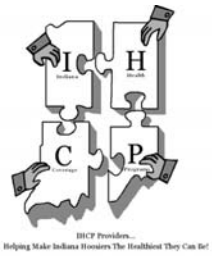
IHCP Provider

Monthly News

Indiana Health Coverage Programs

http://www.indianamedicaid.com



What's New Inside!

Table of Contents

Table of Contents

Common Abbreviations

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
HIP	Healthy Indiana Plan
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 Posted to the IHCP Web Site

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

- *BT200835 – Changes to the Preferred Drug List*
- *BT200836 – 2008 IHCP Provider Seminar*

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.

Top Five Reasons Maintenance or Enrollment Forms Are Returned

To make sure your provider enrollment form is processed as efficiently as possible, check these five items before sending an update:

1. **Authorized Signature Needed**

   The Provider Enrollment Unit must have an original, authorized signature. What does authorized mean? Authorized is a person listed on either Schedule C.1 (ownership names) or Schedule C.3 (managers or anyone with operational authority for the entity) who has authority to make operational decisions for the entity.

2. **Termination Form Needed**

   A request for termination must be submitted on an appropriate form. Because providers are members of multiple groups and have multiple service locations, we need to know whether the termination request is for the entire IHCP program, a service location, a rendering provider from a group location, or a rendering provider from the entire IHCP program. Only then can we process the termination request correctly. Without the appropriate form, an incorrect termination might be made.

3. **Document Is Incomplete**

   If your document is missing information needed to complete the request, it will be returned. Examples include a group application without a rendering linkage form or application, or an electronic funds transfer (EFT) form submitted without the tax identification number or bank account information.

4. **Incomplete Schedule C**

   You must furnish Schedule C information, which includes the names, Social Security numbers (SSNs), and addresses of all owners with 5 percent or more control, as well as the names and SSNs of all managers (or members of the board of directors, if the entity is not-for-profit). The schedules must contain signatures for everyone listed on them.

5. **Rendering Form Needed**

   If you submit a group application without the rendering form, which lists all the rendering providers who will perform the services of the group, an enrollment cannot take place.

If you want to avoid having your updates returned, you may want to use the new maintenance feature on Web interChange. Please see "Maintain Your Provider Enrollment Profile on the Web" below for more information!

Maintain Your Provider Enrollment Profile on the Web

Did you know you can make your own updates through Web interChange quickly, easily, and securely – without submitting paper forms?

You can make changes online that do not require supportive documentation. For example, you can change your additional specialties (not the primary), address, or bank account information for electronic funds transfer (EFT).

Some changes cannot be made online, including changing to a specialty that requires certification, such as waiver or nursing facility, or changing your home office or legal name, which requires a new W-9 form.

In addition, terminations cannot be made online at this time because of managed care primary medical provider (PMP) considerations. For example, an accidental termination could result in the loss of a PMP's assigned patient panel, causing confusion for members.

Online maintenance of your profile requires Web interChange access. If you haven't signed up for Web interChange, be sure to do so. To sign up, complete and mail the form found in the "How to Obtain an

ID" section on the Web interChange Web site at https://interchange.indianamedicaid.com.

The Provider Profile update function is available to any user within the provider's organization who has been granted access by the organization's Web interChange administrator. It is the administrator's responsibility to provide access to only appropriate users. By limiting personnel that have access to this function, administrators can prevent unauthorized changes to the profile. Administrators should also ensure that users do not share their user IDs and passwords. Access to a specific function is available to anyone using that ID and password.

How to Maintain Profile Information

1. Log on to Web interChange.
2. From the Navigation menu, select **Provider Profile**.
3. At the Provider Profile menu, select **View/Edit a Profile**.

*Note: If the user does not have access to maintain a profile, the menu option will say only **View Profile**.*

4. On the Profile Inquiry page, perform an inquiry on the Legacy Provider Identifier (LPI) or National Provider Identifier (NPI) to be maintained.
5. If the service location is active or will be active in the future, and the user has provider maintenance access, an Edit button is displayed next to the service locations.
6. Click **Edit**.

Don't miss out on this opportunity to make your provider profile updates quickly and easily. Sign up for Web interChange and get access for maintenance from your Web interChange administrator.

If you have any questions regarding provider profile maintenance, please contact EDS Provider Enrollment at 1-877-707-5750.

Prior Authorization Requirements for Osteogenic Bone-Growth Stimulator

Effective September 1, 2008, the IHCP no longer requires documented evidence of a failed surgery prior to authorizing an Osteogenic Bone-Growth Stimulator, low-intensity ultrasound, noninvasive (E0760) for treatment of nonunion fractures.

