IHCP Provider

Monthly News

December 2008

Indiana Health Coverage Programs

http://www.indianamedicaid.com

What's New Inside!

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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
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 Providers

New Bulletins on the IHCP Web Site

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

- *BT200839* – Emergency Dental Services
- *BT200840* – Annual Hospice Rates Effective October 1, 2008
- *BT200841* – Hoosier Healthwise Open Enrollment

A complete list of bulletins is available on the IHCP Web site at 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.

Auto-Assigning Wards of the Court and Foster Children into the Indiana *Care Select* Program

The Office of Medicaid Policy and Planning (OMPP) has determined that auto-assigning wards of the court and foster children into the Indiana *Care Select* program will begin statewide in January 2009 with an effective date of January 15, 2009. Wards and foster children who have not selected primary medical providers (PMPs) will be assigned to *Care Select* PMPs.

During the transition, these members may already be receiving specialty care from an IHCP-enrolled specialist, hospital, or ancillary provider. The physicians who ordered the services PRIOR to the January 15, 2009, auto-assignment effective date may not be the same physicians the members are assigned to AFTER January 15, 2009. The *Care Select* Program asks the new PMPs to work with specialists, hospitals, or ancillary providers that have already initiated care for these members by reviewing members' care plans and authorizing the continuation of that care until the new providers can see members for initial primary care visits. Authorize care by releasing your quarterly two-character certification code and National Provider Identifier (NPI) number to these providers, so they may receive reimbursement for their services.

Specialists, hospitals, and ancillary providers who provide services that require prior authorization (PA) in the Traditional Medicaid and *Care Select* Programs are reminded they must contact the member's care management organization (CMO) to request PA. ADVANTAGE[SM] Health Solutions, Inc. processes PA requests for Traditional Medicaid members and members in the ADVANTAGE[SM] *Care Select* network. MDwise processes all PA requests for members in the MDwise *Care Select* network.

There is an exception to this rule if the member switches CMO networks. If the member's previous CMO has suspended a provider's PA request, the provider must submit the requested additional information to the member's original CMO, even if the member has selected a new PMP and a new CMO.

> *Note: Additional information submitted to the member's new CMO – instead of to the member's previous CMO, where the original PA request was sent – will be rejected, and you will need to submit that information to the member's previous CMO.*

If you have received PA from a Hoosier Healthwise managed care organization (MCO), a copy of the MCO's written authorization must be submitted to the member's CMO. Authorizations are valid for 30 days from the date of eligibility in *Care Select* or for the remainder of the PA dates of service, whichever comes first. Providers are always encouraged to fax PA requests to the member's assigned CMO for more efficient PA processing.

You are encouraged to visit each CMO's Web site for additional *Care Select* information. Contact information and Web addresses for CMOs are listed in the IHCP Provider Quick Reference at the end of this newsletter.

For more information, see the following bulletins at http://www.indianamedicaid.com/ihcp/index.asp:

- *BT200723* – Indiana *Care Select*, dated September 13, 2007
- *BT200804* – Updated Indiana *Care Select*, and Prior Authorization and Restricted Card Changes, dated January 15, 2008

Top 10 Reasons Claims Are Denied

If your claim denies, it's probably because of one of the 10 reasons listed below. The list is in order from most frequently occurring to least. To make sure your claims are processed quickly and efficiently, avoid these common mistakes:

1. **EOB Code 558 – *Coinsurance and deductible amount missing***

   Claims will deny when they have no coinsurance and deductible amounts, indicating they are not crossover claims. Follow these billing procedures for different claim types:

   - CMS-1500 crossover claims – The combined total of Medicare coinsurance, deductible, and psych reduction must be reported on the left side of field 22 under the heading code of the CMS-1500 claim form. The Medicare paid amount (actual dollars received from Medicare) must be submitted in field 22 on the right side of the CMS-1500 claim form under the heading, Original Ref No.
   - UB-04 crossover billing – Leave fields 55a and 55b blank. The amount in form field 55c is not necessarily equal to the coinsurance and deductible amounts on the Medicare Remittance Notice (MRN), but is calculated using the correct data for each field.

