Provider Monthly Newsletter

NL200701 **January 2007**

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Abbreviations Used in this Newsletter

ADA	American Dental Association	HIPAA	Health Insurance Portability and Accountability Act	OBRA	Omnibus Budget Reconciliation Act
AVR	Automated Voice Response			OIC	Office of the Inspector General
BBA	Balanced Budget Act	HMO	health maintenance organization	OMPP	Office of Medicaid Policy and Planning
CFR	Code of Federal Regulations	HMS	Health Management Services		
CHOICE	Community and Home Option to Institutional Care for the Elderly and Disabled	IAC	Indiana Administrative Code	OTC	over-the-counter
		IC	Indiana Code	PA	prior authorization
		ICD	International Classification of Diseases	PBM	pharmacy benefits management
CMS	Centers for Medicare & Medicaid Services			PFL	past filing limit
		IIHCP	Indiana Health Coverage Programs	PMP	primary medical provider
DUR	Drug Utilization Review	ISDH	Indiana State Department of Health	POS	point of sale or place of sale
EDI	electronic data interchange	LC	Limited Corporation	ProDUR	Prospective Drug Utilization Review
EDS	Electronic Data Systems	LOC	level of care	PRTF	Psychiatric Residential Treatment Facility
EVS	eligibility verification system	LPI	legacy provider identifier		
FFS	fee-for-service	MAC	maximum allowable cost	RA	Remittance Advice
FQHC	federally-qualified health clinic	MCO	managed care organization	RBMC	risk-based managed care
FSSA	Family and Social Services Administration	MHS	Managed Health Service	RHC	rural health clinic
		MRO	Medicaid Rehabilitation Option	RVU	relative value units
HCBS	home- and community-based services	MRN	Medicare Remittance Notice	SSN	Social Security number
		MRT	Medical Review Team	SUR	Surveillance and Utilization Review
HCE	Health Care Excel	NPI	National Provider Identifier	TIN	tax identification number
HCPCS	Healthcare Common Procedure Coding System	NPPES	National Plan and Provider Enumeration System	TPL	third party liability
				VFC	Vaccine for Children (Program)
HINN	health insurance notice of non-coverage	NUBC	National Uniform Billing Committee		
		NUCC	National Uniform Claim Committee		

Provider News

New Bulletins on the IHCP Web Site

The following bulletins were posted to the IHCP Web site in December:

BT200628 – Member Eligibility Verification

BT200629 – Elimination of Crossover Short Forms for Submission of Medical and Institutional Crossover Claims

BT200630 – New 2007 Healthcare Common Procedure Coding System Codes

A complete list of bulletins is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ Publications/bulletin_results.asp.

As new bulletins are posted to the IHCP Web site, IHCP E-mail Notifications are sent to subscribers. The *April Provider Monthly Newsletter* (*NL200604*) provides complete information about this service. To subscribe, visit the IHCP Web site at http://www.indianamedicaid.com/ihcp/mailing_list/ default.asp.

Omni Upgrade Requirements

Beginning November 30, 2006, EDS made enhancements to the managed care information portion of the Omni member eligibility inquiries. In order to view the managed care information, providers who have an Omni terminal must download the latest Omni software version.

Detailed download instructions can be found in Table 1.5 of bulletin *BT200303*. The Omni managed care enhancements are included in bulletin *BT200628* published December 7, 2006. These bulletins can be accessed from the Indiana Health Coverage Programs (IHCP) Web site at http://www.indianamedicaid.com.

Direct questions about this article to the Omni Help Desk at (317) 488-5051 in the Indianapolis local area, or toll free at 1-800-284-3548.

New Version Indiana Health Coverage Programs Provider Manual Is Available

A new version of the *IHCP Provider Manual* is available on the IHCP Web site at http://www.indianamedicaid.com. Providers **will not** automatically receive copies of this version of the manual by mail, and are encouraged to visit the Web site to view, print, or download copies of the manual.

Revisions to the *IHCP Provider Manual* are posted to the IHCP Web site and they are not automatically mailed. Providers and non-providers may request copies of the manual on CD-ROM or paper according to the following schedule:

Providers
Download from the Web site....... Free
CD-ROM.................................... Free
Original paper copy..................... Free
Additional paper copies.............. $105 each
Non-providers
Download from the Web site ...... Free
CD-ROM.................................... $20 each
Paper copies .... $105 each

Requests for copies of the manual should be made by telephone to customer assistance at (317) 655-3240 in

the Indianapolis local area or 1-800-577-1278 or in writing to the following address:

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

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

Coding Updates

Manual Pricing

EDS has obtained rates from the Medicare Fee-for-Service Payment files located on the CMS Web site for the five codes listed in Table 1.6 (Attachment 5 of this newsletter). These codes are currently being manually priced based on information submitted with the claim. The new rates are effective December 1, 2006. The effective date and information published about code J2353 supersedes the information published in banner page *BR200652*.

Relative Value Unit Corrections

On February 24, 2006, CMS issued corrections to RVU associated with several HCPCS that were published on the 2006 Medicare Physician Fee Schedule. EDS will perform necessary updates to the RVUs for each of the codes listed in Table 1.7 (Attachment 5 of this newsletter). The corrected rate for each code will be effective February 8, 2007. EDS will not perform mass adjustments on the affected codes.

A4253 – Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips

Effective February 1, 2007, a maximum quantity limitation is placed on HCPCS code *A4253 – Blood glucose test or reagent strips for home glucose monitor, per 50 strips.* Providers are permitted to bill up to two units or 100 strips per 30 days. Additional units of A4253 deny unless PA is obtained.

Effective February 1, 2007, all of the following PA criteria is required for additional units of A4253:

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient's medical need.
- A hemoglobin A1C test dated within 90 days prior to the request for additional units of A4253.

A4259 – Lancets, per box of 100

Effective February 1, 2007, a maximum quantity limitation is placed on HCPCS code *A4259 – Lancets,*

per box of 100. Providers are permitted to bill one unit (100 lancets) per 30 days. Additional units of A4259 deny unless PA is obtained.

Effective February 1, 2007, all of the following PA criteria is required for additional units of A4259:

- A signed statement of medical necessity.
- A clear medical recommendation of the number of additional units required to meet the patient's medical need.
- A hemoglobin A1C test dated within 90 days prior to the request for additional units of A4259.

All other billing requirements including crossover claim requirements for reimbursement remain the same for HCPCS codes A4253 and A4259.

Contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278, with questions about this article.

TO ALL PROVIDERS AND MANAGED CARE ORGANIZATIONS: Vaccine for Children Program and Private Stock Use

To address an immediate need for immunizations and a shortage of available influenza vaccine, effective October 15, 2006, the IHCP will not limit reimbursement for any influenza vaccine, regardless of availability from the VFC Program. This policy allows providers to obtain reimbursement for using a privately purchased influenza vaccine if they do not have VFC vaccine due to the shortage crisis. When administering a privately purchased influenza vaccine, reimbursement includes payment for both the cost of the vaccine and the administration fee. Claims will process by the appropriate delivery system (EDS or MCO) for each member regardless of the source of the vaccine stock. Claims are eligible for post review and providers must maintain documentation and invoices related to private stock when substituting for VFC vaccine. RHC and FQHC rates include payment for both the vaccine and administration fee. Refer to bulletin *BT200151* for detailed billing instructions when administering private stock.

