IHCP Provider

Monthly News

January 2009

Indiana Health Coverage Programs

http://www.indianamedicaid.com

What's New Inside!

Table of Contents

Common Abbreviations

ACN	Attachment Control Number
ADA	American Dental Association
ASC	Ambulatory Surgical Centers
AVR	Automated Voice Response
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
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:

- *BT200842* – Changes to the Preferred Drug List
- *BT200843* – Coverage Determinations for the New 2009 Healthcare Common Procedure Coding System Codes
- *BT200844* – Patient Liability

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.

Customer Service Unit Offers Resources for Claim and Coverage Information

The EDS Customer Service Unit tracked calls to determine what types of information providers call about most frequently. Below are resources and tips for providers based on that research:

Claim Status

The Customer Service Unit receives many calls regarding the status of previously submitted claims. However, providers may use other options to obtain claim status.

One of those options is the Web interChange Claim Inquiry feature, which lets providers view the status of claims online. Instructions for using this feature can be found on the Web interChange Help page by clicking on the **Help** menu option, then clicking on the **Claim Inquiry Help** link.

Claim status is also available through the Automated Voice Response system (AVR) at (317) 692-0819 or 1-800-738-6770.

Coverage Information

The *IHCP Provider Manual* contains detailed information regarding program coverage for the IHCP. Chapter 2 provides an outline of the types of programs available and the types of coverage within particular programs; Chapter 8 provides claim-filing instructions for covered services.

Another information tool is the Indiana Medicaid Fee Schedule, which is available online at http://www.indianamedicaid.com. The fee schedule helps providers determine coverage, reimbursement rates for procedure codes, and whether prior authorization is required for a service.

Billing Information

The *IHCP Provider Manual* is an excellent source of information about billing, including:

- General billing instructions – found throughout the manual
- Third-party Liability (TPL) billing – Chapter 5
- Claims processing procedures – Chapter 10. This chapter includes instructions for billing paper and electronic claims with Medicaid as the secondary or tertiary payer, as well as instructions for when Medicare is primary.
- Instructions for specific provider types – Chapter 8. This chapter is particularly helpful on covered services and coding information.

Banner pages, bulletins, and provider newsletters contain regular updates to the provider manual. These publications outline changes in program policies and billing instructions.

Another good source of information is provider field consultants, who are available to provide training in providers' offices. Provider field consultants are listed on the IHCP provider Web site at http://www.indianamedicaid.com under Provider Services, Find Your Field Consultant. For providers without access to the Internet, field consultants are listed in the IHCP monthly provider newsletter. In addition, customer assistance can provide the names and telephone numbers of field consultants and submit requests for on-site visits for training or problem resolution.

Provider Enrollment

Many calls regard the status of provider enrollment applications or updates. Please allow 30 business days for the Provider Enrollment Unit to process enrollment requests, regardless of whether the request is a new enrollment or an update.

The introduction pages of each enrollment form contain detailed instructions for completing the forms, and a checklist on each form lists all required attachments. When EDS receives incomplete provider enrollment or update forms, we must return

the forms to providers. Reading the instructions will help ensure that forms are completed properly and prevent delays in enrollment or change requests.

Web interChange administrators can now have edit access to provider profiles. Users with edit access can change provider addresses (with the exception of the Home Office address), enroll in electronic funds transfer, add specialties, update officer and management information, and more, all without paperwork.

In addition, beginning in 2009, new provider enrollments can be submitted online for billing and group providers (see "Online Provider Enrollment" below).

Adjustments and Replacements

Many customer service calls pertain to the processing of adjustments, voids, and replacements. Adjustments may be initiated by the provider, EDS, Health Management Systems (HMS), or the Office of Medicaid Policy and Planning (OMPP). The region code (the first two digits of the internal control number, or ICN) of a claim adjustment identifies the type and source of the adjustment:

- 50 – noncheck-related claim initiated by the provider via paper adjustment request
- 51 – check-related claim initiated by the provider via paper adjustment request
- 56 – mass adjustment initiated by OMPP
- 62 – Web interChange electronic replacement (adjustment)
- 63 – void claim initiated by the provider via Web interChange
- 80 – mass reprocessing initiated by OMPP

Information About NPIs

To verify the National Provider Identifier (NPI) on provider files, use the Web interChange Provider Profile option.

