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Indiana Health Coverage Programs

Monthly News

Provider Monthly Newsletter

NL200509 **September 2005**

Table of Contents

Abbreviations and Acronyms Used in this Newsletter

1915(b)	Social Security Act section
ACS	Affiliated Computer Services
AVR	Automated Voice Response
BIN	Bank Identification Number (RxBIN)
CCF	Claim Correction Form
CDT	Current Dental Terminology
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
COP	Conditions of Participation
DEA	Drug Enforcement Agency
DUR	Drug Utilization Review
EDI	electronic data interchange
EDS	Electronic Data Systems
EDD	estimated date of delivery
FAQ	frequently asked questions
FFS	fee for service
FQHC	Federally Qualified Health Center
GBA	Palmetto GBA
HCE	Health Care Excel
HIPAA	Health Insurance Portability and Accountability Act
HMS	Health Management Services
IAC	Indiana Administrative Code
ICD	International Classification of Diseases
ICF/MR	Intermediate Care Facility for the Mentally Retarded
IHCP	Indiana Health Coverage Programs
LMP	last menstrual period
IOM	Institute of Medicine
ISDH	Indiana State Department of Health
MCO	Managed Care Organization
MHS	Managed Health Service
MRT	Medical Review Team
OMPP	Office of Medicaid Policy and Planning
PA	prior authorization
PBM	Pharmacy Benefit Manager
PCCM	Primary Care Case Management
PCN	Primary Care Network (RxPCN)
PDL	Preferred Drug List
PMP	primary medical provider
POS	place of service
ProDUR	Prospective Drug Utilization Review
RBMC	Risk-Based Managed Care
RHC	Rural Health Clinic
RID	recipient identification number
SA	State authorization
SFTP	secure file transfer protocol
SUR	Surveillance and Utilization Review
TPL	third party liability

Provider News

All Providers: Update to Prenatal Risk Assessment Form

The purpose of this article is to advise providers that effective 45 days from the date of this publication, the *Prenatal Risk Assessment* form has been updated. A copy of the revised form is included as Attachment 3, and can be accessed on the IHCP Web site at http://www.indianamedicaid.com, in the "Forms" window. Note that the form no longer contains specific *ICD-9-CM* diagnosis codes specific to high-risk pregnancies. Effective 45 days from the date of this publication, providers are advised to refer to Attachment 4 to (1) select the appropriate diagnosis code, and (2) report the appropriate *At Risk of Preterm Birth or Poor Pregnancy Outcome Medical Factor* listed in the table on the *Prenatal Risk Assessment* form.

The factors specific to the *Psychosocial Factors That May Affect Current Pregnancy Outcomes* are listed in Table 9.1. Providers are advised to refer to future provider notifications for updated information. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or toll free at 1-800-577-1278.

> *Note: All billing requirements for Medically High Risk Pregnancy remain unchanged. Physicians must use one of the diagnosis codes listed in Attachment 4 as the primary diagnosis on the* CMS 1500 *or* 837P *claim.*

Table 9.1 – Psychosocial Factors That May Affect Pregnancy Outcomes

Medical Factor	Code	Medical Factor	Code
Acute Reaction to Stress	308.0 – 308.9	Missed Prenatal Appointments, consecutive	V23.7
Domestic Violence	995.80, 995.81	Other and Unspecified Disorders of Eating	307.0 – 307.59, V69.1
High Risk Sexual Behavior	V69.2	Other Personal History Presenting Hazards to Health	V15.01 – V15.09
Lack of Housing Resources	V60.0 – V60.4, V60.8, V60.9	Other Psychosocial Circumstances	V62.0 – V62.9
Late Initial Visit, after 14 weeks or pregnancy	V23.7	Prenatal Care Non-compliance, most recent pregnancy	V23.7
Lead Exposure	V15.86	Unwanted Pregnancy	V61.7

Web InterChange Monitored for HIPAA Security and Privacy

In order to ensure that the interChange Web site is being used appropriately, Web interChange activity is monitored by the Web systems staff of EDS. This monitoring has revealed that some providers have been submitting a batch of eligibility transactions instead of real -time, interactive eligibility transactions, which is the purpose of the Web site.