Timeline for Revised Paper Claim Forms

> *The following information does not apply to providers rendering services in the RBMC delivery system. These providers should contact the MCO with whom they are contracted for information about paper claim form transition.*

The NUCC, the NUBC, and the ADA have revised the layouts of the institutional, professional, and dental paper claim forms. The current institutional UB-92

claim form will be replaced with the institutional UB-04. The current professional CMS-1500 health insurance claim form will be revised to the 08-05 version. The ADA dental claim form will be replaced with J400D. The EDS pharmacy claim forms will be revised to include NPI information. The pharmacy claim forms will be available May 23, 2007, and may be obtained from the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Links to the other new claim forms will be added to the IHCP Web site *Forms* page according to the Start Date in Table 1.1.

The IHCP will be transitioning to the new paper claim forms with the timelines noted in Table 1.1. During the transition period both old and new claim forms will be accepted. All claim forms will have a transition period excluding the Pharmacy claim form. Table 1.1 outlines the transition period and cutover dates for each type of paper claim form.

Contact Information

Providers with questions about this article should contact Customer Assistance at (317) 347-4511 in the Indianapolis local area, or toll free at 1-800-457-4518.

Table 1.1 – Revised Paper Claim Forms Timeline

Current Form	New Form	Transition Period (Old and New Forms Accepted)		Only New Forms Accepted (Cutover Date)
		Start Date	End Date	
CMS-1500	08-05	February 15, 2007	March 31, 2007	April 1, 2007
UB-92	UB-04	April 1, 2007	May 22, 2007	May 23, 2007
Dental	J400D	April 15, 2007	May 22, 2007	May 23, 2007
Pharmacy	Pharmacy	No Transition Period		May 23, 2007

TO ALL IHCP PROVIDERS:
State Plan Services Billed Duplicative of Hospice Care

The purpose of this article is to educate all IHCP providers regarding those services covered under the Medicare and Medicaid hospice per diems for treatment of a member's terminal illness and related conditions and for which non-hospice providers should be billing the hospice rather than the IHCP. The article also notes some examples of inappropriate billing by IHCP providers and reminds IHCP hospice providers of their responsibility to coordinate the overall care of the hospice member with non-hospice providers.

Services Covered Under the Medicare and Medicaid Hospice Per Diems and a brief explanation of non-covered services

State statute requires the IHCP hospice benefit mirror the Medicare hospice benefit in covered services and reimbursement methodology. Services are based on the patient's need, as outlined in the patient's hospice care plan. Federal regulations at *42 CFR Part 418* specify that hospices must list in frequency and scope all services and supplies required to treat the patient's terminal illness and related conditions.

The following list includes the covered services under the Medicare and IHCP hospice per diems:

- Nursing care provided by or under the supervision of a registered nurse.
- Medical social services provided by an individual who has at least a bachelor's degree from a school accredited or approved by the Council of Social Work Education and under the supervision of a physician.
- Physician services provided by the hospice medical director or physician member of the interdisciplinary team. The physician means a physician as defined under *42 CFR Section 410.20*. Physician employees of the hospice must also meet the needs of the patient to the extent that those medical needs are not met by the attending physician.
- Counseling, including dietary provided by a dietician and bereavement provided by the hospice pastoral counselor or the hospice social worker. Additional counseling may be provided by other members of the interdisciplinary team and by other qualified professionals as determined by the hospice.
- Physical, speech, and occupational therapy provided for purposes of symptom control in a manner consistent with standards of accepted practice.
- Spiritual services.
- Volunteers used in defined roles under the supervision of a hospice employee in compliance with *42 CFR 418.70 Condition of Participation—Volunteers*.

- Home health aide and homemaker services to supplement care by the primary caregiver. A home health aide must meet the training, attitude, and skill requirements specified in *42 CFR Section 484.36 Condition of Participation-Home Health Aide Services* (under the Medicare home health benefit). Homemaker services must assist in providing a safe and healthy environment.
- Medical supplies, medications, and medical equipment related to the terminal condition.
- Room and board for dually-eligible Medicare/ IHCP nursing facility residents who elect hospice subject to *405 IAC 1-16-4*.
- Room and board for IHCP-only members residing in nursing facilities subject to *405 IAC 1-16-4*.

The IHCP hospice per diem is distinct in that State Medicaid agencies that have a hospice benefit are required to pay an additional amount for nursing facility room and board for dually-eligible Medicare/Medicaid members and IHCP-only members residing in nursing facilities who elect hospice. The Medicare hospice program does not pay for room and board in a nursing facility as Medicare skilled nursing services cease once a Medicare beneficiary elects hospice.

Non-covered Services

The Medicare and IHCP hospice programs do not expect the hospice to provide care or services to treat conditions **unrelated** to the terminal illness. The patient may obtain those services from an IHCP-enrolled provider as it is outside of the patient's hospice plan of care. The IHCP provider bills the IHCP for those services unrelated to the terminal illness.

There are certain personal care services that are not covered by the hospice program as noted below from the Medicare hospice manual.

Hospice care under the Medicare and Medicaid programs is meant to provide **intermittent** care to assist the patient and the family with end of life care. The federal Medicare program indicates that the hospice program is to provide **limited** custodial care through the home health aide/homemaker/volunteer component of the program. **Sitter and companion services are not covered under the hospice program.** The following is an excerpt from the Medicare hospice training manual.

Section 3.3 Non-Covered Services

"Although the Hospice Medicare Benefit is a comprehensive benefit, it does not require that the hospice provide everything the patient or caregiver might need or desire during the beneficiary's terminal illness. There are some medical services and some non-medical services that the patient might desire, but the provider does not have to cover. The provider needs to

notify the patient in writing of any non-covered service or supply by issuing a health insurance notice of non-coverage (HINN)."

3.3.1 Sitter Services

"Although the Hospice Medicare Benefit does include home health aid, homemaker, and volunteer services, it does not require that the hospice provide sitter services or extended custodial care services."

In addition, the Medicare hospice program does not provide for custodial care for the primary care giver to go to work. Furthermore, hospice homemaker services include preparation of a light meal or light housekeeping around the area where the patient is when the homemaker arrives. Hospice homemaker services do **not** include mopping floors, vacuuming, and washing windows.

In conclusion, hospice providers must be in compliance with state regulations at *405 IAC 5-34-2* which specifies that the hospice and all hospice employees must be licensed in accordance with applicable federal, state, and local laws as required under federal regulations at *42 CFR 418.72* and Indiana state hospice licensure at *IC 16-25-3*.

Hospice Provider's Coordination Responsibilities

Hospice providers are reminded that the IHCP has very specific policies regarding the coordination role of the hospice provider in the overall care for the terminal illness. These policies are outlined in Section 5 of the current *IHCP Hospice Provider Manual* (revision date March 2004). Hospice providers are strongly encouraged to review this section as coordination of care with non-hospice providers has been an ongoing issue with the IHCP hospice program and as plan of care is a commonly sited tag by the ISDH Acute Care Unit when conducting hospice surveys. The *IHCP Hospice Provider Manual* is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Manuals/Other/Hospice_Benefit_Manual.pdf.