Using Web interChange

Web interChange Help pages provide useful information that allows providers to take full advantage of Web interChange features.

Information About Workshops

For information about upcoming seminars and workshops, visit http://www.indianamedicaid.com. Detailed information about upcoming presentation topics, locations, and dates for all IHCP workshops are posted in the Newsletter link of the Web site.

Questioning Eligibility

Many customer service questions concern member eligibility. Providers are encouraged to check a member's eligibility by using one of the following eligibility verification systems:

- Automated Voice Response – AVR
- Omni
- Web interChange

For a better understanding of how spend-down, qualified Medicare beneficiaries (QMBs), and third-party liability (TPL) are related to program eligibility, please refer to the *IHCP Provider Manual, Chapter 2*.

IHCP Faces Shortage of Providers

The IHCP is committed to ensuring that the nearly 850,000 Hoosiers covered by Medicaid have continuous and easy access to quality healthcare.

EDS provider field consultants will begin an outreach effort aimed at contacting providers not currently enrolled in IHCP and educating them about the many benefits of Medicaid enrollment. Outreach will be directed to new physicians nearing or recently completing residency, as well as to established practitioners. Benefits of Medicaid enrollment include:

- The opportunity for providers to expand their practices
- Quick adjudication of claims
- Assistance with claim submission
- Access to provider education and support
- Participation in the latest trends in healthcare reform

Please contact an EDS provider field consultant with suggestions for recruiting and to recommend peers and colleagues who are not currently enrolled in the IHCP.

Online Provider Enrollment

New billing or group providers can now enroll with the IHCP using a Web-based tool instead of a paper application. Enrolling online shortens the time needed to process the application.

The online enrollment tool is located at http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp. It includes help text and frequently asked questions to assist providers with the enrollment process. During the enrollment process, the tool provides a list of documents required for IHCP enrollment. At the end of the process, a system-generated cover letter must be printed and submitted with required addendums such as signature pages and signed W-9 forms. The

addendums are required for EDS to complete the IHCP enrollment process.

The online provider enrollment tool is only for new billing or group providers. Existing group providers cannot use the tool to add rendering providers. Also, existing providers cannot use the tool to add service locations. Those changes are made using paper forms. Forms can be downloaded from the IHCP Provider Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp.

Coverage for Radioimmunotherapy Limited to One Reimbursement Per Lifetime

The IHCP reminds providers that reimbursement for the codes for radioimmunotherapy in Table 1 below are limited to one per lifetime.

Claims billing the codes below in excess of one per lifetime will deny.

Table 1 – Reimbursement Codes for Radioimmunotherapy – One Reimbursement Per Lifetime

Code	Description
A9542	Indium IN-111 Ibritumomab Tiuxetan, Diagnostic, per Study Dose, Up to 5 Millicuries
A9544	Iodine I-131 Tositiumomab, Diagnostic, Per Study Dose
A9545	Iodine I-131 Tositumomab, Therapeutic, Per Treatment Dose
A 9543	Yitrium Y-90 Ibritumomab Tiuxetan, Therapeutic, Per Treatment Dose, Up to 40 Millicuries

Update on the Shortage of VFC Hemophilus Influenza B Vaccine

Hemophilus influenza b vaccine (Hib) HbOC conjugate (four-dose schedule) for intramuscular use is still in short supply, resulting from the Hib recall by Merck as of December 12, 2007. Effective February 1, 2008, the Indiana Health Coverage Programs (IHCP) is not limiting reimbursement for Current Procedural Terminology (CPT®) codes 90645, 90647, 90648, 90698, 90721, and 90748 – regardless of availability from Vaccines for Children (VFC). This policy allows providers to obtain reimbursement for using privately purchased Hib vaccine for VFC-eligible members, even if a VFC vaccine is not available because of delays in receiving the VFC supply. When administering a free VFC vaccine, bill the appropriate CPT code, but do not charge more than the $8 VFC vaccine administration fee and do not bill the separate administration CPT code.

