Indiana Health Coverage Programs

Monthly News

www.indianamedicaid.com

Provider Monthly Newsletter

NL200506 **June 2005**

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Abbreviations and Acronyms Used in this Newsletter

1915(b)	Social Security Act section
ACS	Affiliated Computer Services
ADA	American Dental Association
ASC	Ambulatory Surgical Center
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CPT	current procedural terminology
DAP	Dental Advisory Panel
DEA	Drug Enforcement Agency
E/M	Evaluation and Management
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
ER	emergency room
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HRSA	Health Resources and Services Administration
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IEP	Individual Education Plan
IHCP	Indiana Health Coverage Programs
IPDP	Indiana Prescription Drug Program
ISDH	Indiana State Department of Health
ISP	Internet service provider
MCO	Managed Care Organization
MHS	Managed Health Service
NCPDP	National Council for Prescription Drug Programs
OBRA	Omnibus Budget Reconciliation Act of 1986
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
PDL	Preferred Drug List
PMP	primary medical provider
POS	place of service
PPS	Prospective Payment System
PRTF	Psychiatric Residential Treatment Facility
RA	remittance advice
RBMC	Risk-Based Managed Care
RCP	Restricted Card Program
RHC	Rural Health Clinic
TMJ	temporomandibular joint
TPL	Third Party Liability
VFC	Vaccines for Children

IHCP HIPAA Modifications

Effective June 6, 2005 several HIPAA modifications were implemented, these modifications affect Indiana*AIM* and Web interChange. Bulletin *BT200511* outlines the changes that were implemented. This information is also available on the IHCP Web site at www.indianamedicaid.com on the What's New for Providers Web page. In addition, providers can refer to the IHCP *Companion Guide - 837 Institutional, Professional, and Dental Claim Transaction Guide(s)*.

Provider News

Restricted Card Program Has a New Fax Number

Effective May 23, 2005, the RCP's new fax number is (317) 347-4550. All referrals and other concerns for restricted members in traditional Medicaid, Medicaid Select, and PCCM should be faxed to the new number. Questions about the RCP can be directed to:

Health Care Excel
ATTN: Restricted Card Program
PO Box 531700
Indianapolis, IN 46253-1700
(317) 347-4527 (local Indianapolis area)
1-800-457-4515 (toll free)
Fax: 317-347-4550

Vaccines for Children and Injectables

To address an initial shortage of available meningococcal vaccines under VFC, the IHCP is **not** limiting reimbursement for MCV4 or Menactra vaccine, regardless of availability from the VFC program. This allows providers to obtain reimbursement for using privately purchased meningococcal vaccine if they cannot obtain VFC vaccine. When administering privately purchased meningococcal vaccine, providers may bill for the cost of the vaccine plus its administration, and the IHCP-allowable reimbursement will include payment for both.

Note: If a provider administers a free VFC vaccine, the provider should bill the appropriate meningococcal vaccine procedure code but do not charge more than the $8 VFC vaccine administration fee and not bill the separate administration CPT code.

For dates of service January 14, 2005 and after, use CPT codes *90734 – Meningococcal conjugate vaccine, serogroups A, C, Y and W-135 (tetravalent), for intramuscular use*. One unit of 90734, effective January 14, 2005, equals 0.5ml of the vaccine.

Provider-Purchased Vaccine

When a provider administers immunizations using the provider's private stock, refer to IHCP provider bulletin, *BT200151*, for use of the administration code 90788, as appropriate, for the additional $2.75 rate.

Administration Fee

Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if more than one injection is given on the same date of service and no E/M code is billed, providers may bill a separate administration fee for each injection using 90788. When billing for privately purchased vaccine, bill an administration code in addition to the CPT code to obtain reimbursement for both vaccine and its administration. Do not bill an administration CPT code when billing for VFC vaccine. VFC vaccines must be billed with the CPT code for the vaccine and the provider's charge (not to exceed $8) for VFC vaccine administration. Medicaid maximum fee information can be found on the www.indianamedicaid.com Web site.

Be aware of the member's primary medical provider assignment, managed care delivery system assignment, and third party liability resource(s).

RHCs and FQHCs

Note: RHC- and FQHC-specific encounter rates already include payment for immunizations.

When submitting RHC and FQHC claims to track encounters (such claims will be denied), bill no more than the $8 VFC administration fee for use of VFC influenza vaccine **or** bill the usual and customary rate for the influenza vaccine CPT® plus the administration CPT 90782 for use of provider-purchased meningococcal vaccine.