When the IHCP member elects the IHCP hospice benefit, care for the terminal condition comes under the supervision of the IHCP hospice provider. The IHCP covers the IHCP hospice member's medical care for conditions not related to the terminal illness. The IHCP expects the hospice provider to actively interface and coordinate services with other IHCP providers providing services not included in the hospice plan of care. It is the responsibility of the IHCP provider treating the non-terminal condition to bill for these services.

Examples of Duplicative Billing by Non-Hospice Providers

The IHCP has many different mechanisms for tracking provider utilization issues. Recent audit functions have identified the following duplicate billing by IHCP providers for State plan services that should be included in a hospice member's plan of care or billed to another payer source. The following list is not meant to be all-inclusive:

- Physicians billing for attending physician services for dually-eligible Medicare/Medicaid hospice members that should be billed to Medicare Part B per instructions of the Medicare fiscal intermediary
- Hospitals billing the IHCP for hospital services **unrelated** to the terminal illness for dually-eligible Medicare/Medicaid nursing facility residents electing hospice. The hospitals should bill Medicare for these services by using billing instructions for condition code 7 as outlined by the Medicare fiscal intermediary.
- Transportation services to the hospital for services related to the terminal illness. These services must be paid for by the hospice as part of the hospice per diem per the BBA of 1997. The BBA 1997 has been incorporated into the *42 CFR Part 419*, effective January 23, 2006. Providers should refer to these changes in provider bulletin *BT200607*.
- Physician's offices billing the IHCP for costs for services such as laboratory or X-rays related to the terminal illness. The only services billed by an attending physician are the physician's personal professional services. Cost for services such as laboratory or X-rays must not be included on the attending physician charges to the IHCP when those services relate to the terminal illness and related conditions.
- Pharmacy providers have billed the IHCP for medications included in the hospice plan of care for the treatment of the terminal illness.
- Counseling services that should be obtained and paid for by the hospice provider, such as working with the patient and family when the patient becomes depressed during the stages of grief associated with the dying process.
- Dietary counseling services to ensure adequate nutrition that is palliative in nature during the different phases of the dying process and to ensure that there is a decreased intake of fluid and foods when the patient exhibits signs of an approaching death.
- Nursing facility providers billing the IHCP for room and board on or after the date of hospice election by a dually-eligible Medicare/IHCP or IHCP-only hospice resident. OBRA 1989 and state regulations at *405 IAC 1-16-4* specify that direct

Medicaid payment to the nursing facility must stop when an IHCP-eligible nursing facility resident elects hospice as the hospice is responsible for billing the IHCP for nursing facility room and board and then paying the nursing facility according to their contract.
- Medical supplies and medical equipment related to the terminal illness, such as durable medical equipment and dressings required to care for wounds related to the terminal illness.

Examples of Inappropriate Practices by Hospice Providers

The IHCP has worked very closely with the hospice industry since the implementation of the IHCP hospice program. It is important to note that the IHCP has discovered and provided education to hospice providers regarding utilization trends. The IHCP has noted that some hospice providers have failed to provide services in frequency and scope as required to treat the terminal illness and related conditions when there is another provider of service providing equivalent care for the terminal illness. Hospices have either failed to include the service in the hospice plan of care or provided minimal services and delegated the rest of the care to the non-hospice provider.

ISDH has been citing hospice providers under the tags of plan of care and financial responsibility when this practice has been identified during hospice surveys. While hospice is intermittent care, hospice providers are reminded that they are not a supplement to the care of the terminal illness and related conditions when there are other services provided by another program or payer source (IHCP room and board, HCBS waiver programs, and CHOICE). Hospice providers are required under the Medicare Conditions of Participation of Hospice Care to provide all services in frequency and scope required to treat a patient's terminal illness or related condition. The CMS has also noted in CMS memorandums that the Medicare Conditions of Participation for Hospice Care specify that hospice providers cannot delegate hospice care services for the care of the terminal illness to another provider of service. Hospice core services include physician, nursing, medical social work, and all counseling services under the Medicare and IHCP hospice programs.

The following is a list of program utilization issues identified by the IHCP and by ISDH during hospice surveys. This list is not meant to be exhaustive.

- Hospices delegating hospice core nursing services for the terminal illness and related conditions to nursing staff in nursing facilities. CMS and OIG have advised FSSA in 1998 that a hospice cannot

delegate hospice care nursing services for assessment, treatment and updating, and implementation of the hospice plan of care to the long term care nurse.

- Hospices have delegated hospice core nursing services to the hospice respite nurse serving a waiver client who elected hospice.
- Hospices have told consumers that homemaker services are not included in the Medicare and Medicaid hospice program and some hospices failed to include homemaker services in their program materials.
- Hospices removing home health aide, homemaker and volunteer services from the hospice plan of care to permit the HCBS waiver programs or CHOICE to provide all the personal care services for the HCBS waiver member or CHOICE member who has elected hospice.
- Six years ago, ISDH surveyors noted that hospices were requesting patients to backdate the hospice revocation form one day preceding a hospital admission related to the terminal illness for which the hospice had not authorized the visit. The intent was for the hospital to bill Medicaid for that service since the Medicaid patient could not pay the bill as a result of their non-compliance with the hospice plan of care and hospices did not want to have problems with the local hospital. **The backdating of a hospice revocation form is a violation of federal regulations and the practice outlined above in the preceding paragraph constitutes program misutilization.**
- Failure to provide hospice bereavement services to the family for 13 months following the death of the hospice patient.

IHCP's Fiduciary Responsibility To Recoup Overpayments

The IHCP is considered the funding stream of last resort and as such has a fiduciary responsibility to monitor appropriate claims payment and ensure that any services are paid from the appropriate funding stream. This means that if an IHCP provider billed the IHCP for services that should have been paid for by the Medicare program, the Medicare hospice provider or the Medicaid hospice program, then the IHCP has a fiduciary responsibility to recoup the overpayment from the non-hospice provider.

The FSSA is also responsible for the administration of several programs with a personal care component: HCBS waivers, group homes, and CHOICE. CMS and the *State Operations Manual for Hospice* indicate that a Medicare or Medicaid member receiving care under these programs may elect hospice and continue to receive overlapping personal care services; however,

the hospice must continue to provide all hospice core services and all services in frequency and scope to treat the terminal illness and related conditions. Furthermore, any personal care services provided under the home health aide/homemaker/volunteer component must be provided in frequency and scope as it would have to an individual who was only receiving hospice care at home. Hospices should not delegate any of the hands on care provided by the hospice home health aide to personnel who are not certified as home health aides. The member should not see any reduction of hospice services for the terminal illness simply because there is another provider of service caring for the member.

Contact Information

Questions regarding this article may be directed to Customer Assistance at (317)655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

Reporting Personal Injury Claims

Providers should 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 prepared a form for use when submitting this information; however, use of this form is not required. The *Provider TPL Referral* form can be downloaded from the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp under *Third Party Liability (TPL) Forms*.

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

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

The EDS TPL Casualty Department may be contacted by telephone at (317) 488-5046 in the Indianapolis local area or toll-free at 1-800-457-4510.

