Indiana Health Coverage Programs

Monthly News

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Provider Monthly Newsletter

NL200505 **May 2005**

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Acronyms Used in this Newsletter

1915(b)	Social Security Act section reference
ADA	American Dental Association
ASC	Ambulatory Surgical Center
AVR	Automated Voice Response
CCF	Claim Correction Form
CD-ROM	Compact disk, read-only memory
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CPT	Current Procedural Terminology
DME	durable medical equipment
DUR	Drug Utilization Review
EDI	Electronic Data Interchange
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HPB	Health Professions Bureau
IAC	Indiana Administrative Code
IC	Indiana Code
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IEP	Individual Education Plan
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
ISP	Internet Service Provider
MCO	Managed Care Organization
MHS	Managed Health Service
OIG	Office of the Inspector General
OMPP	Office of Medicaid Policy and Planning
OPPS	Outpatient Prospective Payment System
PA	prior authorization
PCCM	Primary Care Case Management
PHI	Protected Health Information
PMP	primary medical provider
Pro-DUR	Prospective Drug Utilization Review
RA	remittance advice
RBMC	Risk-Based Managed Care
RHC	rural health clinic
SUR	Surveillance and Utilization Review
TPL	Third Party Liability

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Provider News

Provider Eligibility Maintenance and Disenrollments

Provider Enrollment has implemented a verification process that uses HPB data to enhance provider file maintenance. The HPB now submits monthly electronic provider license status reports to EDS. The statuses permit the Provider Enrollment Unit to disenroll providers who no longer have active or probationary licensure.

Additionally, information received from the OIG, OMPP, and IFSSA is used to terminate providers who are not eligible to participate in the IHCP.

The information available to EDS is used to generate termination letters to providers who no longer qualify for enrollment in the IHCP.

Licensure Renewal and IHCP Eligibility

To participate in the IHCP, all providers are required to be duly licensed, registered, or certified (*405 IAC 5-4-1*). Licensure renewal is important to extend providers' IHCP eligibility. Non-renewed licenses are reported as expired or inactive on the HPB reports. Providers listed on the reports are subject to termination. If you do not intend to renew your license, it is important to report the non-renewal to the EDS Provider Enrollment Unit. The information should be reported to EDS on a Provider Enrollment Update Form. The form is available on the IHCP Web site at www.indianamedicaid.com.

If a provider obtains a new license at a later date and wishes to participate in the IHCP, the provider can submit an Provider Enrollment Application with their new license number. The application is available on the IHCP Web site at www.indianamedicaid.com.

The following licensure statuses are subject to termination for participation in the IHCP.

HPB Statuses for Termination

- Closed facility
- Current prerequisites not met
- Deceased
- Emergency suspension
- Expired
- Expired over three years
- Inactive
- Null and void/error
- Retired
- Revoked
- Suspended
- Voluntary Surrender

Non-HPB Termination Reasons

- Excluded by the OIG and CMS
- FSSA determination of non-eligible providers

Payment for Services

Under *IC 12-15-22-4*, following their termination of participation in the IHCP, providers are no longer eligible for payment.

Appeal Process

Under *IC 4-21.5-3-7* and *405 IAC 1-1.5-2*, providers have the right to appeal termination action. To preserve an appeal, providers must specify the reason for the appeal in writing and file the appeal with the ultimate authority for the agency within 15 calendar days of receipt of a termination letter.

Such appeal must be sent to:

E. Mitchell Roob Jr., Secretary
Indiana Family and Social Services Administration
c/o Pat Nolting, Director-Program Operations, Acute Care
402 West Washington Street, Room W382
Indianapolis, IN 46204

If providers elect to appeal a determination, they must also file a statement of issues within 60 days after receipt of notice of the determination. The statement of issues should conform to *405 IAC 1-1.5-2(d)* and be sent to the same address as the appeal request.

Revisions to Radioimmunotherapy Services

This article is to specify revisions to the billing instructions for radioimmunotherapy services using Zevalin or Bexxar. This article supplements the article published in the November 2004 provider newsletter, *NL200411*.

Effective October 1, 2004, revenue code 343, *Diagnostic radiopharmaceuticals*, and revenue code 344, *Therapeutic radiopharmaceuticals*, became valid revenue codes. Providers may use these revenue codes for dates of service on or after October 1, 2004, to report radiopharmaceuticals used for the Zevalin or Bexxar regimen as listed in Table 5.1.

