IHCP Provider

Monthly News

Indiana Health Coverage Programs

http://www.indianamedicaid.com

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Common Abbreviations Used in this Newsletter

ACN	Attachment Control Number
ADA	American Dental Association
ASC	Ambulatory Surgical Centers
AVR	Automated Voice Response
CFR	Code of Federal Regulations
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPS	Child Protective Services
CPT	Current Procedural Terminology
DCS	Department of Child Services
DFR	Division of Family Resources
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EDS	Electronic Data Systems
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
EVS	Eligibility Verification Systems
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability & Accountability Act
ICN	Internal Control Number
IHCP	Indiana Health Coverage Programs
LC	Limited Corporation
LPI	Legacy Provider Identifier
MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MCO	Managed Care Organization
MHS	Managed Health Services
MRO	Medicaid Rehabilitation Option
NDC	National Drug Code
NOA	Notice of Action
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTIOL	New Technology Intraocular Lenses
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PMP	Primary Medical Provider
PRTF	Psychiatric Residential Treatment Facility
RA	Remittance Advice
RBMC	Risk-Based Managed Care
SSN	Social Security Number
SUR	Surveillance and Utilization Review
TIN	Tax Identification Number
TPL	Third-Party Liability
VAN	Value-Added Network
V-CAN	Voluntary Community Assistance Network

All Provider News

New Bulletins and Updated Manual Posted to the IHCP Web Site

The following bulletins and updated manual were posted to the Indiana Health Coverage Programs (IHCP) Web site in recent months:

- *BT200804 – Updated Indiana Care Select and Prior Authorization and Restricted Card Changes*
- *BT200805 – Mental Health Medication Edits and Revised Medical Necessity Review Form*
- *BT200806 – Policy Change for Purchasing Colostomy, Incontinence, and Ostomy Supplies*
- *BT200807 – Community Alternative to Psychiatric Residential Treatment Facilities*
- *BT200808 – Medicaid Reimbursement of Durable Medical Equipment for Nursing Facility Residents*
- *BT200809 – Don't Risk Claim Rejection or Denial!*
- *Hospice Provider Manual*

A complete list of bulletins is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp. E-mail notifications are sent to subscribers as new bulletins are posted. To subscribe, visit the IHCP Web site at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp and click **Open New Account**.

To access the Explanation of Benefits (EOB) codes from the IHCP Web site, click **Provider Services** and then click **EOB descriptions**. Follow the directions at the top of the EOB Web page to print or download the EOB list.

Don't Risk Claim Rejection or Denial!

NPI Update – **Beginning March 1, 2008,** your **claim will deny** if you are a healthcare provider and you submit a claim without a billing provider National Provider Identifier (NPI)! Only atypical providers and First Steps and Pharmacy claims are exempt from this deadline.

Accepted Claim Forms Deadline – **Effective March 1, 2008**, only the CMS-1500 (08-05 version), UB-04, and the American Dental Association (ADA) claim form (2006 version) will be accepted for claims. Older versions of these forms, such as CMS-1500 (12/90), UB-92, or the ADA claim form (2000/2002 version), **will be returned to the provider** causing delays in claim processing.

LPI Deadline – **Effective May 23, 2008**, your Indiana Medicaid Legacy Provider Identifier (LPI) will not be accepted on claims. If you are a healthcare provider, your NPI must be reported on all claims and must establish a one-to-one match with the LPI and service location ZIP Code + 4, or the **claim will be denied**. The service location is the address on file with Provider Enrollment as the service location. Providers may verify the service location address via Web interChange using the Provider Profile function.

Three pieces of information on the claim are used to establish a one-to-one match between the NPI and the physical address where the patient was treated:

1. NPI
2. ZIP Code + 4 of the service location
3. Taxonomy code

Make sure this information is correctly entered on the claim to avoid a denial. Instructions for submitting NPI information on paper claims can be found in these bulletins:

- *BT200702* – Updated UB-04 Paper Claim Form Requirements
- *BT200703* – Updated CMS-1500 Paper Claim Form Requirements
- *BT200705* – Updated ADA 2006 Claim Form Requirements

Note: The effective dates listed above are the claim receipt dates. Any claim received in the IHCP mailroom on or after the effective date will be denied or returned. Please allow mailing time when submitting paper claims.

Make Sure You Are Ready – If you have not already done so, please review your NPI status and confirm that your NPI(s) have been reported to the IHCP. Do this by viewing your Provider Profile on Web interChange at https://interchange.indianamedicaid.com/Administrative/logon.aspx or by contacting your Provider Relations field consultant.