TPL Credit Balance Project

HMS is partnering with EDS to collect credit balances owed to the IHCP. Quarterly, HMS mails letters and credit balance worksheets to select providers notifying

them that the date for refunding credit balances is 60 days from the date of the letter. Providers must reply promptly to these notices. Providers may have credit balances subtracted from future Medicaid payments because adjustments are processed each week. Although only selected providers receive a letter and credit balance worksheet each quarter, all providers may use this credit balance process to return overpayments.

For questions about 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 *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp under *Third Party Liability (TPL) Forms*.

Dental Providers

Dental Claims: Rendering Provider Number Required

This article updates information regarding the implementation of the requirement that was originally published in IHCP banner page *BR200527* on July 5, 2005 (and again beginning with banner page *BR200648* and continuing to date), and addresses billing guidelines for dental billing and rendering providers.

Because of complex changes required for dental providers to implement this requirement, as of January 1, 2007, the IHCP will not be systematically denying claims that are submitted without the rendering provider number. However, this requirement will be implemented with the new paper claim forms on April 15, 2007. At that time, all claims, paper and electronic, will be required to submit the rendering provider number. The billing guidelines are required for HIPAA compliance. Providers who have already modified their billing systems to comply with the new requirement do not need to do any changes. They can still bill their claims with the rendering field completed.

The billing guidelines for the current ADA 1999/2000 claim form are as follows:

1. *Group provider using a paper claim* – Enter the group number and location code(s) in Field 44A on the ADA Dental claim form. Enter the individual rendering number(s) in the *Administrative* column adjacent to each detail.

2. *Group provider using Web interChange* – Enter the group number and location code in the provider numbers field. Enter the individual rendering number in the rendering provider field.

3. *Individual billing provider using a paper claim* – Enter the individual billing number and location code in Field 44A on the ADA Dental claim form. Enter the individual billing number in the *Administrative* column adjacent to each detail.

4. *Individual billing provider using Web interChange* – Enter the individual billing number and location code in the provider number field. Enter their individual billing number in the rendering provider field.

Beginning April 15, 2007, dental providers will receive denials for the following situations:

1. *231 – Rendering provider number is missing – The entire nine-digit number must be used and must be in Field 24K. Please provide and resubmit.*

2. *232 – Rendering provider number is invalid – The entire nine-digit number must be used and must be in Field 24K. Please verify and resubmit.*

> Note: For edits 231 and 232, Field 24K refers to CMS-1500 claim forms. For dental claims, the rendering must be in the Adm field.

3. *1004 – Rendering provider not enrolled in the program billed for the dates of service. Please verify provider number and resubmit.*

4. *1008 – The rendering provider must be an individual provider. Please verify provider number and resubmit.*

5. *1010 – Rendering provider is not an eligible member of billing group or the billing provider is equal to the rendering provider. Please verify provider number and resubmit.*

6. *7509 – Rendering provider on prepayment review.*

Providers who have Administrator access in Web interChange can view their provider profiles to access a list of the rendering providers linked to the group.

Contact Information: Providers can contact the Provider Enrollment Helpline at 1-877-707-5750 to discuss any updates that need to be made to the provider group information.

Durable Medical Equipment Providers

Crossover Claims Being Reprocessed

EDS has obtained additional Medicare intermediary payer IDs. Necessary system modifications have been completed to allow the system to recognize the new payer IDs. DME claims submitted from June 2006, through October 2006, impacted by this addition, did not crossover properly from Medicare. These claims have been identified and will be processed through for reimbursement starting the week of January 8, 2006. Providers should monitor the weekly RAs for a three to four week period for these claims.

If you have questions about these claims, contact Customer Assistance at (317) 655-3240 in the Indianapolis area, or toll free at 1-800-577-1278.

Power Wheelchairs

Pending final review of the expanded power wheelchair codes, providers should continue to bill using the following existing codes and fee schedule amounts. PA is required for power wheelchairs and accessories.

Refer to existing provider notifications for current PA requirements.

- K0010, *Standard-weight frame motorized/power wheelchair*, $4238.90 new, $282.59 rental
- K0011, *Standard-weight frame motorized/power wheelchair with programmable control parameters for speed adjustment, tremor dampening, acceleration control and braking*, $5270.30 new, $351.35 rental
- K0012, *Lightweight portable motorized/power wheelchair*, $3233.10 new, 215.54 rental
- K0014, *Other Motorized/power wheelchair base,* manually priced
- E1230, Power Operated vehicle (three- or four-wheel nonhighway), specify brand name and model number, manually priced
- E1239,Wheelchair, pediatric size, not otherwise specified, manually priced

If you have any questions, contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

Managed Care Providers

2007 Behavioral Health Claim Processing Changes

To coordinate comprehensive medical and behavioral health services for Hoosier Healthwise members, the MCOs will assume risk for most behavioral health services, including outpatient and free-standing psychiatric facility services, effective January 1, 2007.

Providers must submit all behavioral health claims for members enrolled in Hoosier Healthwise RBMC with dates of service on or after January 1, 2007, directly to the member's MCO for claim processing. The only exceptions are claims for MRO and PRTF services. Providers should contact the respective MCO for

questions about claim submission and authorization guidelines.

Providers should continue to submit claims for dates of service prior to January 1, 2007, and MRO and PRTF claims to EDS. EDS continues to process MRO and PRTF claims as fee-for-service claims.

Additional information about Hoosier Healthwise and covered benefits for behavioral health are provided in the *RFS-6-68 Attachment D: Scope of Work*, which is posted on the IHCP Web site at http://www.indianamedicaid.com/ihcp/HoosierHealthwise/content/MCOContractProcurement.asp.

National Provider Identifier

First Step Providers To Be Notified when To Report NPI to IHCP

Please do not report your NPI to the IHCP until further notice. EDS is in the process of making modifications to ensure an easier and more accurate NPI reporting process. You will be notified when you can resume the NPI reporting process.

This applies to First Steps providers only.

NPI Reporting Tool

The IHCP has implemented the Web-based NPI Reporting Tool and now requests that providers begin reporting their NPI to the IHCP. The notification letter provides instructions about how providers report their NPI to the IHCP.

Enrolled health care providers must report their NPI to the IHCP by May 1, 2007, to be paid for services. Any health care provider that does not report its NPI to the IHCP may not be paid for services after May 23, 2007.

All health care providers (for example, physicians, suppliers, hospitals, and others) are eligible for an NPI. Health care providers are individuals or organizations that render health care services. All health care providers that are HIPAA-covered entities, whether they are individuals or organizations, must obtain an NPI to identify themselves in paper and electronic transactions.

Atypical providers are not required to obtain and use an NPI in paper and electronic transactions. An atypical provider is any entity that does not meet the definition of a health care provider as defined in *45 CFR 160.103*. Atypical providers include billing services, value-added networks, repricers, health care clearinghouses, non-emergency transportation service providers, and other entities that do not provide health care services.

The *NPI Fact Sheet* containing information about the NPI is available on the *NPI* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/ ProviderServices/pdf/TR370_npi_facts.pdf.

Obtaining an NPI

To obtain an NPI, visit the NPPES Web site at https://nppes.cms.hhs.gov/NPPES, or call 1-800-465-3203, toll-free, or 1-800-692-2326 (TTY). Providers may apply electronically for their NPI from this Web site or by requesting and completing a paper form and submitting it to NPPES at the address indicated on the form.