Table 5.1 – HCPCS Codes for Diagnostic and Therapeutic Radiopharmaceuticals

Code	Code Description	Revenue Code(s)
C1080	Supply of radiopharmaceutical diagnostic imaging agent, I-131 tositumomab, per dose	343, 636
C1081	Supply of radiopharmaceutical therapeutic imaging agent, I-131 tositumomab, per dose	343, 344, 636
C1082	Supply of radiopharmaceutical diagnostic imaging agent, indium-111 ibritumomab tiuxetan, per dose	343, 636
C1083	Supply of radiopharmaceutical therapeutic imaging agent, yttrium 90 ibritumomab tiuxetan, per dose	344, 636

The article in IHCP provider newsletter *NL200411* listed HCPCS code Q0084, *Chemotherapy administration by infusion technique only, per visit*, to be reported for the administration of rituximab in the Zevalin regimen for the treatment of non-Hodgkin's lymphoma. Effective for dates of service January 1, 2005, Medicare requires OPPS hospital facilities to bill the appropriate CPT© code for chemotherapy administration instead of HCPCS code Q0084. In order to accommodate cross-over claims, providers are required to utilize the appropriate codes listed in Table 5.2 for the administration of rituximab in the Zevalin regimen for dates of service on or after January 1, 2005.

Table 5.2 – HCPCS Codes for Chemotherapy Administration

Code	Code Description	Revenue Code
Q0084	Chemotherapy administration by infusion technique only, per visit	335
96410	Chemotherapy administration, intravenous; infusion technique, up to one hour	335
96414	Chemotherapy administration, intravenous; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	335
96422	Chemotherapy administration, intra-arterial; infusion technique, up to one hour	335
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	335

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

Billing Changes for BOTOX and Myobloc Injections

The purpose of this article is to advise providers of changes in billing for BOTOX and Myobloc injections and provide instructions for billing unused units of Myobloc. Providers may continue to bill these injections using HCPCS codes J0585, *Botulinum toxin type A, per unit* (BOTOX) and J0587, *Botulinum toxin type B, per 100 units* (Myobloc). Previous instructions in the *IHCP Provider Manual* regarding BOTOX injections are still in effect. Providers should direct additional questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

As of July 1, 2005, the IHCP will limit reimbursement for BOTOX and Myobloc injections to the ICD-9-CM diagnosis codes listed in Table 5.3. These diagnosis codes reflect medically necessary diagnoses for these injections. Reimbursement of these injections will also be limited to one treatment session every three months, per member unless an additional injection is medical necessary. The medical record must contain documentation of the medical necessity for additional treatment sessions provided within a three-month period.

Table 5.3 – ICD-9-CM Diagnosis Codes for BOTOX and Myobloc Injections

333.6	333.7	333.81	333.82	333.83	333.84	333.89
334.1	340	341.0	341.1	341.8	341.9	342.10
342.11	342.12	343.0	343.1	343.2	343.3	343.4
343.8	343.9	351.8	378.00	378.01	378.02	378.03
378.04	378.05	378.06	378.07	378.08	378.10	378.11
378.12	378.13	378.14	378.15	378.16	378.17	378.18
378.20	378.21	378.22	378.23	378.24	378.30	378.31
378.32	378.33	378.34	378.35	378.40	378.41	378.42
378.43	378.44	378.45	378.50	378.51	378.52	378.53
378.54	378.55	378.56	378.60	378.61	378.62	378.63
378.71	378.72	378.73	378.81	378.82	378.83	378.84
378.85	378.86	378.87	378.9	478.29	478.75	478.79
530.0	565.0	705.21	723.5	729.1	754.1	

Due to the short shelf life of Myobloc, wastage of the product may be unavoidable. The IHCP has adopted the following policy for billing unused units of Myobloc.

Myobloc is supplied in 2,500, 5,000, and 10,000 units. When billing for Myobloc, the provider must show the number of units given on the claim form. If a vial is split between two or more members, the provider must bill the amount of the Myobloc used for each member and bill the unused amount as wastage on the claim for the last member injected. If the vial is not split between two or more members, the provider may bill the discarded portion to the IHCP. Whenever a provider bills for unused Myobloc, both the amount of agent actually administered and the amount discarded must be documented in the member's medical record. Providers should follow the instructions already provided in the *IHCP Provider Manual* regarding billing unused units of BOTOX.

File Exchange Updates

To ensure the security of PHI and enhance data exchange performance, the current EDS direct connection dial-up method of data exchange is being eliminated and replaced with a solution that requires 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 are required to transition to using *File Exchange* during the next few months.