All immunization dollars should be included and totaled on the line specific for immunizations in cost reports submitted to Myers & Stauffer.

Psychiatric Residential Treatment Facility Update

The *PRTF Model Attestation Letter Addendum* (Attachment 4) has been updated to include State Survey Provider ID so that the ISDH and the OMPP can track facilities. The ISDH issues a State Survey Provider ID after reviewing the *PRTF Attestation Form*. Since the State Survey Provider ID is used for internal purposes, the provider should disregard this field. Providers should direct questions about this update to Provider Enrollment Customer Service at 1-877- 707-5750.

FQHCs and RHCs in RBMC: Contracting Questions and Answers

OMPP recently received several questions about the impact of mandatory RBMC on community health centers, particularly the RHCs. The answers to the following questions address most of the issues raised by the RHCs. Additional information will be provided as it becomes available.

For answers to specific questions, email the OMPP Managed Care team at managedcare@fssa.in.gov. Contract review services are provided by HRSA's Bureau of Primary Health Care.

Reimbursement Issues

1. When submitting a claim to an MCO, is the T1015 encounter code required?

   No. The T code is only necessary when submitting claims to EDS.

2. Can the MCO pay the provider its PPS rate?

   The reimbursement arrangement in the contract is a negotiation between the provider and the health plan. The only federal/state requirement is that the MCO must pay the FQHC/RHC provider at least as much as they would pay a non-FQHC/RHC provider for the same services. However, if the provider is being paid its PPS rate by the MCO, then the provider should not submit requests for supplemental payments to Myers & Stauffer.

3. If the MCO denies a service provided at an FQHC/RHC, does this service get reported to Myers & Stauffer and will the provider receive the PPS rate?

   No. If the MCO denies payment for a service, such as for no authorization, then it cannot be counted as a valid encounter.

4. If a FQHC/RHC provider sees a patient out-of-network, for example, the patient is not a member of the same health plan as the provider, how will the provider know that the non-contracted MCO will report to Myers & Stauffer those out-of-network encounters so the provider can be assured of being reimbursed appropriately?

   The MCOs are required to include out-of-network valid encounters in their reports to Myers & Stauffer. However, there is no process is in place that would assure the out-of-network provider that the encounters had been reported by the MCO.

   OMPP recommends contracting with those MCOs whose members you are likely to serve. If the clinic physicians are contracted with one health plan as PMPs, they also could contract as specialists with the other MCOs. Alternatively, the provider can ask the non-contracted MCO for a copy of its report to Myers &Stauffer for its clinic.

5. How will Medicare crossover claims be handled?

   Since the Hoosier Healthwise program excludes the aged, blind and disabled individuals, Medicare crossover claims should not be an issue. Those claims will continue to be billed to EDS.

6. If the provider's contract with the MCO includes a capitation arrangement, how does the clinic report those payments to Myers & Stauffer?

   All payments made to the provider by an MCO, except for quality incentive payments, are to be included under column E of the supplemental payment request form.

7. If the annual reconciliation process shows that the FQHC/RHC has been paid an amount above their PPS rate, will there be a recoupment from the provider?

   Federal requirements prohibit the State from imposing an upper limit restriction on what the MCO pays the FQHC/RHC provider. If the MCO pays the provider above its PPS amount for the year, excluding quality incentives, the clinic may keep the overage amount. However, if supplemental payments are made to the FQHC/RHC by EDS, the overage is subject to recoupment.

Questions To Consider when Comparing the MCOs

1. What are the PA requirements? What services require PA?
2. What are the referral processes for in-network providers? Out-of-network providers?
3. How is PMP coverage by an out-of-network physician handled?
4. Pharmacy and PDL issues. Which area pharmacies are in the MCO network? What is the process to obtain drugs not on the PDL?
5. What member education and intervention services do they offer? How do they help you manage your patients' care? How do they reduce inappropriate ER utilization?
6. What special programs do they have for improving member health outcomes, such as disease management or prenatal programs?
7. What quality incentives are available?
8. What are the claims filing procedures? How quickly are claims adjudicated? What is the claims dispute/appeal process for contracted providers
9. What are the grievance and appeal procedures for members and providers?