In November 2004 Web interChange was enhanced with *Membership* functionality. *Membership* allows provider organizations to assign one or more administrators to oversee their members' use of the interChange site. *Membership* also aids in the adherence to HIPAA security regulations. The organization's administrator assigns a unique user ID and password for each user within the organization. Passwords must be in the HIPAA compliant format for strong passwords. Sharing user IDs and passwords is a direct violation of the HIPAA security rule. Providers are strongly encouraged to use *Membership* to ensure that unique IDs and passwords are used, as required in the HIPAA security rule.

On at least one occasion, a provider was found to be sharing a password with an outside vendor for the purpose of running batch activity. This type of activity abuses the appropriate way that the interChange eligibility transaction was meant to

be used and violates the HIPAA security rule that went into effect in April 2005. This unauthorized use of the eligibility transaction also negatively impacts those who are using the Web site appropriately. Providers must not share their passwords or setup information through membership user IDs, nor share their passwords with business associates.

InterChange users who use the Web site inappropriately will be contacted by the OMPP and/or EDS. Depending on the severity of the situation, the user's access to Web interChange could be disabled.

Providers who want to send a large amount of eligibility transactions at one time are encouraged to use the HIPAA compliant 270/271 Eligibility Benefit Inquiry and Response Transaction. Using this process, the provider can send multiple eligibility inquiries in a batch format via a secure file transfer protocol (SFTP) connection. The eligibility transactions are processed and a batch response file is created and made available to the provider via secure FTP within 24 hours.

Providers needing additional information about *Membership* administrator access or batch transaction submission should contact the EDS EDI Solutions help desk at (317) 488-5160 in the Indianapolis area or toll free at 1-877-877-5182. To set up a Web interChange administrator for an organization, fill out and mail the *Administrator Request Form* found under *How To Obtain an ID* on the interChange Web site.

Questions may also be e-mailed to inxixTradingPartner@eds.com.

Web InterChange Password Rules To Be Enforced September 30, 2005

Web interChange password regulations were modified in January 2005 to conform to stricter password standards. It was found that there were many users who were unable to immediately adopt all of the new password standards. In order to allow providers the opportunity to assign Web administrators for their organizations to facilitate adoption of the new policy, the changes were not implemented. EDS must now implement the remaining provisions of the password policy to continue proper enforcement of HIPAA security rules.

Beginning **September 30, 2005**, the following password regulations will be enforced:

- Invalid password attempts are restricted to three. If after three attempts the user has still not entered the correct password, the user's ID will be disabled and the user will have to reset the password. Users who are set up under an administrator can do this themselves with the auto-password reset, or they can have their administrators reset them. Users who are not set up with administrators must call the EDS EDI Solutions help desk at (317) 488-5160, option 3 in the Indianapolis area or toll free at 1-877-877-5182 to get their passwords reset.
- When users change their passwords, it cannot be one of their previous six passwords. If users attempt to change their passwords to a value that is equal to one of their previous six, they will receive an error message indicating that they must choose another password.

The following password regulations are already in place and will continue:

- Users are required to change passwords every 90 days. Passwords may be changed at any time by selecting the Change Password button on the left side of the Web page.
- Passwords must be in the HIPAA compliant format for strong passwords. Valid user ID and password format instructions can be found in the *User IDs* and *Passwords* section of Help on the interChange Web site.
- Direct any questions about Web interChange to the EDS EDI Solutions help desk at (317) 488-5160, option 3 in the Indianapolis area or toll free at 1-877-877-5182. Questions can also be e-mailed to inxixElecctronicSolution@eds.com.

Physician Signature Stamps

Effective January 24, 2004, *CMS Transmittal 59* allows for the acceptance of a physician's rubber stamp signature for clinical record documentation, provided it is permitted by Federal, state, and local law, and authorized by the home health agency's or hospice agency's policy. This newsletter article addresses the impact this new policy will have on the Medicaid prior authorization process for home health and hospice services by referring providers to the appropriate regulations for Medicaid.

Chapter 6 of the *IHCP Provider Manual* and state regulations at *405 IAC 5-5-5* specify that the provider must approve the *Indiana Prior Review and Authorization Request* form by personal signature, **or providers and their**

designees may use a signature stamp. Providers that are agencies, corporations, or business entities may authorize one or more representatives to sign requests for prior authorization (PA). Providers should note that this section of the *IHCP Provider Manual* and state regulation address permissible signature requirements for the *Indiana Prior Review and Authorization Request* form, and must be differentiated from the signature requirements for physician orders and care plans. Under the above-mentioned regulation, it is permissible for the agency to use a signature stamp for the *Indiana Prior Review and Authorization Request* form.