Reporting NPI to the IHCP

The NPI Reporting Tool is implemented and is available from http://www.indianamedicaid.com by clicking on the **Report your NPI to the IHCP** link located in the NPI section of the IHCP Web site home page.

When accessing the NPI Reporting Tool, have the following information available:

- The reporting provider's TIN or SSN.
- The NPI notification letter that includes the password needed to access the NPI Reporting Tool.
- Taxonomy codes associated with each IHCP legacy provider identifier being reported.
- Contact name, telephone number, and e-mail address.
- The NPI of all rendering providers affiliated with the group, if applicable.

After logging into the NPI Reporting Tool, you must do the following:

- Enter a contact name, telephone number, and e-mail address, if applicable. The tool displays all active IHCP LPIs affiliated with your TIN.

- Enter an NPI for each IHCP LPI and service location that you want to continue using in paper and electronic transactions after the May 23, 2007, compliance date.
- Select the appropriate taxonomy code for your specialty.

Reporting a Rendering Provider's NPI to the IHCP

If you are a group provider, you must obtain the NPIs of your rendering providers and report them along with your NPI for each service location. All active rendering providers affiliated with the billing provider at a particular service location are displayed in the tool. To report an NPI for a rendering provider, you must take the following steps:

- Enter the NPI for the rendering provider
- Select the appropriate taxonomy for the rendering provider specialty

If the NPI Reporting Tool identifies a rendering provider who is no longer in your group, contact the EDS Provider Enrollment and Waiver line at 1-877-707-5750 to unlink the rendering provider from your group.

Contact Information

Assistance is available for the NPI Reporting Tool by calling the EDS Provider Enrollment and Waiver line at

1-877-707-5750. To manually report your NPI, a paper application is available from the IHCP Web site at http://www.indianamedicaid.com, or by calling the EDS Provider Enrollment and Waiver line. The paper application must be completed, signed, dated, and mailed by May 1, 2007, to:

> **EDS Provider Enrollment**
> **P.O. Box 7263**
> **Indianapolis, IN 46207-7263**

Remember: Providers must report the NPI for each IHCP LPI and service location to the IHCP by May 1, 2007, to continue using paper and electronic submission of transactions after the compliance date.

National Provider Identifier Web Page

The IHCP Web site features an NPI Web page located at http://www.indianamedicaid.com/ihcp/ ProviderServices/npi.asp. This page contains information about the *IHCP NPI Implementation Plan*, instructions for obtaining an NPI, links to other NPI resources on the Web, informational documents like the *NPI Fact Sheet*, and access and instructions for using the NPI Reporting Tool.

Pharmacy Services

Medicare Part D – Prescription Niacin Products

Effective January 1, 2007, CMS will consider all prescription niacin products as covered drugs under the Medicare Part D benefit. Therefore, effective January 1, 2007, Indiana Medicaid will **not** cover these products for Medicare Part D eligible members.

Medicare Part D Tip Sheet for 2007

The *Medicare Part D Tip Sheet for 2007* is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/pdf/TR644-Medicare_D_Tips_for_2007.pdf. This tip sheet, from IFSSA, offers important information for assisting your Medicare-Medicaid dual eligible clients.

Changes to the Over-the-Counter Drug Formulary

This article is to notify all pharmacy providers, prescribing physicians, and health care workers of changes and updates to the IHCP OTC Drug Formulary. The pharmacy OTC formulary and rates are available at http://www.mslcindy.com. These rates are effective on January 19, 2007.

State MAC Legend Drug Updates

Tables 1.4 and 1.5 (Attachment 3 of this newsletter) contain the updates to the State MAC rates and list the effective dates for the changes.

Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 in the Indianapolis local area, or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

Deficit Reduction Act of 2005: HCPCS and NDC Requirement and Change in Associated Implementation Deadline

The OMPP is announcing a change to the implementation date for requiring the NDC for HCPCS coded claims involving drugs. The revised implementation date for this requirement will be July 1, 2007. The details of this change and related claim submission requirements are forthcoming in future provider communications pending upcoming guidance from the CMS. The previous implementation date of January 1, 2007, was announced in the provider monthly newsletter *NL200607*.

Psychiatric Residential Treatment Facility Providers

Single Date of Service Detail Update

Per information published in provider bulletin *BT200404*, PRTF services are reimbursed on a per diem basis. EDS will perform the necessary system modification immediately to allow PRTF providers to bill a single date of service per detail, with a consecutive dates of service per individual CMS-1500 claim form. EDS will also perform a mass adjustment to correct claims that may have been negatively impacted by this modification. The mass adjustment is expected to process during the week of December 25, 2006.

Provider Workshops

Workshop Registration Tool Available

The Workshop Registration Tool is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/workshop/index.aspx. Providers are encouraged to use the tool to register for the 2007 First Quarter Medicaid Provider Workshops.

A *Workshop Registration Tool Quick Reference* is included as Attachment 4 of this newsletter and is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/workshop/pdf/TR636-WorkshopRegistrationQuickReference.pdf. The quick reference includes instructions for creating a registrant profile, registering for a workshop, signing up for classes (sessions), and contact information.

A copy of the *Provider Workshop Registration* form is included as Attachment 2 in this newsletter for those who are unable to access the Workshop Registration Tool.

2007 First Quarter Medicaid Provider Workshops

The IHCP offers workshops free of charge. Sessions are offered at several locations in Indiana. Table 1.2 lists the time, session topic, and description. The schedule allows for a lunch period from noon until 1 p.m.; however, lunch is not provided. **Seating is limited in**

all locations. **Registrations are processed in the order received and registration does not guarantee a spot at the workshop**. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the workshop seating capacity has been reached.

All workshops begin promptly at 8 a.m., local time. General directions to workshop locations are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp. Consult a map or other location tool for specific directions to the exact location.

Seating for the workshops is limited to two registrants per provider number.

A copy of the *Provider Workshop Registration* form is included as Attachment 2 of this newsletter and is available on the *Forms* page of the IHCP Web site. Print or type the information requested on the registration form. List one registrant per form. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop.

Direct questions about the workshop to a field consultant at (317) 488-5072.

For comfort, business casual attire is recommended. Consider bringing a sweater or jacket due to possible room temperature variations.

Table 1.2 – 2007 First Quarter Workshop Session Times, Topics, and Descriptions

Time	Topic	Description
8 a.m. - 10:30 a.m.	Billing Form Changes – Revised Claim Forms	This session gives an overview of the new Compound Prescription Claim Form, Drug Claim Form, ADA-2006 Dental Claim Form, UB-04 Claim Form (CMS-1450), and CMS-1500 Health Insurance Claim Form (version 08/05) required fields. The session addresses reporting of the National Provider Identifier (NPI) on the claim form. This session is ideal for all providers.
10:30 a.m. – 10:45 a.m.	Break	
10:45 a.m. - Noon	Third Party Liability (TPL) and Crossover Claim Billing	This session provides information about TPL and Crossover billing, claims identification, file updates, denial letters, 90-day provision, attachments, and other helpful hints. This session is ideal for advanced billing providers.
Noon – 1 p.m.	Lunch	
1 p.m. – 1:45 p.m.	Managed Care – Anthem	Anthem representatives will present information on the completion of the new claim forms and TPL billing from the managed care perspective. Time will be available for questions and answers.
2 p.m. – 2:45 p.m.	Managed Care – Managed Health Service (MHS)	MHS representatives will present information on the completion of the new claim forms and TPL billing from the managed care perspective. Time will be available for questions and answers.
2:45 p.m. – 3:30 p.m.	Managed Care – MDwise	MDwise representatives will present information on the completion of the new claim forms and TPL billing from the managed care perspective. Time will be available for questions and answers.