The following criteria must be met for diagnosis of a nonunion fracture:

- Serial radiographs must confirm that fracture healing has ceased for three or more months prior to starting treatment with an Osteogenic Stimulator.
- Serial radiographs must include a minimum of two sets of radiographs, each including multiple views of the fracture site, separated by a minimum of 90 days.

Prior authorization (PA) of an Osteogenic Bone-Growth Stimulator is still required and based on the following indications:

- Nonunion of a fracture documented by a minimum of two sets of radiographs obtained prior to starting treatment with the ultrasound stimulator. The radiographs must be separated by a minimum of 90 days, and each must include multiple views of the fracture site. Also required is a written interpretation by a physician stating that there has been no clinically significant evidence of fracture healing between the two sets of radiographs.
- The ultrasonic Osteogenic Stimulator may not be used concurrently with other noninvasive osteogenic devices.

Indiana Health Coverage Programs to Upgrade System October 11-12

The IHCP will upgrade system servers and databases the weekend of October 11-12, 2008. Usage of the IHCP Web interChange Web site will be limited during this time, as will eligibility verification through Omni, the Automated Voice Response (AVR) system, and Pharmacy Point-of-sale (POS). Review Table 1 for more information concerning the system maintenance window.

The completion time for the upgrades is an estimate. Web interChange, Omni, AVR, and POS may be available prior to 5 a.m. October 12, 2008. Providers may attempt to send transactions prior to 5 a.m. This system maintenance will not affect providers submitting batch claims using File Exchange. Questions about this maintenance should be addressed to the Electronic Data Interchange (EDI) Solutions Help Desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

Table 1 – System Maintenance Window

System Function	Unavailable Start Time	Unavailable End Time
Web interChange Omni Eligibility Verification Automated Voice Response (AVR) Pharmacy POS	12 a.m., Sunday, October 12	5 a.m., Sunday, October 12

Centers for Medicare & Medicaid Services Issues Quarterly Updates

The Centers for Medicare & Medicaid Services (CMS) has published the July Quarterly Updates with new and revised codes. Table 2 lists the deleted codes and the appropriate crosswalked procedure codes effective December 31, 2007. Table 3 lists the new Healthcare Common Procedure Coding System (HCPCS), coverage, and prior authorization requirements; and Table 4 lists a new modifier.

Table 2 – Deleted Codes

HCPCS Code	Description	Crosswalk Code
G0377	Administration of vaccine for Part D drug	**Effective January 1, 2008, physicians can no longer bill Medicare Part B for the administration of Medicare Part D-covered vaccines, using procedure code G0377**
G0297	Insertion of single chamber pacing cardioverter defibrillator pulse generator	33240

Table 3 – New HCPCS Coverage and Requirements

HCPCS Code	Description	Coverage/Requirements	Comments
C9242	Injection, fosaprepitant, 1mg	Covered all programs No PA requirements	Effective July 1, 2008 NDC 00006-3884-32
C9356	Tendon, porous matrix of cross-linked collagen and glycosaminoglycan matrix (Tenoglide Tendon Protector Sheet), per square centimeter	Covered all programs No PA requirements	Effective July 1, 2008
C9357	Dermal substitute, granulated cross-linked collagen and glycosaminoglycan matrix (flowable Wound Matrix), 1cc	Covered all programs No PA requirements	Effective July 1, 2008
C9358	Dermal substitute, native, nondenatured collagen (SurgiMend Collagen Matrix), per 0.5 square centimeter	Covered all programs No PA requirements	Effective July 1, 2008
G0398	Home sleep study test (HST) with Type II portable monitor, unattended; minimum of seven channels: EEG, EOG, EMG, ECG/heart rate, airflow, respiratory effort, and oxygen saturation	Not covered	Effective March 13, 2008
G0399	Home sleep test (HST) with Type III portable monitor, unattended; minimum of four channels: two respiratory movement/airflow, one ECG/heart rate and one oxygen saturation	Not covered	Effective March 13, 2008
G0400	Home sleep test (HST) with Type IV portable monitor, unattended; minimum of three channels	Not covered	Effective March 13, 2008

Table 4 – New Modifier

Modifier	Description	Effective Date
CG	Policy Criteria Applied	July 1, 2008

Nursing Home Providers

EDS Processes Mass Adjustment of Medicare Part A Crossover Claims

This is an update of a previous banner page article originally published in *BR200810*, dated March 4, 2008. The mass adjustment of Medicare Part A crossover claims announced at that time was delayed.

