enrolled in the IHCP.

Dentures and the $600 Dental Cap

Dentures are subject to the annual $600 dental cap for members age 21 or older. Services subject to the dental cap that are provided after the cap has been reached are not covered by the IHCP. If the member has exceeded the annual $600 dental cap, the provider must inform the member of the non-covered services as described in the *IHCP Provider Manual*. If the member has been informed of the amount of the non-covered charge(s) prior to the service being rendered, the provider can charge the member the usual and customary fee for the service(s).

If the member exhausted the cap during the course of treatment, the member is responsible only for the Medicaid-allowed amount over the annual $600 dental cap. The following scenario demonstrates the correct method for charging a member when the dental cap is exhausted during treatment. The member receives dental services that exhaust $400 of the dental cap. During the same year, the member requires a complete upper denture, a service that is also included in the dental cap. The current IHCP maximum reimbursement for a complete upper denture (D5110) is $391.25. Therefore, the member will exceed the $600 cap and the member will be responsible for $191.25, if notified of the charges prior to the delivery of the dentures. The provider must maintain documentation to substantiate member notification of the member's portion of financial responsibility prior to providing the service. The *IHCP Provider Manual*, *Chapter 4*, *Section 5*, describes the policy for charging members for non-covered services.

> *$600 cap - $400 cap exhausted = $200 cap remaining*
>
> *$391.25 maximum fee - $200 cap remaining = $191.25 billable to the member*

Where is prior authorization (PA) criteria for dentures, partials, relines, and repairs?

PA information can be found in Chapter 8 of the *IHCP Provider Manual* and IHCP Provider Bulletin *BT200003*. Providers are encouraged to use these resources for PA denture criteria.

Emergency Oral Evaluations

This article reminds providers of the IHCP policy for procedure code *D0140 –- Limited oral examination – problem focused.* IHCP provider bulletin *BT200227*, published June 14, 2002, notified dental providers that procedure code D0140 must be used for evaluation of patients presenting with a specific emergency problem, such as dental emergencies, trauma, and acute infections. Inappropriately filed claims for D0140 are subject to recoupment if the documentation in the dental and medical records does not support the oral evaluation rendered.

In the October 2004 IHCP *Provider Monthly Newsletter*, providers were reminded of the instructions for filing emergency dental claims. All emergency oral examinations and services rendered for emergency conditions must be filed with *Yes* in field *53* of the 2000 ADA dental claim form. Providers should use the following *Omnibus Budget Reconciliation Act (OBRA) of 1986* definition of an emergency medical condition when rendering medical services:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any organ or part.

Procedure code D0140 is not limited to a specified number of visits; however, providers must only use D0140 for oral evaluations for dental emergencies, trauma, and acute infections requiring immediate medical attention. Documentation must be maintained for exams billed using D0140 and the documentation must indicate that the services provided were for a specific problem, such as a dental emergency, trauma, or acute infection.

Providers should direct questions about this information to EDS customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

DME Services

Incontinence Supplies Crosswalk

HCPCS codes A4521-A4538 (with the exception of A4534) for reimbursement of incontinence supplies were deleted December 31, 2004, as part of the annual 2005 HCPCS update. The IHCP adopted HCPCS **T** codes (T4521-4542) for reimbursement of incontinence supplies effective January 1, 2005. Table 7 illustrates the appropriate crosswalk for the incontinence supply codes, and includes the max fee for each code.

CMS implemented HCPCS code *A4520 – Incontinence garment, any type, (e.g. brief, diaper), each,* during the annual 2005 HCPCS update. HCPCS code A4520 is being used by third party payers for reimbursement of all incontinence supplies; however, A4520 is not covered by the IHCP because more specific **T** codes are available. In addition, CMS continued coverage of HCPCS codes *A4534 – Youth-sized incontinence product, brief, each,* and *A4554, Disposable underpads, all sizes (e.g., Chux's).* These **A** codes are non-reimbursable by the IHCP, effective January 1, 2005. Providers must refer to Table 7 for the appropriate **T** code for reimbursement.