The following state regulations apply to Medicaid prior authorization request for home health services and can be viewed on the internet at www.accessindiana.com:

- *405 IAC 5-16-3.1 Home health agency services; limitations*: does not address physician signature stamps for physician orders or written care plans.
- *405 IAC 5-22-2 Nursing services; prior authorization requirements* does not address physician signature stamps for prior authorization of nursing services.

In conclusion, physician signature stamps may be used on the *Indiana Prior Review and Authorization Request* form when requesting Medicaid prior authorization for home health services; however, any physician order or plan of treatment that is attached to the *Indiana Prior Review and Authorization Request* form must include an original signature by the physician.

State regulations for the Medicaid hospice benefit do not specifically provide for physician signature stamps. The following regulations do apply to Medicaid prior authorization request for hospice services with regard to the hospice physician certification and the hospice plan of care. They can be viewed on the internet at www.accessindiana.com.

- *405 IAC 5-34-5 Physician certification*
- *405 IAC 5-34-7 Plan of care*

In order to ensure that the medical director or physician member of the hospice reviewed the plan of care, an original signature is required.

In conclusion, physician signature stamps may be used on the *Indiana Prior Review and Authorization Request* form when requesting Medicaid prior authorization for hospice services; however, any *Medicaid Hospice Physician Certification* form or *Medicaid Hospice Plan of Care* that is attached to the *Indiana Prior Review and Authorization Request* form must include an original signature by the physician.

Furthermore, the IHCP notes that electronic signatures are not acceptable on plans of care submitted to the HCE Prior Authorization Unit.

Home health and hospice providers should contact the Acute Care Division of the Indiana State Department of Health at (317) 233-7474 with regard to ISDH home health and hospice survey rules.

Information To Be Read In Conjunction with Provider Bulletin BT200117 Prior Authorization Request for Home Health

This information should be read in conjunction with information already published in *BT200117* (April 27, 2001 release date). *BT200117* may be viewed on the Indiana Medicaid Web site at www.indianamedicaid.com.

Providers are informed that there have been no changes to Medicaid state regulations at *405 IAC 5-16-3(d)(2)(G)*, which requires a home health agency to state the amount of time required to complete the treatment task on the plan of care. However, the IHCP has made a change to the directions in *BT200117*, which specified that the *Indiana Prior Review and Authorization Request* form and the signed plan of care must reflect the specific frequency and duration of care.

This newsletter notes the following change:

- The *Indiana Prior Review and Authorization Request* form may now reflect the maximum amount of time it may require for the home health agency to care for the patient; however, the provider should only bill the IHCP the actual service units provided on each visit.

ISDH regulations regarding patient care and the medical plan of care that were referenced in *BT200117* have changed. The new home health regulations may be viewed by accessing the IAC on the Web site at www.accessindiana.com. The new regulations may be viewed as follows:

- Encounter defined may be viewed at *410 IAC 17-9-12*.
- Frequency of visits defined may be viewed at *410 IAC 17-9-13*.

- Information regarding patient care and the medical plan of care may be viewed at *410 IAC 17-13-1*.

It is the responsibility of home health providers to ensure that their plans of care are compliant with Medicaid regulations and ISDH survey regulations.

Home health providers may direct any questions regarding the ISDH home health survey process to the ISDH Acute Care Unit at (317) 233-7472. Home health providers may direct any questions regarding Medicaid home health prior authorization to the HCE Prior Authorization Unit at (317) 347-4511 or 1-800-457-4518.

Hospice Benefit Periods and Medicaid Prior Authorization

Prior authorization requests for hospice services are often modified by the HCE PA Unit because the benefit period dates of service exceed the service dates that Indiana*AIM* can approve. The IHCP processes all hospice authorization requests using the Julian date calendar. Hospice care dates cannot overlap from one hospice benefit period to the next in Indiana*AIM*. Providers are asked to review all modified requests to ensure that future requests for hospice benefit periods may be submitted accordingly. Hospice providers may direct any questions regarding hospice authorization to the HCE PA Unit at (317) 347-4511 or 1-800-457-4518.