Additional information about electronic batch claim submission can be found on the IHCP Web site under EDI Solutions: http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_index.asp

For a table showing the fields where the NPI crosswalk information must be submitted for paper and EDI claims, go to: http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_index.asp

Instructions for Medicare HMO Replacement Plans and Claims

Follow these instructions when submitting claims for services adjudicated by a Medicare health maintenance organization (HMO) replacement plan:

- Submit claim to the regular Indiana Health Coverage Programs (IHCP) claims processing address.
- For CMS-1500 claims, enter the payment received from the Medicare replacement plan in field 29, not in field 22.
- For UB-04 claims, enter the prior payment in field 54A-C not in field 39.
- Attach a copy of the Medicare replacement plan remittance advice (RA) or Medicare Remittance Notice (MRN) to every claim with the words Medicare Replacement Policy written on the attachment and on the bottom of the claim form.

These claims are treated like any other third-party liability (TPL) claim. Standard Medicaid prior authorization rules as well as timely filing limits do apply to these claims.

Prior Authorization of Growth Hormones

As of January 1, 2008, IHCP implemented updated prior authorization (PA) forms for the medication class of growth hormones. The new PA criteria were approved by the Drug Utilization Review (DUR) Board in November 2007. The *Growth Hormone Prior Authorization Request Form For Adults (≥ 18 Years of Age)* and the *Growth Hormone Prior Authorization Request Form For Children (< 18 Years of Age)* are located on the following Web site: http://www.indianamedicaid.com/ihcp/Publications/forms.asp under the category Pharmacy Forms or by calling the Affiliated Computer Services (ACS) call center at 1-866-879-0106.

Prior Authorization Rejections

During the transition of PA services to ADVANTAGE Health Solutions[SM] and MDwise, Inc., paper or faxed PA requests submitted to the wrong care management organization (CMO) were forwarded by the CMO to the correct organization.

Beginning February 1, 2008, paper or faxed PA requests submitted to the wrong CMO will be rejected and a notification letter will be sent to the provider.

Electronic PA requests submitted to the wrong CMO via the 278 PA Request and Response transaction will be rejected regardless of the certification type with reason code 78 – *Subscriber/Insured not in Group/Plan* identified. A PA decision form will not be generated.

When providers receive notification that a PA request was rejected, a new PA or a PA update request must be submitted to the correct CMO.

When electronic PA requests are submitted via Web interChange, the system determines which CMO should receive the information and forwards the request to the correct vendor. This process will continue after February 1, 2008.

Providers must verify member eligibility to determine the member's primary medical provider (PMP) and CMO. PA requests must be submitted to the organization to which the member is assigned on the date of the request. This also applies to PA updates submitted for review.

As a reminder, each CMO is responsible for processing medical service PA requests and updates for members assigned to their organization at the time of the request. Additionally, ADVANTAGE Health Solutions - FFS will be responsible for processing the following:

- PA requests and updates for all Traditional Medicaid fee-for-service (FFS) members
- PA requests for risk-based managed care (RBMC) carve-out services
- PA requests for *Medicaid Select* services for members who have not yet transitioned to a *Care Select* program

ACS continues to serve as the pharmacy PA contractor. For pharmacy PA information, contact 1-866-879-0106.

CPT Code 90660 Influenza Virus Vaccine, Live for Intranasal Use

The age restriction for Current Procedural Terminology (CPT[1]) code *90660 – Influenza Virus Vaccine, Live for Intranasal Use* has been updated from ages 5 through 49 to ages 2 through 49. Claims that denied for edit *4034 – Procedure code vs. age restriction* will be reprocessed and/or mass adjusted and began appearing on remittance advice January 30, 2008.

[1] CPT copyright 2007 American Medical Association. All rights reserved.

Money Follows the Person Program Ready to Begin

The Indiana Family and Social Services Administration (FSSA) Division of Aging is gearing up to implement a demonstration program designed to reform the financing and service design of Indiana's long-term care system.

The Money Follows the Person (MFP) Demonstration grant from The Centers for Medicare & Medicaid Services (CMS) will assist the FSSA in its reform efforts to rebalance Indiana's long-term care system to achieve a more appropriate balance between institutional and home- and community-based services (HCBS) options. The CMS grant was awarded to implement a system of appropriate, person-centered, needs-based services for individuals seeking to transition from nursing homes to qualified community-based settings.

Individuals who have resided within nursing facilities for at least six months and have expressed or indicated a desire to return to the community on their 90-day minimum data set (MDS) assessment will be eligible for the demonstration. Participants must also be Medicaid eligible and eligible for either the aged and disabled or traumatic brain injury waiver. The State will receive a higher federal match to provide qualified HCBS for each MFP participant transitioned during the demonstration period.