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 Prime*Step* 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 6.1 lists the scheduled transition dates, by region, by county. The map in Figure 6.1 provides a graphic representation of the transition schedule. Table 6.2 provides MCO contact information.

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 Tippecanoe County Area Public Meeting is scheduled for June 7, 2005 from noon to 1 p.m. at:

Kathryn Weil Center for Education
415 N. 26th St., Suite 400
Lafayette, Indiana

Table 6.1 – Mandatory MCO Transition and Key Dates by Region, by County

County					PMP/MCO Contracts Signed and at MCOs	Prime*Step* Members Enrolled in MCOs
Southern Region Counties						
Bartholomew	Brown	Clark	Clay	Crawford	May 1, 2005	July 1, 2005
Daviess	Dearborn	Decatur	Dubois	Floyd		
Franklin	Greene	Harrison	Jackson	Jefferson		
Jennings	Lawrence	Martin	Monroe	Ohio		
Orange	Owen	Perry	Pike	Ripley		
Scott	Spencer	Switzerland	Washington			

Table 6.1 – Mandatory MCO Transition and Key Dates by Region, by County

County					PMP/MCO Contracts Signed and at MCOs	Prime*Step* Members Enrolled in MCOs
Northern Region Counties						
Adams	Cass	Dekalb	Fulton	Huntington	July 1, 2005	September 1, 2005
Jasper	Kosciusko	LaGrange	Marshall	Miami		
Newton	Noble	Pulaski	Starke	Steuben		
Wabash	Wells	White	Whitely			
Central Region Counties						
Benton	Blackford	Boone	Carroll	Clinton	September 1, 2005	November 1, 2005
Fayette	Fountain	Hamilton	Hancock	Hendricks		
Henry	Jay	Montgomery	Parke	Putnam		
Randolph	Rush	Shelby	Tippecanoe	Tipton		
Union	Vermillion	Warren	Wayne			

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. Prime*Step* 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 member 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 6.2 lists active MCOs in Indiana along with phone numbers and Web sites.

Additional Information

Additional information is available on the IHCP Web site at www.indianamedicaid.com.

Direct questions about the information in this article to the appropriate MCO listed in Table 6.2 or AmeriChoice at 1-800-889-9949, Option 3.

Table 6.2 – 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

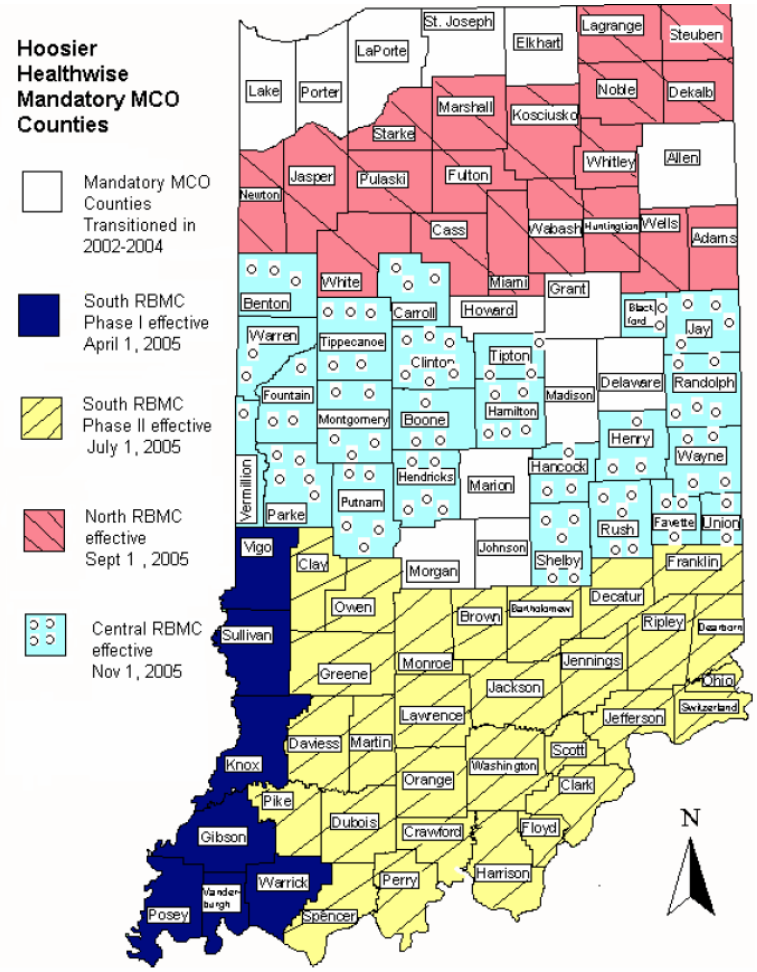

Figure 6.1 – Map of Mandatory MCO Counties

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 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 6.3. 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 6.3 – 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.