Inpatient Day Limitations for Hospice

Providers may refer to Section 6 of the *IHCP Hospice Provider Manual* for more information regarding the limitation of payments for inpatient care under the IHCP Hospice Benefit.

Reimbursement for inpatient days, both general and respite, is subject to an overall annual limitation established by the federal Medicare program as described in *42 CFR 418.98*© and state regulations at *405 IAC 1-16-3*. Total inpatient days (both general inpatient days and inpatient respite care days) for an individual hospice provider, and any contracted agents, may not exceed 20 percent of all days provided to all IHCP hospice members serviced by that specific provider during that 12-month period beginning November 1 of each year, and ending October 31 of the following year.

Myers and Stauffer, the IHCP's long-term care rate-setting contractor, has reviewed the hospice claims information for the period starting November 1, 2003 and ending October 31, 2004, and has found that there are no hospice providers that have exceeded the limitation of inpatient days for this period.

Discharge by Hospice Provider

The information outlined in this newsletter is meant to be read in conjunction with information already published in Section 4 of the *IHCP Hospice Provider Manual*, which may be viewed on the Indiana Medicaid Web site at www.indianamedicaid.com. This newsletter article shall provide clarification regarding whether a hospice provider may discharge a member for non-compliance based on clarification that the IHCP has received from CMS Region V and procedures that must be followed through the ISDH as the state survey agency.

Hospice providers have asked the IHCP to change its policy regarding discharging members for non-compliance with the hospice benefit. The IHCP is required to model the IHCP hospice benefit after Medicare hospice reimbursement methodology and no changes are made to the policies outlined in the *IHCP Hospice Provider Manual* unless the IHCP receives a CMS Transmittal directing such a change or a change to the *Medicare Hospice Manual.*

CMS Region V directed the IHCP to *IOM 102-9-20-2.1* for information regarding Hospice Discharge. Providers may view this section at http://www.cms.hhs.gov/manuals/102_policy/bp102c09.pdf. A reprint of this section is noted below:

20.2.1-Hospice Discharge
(Rev.1, 10-01-03)

HOSP 210, and comments by Sue Jesse Pennington. Ms. Pennington works in the policy area of the CMS Central Office.

The hospice benefit is available only to individuals who are terminally ill; therefore, a hospice may discharge a patient if it discovers that the patient is not terminally ill. Discharge may also be necessary when the patient moves out of the service area of the hospice. The hospice notifies the intermediary of the discharge so that hospice services and billings are terminated as of this date. In this situation, the patient loses the remaining days in the benefit period. However, there is no increase cost to the beneficiary. General coverage under Medicare is

reinstated at the time the patient revokes the benefit or is discharged.

Once a hospice chooses to admit a beneficiary, it may not automatically or routinely discharge the beneficiary at its discretion, even if the care promises to be costly or inconvenient, or the State allows for discharge under State requirements. The election of the hospice benefit is the beneficiary's choice rather than the hospice's choice, and the hospice cannot revoke the beneficiary's election. Neither should the hospice request or demand that patients revoke their election.

In most situations, discharge from a hospice will occur as a result of one of the following:

- The beneficiary decides to revoke the hospice benefit;
- The beneficiary moves away from the geographic area that the hospice defines in its policies as its service area;
- The beneficiary transfers to another hospice;
- The beneficiary's condition improves and he/she is no longer considered terminally ill. In this situation, the hospice will be unable to recertify the patient; or,
- The beneficiary dies.

There may be extraordinary circumstances in which a hospice would be unable to continue to provide hospice care to a patient. These situations would include issues where patient safety is compromised. The hospice must make every effort to resolve these problems satisfactorily before it considers discharge an option. All efforts by the hospice to resolve the problem(s) must be documented in detail in the patient's clinical record and the hospice must notify the fiscal intermediary and State Survey Agency of the circumstances surrounding the impending discharge. The hospice may also need to make referral to other relevant state or community agencies (for example, Adult Protective Services) as appropriate.