   > *Note: If the Medicare paid amount is greater than the billed amount, indicate the correct dollar values in the fields. Then reflect the estimated amount due as $0 in form field 55c. This amount does not have a negative impact on the payment of crossover claims.*

   - UB-04 – Fields 39 through 41 on paper UB-04 claim forms must contain value code A1 to reflect the Medicare deductible amount and value code A2 to reflect the Medicare coinsurance amount. To be reimbursed correctly, UB-04 forms and electronic 837I transactions must show Medicare as the previous payer. Also, UB-04 forms and 837I transactions must contain the Medicare paid amount (actual dollars received from Medicare). You should continue to report third-party liability (TPL) payments on UB-04 forms or 837I transactions.
   - For information about crossover claims for Medicare Part B services that are not considered part of the programs for Federally Qualified Health Centers (FQHC) or rural health clinics (RHCs), refer to the paper claim information in Chapter 10 of the *IHCP Provider Manual*. For more information about requirements for electronic claims transactions, refer to the 837 companion and implementation guides. For links to appropriate Web sites and documents, go to http://www.indianamedicaid.com.

   For more information, see the *IHCP Provider Manual*, Chapter 8.

2. **EOB Code 5001 – *exact duplicate***

   Claims will deny when a submitted claim has the same billing provider number, member identification number, dates of service, and procedure codes as a previously paid claim in the IHCP claim history file, or when another claim in the same cycle has been approved to pay.

   To avoid this error, you should monitor your IHCP Remittance Advice (RA) weekly. Additionally, you can view claim status via Web interChange or Automated Voice Response (AVR). Web interChange or AVR can tell you whether claims have been previously submitted and paid, and why claims were denied as duplicates.

   - Using Web interChange – Claim Inquiry on Web interChange allows you to inquire about previously submitted claims before the claims appear on RA summaries or 835 transactions. This includes 276/277 claim status inquiry and response transactions – batch or interactive (see Section 4 of the *IHCP Provider Manual*). Claims submitted via Web interChange are accessible within two hours and remain accessible for seven years. You can locate claims by date range, claim type, member ID, or internal control number (ICN). When the basic claim information displays, click the desired claim ICN for more detail. In keeping with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), built-in security features allow only the billing provider to view claims he or she submitted. For more information on using Web interChange, see Section 3 of the *IHCP Provider Manual* or go to https://interchange.indianamedicaid.com.

   > *Note: You cannot use Web interChange to view the status of claims submitted to managed care entities.*

- Using AVR – For the claim status portion of the call, have the following information available:
  - ICN
  - Member identification (RID) number with dates of service and total amount billed

For more information, see the *IHCP Provider Manual*, Chapter 3, Section 6.

3. 593 – *Medicare denied amount*

Claims will deny if services denied by Medicare are not submitted on separate claim forms with Medicare denials. Denied details for crossover claims deny with edit 593 – *Medicare denied details*. Crossover claims received by Medicare that have been denied can be resubmitted using Web interChange or by submitting an 837 transaction that indicates attachments are forthcoming. Claim details denied by Medicare require the MRN to be attached for claim adjudication. Paper claims submitted with MRNs attached can be submitted to the following address:

EDS CMS-1500 Claims
P.O. Box 7269
Indianapolis, IN 76207-7279

For more information, see the *IHCP Provider Manual*, Chapter 8.

4. 2017 – *The recipient is enrolled in the Risk Based Managed Care portion of the Hoosier Healthwise Program*

Claims will deny if the IHCP member is enrolled in the risk-based managed care portion of the Hoosier Healthwise program. In that case, you need to bill the Medicaid claim to the appropriate MCO. The IHCP recipient must seek care from the managed care organization, and for every service provided, it is your responsibility to verify eligibility.

For more information, see the *IHCP Provider Manual*, Chapter 2.

5. 2505 – *Recipient covered by private insurance*

Claims will deny if the Medicaid member has insurance primary to Medicaid. When an IHCP member has additional insurance, one of the following criteria must be met before Medicaid pays a claim:

- The service is not covered under the primary insurance policy.
- The benefits of the primary insurance policy are exhausted.
- The recipient is ineligible for the coverage.
- The insurance carrier cannot identify the policyholder.
- The insurance carrier cannot identify the patient. The policy has terminated (make sure the termination date is before the dates of service on the claim).
- It has been more than 90 days since the date of service, and there has been no response from the insurance carrier.
- It has been more than 30 days since the date of service, and there has been no response from the court-ordered absent parent who was to pay medical support.

The appropriate corrections need to be made to the claim.

For more information, see the *IHCP Provider Manual*, Chapter 5.