Corrections to the 2005 Annual HCPCS Update

CMS released corrections to the 2005 Annual HCPCS Update. Attachment 6 lists the new code corrections with coverage determinations and the deleted code corrections with replacement codes. Description changes will be automatically updated in the system. These updates are effective retroactive to January 1, 2005.

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 replaced with a secure FTP solution called File Exchange. This solution is provided by 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. File Exchange is provided by the IHCP and requires access to the Internet through a local ISP.

All trading partners connecting directly with the IHCP to exchange data are required to transition to using File Exchange during the next few months. For a more expansive explanation of the advantages of File Exchange, refer to *NL200505*.

> *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.*

EDS and IHCP have partnered with a service called AllInternetNow® to identify Internet access options for each trading partner. AllInternetNow® is a free service that works with most ISPs. Information packets that contain ISP option information are being sent to each trading partner.

Access the AllInternetNow® Web site at http://edstp.allinternetnow.com.

The *File Exchange How To Guide* is available on the IHCP Web site at www.indianamedicaid.com to provide assistance to trading partners transitioning to File Exchange.

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 and groups are 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. See *NL200505* for more information.

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.

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.

Dental providers that provide treatment for medical conditions may be billing the E/M codes, and these services may include treatment of sleep apnea or TMJ. The scope of practice, defined in *IC 25-14-1-23*, allows for diagnosis or treatment of the human oral cavity, teeth, gums, or maxillary or mandibular structures.

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. Refer to Table 6.4 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 6.4 when a CDT-5 is not appropriate.

Table 6.4 – 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

Package E Dental Provider Notice

Dental providers may have received inappropriate reimbursement for non-emergency services rendered to Package E members. With the assistance of the DAP, the IHCP created a table of the *CDT-5* codes that are allowed for reimbursement of emergency services provided to Package E members.

Note: The listing of a code in Attachment 5 does not eliminate the need for providers to document the emergency medical condition that required treatment.

The codes in Attachment 5 ***may not all be active*** *codes for claims filed with DOS prior to January 1, 2005.*

Radiographs must only be billed when the member presents with symptoms that warrant the diagnostic service.

Additional Information

The *IHCP Provider Manual*, Chapter 2, describes the different eligibility categories within the IHCP. Hoosier Healthwise Package E members are eligible only for services to treat an emergency medical condition(s). OBRA defines an emergency medical condition as follows:

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 an organ or part.

Non-emergency services for Package E members are IHCP non-covered services. Providers must refer to the *IHCP Provider Manual*, Chapter 4, for the requirements when billing an IHCP member for non-covered services.

In addition, providers are encouraged to refer to the *IHCP Provider Manual* and IHCP provider newsletters *NL200410* and *NL200504* for related information.

NL200410 reminded dental providers of the importance of eligibility verification prior to rendering services to IHCP members. It is important to verify eligibility prior to each visit, as eligibility can change, be terminated, or include service limitations dependent on the program in which the member is enrolled.

NL200504 reiterated the policy stated in the *IHCP Provider Manual* about field 53 of the *ADA Dental Claim Form.* Field 53 is a required field and must be used to specify if the services performed were for emergency care. Providers must indicate "**Yes**" for all emergency care. All services are subject to post-payment review and documentation must support medical necessity for the services performed.

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

HoosierRx

HoosierRx Program Transition

On June 27, 2005, EDS will assume processing of claims for the IPDP, also known as the HoosierRx program. Any claim that is billed on or after June 27, 2005 will be processed by EDS, regardless of date of service.

Currently, providers transmit all HoosierRx claims to ACS State Healthcare. ACS will continue to accept HoosierRx claims until Sunday afternoon, June 26, 2005. To facilitate the transition from ACS to EDS, the HoosierRx claims processing system will be unavailable from late afternoon on June 26 until the morning of June 27. Providers that submit HoosierRx claims for processing during the transition time period will receive a POS message that the claim cannot be processed.

Providers are reminded that prescriptions filled during the downtime are still subject to all applicable edits, member benefit dollar limits, and member copayment amounts.