Table 1.3 lists the workshop dates, registration deadlines, and Indiana locations for each workshop.

Table 1.3 – 2007 First Quarter Workshop Dates, Registration Deadlines, and Locations

Workshop Date	Registration Deadline	Location
February 6, 2007	January 23, 2007	Wishard Hospital Myers Auditorium 1001 W. 10th St. Indianapolis, IN 46202
February 15, 2007	February 1, 2007	Bloomington Hospital 601 W. Second St. Bloomington, IN 47403
February 19, 2007	February 5, 2007	Ball Memorial Hospital Outpatient Medical Pavilion, Rooms 2 – 5 2401 University Ave. Muncie, IN 47303
February 20, 2007	February 6, 2007	St. Josephs Regional Medical Center Education Center 801 E. LaSalle Ave. South Bend, IN 46617
February 21, 2007	February 7, 2007	Deaconess Hospital Auditorium 600 Mary St. Evansville, IN 47747
February 22, 2007	February 8, 2007	Parkview Hospital Administration Auditorium at the Corporate Offices 10501 Corporate Dr. Fort Wayne, IN 46845
February 27, 2007	February 13, 2007	Floyd Memorial Hospital 1850 State St. New Albany, IN 47150
February 27, 2007	February 13, 2007	St. Margaret Mercy Hospital 5454 Hohman Ave. Hammond, IN 46320
February 28, 2007	February 14, 2006	Lafayette Home Hospital Medical Arts Building Kathryn Weil Center 415 N. 26th St. Lafayette, IN 47904,

Contact Information

A map of provider representative territories and updated information about the provider field consultants are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm. The *Indiana Health Coverage Programs Quick Reference* is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf. These Web documents are updated whenever changes occur.

Provider Relations Field Consultants

Territory Number	Provider Relations Consultant	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke
2	Rhonda Rupel	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, Whitley

Provider Relations Field Consultants

Territory Number	Provider Relations Consultant	Telephone	Counties Served
3	Tawanna Danzie	(317) 488-5197	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, White
4	Daryl Davidson	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, Wells
5	Jenny Atkins (temp)	(317) 488-5356	Marion
6	Shantel Silnes	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington
7	Virginia Hudson	(317) 488-5148	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
8	Ken Guth	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
9	Tina King (temp)	(317) 488-5123	Out-of-State

Provider Relations Field Consultants for Bordering States

State	City	Provider Relations Consultant	Telephone
Illinois	Chicago/Watseka	Jean Downs	(317) 488-5071
	Danville	Virginia Hudson	(317) 488-5148
Kentucky	Owensboro	Ken Guth	(317) 488-5153
	Louisville	Tina King	(317) 488-5123
Michigan	Sturgis	Rhonda Rupel	(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.

For Provider Concerns

Name	Title	Telephone
Tina King	Provider Relations Supervisor	(317) 488-5154

If you need additional copies of this newsletter, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/newsletters.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization			
AVR System (including eligibility verification) (317) 692-0819 1-800-738-6770	**EDS Administrative Review** Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	**EDS Customer Assistance** (317) 655-3240 1-800-577-1278 Opt 1 = Pharmacy, Opt 2 = First Steps	**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 Opt 1 = First Steps, Opt 2 = Pharmacy	**EDS Omni Help Desk** (317) 488-5051 1-800-284-3548	**EDS Provider Written Correspondence** P.O. Box 7263 Indianapolis, IN 46207-7263
EDS Provider Enrollment and Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	**EDS Third Party Liability (TPL)** (317) 488-5046 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 Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 or 1-800-457-4515	**HCE SUR Department** P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515	**IHCP Web Site** http://www.indianamedicaid.com	

Pharmacy Benefit Manager			
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	**EDS Pharmacy Services Help Desk for POS claims processing** (317) 655-3240 1-800-577-1278 or INXIXPharmacy@EDS.com	**EDS Pharmacy Claims** P.O. Box 7268 Indianapolis, IN 46207-7268	**Indiana DUR Board** INXIXDURQuestions@acs-inc.com
EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	**Indiana Administrative Review/ Pharmacy Claims** EDS Pharmacy Claims Admin. Review P.O. Box 7263 Indianapolis, IN 46207-7263	**PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center** 1-866-879-0106 Fax: 1-866-780-2198	**To make refunds to IHCP for pharmacy claims send check to:** EDS Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303

Hoosier Healthwise (Managed Care Organizations) and *Medicaid Select* (Effective January 1, 2007)			
Anthem http://www.anthem.com Claims 1-888-232-9613 Member Services 1-866-408-6131 1-888-232-9613 (Prospective Member) TTY: 1-866-408-7188 Fax: 1-866-408-7087 PA 1-866-408-7187 Fax: 1-866-406-2803 Provider Services 1-866-408-6132 1-800-618-3141 (Prospective Provider) Fax: 1-866-408-7087 Transportation 1-800-508-7230 TTY: 1-866-910-1603 Fax: (317) 291-9446 Pharmacy 1-866-629-1608 TTY: 1-800-905-9821 PA Fax: 1-866-408-7103	**CareSource** http://www.caresource-indiana.com Claims 1-866-930-0017 Member Services 1-800-488-0134 PA 1-866-930-0017 Provider Services 1-866-930-0017	**Harmony Health Plan** http://www.harmonyhmi.com Claims (317) 423-3000 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)** http://www.managedhealthservices.com Claims 1-877-MHS-4U4U or 1-877-647-4848 Member Services 1-877-MHS-4U4U or 1-877-647-4848 PA/Medical Management 1-877-MHS-4U4U or 1-877-647-4848 Pharmacy - US Script (PBM) 1-800-460-8988 Pharmacy PA 1-866-399-0928 Fax: 1-866-399-0929 Provider Services 1-877-MHS-4U4U or 1-877-647-4848 Nursewise 1-877-MHS-4U4U or 1-877-647-4848
	MDwise http://www.mdwise.org Claims (317) 630-2831 or 1-800-356-1204 Member Services (317) 630-2831 or 1-800-356-1204 PA/Medical Management (317) 630-2831 or 1-800-356-1204 Provider Services (317) 630-2831 or 1-800-356-1204 Pharmacy (317) 630-2831 or 1-800-356-1204	**Molina Healthcare** http://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	*Medicaid Select* http://www.medicaidselect.com Claims - EDS Customer Assistance (317) 655-3240 or 1-800-577-1278 Member Services 1-877-633-7353, Option 1 PA HCE: (317) 347-4511 or 1-800-457-4518 Provider Services for PMPs 1-877-633-7353, Option 3 Pharmacy – see 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)		Rate Setting	
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	**Myers and Stauffer, LC** http://www.mslcindy.com/ 9265 Counselors Row, Suite 200 Indianapolis IN 46240	(317) 846–9521 1-800-877–6927 Fax (317) 571–8481 MDS Help Desk: (317) 816–4122

INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER WORKSHOP REGISTRATION

Indicate the workshop you will be attending in Indiana. **Print** or **type** the information on this form and fax it to (317) 488-5376.