In July 2005, FSSA Secretary Mitchell Roob, Jr. announced the agency's Aging Reform Initiative. The initiative included proposals to improve access to an array of long-term care services and expand capacity of HCBS. The reform effort targeted increased public awareness about personal responsibility for planning for long-term care and increased consumer choice of long-term care options. It also included a proposal to balance government funding for long-term care. The MFP Rebalancing Demonstration is a positive step in realizing this initiative.

FSSA's Division of Aging will contract with the Indiana Association of Area Agencies on Aging (IAAAA) and its 16 members throughout the state to conduct the transitions. Each Area Agency on Aging (AAA) will employ a transition nurse and transition specialist to assist individuals in their respective areas.

The transition nurse and transition specialist will work with the MFP participant and others chosen by the participant to serve on his or her transition team. Transition teams will identify the basic, social, medical, nutritional, and support networks necessary for the MFP participant to thrive within the community of his or her choice. Throughout the first 12 months of the MFP participant's transition into the community, services through the aged and disabled waiver will be made available to the participant.

Upon discharge from a nursing facility or other inpatient facility as defined by CMS, MFP participants will have a six-week transition period during which all of their needs are safely and adequately assured. During this time, the transition specialist and/or transition nurse will meet weekly with the participant.

Since the demonstration uses person-centered planning, the MFP participant will be able to choose an HCBS case manager to continue his or her care management beyond the first six weeks of transition.

While the transition specialist will be listed as a possible case manager, there are also other case managers from which the MFP participant may choose. Whoever the MFP participant chooses as a case manager will meet with the participant at least every 90 days (or more frequently if designated by the participant's plan of care) to ensure health and safety are appropriate, and that the social, medical, and basic needs of the participant are adequate to a successful transition.

During the first 12 months that an MFP participant is enrolled in the demonstration, he or she will receive services made available through the aged and disabled waiver, which will be funded through the enhanced federal match. Depending upon the needs of the individual, he or she will "transfer" to the traditional aged and disabled or traumatic brain injury waiver on day 366. This will result in a transparent and seamless transition for the participant, as services will continue and funding sources will transfer from the enhanced match to traditional Medicaid.

Throughout the first year of transition, all MFP participants will have access to services available through the aged and disabled waiver. For MFP participants, $1,500 in transition funding will be available, rather than the $1,000 provided to traditional aged and disabled waiver participants. This funding assists with rent and utility deposits, and needs such as linens, bedding, kitchenware, appliances, and so forth. MFP participants will have access to a supplemental service, enhanced transportation, which is provided above and beyond what is provided through the waiver. Also, two demonstration services, post-transition healthcare coordination by a nurse and personal emergency response systems (PERS), will be provided.

While this demonstration service seeks to transition a targeted population, FSSA believes that the need for nursing facility care will never be obsolete. The goal of the Money Follows the Person Demonstration is to

assist persons who can thrive in a community-based setting safely. Participants will be able to transition because of the care extended to them while residing within nursing facilities. Thank you for your professionalism and your excellent service to these individuals!

For more information about the Money Follows the Person Rebalancing Demonstration, please contact Satrina McDonald, director of the program, at Satrina.McDonald@fssa.in.gov.

Voids and Replacements

An adjustment request for a previously paid claim can be submitted only when an incorrect or partial payment has been made on a claim, including a claim that incorrectly paid zero dollars. Please note that claims in **denied** status **cannot** be adjusted.

The denied claim must be submitted as a new day claim. In addition, line item denials for paid CMS-1500, Pharmacy, and ADA dental claim forms can be billed as a new claim to the correct claims processing address. Therefore, it is not necessary to submit denied line items of paid claims as an adjustment. Please refer to the *IHCP Provider Manual, Chapter 10*, for exceptions to this policy.

Providers are reminded that when a paper adjustment request is submitted to the Adjustment Unit for processing, the request is reviewed for the following information:

- The claim internal control number (ICN) represents the most recent activity for the claim to be adjusted.
- If the claim or detail has been denied for a benefit limitation audit, the claim cannot be processed through the Adjustment Unit.
- If additional units are requested, the billed amount for the service should also be increased to reflect the appropriate billed amount for the units on the claim.
- Each claim must have its own adjustment request form for check related and non-check related adjustments.
- The adjustment request represents all changes for the claim. Providers cannot submit multiple adjustment forms to perform multiple changes on the same claim.
- A TPL Explanation of Benefits must be attached to support changes in the TPL amount.
- Adjustment requests submitted beyond the one-year filing limit must include past filing documentation.