After speaking to representatives from CMS Region V and ISDH, the IHCP recommends the following steps be taken when an IHCP-only hospice member is non-compliant with the hospice care philosophy:

During those situations where a hospice provider feels that a member has reflected significant non-compliance with the hospice plan of care, the documentation standard outlined below in the last paragraph of *IOM 102-9-20-2.1* must be followed; the hospice must contact the State Survey Agency (SA); and then the SA contacts CMS for CMS to determine that the member may be discharged. It is very important that a hospice have written clear admissions policies, inform members of their responsibilities under the hospice benefit, and document thoroughly the issues of non-compliance before taking the concern to the SA. Hospice providers who have questions for the SA may contact the ISDH, Acute Care Unit at (317) 233-7472.

The *IHCP Hospice Provider Manual* states, "If a member is noncompliant with hospice care, the hospice provider can counsel the member to revoke hospice care by explaining the disadvantages of revoking the hospice benefit. If the member chooses not to revoke, the member is responsible for the charges resulting from the non-compliance. It is the hospice provider's responsibility to inform the member of the member's responsibility for services not covered under the hospice benefit." At a recent conference, representatives from CMS, Palmetto GBA-Medicare fiscal intermediary, the ISDH, and the IHCP discussed this issue. It was determined that while Palmetto GBA and the IHCP have indicated in their hospice manuals that a hospice may counsel a member to revoke hospice care, the ISDH survey guidelines do not permit this process since hospice revocation should be solely a patient-initiated action. For this reason, the IHCP is rescinding this paragraph of the IHCP hospice manual with regard to hospices counseling the member to revoke when the member is non-compliant. As part of their admissions process, hospice providers should explain to members what is covered by the hospice program, explain what actions would constitute non-compliance with the hospice care philosophy, and inform the member that the member is responsible for the charges resulting from the non-compliance. If non-compliance occurs, the hospice should follow the documentation requirements and procedures outlined in *IOM 102-9-20-2.1*

The IHCP has been informed by CMS that the *proposed* Medicare Hospice Conditions of Participation (COP) may address this issue more directly. Please be advised that when the new COPs are finalized, the IHCP will review them completely and make necessary revisions to the *IHCP Hospice Manual* regarding hospice discharge and any other applicable policy changes.

Reporting Personal Injury Claims

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

The TPL Casualty Department has prepared a form to use when submitting this information; however, use of this form is not required. The *Provider TPL Referral* form is Attachment 7 of this newsletter and is also available on the IHCP Web site at www.indianamedicaid.com under *Publications, Forms, TPL Forms*.

Send this form to the TPL Casualty Department by e-mail at INXIXTPLCasualty@eds.com, by facsimile at (317) 488-5217, by telephone at (317) 488-5046 in the Indianapolis local area or toll-free at 1-800-457-4510, or by mail to the following address:

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

All Providers: TPL Credit Balance Project

HMS is partnering with EDS in collecting credit balances owed to the IHCP. HMS mails letters and credit balance worksheets to select providers on a quarterly basis, and the due date for refunding credit balances is 60 days from the date of the letter. A copy of the worksheet and instructions (Attachment 8) are included with this newsletter. For providers who want to have credit balances subtracted from future Medicaid payments, adjustments are processed on a weekly basis. Although only selected providers are receiving a letter and credit balance worksheet each quarter, all providers are welcome to use this credit balance process to return any type of overpayments. For questions regarding the credit balance collection process or requests for copies of the credit balance worksheet and instructions, contact HMS Provider Relations at 1-877-264-4854 (toll free). The credit balance worksheet and instructions can be downloaded from the www.indianamedicaid.com Web site.

Correction: MRT Providers

Effective immediately, this article deletes lines 2 and 3 of *Table 1 - The Medical Review Team (MRT) Procedure Codes and Fee Schedule* published in IHCP Provider bulletin *BT200514* (Table 9.2) and replaces the 96100 SE U1 and 96100 SE U2 with the information contained in Table 9.3.