When administering a privately purchased vaccine that contains Hib as a component, providers may bill for the cost of the vaccine and administration. The IHCP-allowable reimbursement is based on the average wholesale price (AWP) of the vaccine. Providers may separately bill an appropriate CPT administration code, in addition to the Healthcare Common Procedure Coding System (HCPCS) code.

Please note that CPT administration codes listed in earlier banner pages are no longer valid after December 31, 2008. See Table 2 for new codes effective January 1, 2009.

Table 2 – New Codes Effective January 1, 2009

Former Code	Description	New Code
90772	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Subcutaneous or Intramuscular	96372
90773	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Intra-arterial	96373
90774	Therapeutic, Prophylactic, or Diagnostic Injection (Specify Substance or Drug); Intravenous Push, Single, or Initial Substance/Drug	96374

If an evaluation and management (E/M) code is billed with the same date of service as an office-administered immunization, do not bill the separate administration code. Reimbursement for the vaccine administration is included in the E/M code allowed amount. Separate reimbursement is allowed when the administration of the vaccine is the only service provided and billed by the practitioner. In addition, if more than one immunization is provided on the same date of service, and no E/M code is billed, providers may bill a separate administration fee for each immunization that is provided, as appropriate.

Continue to submit claims to the appropriate delivery system – EDS or the appropriate managed care organization (MCO) – for each member, regardless of the source of the vaccine stock. Claims are eligible

for postpayment review. Providers must maintain documentation and invoices related to private stock when substituting for VFC vaccine.

Rural health clinic (RHC) and Federally Qualified Health Center (FQHC) rates include payment for the vaccine and administration fee, and cannot be billed separately on claims submitted to EDS. RHCs and FQHCs must separately verify the billing policy for each MCO to which they submit claims.

Kinrix and Rotarix Will Be Covered Through VFC

In October 2008, two new vaccines, Kinrix and Rotarix, became available through the Indiana VFC Program. The Current Procedural Terminology (CPT®) codes for Kinrix (90696) and Rotarix (90681) vaccines were recently released by the Centers for Medicare & Medicaid Services (CMS), along with the 2009 HCPC annual updates. The Office of Medicaid Policy and Planning (OMPP) is now determining coverage of the 2009 codes. Please refer to future banner pages and bulletins for instructions about resubmitting denied claims.

Mandate of Red Claim Forms Postponed

Banner page *BR200852*, dated December 23, 2008, stated that standard red-ink claim forms would be mandated beginning January 19, 2009. The implementation date has been postponed indefinitely. Claims submitted on black-ink claim forms will still be accepted after January 19.

Providers are encouraged to submit claims electronically or on the standard red-ink form to speed claim processing and improve the accuracy of data entry. The IHCP has implemented software that uses an optical character recognition (OCR) program to read the data for claim processing from the red-ink claim forms.

All claims are processed within the required time frames for paper claims. However, electronic claims are processed the fastest because they require less human interaction. Red-ink claims are processed the second fastest and black-ink claims the slowest.

Prepayment Review Transitions from HCE to EDS

The Office of Medicaid Policy and Planning (OMPP) transitioned the prepayment review functions from Health Care Excel (HCE) to EDS effective January 1, 2009.

The post office box and telephone numbers for Surveillance and Utilization Review (SUR) have not changed.

All SUR questions, including questions about prepayment review, should be directed to EDS using the information below:

IHCP Provider and Member Concern Line (Fraud and Abuse)
(317) 347-4527 or 1-800-457-4515

IHCP SUR Department
P.O. Box 531700
Indianapolis, IN 46253-1700
(317) 347-4527 or 1-800-457-4515

Physicians, Hospitals, Clinics, Mental Health, and Pharmacy Providers

RespiGam No Longer Eligible for Reimbursement

Effective immediately, the IHCP no longer reimburses for the drug RespiGam (RSV-IVIG), which is no longer manufactured. The following codes are no longer reimbursable: CPT 90379 – *Respiratory Syncytial Virus Immune Globulin (RSV-IGIV), for Intravenous Use* and Healthcare Common Procedure Coding System code HCPCS J1565 – *Injection, Respiratory Syncytial Virus Immune Globulin, Intravenous, 50 mg*. The IHCP will continue to provide coverage for Synagis, as detailed in the *IHCP Provider Manual* and *BR200240*, dated October 1, 2002.