All POS pharmacy claims transactions will continue to follow the NCPDP version 5.1 standard. Table 6.5 contains the significant changes to the *HoosierRx (NCPDP) Transactions Payer Sheet*:

Table 6.5 – *HoosierRx (NCPDP) Transactions Payer Sheet* Changes

Field	Field Name	Current Value	Value(s) for Use Effective 06/27/05
101-A1	BIN Number	610084	610467
104-A4	Processor Control Number	DRSHPROD – production DRSHACCP – test	INCAIDPROD – production INCAIDTEST - test
202-B2	Service Provider ID Qualifier	07 – NCPDP Provider ID	05 – Medicaid

(Continued)

Table 6.5 – *HoosierRx (NCPDP) Transactions Payer Sheet* Changes

Field	Field Name	Current Value	Value(s) for Use Effective 06/27/05
201-B1	Service Provider ID	NCPDP/NABP number	10-character billing pharmacy provider ID number assigned by the IHCP or the IPDP
302-C2	Cardholder ID	10-digit IPDP Member ID number	12-digit IPDP Member ID number (starts with '**70**')
301-C1	Group ID	INSENR100	INSENR100 (This value stays the same in the transition)
466-EZ	Prescriber ID Qualifier	12 – DEA Number 13 – State Issued 99 – Other	08 – State License
411-DB	Prescriber ID	DEA number or state license number of the prescriber	8-digit IN license number (See Payer Sheet for license numbers for OOS prescribers)

The complete *NCPDP 5.1 Transactions Payer Sheets*, effective for HoosierRx pharmacy transactions for EDS submission, can be found on the HoosierRx Web site at www.in.gov/fssa/hoosierrx/ or through the HoosierRx link under Pharmacy Services on the IHCP Web site at www.indianamedicaid.com.

Pharmacy Services

Hoosier Healthwise Mandatory RBMC Enrollment

The OMPP is implementing Hoosier Healthwise mandatory RBMC enrollment across all Indiana counties in 2005. (See also IHCP provider bulletin *BT200506*.)

This article provides information to assist pharmacies with the transition to RBMC via two resources:

1. Table 6.6 provides a listing of the pharmacy directors for each Hoosier Healthwise MCO. Pharmacies participating in the Hoosier Healthwise program should refer to Table 6.6 for assistance in the transition.
2. Attachment 7 is a compendium of pharmacy-related contact information. It focuses on billing assistance, claims, and PA-related matters for each of the Hoosier Healthwise MCOs.

Table 6.6 – Pharmacy Directors for Hoosier Healthwise MCOs

MCO	Contact	Phone	Fax	E-mail
Managed Health Services (MHS) 1099 N. Meridian St., Suite 400 Indianapolis, Indiana 46204	Larry Harrison, RPh, MBA Director of Pharmacy	(317) 684-9478 Ext 20173	(317) 684-9280	lharrison@centene.com
MDwise 1099 N. Meridian St., Suite 320 Indianapolis, IN 46204	Kelly Henderson, PharmD, CDM Director of Pharmacy	(317) 829-8161	(317) 829-5530	khenderson@mdwise.org
Harmony Health Plan 41 E. Washington St., Suite 305 Indianapolis, IN 46204	Chris Johnson Director of Pharmacy	1-866-231-1338 (toll free)	(317) 917-8090	chris.johnson@wellcare.com
Molina Healthcare, Inc. 8001 Broadway Suite 400 Merrillville, IN 46410	Avis Davis, RPh, MBA	1-800-642-4509 Ext 163203 (toll free)	(219) 736-9140	avis.davis@molinahealthcare.com
CareSource One Dayton Centre One South Main Street Dayton, OH 45402	Jon Keeley Director of Pharmacy	(937) 531-2011	(937) 531-2434	jon.keeley@care-source.com

Provider Workshops

June 2005 Workshops for Medicaid Providers

The OMPP, CHIP, and EDS offer IHCP 2005 workshops free of charge. Sessions are offered at several locations in Indiana. Table 6.7 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 to two registrants per provider number in all locations. EDS processes registrations chronologically based on the date of the workshop and in the order received. Registration does not guarantee a spot in the workshop. A confirmation letter or fax is sent upon receipt of a registration. If a confirmation letter is not received, the seating capacity has been reached for that workshop.