6. 4021 – *Procedure code is not covered for the dates of service for the program billed*

Claims will deny if the procedure code billed is not covered by the type of IHCP enrollment the member is eligible for when the services were performed. It is the provider's responsibility to verify the IHCP members' eligibility for every service provided. To determine whether a service is covered by the IHCP, refer to the IHCP Medicaid Fee Schedule on the IHCP Web site at http://www.indianamedicaid.com.

For more information, see the *IHCP Provider Manual*, Chapter 8.

7. 4095 – *A nonsurgical service is not reimbursed individually if performed in conjunction with an outpatient surgery*

You must include all outpatient services provided on the day of surgery on a single claim. Include charges for any other services provided the day of surgery with the charge for the surgery. Add-on or stand-alone services are not separately reimbursable.

For more information, see the *IHCP Provider Manual*, Chapter 8, Section 2.

8. 217 – *National Drug Code (NDC) is missing*

Claims will deny if the procedure code submitted requires a National Drug Code (NDC), and a claim is submitted with the NDC missing. An NDC is an 11-digit, three-segment number assigned to each medication listed under Section 510 of the Federal Food, Drug, and Cosmetic Act. This number identifies the labeler or vendor, product, and

package size. NDCs must be configured to match the First DataBank (FDB) drug file: labeler code – first five digits; drug name, strength, and dosage form – next four digits; and package size – last two digits.

Submitted NDCs must be 11 characters long and must appear in the five-four-two configuration. For example, 12345-1234-12 is a correctly configured NDC. Also, zero can be a valid digit in an NDC, which may lead to confusion if you are trying to equate the NDC to its FDA standard. For example, 12345-0678-09 (11 digits) could appear as 12345-678-09 or as 12345-0678-9 on a drug's label, depending on the labeler's configuration. To ensure proper payment of claims, NDCs must be exactly 11 characters long. Add zeros to the left of a section of the NDC if needed. For example, if the FDA standard is 12345-678-9, add a zero to the left of the second and third sections of the number to make it 12345-0678-09.

Procedure codes that require NDCs can be found at: http://www.indianamedicaid.com/ihcp/ProviderServices/pdf/PG%20154%20codes%20as%20of%205_06_08.pdf.

For more information, see the *IHCP Provider Manual*, Chapter 9.

9. 219 – *Quantity dispensed or information administered is missing*

Claims will deny if the NDC quantity-dispensed information is missing. To include the quantity on a claim, enter the NDC quantity (administered amount) with up to three decimal places, such as 1234.567. The information must be entered without delimiters, such as commas or hyphens, and unused spaces for the quantity are left blank. The description field on the UB-04 is 24 characters in length. An example of completed information is shown below. For more information, see the *IHCP Provider Manual*, Chapter 9.

Figure 1 – Example of the UB-04 Description Field

N	4	1	2	3	4	5	6	7	8	9	0	1	U	N	1	2	3	4	.	5	6	7	

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	636	N450242006001ML 0.4	J9035	01/07/08	1	78 95			1
2									2
3									3

10. 810 – *NDC unit qualifier (unit of measure) missing*

Claims will deny if the NDC unit qualifier is missing. Please use the following qualifiers when submitting claims with procedure codes that require NDCs:

- F2 – International Unit
- GR – Gram
- ML – Milliliter
- UN – Unit

For more information, see the *IHCP Provider Manual*, Chapter 8, as well as *BT200713* and *BT200731*.

Please monitor bulletins, banner pages, and newsletters for future coding information and clarification of billing practices.

Online Provider Enrollment Coming January 1, 2009

You will soon be able to enroll in IHCP using the Internet, rather than completing paper forms and mailing them. You can enroll quickly and easily as a new billing or group provider using a Web-based enrollment tool. Watch for more information as the process is rolled out.

Pricing Change for HCPCS G0238

Effective for claims with dates of service as of January 13, 2009, the rate for Healthcare Common Procedure Coding System (HCPCS) code G0238 – *Therapeutic Procedures To Improve Respiratory Function, Other Than Described By G0237, One On One, Face To Face Per 15 Minutes (Includes Monitoring)* will be $12.98 per unit.

2009 Healthcare Common Procedure Coding System Updates Are Available

The 2009 HCPCS updates are available for download on the following Web site: http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS.

The new codes, deleted codes, codes with description changes, and new modifiers are currently under review. EDS will publish a provider bulletin containing information about IHCP coverage, prior authorization requirements, and pricing, as applicable. EDS anticipates publication of the bulletin during the last week of December 2008.