As a reminder, providers are always encouraged to perform voids and replacements to paid claims by using Web interChange.

All Mental Health Providers

Expediting Claims for Dually Eligible Members

It is now possible for providers to expedite claim payment for members that are dually eligible for Medicare and Medicaid when modifiers HE or HO are appended to the procedure billed. Providers can now use the *Claim Notes* field or segment on an 837P transaction instead of submitting a paper claim with attachments. This process should only be used by providers who are not approved to bill Medicare. The text entered in the *Claim Notes* field or segment should read, "Provider not approved to bill services to Medicare." This allows the claim to suspend for review of the *Claim Note* field or segment and the claim is adjudicated accordingly.

All Early and Periodic Screening, Diagnosis, and Treatment Services Providers

Mass Adjustment for Claims with Dates of Service between January 1, 2008, and January 23, 2008

The new rates for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) exams were published in the banner page *BR200805* dated January 29, 2008. The new rates are effective for dates of service on or after January 1, 2008, when the claim is billed with a primary diagnosis of V20.2 and the following CPT codes: 99381, 99382, 99383, 99384, 99385, 99391, 99392, 99393, 99394, and 99395.

The new rates were not entered into the system until January 23, 2008. Claims with dates of service from January 1, 2008, through January 23, 2008, were systematically mass adjusted during the week of February 11, 2008. For the affected exam codes, the EPSDT rate that is currently $50 will be changed to $75, and the EPSDT rate that is currently $37 will be changed to $62.

All Physician Service Providers Including Providers of Early and Periodic Screening, Diagnosis, and Treatment Services

Fee Changes for Certain Physician and EPSDT Services

The fee amounts for several CPT® codes have been increased. The affected codes, descriptions, and resource-based relative value scale (RBRVS) or maximum allowable fee amounts are listed in Table 1. The new fees are effective for services provided on or after January 1, 2008.

For procedure code *99051 – Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service*, providers may bill a maximum of one unit per patient per day. Evening hours are defined as routinely scheduled after 5 p.m. in the prevailing time zone. Providers may only bill for the following holidays, which represent days when physician offices are generally closed for the day: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day. When billing for 99051, please document in the medical chart the time, date, or holiday, as applicable. All other billing requirements will remain unchanged.

Table 1 – Fee Changes for Physician and EPSDT Service Provider

CPT Procedure Code	Procedure Code Description	Old RBRVS Fee or Maximum Allowable Amount	New RBRVS Fee or Maximum Allowable Amount
59425	Antepartum Care	$29.31	$40.57
59426	Antepartum Care	$29.31	$43.73
99051	Svcs During Provider's Ext. Hours	N/A	$11.00
99203	Office/Outpatient Visit, New	$46.85	$47.44
99204	Office/Outpatient Visit, New	$70.14	$73.51
99205	Office/Outpatient Visit, New	$88.36	$93.13
99212	Office/Outpatient Visit, Est	$18.20	$19.37
99213	Office/Outpatient Visit, Est	$25.98	$31.96
99214	Office/Outpatient Visit, Est	$40.43	$48.54
99215	Office/Outpatient Visit, Est	$63.87	$65.25
99221	Initial Hospital Care	$48.49	$54.05
99223	Initial Hospital Care	$103.60	$108.09
99232	Subsequent Hospital Care	$37.20	$40.35
99233	Subsequent Hospital Care	$51.86	$57.47
99242	Office Consultation	$52.93	$59.27
99243	Office Consultation	$68.63	$81.03
99244	Office Consultation	$96.82	$121.18
99245	Office Consultation	$130.47	$148.04
99253	Inpatient Consultation	$70.63	$76.19
99254	Inpatient Consultation	$97.44	$110.64
99255	Inpatient Consultation	$132.11	$133.68
99282	Emergency Dept Visit	$23.74	$26.06
99284	Emergency Dept Visit	$66.93	$75.73
99285	Emergency Dept Visit	$105.28	$112.39
99291	Critical Care, First Hour	$142.35	$165.99