All workshops show local times and begin promptly. General directions to workshop locations are available on the IHCP Web site at www.indianamedicaid.com. On the Web site, click *Provider Services, Education Opportunities, Provider Workshops.* Consult a map or other location tool for specific directions to the location.

The *Provider Workshop Registration* form is available in the Attachments section of this newsletter. Print or type the information requested on the registration form. List one registrant per form. Fax the completed registration forms to EDS at (317) 488-5376. 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.

Table 6.7 – June Workshop Session Times, Topic, and Description

Time	Topic	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 6.8 lists the dates and Indiana locations for the workshops.

Table 6.8 – 2nd Quarter 2005 Workshop Dates, Deadlines, and Locations

Workshop Date	Registration Deadline	Location
June 15, 2005	June 8, 2005	Unity Health Care 1345 Unity Pl., Room D Lafayette
June 16, 2005	June 9, 2005	St. Mary's Medical Center Manor Auditorium 3700 Washington Ave. 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

Contact Information

IHCP Provider Field Consultants, Effective June 1, 2005

Territory Number	Provider Consultant	Telephone	Counties Served
1	Jenny Atkins (temp)	(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	Pat Duncan	(317) 488-5101	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Daryl Davidson	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, and Wells
5	Natalie Snow	(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	Mona Green	(317) 488-5326	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	Jenny Atkins (temp)	(317) 488-5312
	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) 488-5148

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		
☐ 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)		
☐ 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)		
☐ Lafayette, June 15, 2005	☐ Evansville, June 16, 2005	☐ Columbus, June 21, 2005
☐ Ft. Wayne, June 23, 2005	☐ Richmond, June 24, 2005	
Managed Care Roundtable		
☐ 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: _____

PRTF Model Attestation Letter Addendum

Psychiatric Residential Treatment Facility (PRTF)

Model Attestation Letter Addendum

Facility Name
Address
City, State, ZIP
Telephone Number

Medicaid Provider Number:

State Survey Provider Number:
(For Internal Use Only)

Dear Indiana Medicaid:

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. Based upon my personal knowledge and belief, I attest that the _____(Name of the Facility) hereby complies with all of the requirements set forth in the interim rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (*Psych Under 21* rule).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly known as HCFA), the State Medicaid Agency or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at *431.610*, have the right to validate that _____ (Name of the Facility) is in compliance with the requirements set forth in the *Psych Under 21* rule, and to investigate serious occurrences as defined under this rule.

In addition, I will notify the Indiana Health Coverage Programs immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the State Medicaid Agency if it is my believe that _____(Name of the Facility) is out of compliance with the requirements set forth in the *Psych Under 21* rule.

Signature_____ This attestation must be signed by an individual who has the legal authority to obligate the facility.

Printed Name_____

Title_____

Date_____

Instructions: Remove "Model Attestation Letter" from the header and replace with your company name, and attach signed attestation letter to the provider enrollment application.

CDT-5 Codes Allowed for Package E Members

CDT-5 Code	Description
D0140	Limited oral evaluation – problem focused
D0210	Intraoral – complete series (including bitewings)
D0220	Intraoral – periapical – first film
D0230	Intraoral – periapical – each additional film
D0240	Intraoral – occlusal film
D0270	Bitewing – single film
D0272	Bitewings – two films
D0274	Bitewings – four films
D0330	Panoramic film
D7110	Extraction, coronal remnants – deciduous tooth
D7140	Extraction, erupted tooth or exposed root
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220	Removal of impacted tooth – soft tissue
D7230	Removal of impacted tooth – partially bony
D7240	Removal of impacted tooth – completely bony
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications
D7250	Surgical removal of residual tooth roots (cutting procedure)
D7260	Oroantral fistula closure
D7261	Primary closure of sinus perforation
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280	Surgical access of unerupted tooth (impacted tooth not intended for extraction)
D7282	Mobilization of erupted or malpositioned tooth to aid eruption
D7285	Biopsy of oral tissue – hard
D7286	Biopsy of oral tissue – soft
D7288	Brush biopsy – transepithelial sample collection
D7510	Incision and drainage of abscess – intraoral soft tissue
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7520	Incision and drainage of abscess – extraoral soft tissue
D7521	Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces)
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue
D7540	Removal of reaction producing foreign bodies, musculoskeletal system
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body
D7610	Maxilla – open reduction (simple fracture)
D7620	Maxilla – closed reduction (simple fracture)
D7630	Mandible – open reduction (simple fracture)
D7640	Mandible – closed reduction (simple fracture)
D7650	Malar and/or zygomatic arch – open reduction (simple fracture)