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 telephone charges for direct connection dial-up and the need for a dedicated line.
- Provides capability to send files 24 hours a day, seven days a week.
- Maintains outgoing files in the trading partner's home directory for 30 days.

Note: Providers who send transactions through a clearinghouse are not 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. To help simplify the trading partner's search for an ISP, EDS and the IHCP are working with a

service called AllInternetNow to identify Internet access options for each trading partner. AllInternetNow is a free service that works with most ISPs, such as SBC, Verizon, EarthLink and others. An AllInternetNow search shows available ISP options, such as dial-up and DSL, for each trading partner location. Additionally, information packets that contain ISP option information are being sent to each trading partner location over the next few weeks.

The *File Exchange How To Guide* is available to provide step-by-step assistance to trading partners switching from the current method to data exchange to using File Exchange. An updated communications guide and updates to the IHCP Web site, provider newsletters, and banner page articles are available at http://www.indianamedicaid.com.

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.

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.

Corrections to the 2005 Annual HCPCS Update

The CMS released corrections to the 2005 Annual HCPCS Update. Table 5.4 lists the new code corrections with coverage determinations, and Table 5.5 lists the deleted code corrections with replacement codes. Description changes will be automatically updated in the system. These updates will be effective retroactively to January 1, 2005.

Table 5.4 – Corrections to the New 2005 HCPCS Codes, Effective January 1, 2005

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage
G0369	Pharmacy supply fee for initial immunosuppressive drug(s) first month following transplant	Not applicable for all programs, Not applicable for Package C		Non-reimbursable for all programs, Non-reimbursable for Package C Service is billable on the pharmacy claim form
G0370	Pharmacy supply fee for oral anti-cancer, oral anti-emetic or immunosuppressive drug(s)	Not applicable for all programs, Not applicable for Package C		Non-reimbursable for all programs, Non-reimbursable for Package C Service is billable on the pharmacy claim form
G0371	Pharmacy dispensing fee for inhalation drug(s); per 30 days	Not applicable for all programs, Not applicable for Package C		Non-reimbursable for all programs, Non-reimbursable for Package C Service is billable on the pharmacy claim form
G0374	Pharmacy dispensing fee for inhalation drug(s), per 90 days	Not applicable for all programs, Not applicable for Package C		Non-reimbursable for all programs, Non-reimbursable for Package C Service is billable on the pharmacy claim form

(Continued)

Table 5.4 – Corrections to the New 2005 HCPCS Codes, Effective January 1, 2005

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage
G9021	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment Level 1: not at all (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9022	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment Level 2: a little (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9023	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment Level 3: quite a bit (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9024	Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment Level 4: very much (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9025	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment Level 1: not at all (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9026	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment Level 2: a little (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9027	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment Level 3: quite a bit (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9028	Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment Level 4: very much (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C

(Continued)

Table 5.4 – Corrections to the New 2005 HCPCS Codes, Effective January 1, 2005

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage
G9029	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration; assessment Level 1: not at all (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9030	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration; assessment Level 2: a little (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9031	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration; assessment Level 3: quite a bit (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9032	Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration; assessment Level 4: very much (for use in a Medicare-approved demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9034	Services provided by occupational therapist (demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9035	Services provided by orientation and mobility specialist (demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9036	Services provided by low vision therapist (demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C
G9037	Services provided by rehabilitation teacher (demonstration project)	Not applicable for all programs, Not applicable for Package C		Non-covered for all programs, Non-covered for Package C

Table 5.5 – Corrections to the Deleted 2005 HCPCS Codes, Effective January 1, 2005

Procedure Code	Modifier	Description	Replacement Code
A4534		Youth-sized incontinence product, brief, each	This is a non-reimbursable code under the IHCP. Service is billable under HCPCS code T4533.
	CG	Innovator Drug Dispensed	CMS stated that this modifier should never have been established. No replacement is necessary.

New Provider Manual Available

A new version of the *IHCP Provider Manual* is available on the IHCP Web site at www.indianamedicaid.com. Version 5.1 of the *IHCP Provider Manual* includes information that is effective as of January 1, 2005. Providers **will not** automatically receive copies of this version of the manual by mail. Providers should visit the Web site to view, print, or download copies of the manual.

During 2005, the IHCP plans to update to the *IHCP Provider Manual* more frequently in an

effort to keep providers more up-to-date. To accomplish more frequent updates, quarterly revisions to the *IHCP Provider Manual* will be posted to the IHCP Web site and they will not be automatically mailed. Once annually, a CD-ROM copy of the *IHCP Provider Manual* will be mailed each billing provider *mail to* addresses. The next mailing is scheduled for the third quarter of 2005.