CPT Procedure Code	Procedure Code Description	Old RBRVS Fee or Maximum Allowable Amount	New RBRVS Fee or Maximum Allowable Amount
99292	Critical Care, ea Add'l 30 Min	$69.31	$76.15
99354	Prolonged Service, Office	$46.85	$59.79
99355	Prolonged Service, Office	$20.82	$60.16
99356	Prolonged Service, Inpatient	$46.85	$54.85
99357	Prolonged Service, Inpatient	$20.82	$54.74
99381*	Init Pm E/M, New Pat, Inf	$39.85	$58.54
99382*	Init Pm E/M, New Pat 1-4 Yrs	$34.52	$64.23
99383*	Prev Visit, New, Age 5-11	$34.82	$63.97
99384*	Prev Visit, New, Age 12-17	$32.00	$69.80
99385*	Prev Visit, New, Age 18-39	$48.94	$69.80
99386	Prev Visit, New, Age 40-64	$48.94	$81.60
99387	Init Pm E/M, New Pat 65+ Yrs	$48.94	$89.84
99391**	Per Pm Reeval, Est Pat, Inf	$24.35	$50.43
99392**	Prev Visit, Est, Age 1-4	$24.36	$56.00
99393**	Prev Visit, Est, Age 5-11	$25.01	$56.00
99394**	Prev Visit, Est, Age 12-17	$25.32	$61.69
99395**	Prev Visit, Est, Age 18-39	$34.82	$61.69
99396	Prev Visit, Est, Age 40-64	$34.82	$67.52
99397	Per Pm Reeval Est Pat 65+ Yr	$34.82	$76.02

The rates listed above are for non-EPSDT services.

For procedure codes marked with one asterisk (*), the current EPSDT rate is $50; the new EPSDT rate is $75.

For procedure codes marked with two asterisks (**), the current EPSDT rate is $37; the new EPSDT rate is $62.

All Dental Providers

Fee Changes for Certain Dental Services

The maximum allowable fee amounts for several Current Dental Terminology (CDT[2]) codes have been increased. The affected codes, descriptions, and maximum allowable fee amounts are listed in Table 2. The new maximum allowable fee amounts are effective for services provided on or after January 1, 2008. All billing requirements and the annual dental cap amount for certain adult dental services will remain unchanged.

Table 2 – New Maximum Allowable Fee Amounts for CPT Codes

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D0120	Periodic Oral Exam	$20.25	$22.58
D0140	Limited Oral Exam – Problem Focused	$33.25	$37.08
D0270	Bitewing – Single Film	$15.50	$17.29

[2] CDT is copyrighted by the American Dental Association.

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D0272	Bitewings – Two Films	$22.25	$24.81
D0274	Bitewings – Four Films	$33.25	$35.17
D0330	Panoramic Film	$61.00	$64.52
D1351	Sealant per Tooth	$27.75	$29.35
D1510	Space Maintainer – Fixed - Unilateral	$174.25	$194.34
D1515	Space Maintainer – Fixed - Bilateral	$249.75	$278.54
D2140	Amalgam – One Surface, Primary or Permanent for Tooth Codes A - T = Child	$51.00	$56.88
D2140	Amalgam – One Surface, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$55.50	$61.90
D2150	Amalgam – Two Surfaces, Primary or Permanent for Tooth Codes A - T = Child	$64.50	$71.93
D2150	Amalgam – Two Surfaces, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$72.51	$81.14
D2160	Amalgam – Three Surface, Primary or Permanent for Tooth Codes A - T = Child	$77.75	$86.71
D2160	Amalgam – Three Surfaces Primary or Permanent for Tooth Codes 1 - 32 = Adult	$86.50	$96.47
D2161	Amalgam – Four or More Surfaces, Primary or Permanent for Tooth Codes A - T = Child	$83.50	$93.13
D2161	Amalgam – Four or More Surfaces, Primary or Permanent for Tooth Codes 1 - 32 = Adult	$104.25	$116.27
D2330	Resin – One Surface - Anterior	$71.00	$79.18
D2331	Resin – Two Surfaces - Anterior	$86.50	$96.47
D2332	Resin – Three Surfaces - Anterior	$105.50	$111.58
D2335	Resin – Four or More Surfaces or Involving Incisal Angle (Anterior)	$138.75	$154.74
D2920	Recement Crowns	$52.25	$58.27
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	$139.75	$155.86
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	$166.50	$185.69
D2940	Sedative Filling	$54.50	$60.78
D3220	Therapeutic Pulpotomy (Excluding Final Restoration)	$94.25	$105.11
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restoration)	$122.00	$136.06
D3310	Endodontic Therapy – Anterior (Excluding Final Restoration)	$338.50	$377.52
D3320	Endodontic Therapy – Bicuspid (Excluding Final Restoration)	$416.25	$464.23
D3330	Endodontic Therapy – Molar (Excluding Final Restoration)	$524.00	$569.32
D4210	Gingivectomy or Gingivoplasty – Four or More Contiguous Teeth or Bounded Teeth per Quadrant	$333.00	$371.38
D4211	Gingivectomy or Gingivoplasty – One to Three Contiguous Teeth or Bounded Teeth per Quadrant	$114.25	$127.42