Crossover claims for members with primary insurance that have been billed using A4520 must be billed to the IHCP using the appropriate **T** codes for the incontinence supplies on a CMS-1500 claim form. The provider must indicate the primary payment received in Field 29 of the CMS-1500 claim form. All TPL claims are subject to post-payment review.

Table 7 – Incontinence Supply Crosswalk

Deleted Code	Description	Max Fee	New Code	Description	Max Fee
A4521	Adult-sized incontinence product, diaper, small size, each	$1.05	T4521	Adult sized disposable incontinence product, brief/diaper, small each	$1.05
A4522	Adult-sized incontinence product, diaper, medium size, each	$1.05	T4522	Adult sized disposable incontinence product, brief/diaper, medium each	$1.05
A4523	Adult-sized incontinence product, diaper, large size, each	$1.05	T4523	Adult sized disposable incontinence product, brief/diaper, large, each	$1.05
A4524	Adult-sized incontinence product, diaper, extra large size, each	$1.05	T4524	Adult sized disposable incontinence product, brief/diaper, extra large, each	$1.05
A4525	Adult-sized incontinence product, brief, small size, each	$1.47	T4525	Adult sized disposable incontinence product, protective underwear/pull-on, small size, each	$1.47
A4526	Adult-sized incontinence product, brief, medium size, each	$1.47	T4526	Adult sized disposable incontinence product, protective underwear/pull-on, medium size, each	$1.47

(Continued)

Table 7 – Incontinence Supply Crosswalk

Deleted Code	Description	Max Fee	New Code	Description	Max Fee
A4527	Adult-sized incontinence product, brief, large size, each	$1.47	T4527	Adult sized disposable incontinence product, protective underwear/pull-on, large size, each	$1.47
A4528	Adult-sized incontinence product, brief, extra-large size, each	$1.47	T4528	Adult sized disposable incontinence product, protective underwear/pull-on, extra large size, each	$1.47
A4529	Child-sized incontinence product, diaper, small/medium size, each	$1.05	T4529	Pediatric sized disposable incontinence product, brief/diaper, small/medium size, each	$1.05
A4530	Child-sized incontinence product, diaper, large size, each	$1.05	T4530	Pediatric sized disposable incontinence product, brief/diaper, large size, each	$1.05
A4531	Child-sized incontinence product, brief, small/medium size, each	$1.47	T4531	Pediatric sized disposable incontinence product protective underwear/pull-ons, small/medium size, each	$1.47
A4532	Child-sized incontinence product, brief, large size, each	$1.47	T4532	Pediatric sized disposable incontinence product protective underwear/pull-ons, large size, each	$1.47
A4533	Youth-sized incontinence product, diaper, each	$1.05	T4533	Youth sized disposable incontinence product, brief/diaper, each	$1.05
A4534	Youth-sized incontinence product, brief, each	$1.47	T4534	Youth sized disposable incontinence product, protective underwear/pull-ons, each	$1.47
A4535	Disposable liner/shield for incontinence, each	$0.33	T4535	Disposable liner/shield/guard/pad/ undergarment, for incontinence, each	$0.33
A4536	Protective underwear, washable, any size, each	$12.95	T4536	Incontinence product, protective underwear/pull on reusable, any size, each	$12.95
A4537	Under pad, reusable/washable, any size, each	$22.00	T4537	Incontinence product, protective underpad, reusable, bed size, each	$22.00
A4538	Diaper, reusable, provided by a diaper service, each diaper	Non-covered	T4538	Diaper service, reusable diaper, each diaper	Non-covered

(Continued)