Billing Form Changes – Revised Claim Forms (8 a.m. - 10:30 a.m.)

☐ Indianapolis, February 6, 2007	☐ Bloomington, February 15, 2007	☐ Muncie, February 19, 2007
☐ South Bend, February 20, 2007	☐ Evansville, February 21, 2007	☐ Fort Wayne, February 22, 2007
☐ New Albany, February 27, 2007	☐ Hammond, February 27, 2007	

Third Party Liability (TPL) and Crossover Claim Billing (10:45 a.m. – Noon)

☐ Indianapolis, February 6, 2007	☐ Bloomington, February 15, 2007	☐ Muncie, February 19, 2007
☐ South Bend, February 20, 2007	☐ Evansville, February 21, 2007	☐ Fort Wayne, February 22, 2007
☐ New Albany, February 27, 2007	☐ Hammond, February 27, 2007	

Managed Care – Anthem (1 p.m. – 1:45 p.m.)

☐ Indianapolis, February 6, 2007	☐ Bloomington, February 15, 2007	☐ Muncie, February 19, 2007
☐ South Bend, February 20, 2007	☐ Evansville, February 21, 2007	☐ Fort Wayne, February 22, 2007
☐ New Albany, February 27, 2007	☐ Hammond, February 27, 2007	

Managed Care – Managed Health Service (MHS) (2 p.m. – 2:45 p.m.)

☐ Indianapolis, February 6, 2007	☐ Bloomington, February 15, 2007	☐ Muncie, February 19, 2007
☐ South Bend, February 20, 2007	☐ Evansville, February 21, 2007	☐ Fort Wayne, February 22, 2007
☐ New Albany, February 27, 2007	☐ Hammond, February 27, 2007	

Managed Care – MDwise (2:45 p.m. – 3:30 p.m.)

☐ Indianapolis, February 6, 2007	☐ Bloomington, February 15, 2007	☐ Muncie, February 19, 2007
☐ South Bend, February 20, 2007	☐ Evansville, February 21, 2007	☐ Fort Wayne, February 22, 2007
☐ New Albany, February 27, 2007	☐ Hammond, February 27, 2007	

Registrant Information *(One registrant per form)*

Name of Registrant: _____

Provider Name: _____ Provider Number: _____

Provider Address: _____

City: _____ State: _____ ZIP: _____

Provider Telephone: _____ Provider Fax: _____

Provider E-mail Address: _____

State MAC Legend Drug Updates

Effective for Dates of Service On or After January 12, 2007

Table 1.4 – **Additions** to the State MAC Legend Drugs
Effective for Dates of Service On or After January 12, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AZITHROMICIN 200MG/5 ML SUSPENSION	1.27520	SERTRALINE HCL 25 MG TABLET	2.16840
PRAVASTATIN SODIUM 20 MG TABLET	2.30100	SERTRALINE HCL 50 MG TABLET	2.27293
PRAVASTATIN SODIUM 40 MG TABLET	3.43640	SERTRALINE HCL 100 MG TABLET	2.17696
SERTRALINE 20 MG/ML ORAL CONCENTRATE	0.79667		

Effective for Dates of Service On or After February 2, 2007

Table 1.5 – **Decreases** to the State MAC Rates for Legend Drugs
Effective for Dates of Service On or After February 2, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMPHETAMINE SALTS 20 MG TABLET	0.26799	OXYCODONE/APAP 7.5/325 MG TABLET	0.46500
MORPHINE SULFATE 30 MG TABLET SA	0.54915	PROMETHAZINE 25 MG SUPPOSITORY	0.60200
NABUMETONE 750 MG TABLET	0.44329		

Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 in the Indianapolis local area, or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

EDS

| Quick Reference

>> Workshop Registration Tool Quick Reference   www.indianamedicaid.com

Following are the instructions for accessing and using the Workshop Registration Tool offered by the Indiana Health Coverage Programs (IHCP) on the IHCP Web site at http://www.indianamedicaid.com/ihcp/workshop/index.aspx. The Workshop Registration Tool enables providers and their staff to enroll in the Quarterly Medicaid Provider Workshops, change reservations, and review topics to be covered.

Workshop Registration Sign Up

In order to enroll in workshop sessions, you must sign up to access the service. You must create a Workshop Registrant Profile. You only need to create the profile once unless you have changes to your e-mail address.

1. Go to the IHCP Web site at http://www.indianamedicaid.com.

2. From the menu bar, select **Provider Services, Education Opportunities, Workshop Registration** (Figure 1). The *Workshop Registration, Choose from the Following Options* page displays.

3. Click on Workshop Registration Sign Up (Figure 2).
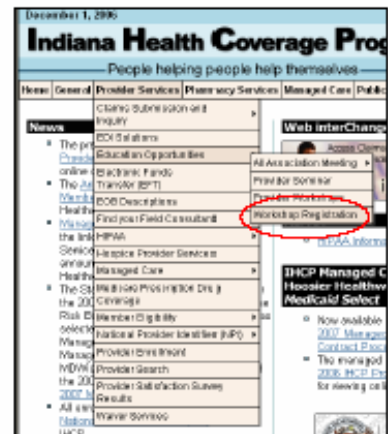
Figure 1 – Provider Services, Education Opportunities, Workshop Registration
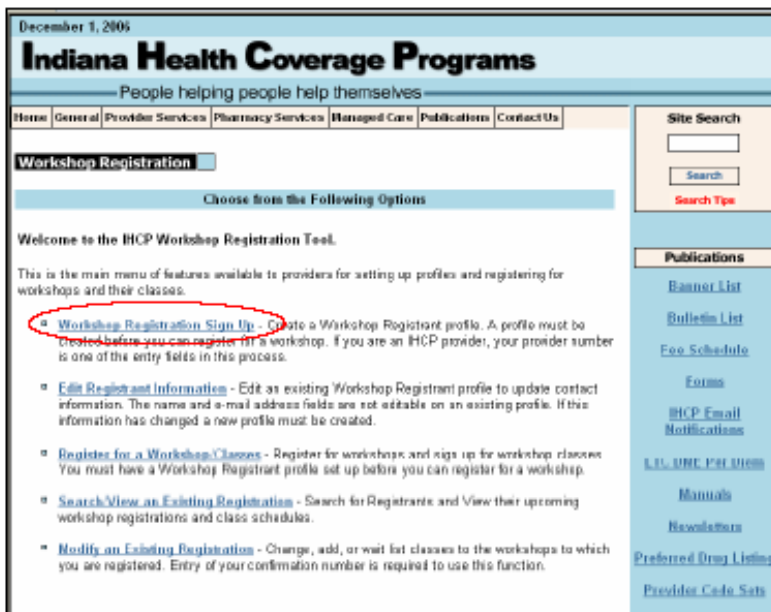
Figure 2 – Workshop Registration Sign Up

4. On the *Workshop Registration Sign Up Page* (Figure 3), complete the requested information. The fields marked with an asterisk (*) are required fields.

< 1 >

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5. To access help text for this page, click on the **Submit** button at the bottom of the page prior to entering any of the fields. The help text displays in red. The help text also displays if required fields are left blank and you click on **Submit**.