CDT Procedure Code	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
D4341	Periodontal Scaling and Root Planing – Four or More Teeth per Quadrant	$138.75	$154.74
D4355	Full Mouth Debridement	$88.00	$98.14
D5110	Complete Upper (Denture) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$391.25	$436.35
D5120	Complete Lower (Denture) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	394.13	$439.56
D5211	Upper Partial – Acrylic Base (Including any Conventional Clasps and Rests) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$328.00	$365.81
D5212	Lower Partial – Acrylic Base (Including any Conventional Clasps and Rests) Rate is for members age >= 21. Rate for members under 21 years of age remains unchanged.	$333.00	$371.38
D7140	Extraction – Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	$72.25	$77.24
D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap and Removal of Bone	$144.25	$154.20
D7220	Removal of Impacted Tooth – Soft Tissue	$166.50	$185.69
D7230	Removal of Impacted Tooth – Partially Bony	$220.00	$247.59
D7240	Removal of Impacted Tooth – Completely Bony	$288.50	$321.76
D7250	Surgical Removal of Residual Tooth Roots (Cutting Procedure)	$166.50	$185.69
D7286	Biopsy of Oral Tissue Soft	$154.75	$172.59
D7310	Alveoloplasty in Conjunction with Extractions – Four or More Teeth or Tooth Spaces, per Quadrant	$166.50	$185.69
D7320	Alveoloplasty not in Conjunction with Extractions – Four or More Teeth or Tooth Spaces, per Quadrant	$222.00	$247.59
D7410	Excision of Benign Lesion up to 1.25 CM	$97.02	$111.48
D7910	Suture of Small Wound up to 5 CM	$105.50	$117.66
D9230	Analgesia	$27.75	$30.95

All Ambulance Providers

Fee Changes for Certain Ambulance Services

The maximum allowable fee amounts for several Healthcare Common Procedure Coding System (HCPCS) codes have been increased. The affected codes, descriptions, and maximum allowable fee amounts are listed in Table 3. The new maximum allowable fees are effective for services provided on or after January 1, 2008. All billing requirements will remain unchanged.

Table 3 – Fee Changes for Ambulance Services

HCPCS Procedure Code	Procedure Code Modifier	Procedure Code Description	Old Maximum Allowable Fee Amount	New Maximum Allowable Fee Amount
A0225		Ambulance Service, Neonatal	$150.00	$160.84
A0425	U1-ALS	Ground Mileage, Advanced Life Support (ALS)	$4.00	$4.41
A0425	U2-BLS	Ground Mileage, Basic Life Support (BLS)	$3.00	$3.31
A0426		Ambulance Service, ALS	$85.00	$95.84
A0427		Ambulance Service, Emergency, ALS	$150.00	$160.84
A0428		Ambulance Service, BLS	$85.00	$95.84
A0429		Ambulance Service, Emergency, BLS	$100.00	$110.84
A0433		Advanced ALS, Level 2	$150.00	$160.84

Provider Workshops

2008 First Quarter Medicaid Provider Workshops

The IHCP offers workshops free of charge. Sessions are offered at several locations in Indiana. Table 4 lists the time, session topic, and description. The schedule allows for a lunch period from 12:30 p.m. until 1:30 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.

Workshop registration dates, registration deadlines, and locations are listed in Table 5. 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.

Providers may register online at www.indianamedicaid.com. A copy of the *Provider Workshop Registration* form is included in this newsletter. List one registrant per form. Fax completed registration forms to EDS at (317) 488-5376. The *Registration* form is also available on the *Forms* page of the IHCP Web site.

Questions about the workshops can be directed to a field consultant at (317) 488-5072.

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

Table 4 – 2008 First Quarter Workshop Session Times, Topics, and Descriptions

Time	Topic	Description
8 a.m. – 10 a.m.	*Care Select* and Prior Authorization Changes Presented by EDS, ADVANTAGE, and MDwise consultants will follow with a roundtable	This session provides an overview of the care management program known as *Care Select*. Emphasis is given to the prior authorization (PA) process and the change of PA contractors. Additional topics include the phase-in schedule, populations served, and functions performed by the *Care Select* contractors. The contractors will be present for a question-and-answer roundtable.
10:15 a.m. – 10:45 a.m.	IHCP Updates Presented by EDS	This session provides an update of recent and upcoming changes within the IHCP. Topics include a review of the National Provider Identifier (NPI) Edits (error codes 1100 to 1157) that will cause claim denials when Phase III of NPI is implemented, and a review of National Drug Code (NDC) billing requirements that will be mandated for UB-04 claim forms beginning July 1, 2008.
11 a.m. – 12:30 p.m.	Healthy Indiana Plan (HIP) Presented by Anthem Blue Cross and Blue Shield, and MDwise with AmeriChoice representatives	This session provides an overview of the new Healthy Indiana Plan that went into effect January 1, 2008. Topics include a plan overview, enhanced service plan, member eligibility, Personal Wellness and Responsibility (POWER) account, and covered services.
12:30 p.m. – 1:30 p.m.	Lunch	
1:30 p.m. – 2 p.m.	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Presented by EDS	This session presents the purpose and goals of the EPSDT program. Discussion focuses on appropriate EPSDT screenings for targeted age ranges.
2:30 p.m. – 4 p.m.	Managed Care Roundtable – MDwise, MHS, and Anthem	Representatives from each managed care organization (MCO) provide program updates involving the Hoosier Healthwise, risk-based managed care programs. An in-depth roundtable discussion of the EPSDT program is included.