Long-term Care and Rehabilitation Providers

Tips for Long-term Care Documentation

Long-term care (LTC) case-mix auditors are frequently asked for specific information about how, what, and how often to document. There is no simple answer to these questions. In Indiana, the Supportive Documentation Guidelines provide information on what documentation is required to determine the appropriate RUG (Resource Utilization Group) category for each resident.

The minimum data set (MDS) entries can be verified by reviewing the entire clinical record that supports and is consistent with the responses on the MDS. These can include hospital transfer sheets, therapy notes, restorative nursing notes, daily nursing notes, hospital and facility medication and treatment records, skin assessments, behavior logs, or input and output (I&O) sheets. Please note that for documentation to be accepted, it needs to be appropriately signed with credentials, dated, and specific for that resident. Please note any time-frame requirements, when applicable.

The Centers for Medicare & Medicaid Services (CMS) and the State of Indiana do not impose specific forms on nursing facilities, but instead require legible entries with complete dates and signatures with credentials for each entry. LTC auditors look for descriptive documentation with specific examples within the time frame of the MDS.

A good tip is to avoid filler statements for mood or behaviors, such as "occasionally, sometimes, or often." These are not measurable. Another question to ask is: Did the event happen within the time frame of the MDS?

A key point to remember when documenting is that any future person reviewing the documentation, including LTC auditors, may not know the resident personally and will reference only what was written. Document only items that are relevant to the resident. For the Medicare prospective payment system (PPS), documentation must substantiate the resident's need for Part A services and his or her response to these services. This type of charting is a standard of care and should be a methodology for all charting. In other words, any needs for services, subsequent treatments, and responses to those treatments must be captured and documented in the appropriate places. Documentation should include the care plan, nursing notes, and so forth. These various areas must reflect a consistent picture of the resident.

In summary, look at the clinical record as an opportunity to "paint a picture" of the resident and his or her status and functional abilities, as well as the treatment and care provided, the resident's subsequent responses, and their impact on the plan of care. This will provide an accurate representation of the resident and of the services needed and provided. Remember all rules of appropriate documentation and charting apply, as well as nursing standards of care.

Dental Providers

Pricing for Prefabricated Stainless Steel Crowns

Effective November 25, 2008, the IHCP began covering prefabricated esthetic coated stainless steel crowns (CDT code D2934) for primary anterior teeth only. The service is reimbursed at a Max Fee rate of $155.86. Members are restricted to one type of crown per tooth, and billing for more than one crown per tooth will result in claim denial.

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

FSSA Recognizes PMPs That Provide Superior Care and Service

The Indiana Family and Social Services Administration's (FSSA) Office of Medicaid Policy and Planning (OMPP) has selected 19 providers to be among the first to receive the *Care Select* Primary Medical Provider (PMP) Service Excellence Award. The award recognizes providers for the quality of care and service provided to Indiana's *Care Select* population.

"*Care Select* has seen great success in its first year of operation, providing improved quality, continuity, and coordination of care for its members," said FSSA Secretary Mitch Roob. "Without the care and dedication of providers such as these, the realization of this program would have been impossible."

"I would like to commend these providers and their staffs for the time, effort, and service they have already given to Indiana *Care Select* members," said OMPP Director Jeff Wells, M.D. "The collaboration of all the enrolled physicians and providers this first year has been excellent, and we look forward to continuing these efforts."

Care Select is a care management program created to serve Hoosiers by:

- Tailoring benefits to people more effectively
- Improving the quality of care and health outcomes
- Controlling the growth of healthcare costs
- Providing a more holistic approach to members' health needs.