In an effort to keep mailing costs to the IHCP at a minimum, providers are encouraged to access the provider manual on the Web. However, if a CD-ROM copy is needed, providers may request a copy free-of-charge. Nonproviders may request CD-ROM copies for $20 each.

In addition, providers may request one free paper copy of this version of the manual and additional paper copies for $92. Nonproviders may also request paper copies for $92 each. Requests for copies of the manual should be made by telephone to customer assistance at customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 or in writing to the following address:

EDS Written Correspondence Unit
c/o Provider Manual Request
P.O. Box 7263
Indianapolis, IN 46207-7263

Requests that require payment must be made by mail and the requestor must supply a mailing address and include full payment. Make checks payable to EDS. Allow 10-14 business days for processing.

State-Wide Hoosier Healthwise Mandatory MCO Transition

The OMPP is implementing Hoosier Healthwise mandatory RBMC enrollment across all Indiana counties in 2005. This transitions 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 5.6 lists the scheduled transition dates, by county, for the southern region of the state, Table 5.7 for the northern region of the state, and Table 5.8 for the central region of the state. The map in Figure 5.1 provides a graphic representation of the transition schedule. Table 5.9 provides MCO contact information.

Table 5.6 – Southern Region Counties for Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
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

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
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

(Continued)

Table 5.6 – Southern Region Counties for Mandatory MCO Transition and Key Dates

County	PMP/MCO Contracts Signed and at MCOs	PrimeStep Members Enrolled in MCOs
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
Jefferson	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 5.7 – 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 5.8 – 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