Table 7 – Incontinence Supply Crosswalk

Deleted Code	Description	Max Fee	New Code	Description	Max Fee
N/A	N/A	N/A	T4539	Incontinence product, diaper/brief, reusable, any size, each	Manual price
A4537	Under pad, reusable/washable, any size, each	$22.00	T4540	Incontinence product, protective underpad, reusable, chair size	$22.00
A4554	Disposable underpads, all sizes (e.g. chux’s)	$0.47	T4541	Incontinence product, disposable underpad, large, each	$0.47
A4554	Disposable underpads, all sizes (e.g. chux’s)	$0.47	T4542	Incontinence product, disposable underpad, small, each	$0.47

Providers should direct questions about this policy to EDS customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

IHCP Provider Field Consultants Effective April 1, 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 April 1, 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	

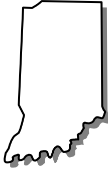
Pharmacy Benefit Manager			
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	**ACS PBM Call Center for Pharmacy Services/POS/ProDUR** 1-866-645-8344 or Indiana.ProviderRelations@acs-inc.com	**ACS Preferred Drug List Clinical Call Center** 1-866-879-0106	**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 www.caresource-indiana.com 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 indicate the workshop you will be attending in Indiana. **Print** or **type** the information below and fax to (317) 488-5376.

Program Updates		
☐ Terre Haute, May 19, 2005	☐ South Bend, May 25, 2005	☐ East Chicago, June 3, 2005
☐ Indianapolis, June 7, 2005	☐ Lafayette, June 15, 2005	☐ Evansville, June 16, 2005
☐ Columbus, June 21, 2005	☐ Ft. Wayne, June 23, 2005	☐ Richmond, June 24, 2005
278 Transaction (HIPAA Transaction for Prior Authorization)		
☐ Terre Haute, May 19, 2005	☐ South Bend, May 25, 2005	☐ East Chicago, June 3, 2005
☐ Indianapolis, June 7, 2005	☐ Lafayette, June 15, 2005	☐ Evansville, June 16, 2005
☐ Columbus, June 21, 2005	☐ Ft. Wayne, June 23, 2005	☐ Richmond, June 24, 2005
Third Party Liability (TPL)		
☐ Terre Haute, May 19, 2005	☐ South Bend, May 25, 2005	☐ East Chicago, June 3, 2005
☐ Indianapolis, June 7, 2005	☐ Lafayette, June 15, 2005	☐ Evansville, June 16, 2005
☐ Columbus, June 21, 2005	☐ Ft. Wayne, June 23, 2005	☐ Richmond, June 24, 2005
Managed Care Roundtable		
☐ Terre Haute, May 19, 2005	☐ South Bend, May 25, 2005	☐ East Chicago, June 3, 2005
☐ Indianapolis, June 7, 2005	☐ Lafayette, June 15, 2005	☐ Evansville, June 16, 2005
☐ Columbus, June 21, 2005	☐ Ft. Wayne, June 23, 2005	☐ Richmond, June 24, 2005

Registrant Information

Name of Registrant: ______________________________

Provider Number: ______________________________

Provider Name: ______________________________

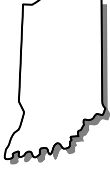
Provider Address: ______________________________

City: ______________ State: __________ ZIP: ______________

Provider Telephone: ______________ Provider Fax: ______________

Provider E-Mail Address: ______________________________

Indiana Health Coverage Programs



PROVIDER TPL REFERRAL FORM

Providers: Please complete if you have received a request for medical records from an IHCP member's attorney relating to a personal injury claim or if you have information about a personal injury claim being pursued by an IHCP member.