Table 9.2 – MRT Replacement Code 96100

MRT Code	Replacement Code	Description	MRT Rate
IQ Eval 1 Unit = 1 Hour (Partial Unit Billing Allowed)	96100 SE U1	**96100** Psychological testing (includes psychodiagnostic assessment of personality) **SE** State and/or Federally funded programs/services **U1** IQ Evaluation	$80.00 per hour
Psychological Testing 1 Unit = 1 Hour (Partial Unit Billing Allowed)	96100 SE U2	**96100** Psychological testing (includes psychodiagnostic assessment of personality) **SE** State and/or Federally funded programs/services **U2** Psychological Testing	$80.00 per hour

Table 9.3 – MRT Replacement Code 96100 – Correction

MRT Code	Replacement Code	Description	MRT Rate
Psychological Testing/IQ Eval 1 Unit = 1 Hour Max Units: 2 Hours (Partial Unit Billing Allowed)	96100 SE	**96100** Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour **SE** State and/or Federally funded programs/services	$80.00 per hour

Correction – MRT and PASRR Providers

Effective immediately, this article replaces information published in IHCP provider bulletins, *BT200513* and *BT200514* for form locator 24A in *Table 2 – CMS-1500 Claim Form Locator Descriptions* (Table 9.4 in this publication) with the information contained in Table 9.5.

Providers **should not bill** date ranges, but only for the single date of service. For example, if a provider renders services on June 30, 2005 and July 1, 2005, then the provider must bill each date of service as a separate line item on the claim. The provider cannot bill the service on one line using the date range of June 30, 2005 to July 1, 2005.

Table 9.4 – Form Locator 24A

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For services requiring authorization, the FROM date of service cannot be prior to the date the service was authorized. The TO date of service cannot exceed the date the specific service was terminated. For multiple services over a span of time, which apply to the same procedure code, the following apply: ▪ If the dates of service are consecutive, for example, one service per day, the FROM and TO dates of service can include the span of time with respective service units indicated in field 24G. Example – One unit of service per day for five days is submitted FROM 100102 TO 100502 for five units. ▪ If the dates of service are non-consecutive, each date of service is indicated on a separate line. Example – one service on each of the following days: 100102, 100502, 100602, and 101502 are not submitted FROM 100102 TO 101502. Rather, 100102 and 101502 are submitted on individual service lines with one unit of service each and 100502 through 100602 are submitted with two units of service on the same line.			
24A	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six date ranges are allowed per form. **Required.**	X	

Table 9.5 – Form Locator 24A – Correction

Form Locator	Narrative Description/Explanation	Complete for PASRR	
		Yes	No
Date of service is the date the specific services were actually supplied, dispensed, or rendered to the patient. For services requiring authorization, the FROM date of service cannot be prior to the date the service was authorized. The TO date of service cannot exceed the date the specific service was terminated.			
24A	**DATE OF SERVICE** – Provide the FROM and TO dates in MMDDYY format. Up to six FROM and TO dates are allowed per form. **FROM and TO dates must be the same – no date ranges are allowed**. **Required.**	X	

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.

Mandatory MCO Enrollment

The OMPP 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. As of September 1, 2005, both the Southern and Northern Regions are fully served by managed care organizations. Table 9.6 lists the remaining Central Region transition dates. Refer to the IHCP quick reference guide in Attachment 2 for MCO contact information.

Mandatory MCO Enrollment Information for Primary Medical Providers

PMPs who render services to members in the affected counties should refer to the August 2005 IHCP *Provider Monthly Newsletter*, *NL200508*, to determine the impact of the upcoming changes.

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.

Table 9.6 – Central Region Counties and Key Transition Dates

County					PMP/MCO Contracts Signed and at MCOs	Prime*Step* Members Enrolled in MCOs
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 Non-primary Medical Providers

Please refer to the August 2005 IHCP *Provider Monthly Newsletter*, *NL200508*, for non-primary medical provider information.

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

FQHC/RHC questions and answers are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/HoosierHealthwise/content/FAQ/managed_care.asp

Additional Information

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

Providers should submit direct questions about the information in this article to the appropriate MCO listed in Attachment 2.

Dental Services

Correction – Package E Dental Provider Notice

The *CDT-5 Codes Allowed for Package E Members* table published in IHCP provider newsletter *NL200506, Attachment 5* is included as Attachment 6 in this newsletter with the following corrections:

- Code D7110 is corrected to read D7111.
- Codes D7530, D7540, and D7550 are removed as they are non-covered in Indiana*AIM*.