Table 5 – 2008 First Quarter Workshop Dates, Registration Deadlines, and Locations

Workshop Date	Registration Deadline	Location
February 19, 2008	February 5, 2008	Wishard Hospital Myers Auditorium 1001 W. 10th St. Indianapolis, IN 46237
March 4, 2008	February 19, 2008	Reid Hospital Wallace Auditorium 1401 Chester Blvd. Richmond, IN 47374
March 5, 2008	February 20, 2008	St. Catherine's Hospital Professional Office Bldg. 4321 Fir St. East Chicago, IN 46312
March 7, 2008	February 22, 2008	St. Joseph Regional Medical Center Education Center 801 E. LaSalle Ave. South Bend, IN 46617
March 12, 2008	February 27, 2008	Parkview Hospital Administration Auditorium at the Corporate Offices 10501 Corporate Dr. Fort Wayne, IN 46845
March 14, 2008	February 29, 2008	Columbus Regional Hospital Kroot Auditorium 2400 E. 17th St. Columbus, IN 47201
March 19, 2008	March 5, 2008	Deaconess Hospital Bernard Schnacke Auditorium 600 Mary St. Evansville, IN 47747
March 20, 2008	March 6, 2008	Unity Healthcare 1345 Unity Pl. Lafayette, IN 47905
March 27, 2008	March 13, 2008	Union Hospital Landsbaum Center Auditorium 1433 N. 6 ½ St. Terre Haute, IN 47804

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.

***Care Select* and Prior Authorization Changes (8 a.m. – 10 a.m.)**		
☐ Indianapolis, February 19, 2008	☐ Richmond, March 4, 2008	☐ East Chicago, March 5, 2008
☐ South Bend, March 7, 2008	☐ Fort Wayne, March 12, 2008	☐ Columbus, March 14, 2008
☐ Evansville, March 19, 2008	☐ Lafayette, March 20, 2008	☐ Terre Haute, March 27, 2008
IHCP Updates (10:15 a.m. – 10:45 a.m.)		
☐ Indianapolis, February 19, 2008	☐ Richmond, March 4, 2008	☐ East Chicago, March 5, 2008
☐ South Bend, March 7, 2008	☐ Fort Wayne, March 12, 2008	☐ Columbus, March 14, 2008
☐ Evansville, March 19, 2008	☐ Lafayette, March 20, 2008	☐ Terre Haute, March 27, 2008
Healthy Indiana Plan HIP (11 a.m. – 12:30 p.m.)		
☐ Indianapolis, February 19, 2008	☐ Richmond, March 4, 2008	☐ East Chicago, March 5, 2008
☐ South Bend, March 7, 2008	☐ Fort Wayne, March 12, 2008	☐ Columbus, March 14, 2008
☐ Evansville, March 19, 2008	☐ Lafayette, March 20, 2008	☐ Terre Haute, March 27, 2008
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) (1:30 p.m. – 2 p.m.)		
☐ Indianapolis, February 19, 2008	☐ Richmond, March 4, 2008	☐ East Chicago, March 5, 2008
☐ South Bend, March 7, 2008	☐ Fort Wayne, March 12, 2008	☐ Columbus, March 14, 2008
☐ Evansville, March 19, 2008	☐ Lafayette, March 20, 2008	☐ Terre Haute, March 27, 2008
Managed Care Roundtable – MDwise, MHS, and Anthem (2:30 p.m. – 4 p.m.)		
☐ Indianapolis, February 19, 2008	☐ Richmond, March 4, 2008	☐ East Chicago, March 5, 2008
☐ South Bend, March 7, 2008	☐ Fort Wayne, March 12, 2008	☐ Columbus, March 14, 2008
☐ Evansville, March 19, 2008	☐ Lafayette, March 20, 2008	☐ Terre Haute, March 27, 2008