Services are provided by FSSA's two care management organizations (CMOs) – ADVANTAGE Health Solutions[SM] and MDwise, Inc. Since *Care Select*'s implementation in November 2007, nearly 3,000 physicians have enrolled as *Care Select* PMPs. Below are the recipients of the *Care Select* Primary Medical Provider (PMP) Service Excellence Award:

Table 3 – Recipients of the *Care Select* PMP Service Excellence Award

Provider	County Served
Dr. Mary Lynn Bundy	Floyd
Dr. Daniel Herman Jr.	Knox
Dr. Odies Williams	Lake
Dr. Paul Okolocha	Lake
Dr. Becky Allmon	Lawrence
Dr. Segun Rasaki	Marion
Dr. Luella Bangura	Tippecanoe
Dr. Edward Lagunzad	Vanderburgh
Dr. Yu Cui	Vanderburgh
Dr. Nedu Gopala	Vigo
Dr. Rashidul Islam	Harrison
Dr. James Whitfield	Howard
Dr. John Barker	Marion
Dr. Clarence Thomas	Marion
Dr. Peggy Sankey	Parke, Vermillion
Dr. Jeffrey Miller	Porter
Dr. Daniel Triezenberg	St. Joseph
Dr. Jessica Mercer	Vanderburgh
Dr. George Merkle	Wells

For more information on *Care Select*, go to http://www.in.gov/fssa/ompp/2546.htm.

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 8, 2008, for additional information.

Provider Workshops

Federally Qualified Health Center and Rural Health Clinic Workshop Scheduled for January 28, 2009

EDS Provider Relations is offering a workshop for the FQHC and RHC provider community. Participating with EDS will be representatives from the MCOs and the CMOs who help administer *Care Select*. This will be an excellent opportunity to become more familiar with Medicaid policies, procedures, and billing specific to FQHCs and RHCs.

The workshop will be Wednesday, January 28. Details are below:

Workshop location and time:
Daviess Community Hospital
Education Room 1
1314 E. Walnut St.
Washington, IN 47501
Time: 8:30 a.m.-noon

The agenda includes the following:

- How to check eligibility
- How to file a claim
- How to bill services
- What causes claims to deny
- Avenues to resolve denied claims
- An extensive question-and-answer period

Providers may enroll in the workshop at http://www.indianamedicaid.com/ by selecting Provider Services, Education Opportunities, Workshop Registration. If you have questions, please call Provider Relations at (317) 488-5072.

IHCP Offers First-quarter Medicaid Provider Workshops

The IHCP is again offering quarterly provider workshops free of charge – see Table 4 for topics, times, and descriptions. The schedule allows for lunch; however, lunch is not provided. Registrations are processed in the order received, and registration does not guarantee a spot at the workshop – seating is limited in all locations, and only two registrants are allowed per provider number. Confirmation letters are sent upon receipt of registrations. If you do not receive a confirmation letter, the workshop is full.

Workshop dates, registration deadlines, and locations are listed in Table 5. General directions to workshop locations are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp.

Register online at http://www.indianamedicaid.com. Click on Provider Services, then Education Opportunities. Another registration option is the form on page 12. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop. The Provider Workshop Registration form is also available on the Forms page of the IHCP Web site.

If you have questions about a workshop, please contact a field consultant at (317) 488-5072.

Table 4 – First-quarter Provider Workshop Topics, Times, and Descriptions

Time	Topic	Description
9-9:55 a.m.	Medical Review Team, presented by EDS	An overview of billing requirements and frequent billing errors affecting MRT claims; important for those providing MRT disability exams and those who wish to learn about the MRT process.
10-11 a.m.	Hoosier Healthwise Open Enrollment,	An introduction to open enrollment, which begins first-quarter 2009 and allows members to remain with a single managed care