EDS has processed a mass adjustment of Medicare Part A crossover claims with dates of service from October 1, 2001, through March 26, 2002. During this time, an emergency rule was in effect that capped Medicaid reimbursement of crossover claims at the Medicaid allowable rate. The State was sued and prevented from implementing this emergency rule, as well as three others. On appeal, the court found in favor of the State and sent the case back to the trial court for a determination of the amount the State was owed in restitution from providers (see IFSSA v. Amhealth et al, 790 N.E.2d162).

The lawsuit involved the nursing facility industry's challenge of four emergency rules that, in aggregate, reduced Medicaid reimbursement. As a result of a settlement with the plaintiffs, only Medicare Part A crossover claims will be adjusted and recouped from nursing facility providers.

The final phase of adjustments began appearing on the September 23 Remittance Advice (RA) statement for claims with dates of service between March 1, 2002, and March 26, 2002. Claims with From dates of service prior to March 26, 2002, but To dates of service after March 26, 2002, were included in the mass adjustment. Claims that have To dates of service beyond March 26, 2002, without an accommodation revenue code, such as ancillary services, may need to be resubmitted with the appropriate type of bill, as noted below. These claims have internal control numbers (ICNs) starting with 56, which reflect mass-adjusted claims. An accounts receivable (A/R) is set up to recover the overpayment. Following review of the RA, providers who disagree with any adjustment amounts may request an administrative review by writing to the following address:

EDS Administrative Review
Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

In the request, explain why you disagree with the adjustment amount and include copies of all pertinent documentation. Detailed information about the administrative review process is available in the *Indiana Health Coverage Programs Provider Manual.*

If you have specific claims that were billed and adjudicated during this time frame – March 2, 2002, to March 26, 2002 – your claims were mass adjusted. These mass-adjusted claims contain details billed with services that are not included in the nursing facility per diem rate, such as lab or radiology services. You may resubmit the claims electronically or via paper for reimbursement consideration. Providers should submit these ancillary services as outpatient crossover claims with the appropriate type of bill, so the IHCP can calculate the Medicaid allowed amount for each detail submitted and compare this amount to the Medicare paid. If the Medicare paid amount is less than the Medicaid allowed amount, a portion or all the coinsurance or deductible amount will be reimbursed.

All Pharmacy Providers and Prescribing Practitioners

CMS to Audit Pharmacies for Compliance with TRPP Requirements

The CMS has advised that, at some time in the future, it will audit individual pharmacies for compliance with Tamper Resistant Prescription Pad/Paper (TRPP) requirements. Please be certain that all Medicaid prescriptions you fill that are subject to TRPP requirements – as referenced in *BT200810*, dated February 22, 2008, and *BT200834*, dated August 21, 2008 – are fully compliant with the requirements. Payment for claims arising from noncompliant prescriptions would be recouped in the event of a state or federal audit finding of noncompliance.

New Web Site for National Drug Code to Procedure Code Unit Conversion

The Palmetto Government Benefits Administrators (GBA) Web site has changed. This Web site is used for reference when submitting National Drug Codes (NDCs) with HCPCS codes on professional and outpatient claims – as found in bulletin *BT200713*, dated May 29, 2007. The new Web site, hosted by Noridian Administrative Service, is https://www.dmepdac.com.

Updated NCPDP Payer Sheets

Please check the updated National Council for Prescription Drug Programs (NCPDP) payer sheets for the following information:

- DAW 6 definition has been updated for use when communicating on a claim whose brand is medically necessary, or when the brand is preferred to its generic equivalent on the Preferred Drug List (PDL).
- NCPDP fields 479-H8, "*Other Amount Claimed Submitted Qualifier*," and 480-H9, "*Other Amount Claimed Submitted*," have been added for use when submitting *Other Coverage Code 8* on claims (see Table 5). These fields have always been required, but were omitted from prior versions of the Payer Sheets in error.

Table 5 – National Council for Prescription Drug Programs Payer Sheets

Field	Field Name	Field Format	Type	Value	Comments
479-H8	*Other Amount Claimed Submitted Qualifier*	x(2)	N	99	Mandatory when segment is present
479-H9	*Other Amount Claimed Submitted*	9(9)v99b or 9(9)v99-	D	s$$$$$$cc s9(6)v99	Required when submitting a claim with *Other Coverage Code 8* in field 308-C8 – billing for third-party liability (TPL) copay only

Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented. Please refer to Provider Bulletin *BT200709*, dated May 3, 2007. The utilization edits are reviewed quarterly and the following changes and additions in Table 6 will be effective October 20, 2008.