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: _____

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
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	Bill Woodruff	(317) 488-5098	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	Tawanna Danzie	(317) 488-5197	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
Kentucky	Louisville	Shantel Silnes	(317) 488-5123
Michigan	Sturgis	Rhonda Rupel	(317) 488-5080
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Shantel Silnes	(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

Indiana Health Coverage Programs Quick Reference

http://www.indianamedicaid.com

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization

ADVANTAGE Health Solutions Prior Authorization – FFS P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720 or Fax: 1-800-689-2759	Automated Voice Response (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 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 or 1-800-284-3548
EDS TPL (317) 488-5046 or 1-800-457-4510 Fax (317) 488-5217	EDS Provider Enrollment and Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	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	Premium Collection Services Package C Payment Line 1-866-404-7113 Package C Payment Mailing Address Hoosier Healthwise P.O. Box 3127 Indianapolis, IN 46206-3127	M.E.D. Works 1-866-273-5897 M.E.D. Works Payment Mailing Address PO Box 946 Indianapolis, IN 46206	

Pharmacy Services Contact Information

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 or 1-800-577-1278 INXIXPharmacy@EDS.com	EDS Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268	EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265
Pharmacy Benefit Management Inquiries PDL@fssa.state.in.us	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 or 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

Enrollment Broker Helplines	Hoosier Healthwise Managed Care Organizations (MCOs)		
Hoosier Healthwise http://www.healthcareforhoosiers.com 1-800-889-9949 *Care Select* http://www.indianacareselect.com 1-866-963-7383 HIP http://www.HIP.in.gov 1-877-438-4479	Anthem http://www.anthem.com Claims 1-888-232-9613 Member Services 1-866-408-6131 PA 1-866-408-7187 or Fax: 1-866-406-2803 Provider Services 1-866-408-6132 or Fax: 1-866-408-7087 Prospective Providers 1-800-618-3141 or Fax: 1-866-408-7087 Transportation 1-800-508-7230 Pharmacy 1-866-629-1608 or PA Fax: 1-866-408-7103	MDwise http://www.mdwise.org Claims, Member Services PA/Medical Management, Provider Services, and Pharmacy (317) 630-2831 or 1-800-356-1204	Managed Health Services (MHS) http://www.managedhealthservices.com Claims, Member Services, PA/Medical Management, Provider Services, and Nursewise 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

Care Select – Care Management Organizations (CMOs)		Healthy Indiana Plan (HIP) Organizations	HIP – Enhanced Services Plan (ESP) Organizations
ADVANTAGE Health Solutions http://www.advantageplan.com/ Member Services 1-800-784-3981 Provider Services 1-866-504-6708 PA 1-800-784-3981 or Fax 1-800-689-2759 P.O. Box 80068 Indianapolis, IN 46280 Hospice Member Disenrollment Fax: (317) 810-4488	MDwise http://www.mdwise.org Member Services and Provider Services 1-866-440-2449 Member Services Fax: 1-877-822-7188 PA 1-866-440-2449 or Fax 1-877-822-7186 P.O. Box 44214 Indianapolis, Indiana 46244-0214	MDwise with AmeriChoice http://www.mdwise.org Claims, Member Services and Provider Services 1-877-822-7196 or 317-822-7196 Fax: 1-877-822-7192 or 317-822-7192 Medical Claims P.O. Box 31363 Salt Lake City, UT 84131-0363 Behavioral Health Claims 1-800-818-6872 3405 W. Dr. Martin Luther King, Jr., Ste 101 Tampa, FL 33607	ACS – Non Pharmacy P.O. Box 33077 Indianapolis, IN 46203-0077 1-866-674-1461 or 317-614-2032 Pharmacy PA ACS 1-866-879-0106 Fax 1-877-822-7186 EDS Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268 1-800-577-1278 or 317-655-3240
Pharmacy See Pharmacy Services Contact Information above	EDS Claims Providers (317) 655-3240 or 1-800-577-1278 Members (317)-713-9627 or 1-800-457-4584	Anthem Blue Cross and Blue Shield http://www.anthem.com Member Services 1-800-553-2019 Provider Inquiry 1-800-345-4344 P.O. Box 37010 Louisville, KY 40233-7180 PA 1-866-398-1922	

Paper 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

To make refunds to IHCP: EDS Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	To make refunds for CA PRTF EDS/CA PRTF Refunds P.O. Box 7247 Indianapolis, IN 46207	To make refunds for MFP EDS/MFP Refunds P.O. Box 7194 Indianapolis, IN 46207	To Return Uncashed IHCP Checks: EDS Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	Pharmacy See Pharmacy Services Contact Information above