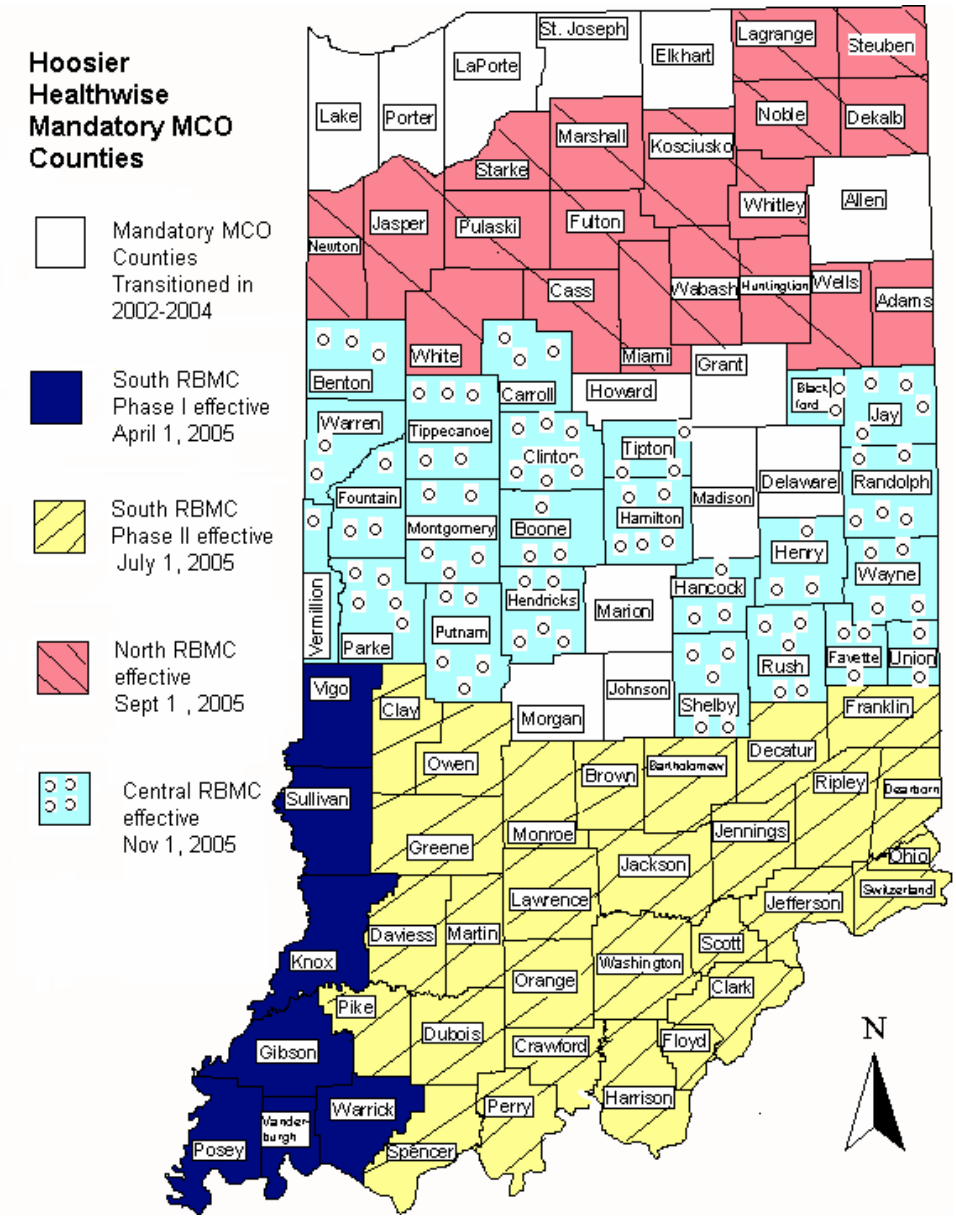

Figure 5.1 – Map of Mandatory MCO Counties

RBMC Public Meetings

The OMPP is holding a series of public meetings about the transition to mandatory RBMC for the Hoosier Healthwise program. The meeting's agenda includes 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:

- Tippecanoe County Area Public Meeting: To be scheduled.

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

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. 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, 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 do 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 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 an 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 5.9 lists active MCOs in Indiana along with phone numbers and Web sites.

Table 5.9 – 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 5.9 or AmeriChoice at 1-800-889-9949, Option 3.

Dental Services

RBMC Carve Out Dental Guidelines

Dental services, which are performed by the following dental specialists and billed on ADA 1999 Version 2000 Dental Claim Form (ADA 2000) or the 837 Health Care Claim: Dental (837D) electronic transaction, are carved out or excluded from the responsibility of Hoosier Healthwise RBMC:

- Endodontists
- General Dentistry Practitioners
- Oral Surgeons
- Orthodontists
- Pediatric Dentists
- Periodontists
- Mobile Dentists
- Prosthodontists
- Dental Clinics

All dental services billed using CDT-5 procedure codes must be submitted to EDS using either the *ADA 2000* claim form or the 837D transaction.

When dental services will be provided in an inpatient or outpatient hospital setting or an ASC for an RBMC member, the dental providers must first contact the member's MCO before rendering services to determine whether prior authorization is required. When the provider obtains MCO authorization and provides services, the services must then be billed as follows:

Dental-related facility charges must be billed on a *UB-92* claim form. Dental services provided in an inpatient, outpatient, or ASC setting can be billed with CDT-5 codes on a dental claim form. These services are carved out of RBMC, and must be billed to EDS using the *ADA 2000* claim form or the 837D transaction. All other associated professional services (such as, oral surgery, radiology, and anesthesia) as well as ancillary services related to the dental services must be billed to the MCO on the *CMS-1500* claim form or the 837P transaction, along with appropriate authorization information. See Table 5.10 for a list of CPT codes that may be billed to a member's MCO. Dental providers should only bill the codes listed in Table 5.10 when a CDT-5 is not appropriate.

Table 5.10 – Dental Related Anesthesia, Surgery, Radiology and Laboratory CPT Codes

Code	Description
00100 – 00352	Anesthesia (Head and Neck)
10021 – 11646	Removal of Lesions or Skin Tags
12001 – 16036	Wound Repair, Skin Grafts and Flaps, Burns
17000 – 17999	Lesions
20150 – 20694	TMJ Treatments, Biopsy
20900 – 20926	Grafts
20999	Unlisted Procedure, Musculoskeletal System, General
21010 – 21499	Musculoskeletal System Repairs
29800 – 29804	Arthroscopy, TMJ
40490 – 42999	Oral Surgery (above Esophagus)
64716	Neuroplasty and/or Transposition; Cranial Nerve
70100 – 70380	Radiology
71010	Radiological Exam, Chest, Single View, Frontal
72020	Radiological Exam, Spine, Single View, Specify Level
72040	Radiological Exam, Spine, Cervical; Two or Three Views
72072	Radiological Exam, Spine, Thoracic, Three Views
72146	MRI, Spinal Canal and Contents, Thoracic
72285	Diskography, Cervical or Thoracic, Radiological Supervision and Interpretation
76100	Radiological Exam, Single Plane Body Section, other than with Urography
76536	Ultrasound, Soft Tissues of Head and Neck, B-Scan, and/or Real Time with Image
80048 – 89399	Pathology and Laboratory Codes

Note: If a member is enrolled in the PCCM delivery system, the PMP must authorize services rendered in an inpatient, outpatient, or ASC setting for providers to receive reimbursement.