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

Pharmacy Services

New Medicare Prescription Drug Benefit

Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing the new Medicare prescription drug coverage. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

The IHCP will provide information as it becomes available with banner pages, the IHCP provider newsletter, bulletins, and the IHCP Web site. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare Prescription Drug Benefit.

For more information about the Medicare Prescription Drug Benefit visit the CMS Web site at http://www.cms.gov/medicarereform/.

You may also learn more about this topic by accessing a fact sheet from the CMS Web site at http://www.cms.hhs.gov/medicarereform/factsheets.asp.

Hoosier Healthwise Mandatory RBMC Enrollment

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

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

1. Table 9.7 provides a listing of the pharmacy directors for each Hoosier Healthwise MCO. Pharmacies participating in the Hoosier Healthwise program should refer to Table 9.7 for assistance in the transition.
2. Attachment 5 to this newsletter 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 9.7 – 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

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	Jenny Atkins	(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

Prenatal Risk Assessment Form

Patient Name	**RID Number**	**LMP**
Provider Name	**Medicaid Provider ID Number**	**EDD**
Provider Telephone Number	**Plan (check one)** ☐ **FFS** ☐ **PCCM** ☐ **MCO Name**_____	

***At Risk of Preterm Birth or Poor Pregnancy Outcome**
Medical Factors (Please check all that apply)

- ☐ **1. Anemias, Acquired and Hereditary**
- ☐ **2. Current Drug or Alcohol Abuse**
- ☐ **3. Current Malignancy or Leukemia**
- ☐ **4. Diabetes**
- ☐ **5. Excessive Vomiting in Pregnancy**
- ☐ **6. History of a Previous Pregnancy Resulting in a Congenital Anomaly or Complication to Infant**
- ☐ **7. Infections Affecting Pregnancy**
- ☐ **8. Hypertension and Related Disorders in Current or Previous Pregnancy**
- ☐ **9. Maternal Diseases or History Affecting Pregnancy**
- ☐ **10. Multiple Gestation/Grand Multipara**
- ☐ **11. Other (for medical high risk – pregnancy)**
- ☐ **12. Other Specified Complications of Pregnancy**
- ☐ **13. Pregnancy with History of Abortion**
- ☐ **14. Preterm Complications, History of or with Current Pregnancy**
- ☐ **15. Preterm Labor in Current Pregnancy or Previous Pregnancy**
- ☐ **16. Potential Structural Complications of Pregnancy or Delivery**
- ☐ **17. Primigravida, less than 17 years or more than 35 years**
- ☐ **18. Renal Complications and Infections**
- ☐ **19. Respiratory Disease, History of or Acquired**
- ☐ **20. Smoking, more than 10 cigarettes per day**

Psychosocial Factors That May Affect Current Pregnancy Outcome
Please check all that apply

- ☐ **21. Acute Reaction to Stress**
- ☐ **22. Domestic Violence**
- ☐ **23. High Risk Sexual Behavior**
- ☐ **24. Lack of Housing Resources**
- ☐ **25. Late Initial Visit, after 14 weeks of pregnancy**
- ☐ **26. Lead Exposure**
- ☐ **27. Missed Prenatal Appointments, consecutive**
- ☐ **28. Other and Unspecified Disorders of Eating**
- ☐ **29. Other Personal History Presenting Hazards to Health**
- ☐ **30. Other Psychosocial Circumstances**
- ☐ **31. Prenatal Care Non-compliance, most recent pregnancy**
- ☐ **32. Unwanted Pregnancy**

Other Risk Factors Affecting Medical or Psychosocial Condition Not Described in Any Above Listing
(Include ICD-9 Diagnosis Codes)

Provider Signature	**Date**

*NOTE: Refer to provider notifications for update information.

ICD-9-CM Diagnosis Codes for At Risk of Preterm Birth or Poor Pregnancy Outcome Medical Factors