(Continued)

CDT-5 Codes Allowed for Package E Members

CDT-5 Code	Description
D7660	Malar and/or zygomatic arch – closed reduction (simple fracture)
D7670	Alveolus – closed reduction, may include stabilization of teeth(simple fracture)
D7671	Alveolus – open reduction, may include stabilization of teeth (simple fracture)
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches (simple fracture)
D7710	Mandible – open reduction (compound fracture)
D7720	Mandible – closed reduction (compound fracture)
D7730	Malar and/or zygomatic arch – open reduction (compound fracture)
D7740	Malar and/or zygomatic arch – closed reduction (compound fracture)
D7750	Alveolus – closed reduction, may include stabilization of teeth(compound fracture)
D7760	Alveolus – open reduction, may include stabilization of teeth (compound fracture)
D7770	Facial bones – complicated reduction with fixation and multiple surgical approaches (compound fracture)
D7771	Mandible – open reduction (compound fracture)
D7780	Mandible – closed reduction (compound fracture)
D7910	Suture of small wounds up to 5cm (excludes surgical incisions)
D7911	Complicated suture – up to 5cm (excludes surgical incisions)
D7912	Complicated suture – greater than 5cm (excludes surgical incisions)
D7999	Unspecified oral surgery procedure - by report (use for supernumerary tooth extractions)
D9220	General anesthesia – first 30 minutes. (Only covered if medically necessary. Only covered in the office setting for members less than 21 years of age. Only covered for members 21 years of age and older in the hospital (inpatient or outpatient) or ASC setting.)
D9221	General anesthesia – each additional 15 minutes. (See D9220)
D9230	Analgesia, anioxlysis, inhalation of nitrous oxide. (Only covered for members 20 years of age and younger and limited to one unit per visit.)
D9241	Intravenous conscious sedation/analgesia – first 30 minutes. (Covered for oral surgical procedures only.)
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes. (Covered for oral surgical procedures only.)
D9248	Non-intravenous conscious sedation
D9920	Behavior management

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
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

(Continued)

Corrections to the New 2005 HCPCS Codes, Effective January 1, 2005

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage
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
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

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.

Hoosier Healthwise Mandatory RBMC Enrollment

MDwise / PerformRx

Pharmacy Help Desk
1-800-558-1655

To Process Claim:
RxBIN: **600428**
RxPCN: **03210000**
Hoosier Healthwise Card #
Date of Birth
Prescriber DEA #

PDL and PA forms found at:
www.mdwise.org
(Clinical PAs should be submitted by the prescriber)

Harmony / Walgreens Health Initiatives

Pharmacy Help Desk
1-877-647-7473

To Process Claim:
RxBIN: **603286**
RxPCN: **01410000**
RxGroup: **476257**
Hoosier Healthwise Card #
Date of Birth
Prescriber DEA #

PDL and PA forms found at:
www.harmonyhmi.com
(Clinical PAs should be submitted by the prescriber)

MHS / scrip solutions

Pharmacy Help Desk
1-800-213-5640

To Process Claim:
RxBIN: **900020**
RxPCN: **CLAIMWT**
RxGroup: **MHSINN**
MHSINC
MHSINS
MHSINTS
Hoosier Healthwise Card #
Date of Birth
Prescriber DEA #

PDL and PA forms
or Rx questions:
1-800-944-9661

Molina / RxAmerica

Pharmacy Help Desk
1-800-642-4509
Fax: (219) 736-9140

To Process Claim:
RxBIN: **610473**
RxPCN: **Not required**
RxGroup: **Not required**
Hoosier Healthwise Card #
Date of Birth
Prescriber DEA #

PDL and PA forms found at:
www.molinahealthcare.com
(Clinical PAs should be submitted by the prescriber)

careSource / Express Scripts

ESI Pharmacy Help Desk
1-800-417-8164
CareSource Pharmacy
PA and Help Desk
1-800-488-0134
PA Fax: 1-866-930-0019

To Process Claim:
RxBIN: **003858**
RxPCN: **A4**
RxGroup: **C4SA**
Hoosier Healthwise Card #
Date of Birth
Prescriber DEA #

PDL found at:
www.care-source.com