Table 6 – Updates to Utilization Edits

Name of Medication and Strength	Utilization Edit
Lexapro 20mg tablet	One and a half per day
Luvox CR 100mg, 150mg capsules	Two per day
Pristiq 50mg, 100mg tablets	One per day
Sarafem 10mg, 20mg tablets	One per day
Vyvanse 20mg, 40mg, 60mg capsules	One per day

All Dental Providers

Preventive Pediatric Oral Health Care

As part of the requirements for providing Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services under the federal Medicaid program (Section 1905(r)(3) of the Social Security Act), the Office of Medicaid Policy and Planning has adopted the American Academy of Pediatric Dentistry's updated Recommendations for Preventive Pediatric Oral Health Care. Services expected to be rendered and their frequency are given in the Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule in Table 7. See the Healthwatch/*EPSDT Provider Manual* at www.indianamedicaid.com for more detailed billing information.

Table 7 – Indiana Health Coverage Programs EPSDT Dental Periodicity Schedule

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Clinical oral examination[1,2] to include:	■	■	■	■	■
Assess oral growth and development[3]	■	■	■	■	■
Caries-risk assessment[4]	■	■	■	■	■
Anticipatory guidance/counseling[6]	■	■	■	■	■

Service Provided	Age				
	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Injury prevention counseling[7]	■	■	■	■	■
Counseling for nonnutritive habits[8]	■	■	■	■	■
Counseling for speech/language development	■	■	■		
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
Assessment for pit and fissure sealants[9]			■	■	■
Transition to adult dental care					■
Radiographic assessment[5]	■	■	■	■	■
Prophylaxis and topical fluoride[4,5]	■	■	■	■	■
Assessment and treatment of developing malocclusion			■	■	■
Assessment and/or removal of third molars					■

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

[2]Includes assessment of pathology and injuries

[3]By clinical examination

[4]Must be repeated regularly and frequently to maximize effectiveness

[5]Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease

[6]Appropriate discussion and counseling should be an integral part of each visit for care.

[7]Initially play objects, pacifiers, car seats; then, when learning to walk, sports and routine playing, including the importance of mouth guards

[8]At first, discuss the need for additional sucking: digits versus pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

[9]For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

All Waiver Providers

Clarification of Billing for Nonwaiver Services

Home and Community-Based Services (HCBS) Waiver providers who are also enrolled as nonwaiver Medicaid providers must report the billing taxonomy code on all claims for nonwaiver services. The billing taxonomy code should be indicated in box 33b of the CMS-1500 claim form and must be preceded by the "ZZ" qualifier. Claims submitted without the taxonomy code for nonwaiver services will be processed under the HCBS Waiver billing LPI and will deny with edit 1012 – *Rend Prov Specialty not Eligible to Render Proc Code.* Claims that deny with this edit must be resubmitted with the billing taxonomy code.

As a reminder, claims for waiver services may be submitted with the LPI only; the NPI is not required for these claims.

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.

Table 8 – 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 – UB-04 Billing Providers and Dental Providers
	Mona Green	(317) 488-5309	Marion – CMS-1500 Billing Providers
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

Table 9 – Provider Relations Field Consultants for Bordering States

State	City	Provider Relations Consultant	Telephone
Illinois	Chicago/Watseka	Jean Downs	(317) 488-5071
Illinois	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.

Table 10 – For Provider Concerns

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

Indiana Health Coverage Programs Quick Reference

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 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 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 (MAXIMUS)	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 Fax: 1-866-406-2803 Provider Services 1-866-408-6132 Fax: 1-866-408-7087 Prospective Providers 1-800-618-3141 Fax: 1-866-408-7087 Transportation 1-800-508-7230 Pharmacy 1-866-629-1608 PA: 1-877-652-1223 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

Indiana Health Coverage Programs Quick Reference

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 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 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 1-800-577-1278 Members (317)-713-9627 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-04 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

Restricted Card Program		
ADVANTAGE Health Solutions – FFS Attn: Restricted Card Program P.O. Box 40789 Indianapolis, IN 46240 1-800-784-3981 Fax: 1-800-689-2759	ADVANTAGE Health Solutions – Care Select Attn: Restricted Card Program P.O. Box 40789 Indianapolis, IN 46240 1-800-784-3981 Fax: 1-800-689-2759	MDwise – Care Select Attn: Restricted Card Program 1099 N. Meridian St., Suite 320 P.O. Box 44214 Indianapolis, IN 46204 1-866-440-2449 or Fax: 1-877-822-7188