Incontinence, Ostomy, and Urological Supplies

In bulletin *BT200815*, dated March 26, 2008, a procedure code was mistakenly listed in Table 1. Procedure code A4542 should not have been included in this table. Procedure code T4542 – *Incontinence product, disposable underpad, small size, each*, should have been listed. Procedure code T4542 is a covered code and part of the contract with three vendors to provide incontinence, ostomy, and urological supplies.

VFC Flu Vaccine

The flu season is starting. To address the need for immunizations and deal with potential shortage of available influenza vaccines, the IHCP is not limiting reimbursement for any influenza vaccines, regardless of their availability from the Vaccines for Children (VFC) program.

This policy, effective October 1, 2008, allows you to obtain reimbursement for privately purchased influenza vaccines for eligible VFC members when VFC vaccines are not available and supplies are delayed. If you administer a free VFC vaccine, you should bill the appropriate Current Procedural Terminology (CPT®) procedure code but not charge more than the $8 VFC vaccine administration fee. Do not bill the separate administration CPT code.

When administering a privately purchased influenza vaccine, you may bill for the cost and administration of the vaccine. The IHCP-allowable reimbursement is based on the average wholesale price (AWP) of the vaccine. You may separately bill an appropriate CPT administration code (90772-90774, 90779) in addition to the CPT vaccine procedure code. If an evaluation and management (E/M) service code is billed with the same date of service as an office-administered immunization, do not bill the vaccine administration code separately. Reimbursement for administration is included in the E/M code allowed amount. Separate reimbursement is allowed when the administration of the drug is the only service billed by the practitioner. In addition, if you give more than one injection on the same date of service and no E/M code is billed, you may bill for an administration fee for each injection using 90772-90774 or 90779, as appropriate.

Remember – bill no more than the $8 VFC administration fee for free VFC influenza vaccine; or bill your usual and customary rate for the influenza vaccine CPT plus the appropriate administration CPT for provider-purchased influenza vaccine when the immunization is provided without the E/M service.

You must continue to submit claims to the appropriate delivery system (EDS or the member's managed care organization) for each member, regardless of the source of the vaccine stock. Claims are eligible for post-payment review, and you must maintain documentation and invoices related to private stock when substituting for VFC vaccine. Rates for RHCs and FQHCs include payment for the vaccine and administration fee.

Long Term Care and Rehabilitation Providers

Meet the Long Term Care Unit

The LTC Unit comprises clinical auditors located throughout the state of Indiana. Many of you who are LTC providers have met our audit teams during on-site case-mix audits. LTC audits include:

- Analyses of supporting documentation regarding minimum data set (MDS) items that resulted in a Resource Utilization Group (RUG)-III classification
- Level of Care (LOC) reviews
- Examinations of Level I and Level II Pre-Admission Screening and Resident Reviews (PASRR), and compliance with recommendations

- Reviews of residents admitted for traumatic brain injuries, end-of-therapy compliance, and visual reviews of Stage III and IV ulcers

Remember that standards of care, as well as all regulatory and licensure expectations (as with scope of practice), apply.

Educational Training Sessions

The LTC Unit also offers case-mix presentations at your facility on request. These presentations cover audit protocol and review requirements for supportive documentation.

To schedule a session, call (317) 488-5062. Please request training sessions several months in advance.

Long Term Care Help Desk

For your convenience, EDS offers an LTC help desk to answer questions about LOC/450B/B98 and claims. Call (317) 488-5094 and leave a message with your question, including all pertinent information. We will research your question and respond via telephone in the order questions are received. Because staff members are out of the office frequently for audits, the staff is not be able to respond to inquiries immediately. Please allow three to four weeks for a response.

Hospital Providers

Reimbursement of Inpatient Blood Factor Claims

Reimbursement for inpatient blood factor products has changed for claims with administration dates of October 12, 2008, and later.

Indiana Medicaid will reimburse providers for claims for blood factor products administered during inpatient hospital stays at the lowest of the following:

- The Estimated Acquisition Cost (84 percent of the Average Wholesale Price)
- Inpatient blood factor – State maximum allowable cost (MAC) or
- Submitted charge

Effective for claims with administration dates on or after October 12, 2008, blood factor that is used during inpatient hospital stays should be billed separately from the inpatient hospital diagnosis related group or Level of Care claim. If a patient is admitted prior to October 12, 2008, and blood factor is administered prior to October 12, 2008, the charges should remain on the inpatient claim.