The MCOs are responsible for determining which services require PA for its members. The MCOs' decisions to authorize, modify, or deny a given request is based on medical necessity, reasonableness, and other criteria. A provider must make requests for reviews and appeals by contacting the appropriate MCO.

CareSource:
PA 1-866-930-0017
Provider Services 1-866-930-0017

Harmony Health Plan:
PA/Medical Management 1-800-504-2766
Provider Services 1-800-504-2766

Managed Health Services (MHS):
PA/Medical Management 1-800-464-0991
Provider Services 1-800-414-9475

MDwise:
PA/Medical Management 1-800-356-1204 or (317) 630-2831
Provider Services 1-800-356-1204 or (317) 630-2831

Molina:
PA 1-800-642-4509
Provider Services 1-800-642-4509

Vision Services

Ophthalmologists, Optometrists, and Opticians

The purpose of this article is to notify vision providers that reimbursement is not available for more than one unit for eye exams and other ophthalmologic procedures detailed in this article. Effective immediately, IHCP providers may only bill one unit, per member, per day for the procedures indicated in Table 5.11. Claims that have more than one unit per day for these codes will automatically cutback and pay for one unit. Providers who have been reimbursed for more than one unit may be subject to post payment review and possible recoupment. Providers should direct additional questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Table 5.11 – Eye Exams and Other Ophthalmological Services

CPT Code	Definition
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, one or more visits
92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; complete
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited
92020	Gonioscopy (separate procedure)
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., restrictive or paretic muscle with diplopia) with interpretation and report (separate procedure)
92065	Orthoptic and/or pleoptic training, with continuing medical direction and evaluation
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopus 3 or 7 equivalent)

(Continued)

Table 5.11 – Eye Exams and Other Ophthalmological Services

CPT Code	Definition
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 degrees, or quantitative, automated threshold perimetry, Octopus programs G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)
92100	Serial tonometry (separate procedure) with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)
92120	Tonography with interpretation and report, recording indentation tonometer method or perilimbal suction method
92130	Tonography with water provocation
92140	Provocative tests for glaucoma, with interpretation and report, without tonography
92250	Fundus photography with interpretation and report
92260	Ophthalmodynanometry
92265	Needle oculoelectromyography, one or more extraocular muscles, one or both eyes, with interpretation and report
92270	Electro-oculography with interpretation and report
92275	Electroretinography with interpretation and report
92284	Dark adaptation examination, with interpretation and report
92285	External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereo-photography)
92286	Special anterior segment photography with interpretation and report; with specular endothelial microscopy and cell count
92287	Special anterior segment photography with interpretation and report; with fluorescein angiography
92311	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, one eye
92312	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneal lens for aphakia, both eyes
92313	Prescription of optical and physical characteristics of and fitting of contact lens, with medical supervision of adaptation; corneoscleral lens
92315	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, one eye
92316	Prescription of optical and physical characteristics of contact lens, with medical supervision of adaptation and direction of fitting by independent technician; corneal lens for aphakia, both eyes

Provider Workshops

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 5.12 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 5.12 – 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 5.13 lists the dates and Indiana locations for each workshop.

Table 5.13 – 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

(Continued)

Table 5.13 – Second Quarter Workshop Dates, Deadlines, and Locations

Workshop Date	Registration Deadline	Location
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 19 of this newsletter. Print or type the information requested on the registration form. List one registrant per form.

Contact Information

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, Starke
2	Debbie Williams	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, Whitley
3	Pat Duncan	(317) 488-5101	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, White
4	Natalie Snow	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, Wells
5	Jenny Atkins (temp)	(317) 488-5312	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, Washington
7	Mona Green	(317) 488-5326	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
8	Jessica Ferguson (temp)	(317) 488-5197	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, 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	Owensboro	Jessica Ferguson	(317) 488-5197
	Louisville	Tina King	(317) 488-5123
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.

Member and Provider Relations Leaders

Title	Name	Telephone
Director of Member and Provider Relations	Marcia Meece-Bagwell	(317) 488-5345
Team Coordinator	Phyllis Salyers	(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/Pro-DUR** 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 Pro-DUR 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

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: _____