	presented by EDS and the three managed care organizations (MCOs)	organization for an entire year. You will learn about the new platform and understand the changes affecting primary medical providers. Representatives from Anthem, MDwise and Managed Health Services (MHS) will respond to questions during a question-and-answer period.
11:10-12:30 p.m.	Managed Care Roundtable, presented by Anthem, MDwise, and MHS	An overview of Healthcare Effectiveness Data and Information Set (HEDIS), and the performance measures used by each MCO. (HEDIS is a set of standardized performance measures designed to ensure that the public has the information it needs to give the most complete view of health-plan quality.) Covers HEDIS requirements, what is required for HEDIS documentation within the performance measures, and how HEDIS performance measures affect your practice. The MCOs will provide information on prior authorization changes (MHS); prenatal care coordination (Anthem); and behavioral health and its transition from CompCare to the MDwise delivery systems (MDwise).
12:30-1:30 p.m.	Lunch	
1:30-2:15 p.m.	Healthy Indiana Plan Roundtable, presented by Anthem Blue Cross Blue Shield and MDwise with AmeriChoice	Representatives from the two HIP plans will answer questions about the provider experience since the program was implemented January 1, 2008. Representatives will also explain how the POWER account works within the HIP.
2:20-3 p.m.	*Care Select*, presented by ADVANTAGE Health Solutions[SM] and MDwise	Representatives from the two care management organizations will present an overview of the care coordination conference – a new service payable to *Care Select* PMPs. The overview will provide information about how CMOs will coordinate conferences with PMPs to review members' progress and care management plans. The session will also outline who in the PMP's office can participate in the conference and how to submit claims for reimbursement. CMOs will answer questions pertaining to prior authorization, care management, the Restricted Card program, and referrals. EDS will answer questions about claims processing.
3:10-4 p.m.	IHCP Updates, presented by EDS	Provides updates within the IHCP, including the correct use of fields 50 a-c on the UB-04 claim form, implementation of optical character recognition (OCR), and provider profile maintenance using Web interChange. Also includes a demonstration of online provider enrollment, which allows non-IHCP providers to enroll using the Internet instead of paper forms.

Table 5 – Workshop Dates, Registration Deadlines, and Locations

Workshop Date	**Registration Deadline**	**Location**
February 17, 2009	February 12, 2009	Lutheran Hospital, Kachmann Auditorium, 7950 E. Jefferson Blvd., Fort Wayne, IN 46804
February 23, 2009	February 9, 2009	Clarian North Learning Center, 11725 N. Illinois, Carmel, IN 46032
February 25, 2009	February 11, 2009	Porter Hospital, Stoner Auditorium, 814 LaPorte Ave., Valparaiso, IN
February 26, 2009	February 12, 2009	Elkhart General Hospital, Auditorium B, 600 East Blvd., Elkhart, IN 46514
March 3, 2009	February 17, 2009	St. Joseph Regional Hospital, 1907 W. Sycamore St., Kokomo, IN 46901

March 10, 2009	February 24, 2009	Dearborn County Hospital, Dearborn/Ohio Room, 603 Wilson Creek Rd., Lawrenceburg, IN 47052
March 19, 2009	March 5, 2009	Union Hospital, Landsbaum Center Auditorium, 1433 6½ Street, Terre Haute, IN (enter Women's and Children's entrance)
March 24, 2009	March 10, 2009	St. Mary's Medical Center, Amphitheatre, 3700 Washington Ave., Evansville, IN 47750
March 31, 2009	March 17, 2009	Ball Memorial Hospital, Outpatient Medical Pavilion Conference Room 1, 2401 W. University Ave., Muncie, IN 47303

INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER WORKSHOP REGISTRATION

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

Medical Review Team (9-9:55 a.m.)		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009
Hoosier Healthwise Open Enrollment (10-11 a.m.)		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009
Managed Care Roundtable (11:10 a.m. -12:30 p.m.)		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009
Healthy Indiana Plan Roundtable (1:30-2:15 p.m.)		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009
***Care Select* (2:20-3 p.m.)**		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009
IHCP Updates (3:10-4 p.m.)		
☐ Fort Wayne, February 17, 2009	☐ Elkhart, February 26, 2009	☐ Terre Haute, March 19, 2009
☐ Indianapolis, February 23, 2009	☐ Kokomo, March 3, 2009	☐ Evansville, March 24, 2009
☐ Valparaiso, February 25, 2009	☐ Lawrenceburg, March 10, 2009	☐ Muncie, March 31, 2009

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

Table 6 – 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 7 – 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 8 – 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	IHCP Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 or 1-800-457-4515
IHCP 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 SM 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