Medical Factor	Code	Medical Factor	Code
Anemias, Acquired and Hereditary	282.0 – 282.3, 282.4X, 282.5, 282.6X, 282.7 – 282.9, 283.1X – 283.9, 284.X, 285.0 – 285.9, 287X, 288X, 648.20, 648.23	Other (for Medical High-Risk-Pregnancy)	Examples include V23.1, V23.4X, V23.8X, and V23.9
Current Drug or Alcohol Abuse	304.00 – 304.93, 648.30, 648.33	Other Specified Complications of Pregnancy	646.80, 646.83
Current Malignancy or Leukemia	140.0 – 174.9, 176.0 – 184.9, 188.0 – 214.3, 214.8 – 221.9, 223.0 – 233.3, 233.7 – 236.3, 236.7 – 239.9	Pregnancy with History of Abortion	646.30, 646.33, V23.2
Diabetes	648.00, 648.03, 648.80, 648.83	Preterm Complications, History of or with Current Pregnancy	640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.00, 641.03, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93, 658.10, 658.13, 671.30, 671.33, 760.5
Excessive Vomiting in Pregnancy	643.00, 643.03, 643.10, 643.13, 643.20, 643.23, 643.80, 643.83, 643.90. 643.93	Preterm Labor in Current Pregnancy or Previous Pregnancy	644.00, 644.03, 644.10, 644.13, 644.20, 654.50, 654.53, V13.21
History of a Previous Pregnancy Resulting in a Congenital Anomaly or Complication to Infant	286.0 – 286.4, 317, 318.X, 319, V19.5, V23.41	Potential Structural Complications of Pregnancy or Delivery	629.23, 648.70, 648.73, 654.00, 654.03, 654.10, 654.13, 654.20, 654.23, 654.50, 654.53, 654.60, 654.63, 654.70, 657.00, 657.03, 658.00, 658.03
Infections Affecting Pregnancy	041.02, 042, 079.5X, 090.X – 099.XX, 616.10, 647.33, 647.53, 655.33, 795.71, V01.6, V08	Primigravida, less than 17 years or more than 35 years	659.40, 659.43, 659.50, 659.53, 659.60, 659.63, V23.81 – V23.84
Hypertension and Related Disorders in Current or Previous Pregnancy	642.00, 642.03, 642.10, 642.13, 642.20, 642.23, 642.30, 642.33, 642.40, 642.43, 642.50, 642.53, 642.60, 642.63, 642.70, 642.73, 642.90, 642.93	Renal Complications and Infections	580.0 – 593.9, 646.20, 646.23, 646.60, 646.63
Maternal Diseases or History Affecting Pregnancy	345.00 – 345.91, 523.0 – 523.9, 646.13, 646.70, 646.73, 646.80, 646.83, 648.10, 648.13, 648.50, 648.53, 648.60, 648.63, 656.23, V23.82, V23.84, V42.0 – V42.9	Respiratory Disease, History of or Acquired	480.0 – 487.0, 491.0 – 491.9, 493.0X – 493.92, V46.1X
Multiple Gestation/Grand Multipara	651.00, 651.03, 651.10, 651.13, 651.20, 651.23, 651.30, 651.33, 651.40, 651.43, 651.50, 651.53, 651.60, 651.63, 651.80, 651.83, 651.90, 651.93, 659.40, 659.43 V23.3	Smoking, more than 10 cigarettes per day	305.1, 648.33, V15.82

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 Health Plan / 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 / scripsolutions

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 Healthcare / 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

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
D7111	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)
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)
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)

(Continued)

CDT-5 Codes Allowed for Package E Members

CDT-5 Code	Description
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

* Correction to code published in IHCP provider newsletter *NL200506*, Attachment 5.

Codes D7530, D7540, and D7550 are removed from this table as they are non-covered in Indiana*AIM*.

Indiana Health Coverage Programs

PROVIDER TPL REFERRAL FORM

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

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

Please send this information to the TPL Casualty Department by e-mail at INXIXCasualty@eds.com, by facsimile at (317) 488-5217, by telephone at (317) 488-5046 in the Indianapolis local area or 1-800-457-4510, or by U.S. mail to the following address:

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

Form Number: TPL0006
Revision Date: March 2005

Indiana OMPP - Credit Balance Worksheet

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

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

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

7. PATIENT NAME	8. MEDICAID ID NUMBER	9. MEDICARE ID NUMBER	10. EMPLOYER NAME

11. INSURER NAME	12. POLICY HOLDER NAME	13. POLICY NUMBER	14. GROUP NUMBER

HMS PROJECT (OFFICE USE ONLY)
General

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

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

Please direct questions to (877) 264-4854.

Please fax completed worksheets to (214) 905-2064.

IHCP Credit Balance Worksheet Instructions

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