Hospitals are prohibited from submitting charges for blood factor administered on or after October 12, 2008, during inpatient hospital stays on UB-04 claims. Instead, hospitals should submit their claims for blood factor used during inpatient hospital stays on the CMS-1500 claim form and should include both the NDC and the NDC quantity of the blood factor on the claims. Hospitals should use the NPIs for their facilities on their CMS-1500 claim forms.

Claims with quantities greater than 9,999.99 units must be special batched because the NDC code will be the same for each detail and will deny for duplicates.

Please see *BT200837* – Reimbursement of Inpatient Blood Factor Claims, dated October 7, 2008, for additional information.

Dental Providers

Emergency Dental Services

Please keep in mind that Package E fee-for-service members are eligible for emergency services only. The Omnibus Budget Reconciliation Act (OBRA) of 1986 defines an emergency medical condition as follows:

> *A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of an organ or part.*

Emergency Services Only Package E members are eligible for certain dental procedures.

The Current Dental Terminology (CDT) codes for emergency dental services are currently under review by the OMPP.

Please see *BT200839* – Emergency Dental Services, dated October 21, 2008, for more information. The bulletin includes a list of applicable Current Dental Terminology, version 5 (CDT-5), codes that are billable to the IHCP and tips for filing claims.

Care Select Providers

Claims Denied for Edit 1049 – *Care Select member's PMP is missing*

From May 23, 2008, through October 22, 2008, claims were denied inappropriately for edit 1049 – *Care Select member's PMP is missing or invalid*. EDS updated the claim processing system on October 22, 2008, to correct the problem. If you received this denial for claims during this time frame, please resubmit denied claims for processing.

MDwise Managed Care Providers

Behavioral Health Care Services for Members of MDwise Hoosier Healthwise and the Healthy Indiana Plan

Beginning January 1, 2009, MDwise will assume clinical and financial responsibility for behavioral health services within its networks for members of Hoosier Healthwise and the Healthy Indiana Plan (HIP). This transition supports the goal of the OMPP to move toward more integrated care for its Medicaid members. Therefore, on December 31, 2008, the MDwise contract with CompCare will expire, and the behavioral healthcare needs of MDwise Hoosier Healthwise and HIP members will be managed and paid for within the MDwise network.

This represents a significant change in how you, as MDwise providers, obtain authorization and are paid for your services. MDwise believes this will deliver less fragmented and more holistic care as we address the physical and behavioral healthcare needs of members. As with any new initiative, there will be a time of transition and adjustment to new procedures, but you have MDwise's commitment to work tirelessly to aid you through this process.

The MDwise Model

MDwise uses a model in which members are assigned to primary medical providers (PMPs) in one of nine networks (called delivery systems). The delivery systems have networks of PMPs, specialists, and ancillary providers in their designated service areas and arrange for the provision of most covered services. Delivery system staff conduct medical and care management activities for their respective members. Your MDwise members will remain assigned to one of these delivery systems; however, the delivery system to which the member is assigned, instead of CompCare, will now manage the behavioral health services. Eligibility and members' assigned delivery systems can be verified through one of the Eligibility Verification Systems – Omni, Automated Voice Response, or Web interChange at https://interchange.indianamedicaid.com/Administrative/logon.aspx.

MDwise Behavioral Health Network

The current CompCare provider network will transition to the MDwise Behavioral Health Network January 1, 2009. MDwise is partnering with Behavioral Health Management Inc. (BHMI) to build this network. BHMI is an administrative organization that represents a consortium of all 30 community mental health centers throughout Indiana. A key BHMI partner, Indiana-based InteCare, is responsible for reaching out to provide contracting and credentialing for all providers who wish to participate in the new MDwise Behavioral Health Network. The network will include hospitals, practice groups, and independent behavioral health providers.

If you are not already credentialed by InteCare, or you have questions about contracting or credentialing, please call BHMI at 1-866-323-3464 or in the Indianapolis local area at (317) 237-5774.

InteCare also accepts the Council for Affordable Quality Healthcare (CAQH) credentialing application or the Hoosier Healthwise Standardized Behavioral Health Credentialing Application.

Thank you for your continued support of MDwise and our members. MDwise and BHMI look forward to your participation in the new MDwise Behavioral Health Network – as providers in one or all of the MDwise Medicaid Programs.

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 P.O. 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

Note: The IHCP Provider Quick Reference published in the November Provider Newsletter was not formatted correctly. We apologize for any confusion or inconvenience the formatting error caused.