Figure 3 – Workshop Registration Sign Up Page

6. After completing the form, click on **Submit**. If there is an error such as missing information, the red help text displays next to the missing information and an error message displays at the top of the page.

When the form is complete and submitted, the *Workshop Registration Sign Up Confirmation* page displays (Figure 4).

< 2 >

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Figure 4 – Workshop Registration Sign Up Confirmation Page

Sign Up for Workshops and Classes

1. On the *Workshop Registration Sign Up Confirmation* page, click on **Sign Up for Workshops and Classes**. The link takes you to the *Select a Workshop to Register For* page (Figure 5).

2. In the *Search for a Workshop* section, click on **Display All Workshops**. The lower portion of the page is populated with the available workshops.

3. If you are interested in a specific date or a range of dates (**Date Range**) or want to search by location (**Location**), these features can be used to narrow the search.

< 3 >

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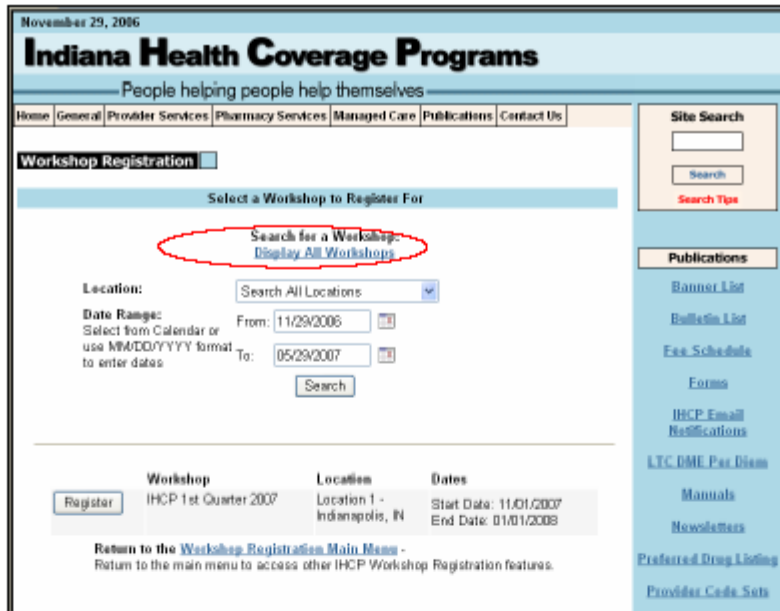
Figure 5 – Select a Workshop to Register For and Search for a Workshop

4. Select the workshop you want to register for by clicking the **Register** button next to the pertinent workshop information. The *Register for a Workshop* page displays (Figure 6).

5. Enter the e-mail address of the registrant in the **E-mail** field and click **Go** (Figure 7). This e-mail address must match the one in your profile. If this is someone else in your organization who does not have profile, click on **Create a Workshop Registrant Profile** and create a profile for that person (Figure 6).

Once you register for a workshop, you can then select the classes (sessions) you want to attend at that workshop.

If you have registered for a workshop using the Workshop Registration Tool and have received a confirmation number, you can access your workshop registration information by entering that number in the **Confirmation #** field and clicking **Go**. You must have your confirmation number in order to verify information, make changes, or cancel your registration for individual classes (sessions) or the entire workshop.

To register for classes (sessions) being held at the selected workshop, click on **Register** in the *Select from the following entries for this e-mail address*.

< 4 >

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Figure 6 – Register for a Workshop Page

6. When you click on **Register**, the *Sign up for Classes for Workshop* page displays (Figure 7).

7. To select the class you want, click on the appropriate radio button in the **Select Class** field. Then click on **Signup and Confirm Workshop Registration**.

   For all other features available on this page you must enter your **Confirmation #**.

8. If you have already signed up for a workshop and classes, click on the appropriate radio button in the **Select Class** field and use the **Cancel Registration** button to cancel your registration for a selected class.

   To change classes, you must first cancel your enrollment in a class before selecting another class to replace it.

   You cannot be enrolled in two classes scheduled to be held at the same time. The tool will prompt you if this occurs and require you to make another selection.

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Figure 7 – Sign up for Classes for Workshop Page

9. After clicking on the **Signup and Confirm Workshop Registration** button, the *Register for a Workshop* page displays (Figure 8). The selected class, location, date, and time are displayed. Your confirmation number displays on the page.

10. After registering for a workshop and registering for a class, to sign up for additional classes, click on **Sign up for More Classes**. This feature is also used for modifying your existing registration for this workshop.

    Always print the *Register for a Workshop* page. You must retain a copy of your Confirmation Number.

    From this page you can add classes, add registrants, or sign up for a different workshop.

Figure 8 – Register for a Workshop Page, Print a Confirmation

Setting up a profile, registering or changing a workshop, registering or changing a class all result in an e-mail confirming your actions. The e-mail is sent to the e-mail address entered in the profile of the registrant.

As all of the pages in the Workshop Registration Tool remind you, if you have any questions, please call EDS at (317) 488-5072. You must leave a message with your name and telephone number. Your call will be returned within 48 hours.

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Coding Updates

Table 1.6 – Manual Pricing – New Rates
Effective for Dates of Service On or After December 1, 2006

HCPCS Code	Code Description	Rate Effective for Dates of Service On or After February 8, 2007
L1510	THKAO, STANDING FRAME	$957.56
86336	INHIBIN A	$21.47
L3002	FOOT INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH	$130.33
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	Remains manually priced.
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	$2.02

Table 1.7 – Relative Value Unit Corrections associated with HCPCS published on the 2006 Medicare Physician Fee Schedule
Effective for Dates of Service On or After February 8, 2007

HCPCS Code	Code Description	Current Rate	Rate Effective for Dates of Service On or After February 8, 2007
90773	THER/PROPH/DIAG INJ, IA	$13.35	$13.09
92626	EVAL AUD REHAB STATUS	$15.13	$57.85
92627	EVAL AUD STATUS REHAB ADD-ON	$15.13	$14.54
96401	CHEMO, ANTI-NEOPL, SQ/IM	$45.65	$36.33
96402	CHEMO HORMON ANTINEOPL SQ/IM	$24.63	$31.63
96405	CHEMO INTRALESIONAL, UP TO 7	$25.14	$21.24
96406	CHEMO INTRALESIONAL OVER 7	$38.06	$30.38
97606	NEG PRESS WOUND TX, > 50 CM	$26.33	$23.48
99300	IC, INFANT PBW 2501-5000 GM	$124.47	$91.25
99324	DOMICIL/R-HOME VISIT NEW PAT	$38.90	$41.74
99325	DOMICIL/R-HOME VISIT NEW PAT	$57.89	$61.26
99326	DOMICIL/R-HOME VISIT NEW PAT	$85.32	$88.94
99327	DOMICIL/R-HOME VISIT NEW PAT	$114.06	$117.17
99328	DOMICIL/R-HOME VISIT NEW PAT	$142.26	$145.11
99334	DOMICIL/R-HOME VISIT EST PAT	$28.63	$32.26
99335	DOMICIL/R-HOME VISIT EST PAT	$47.35	$51.23
99336	DOMICIL/R-HOME VISIT EST PAT	$75.05	$79.20
99337	DOMICIL/R-HOME VISIT EST PAT	$112.25	$116.65