1. Name of IHCP Member: ______________________
2. Member Number: ______________________
3. Date of Birth: ______________________
4. Social Security Number: ______________________
5. Member's Home Address: ______________________
6. Member's Telephone Number: ______________________
7. Date of Accident or Injury: ______________________
8. Brief Description of Accident and Injuries:

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____
____

9. Member's Attorney Name, Address, and Phone Number:

____
____
____

10. Insurance Information (Name of liability insurance carrier, policy number, claim number, adjuster's name, address, and phone number)

____
____
____
____

Please send this information to the TPL Casualty Department by e-mail at INXIXCasualty@eds.com, by facsimile at (317) 488-5127, by telephone at (317) 488-5046 in the Indianapolis local area or 1-800-457-4510, or by U.S. mail to the following address:

EDS TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7762

Form Number: TPL0006
Revision Date: March 2005

INDIANA HEALTH CARE PROGRAM (IHCP)
CREDIT BALANCE WORKSHEET INSTRUCTIONS

1. **PROVIDER NAME** – This field must contain the name of the provider that received payment from IHCP.
2. **MEDICAID PROVIDER #** – This field must contain the nine (9) digit provider number assigned by IHCP.
3. **TELEPHONE NUMBER** – This field must contain the telephone number of the contact person.
4. **DATE** – This field must contain the current date.
5. **CONTACT PERSON** – This field must contain the name of the person in your organization familiar with the listed credit balances.
6. **THIRD PARTY TYPE** – This field must be checked to determine what other payor type was involved in the credit balance, if any.
7. **PATIENT NAME** – This field must contain the name of the patient.
8. **MEDICAID ID NUMBER** – This field must contain the twelve (12)-digit Recipient Identification number (RID), assigned to the recipient.
9. **MEDICARE ID NUMBER** – This field must contain the Health Insurance Claim number assigned by Medicare.
10. **EMPLOYER NAME** – This field must contain the name of the employer.
11. **INSURER NAME** – This field must contain the name of the third party insurer, if any.
12. **POLICY HOLDER NAME** – This field must contain the name of the policy holder or employee.
13. **POLICY NUMBER** – This field must contain the policy number assigned by the third party insurer.
14. **GROUP NUMBER** – This field must contain the insurer's number for the employer's plan.
15. **PAY TO PROVIDER NUMBER** – This field must contain the nine (9)-digit provider number assigned by IHCP that the refund originates from. Be sure to include your service location.
16. **CLAIM CONTROL NUMBER** – This field must contain the thirteen (13) digit number assigned to the claim.
17. **SERVICE DATES** – This field must contain the service dates of the claim.
18. **MEDICAID PAID AMOUNT** – This field must contain the amount paid by IHCP.
19. **REFUND AMOUNT** – This field must contain the amount owed to IHCP as refund.
20. **TOTAL REFUND AMOUNT FROM ALL PAGES** – This field must contain the total refund amount from all pages.
21. **CLAIM LEVEL ADJUSTMENT TO OCCUR IMMEDIATELY ?** – "YES" must be circled, if an adjustment is to occur immediately; "NO" must be circled if an adjustment is not to occur immediately.
22. **TOTAL THIS PAGE** – This field must contain page number information. Example "1 of 3".

INDIANA OFFICE OF MEDICAID POLICY AND PLANNING - CREDIT BALANCE WORKSHEET

1. PROVIDER NAME: ____________________ **4. DATE:** ____________________

2. MEDICAID PROVIDER #: ____________________ **5. CONTACT PERSON:** ____________________

3. TELEPHONE NUMBER: ____________________ **6. THIRD PARTY TYPE:** HEALTH___ MEDICARE___ CASUALTY___ OTHER___

7. PATIENT NAME	8. MEDICAID ID NUMBER	9. MEDICARE ID NUMBER	10. EMPLOYER NAME
11. INSURER NAME	**12. POLICY HOLDER NAME**	**13. POLICY NUMBER**	**14. GROUP NUMBER**

HMS PROJECT (OFFICE USE ONLY)
Hospital-Self Audit

15. PAY TO PROVIDER NUMBER	16. CLAIM CONTROL NUMBER	17. SERVICE DATES BEGIN	17. SERVICE DATES END	18. MEDICAID PAID AMOUNT	19. REFUND AMOUNT
				22. TOTAL THIS PAGE	

20. TOTAL REFUND AMOUNT FROM ALL PAGES	21. CLAIM LEVEL ADJUSTMENT TO OCCUR IMMEDIATELY?
	YES / NO