IHCP Provider

Monthly News

March 2009

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
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:

- *BT200843* – Coverage Determinations for the New 2009 Healthcare Common Procedure Coding System Codes
- *BT200844* – Patient Liability
- *BT200845* – Clarification of Prior Authorization Process for Psychiatric Residential Treatment Facilities
- *BT200901* – Clarification of Prior Authorization Policies for System Update Requests

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.

Claim Submission Options

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, via Web interChange, or on the standard red-ink claim form to speed claim processing and improve the accuracy of data entry. Below is a summary of the claims submission options available to providers. Provider field consultants can provide additional information about any of the options for filing claims.

Web interChange

Web interChange is a **free**, Internet-based software tool available to all IHCP providers. It enables providers to perform many IHCP business transactions, including the following:

- Submit claims, including institutional, professional, dental, third-party liability, and Medicare crossover claims, electronically to the IHCP
- Copy, void, and replace claims
- View claim status online
- Request prior authorization (PA) and view the status of PA requests
- Inquire about checks
- Maintain Provider Profiles
- Verify member eligibility by member ID, Social Security number, Medicare number, or name and date of birth

Claims submitted electronically are processed with less human interaction, therefore reducing processing time.

Red-ink Claim Forms

For providers that aren't ready to go electronic, we recommend using the standard red-ink claim form with typewritten data. Red-ink claim forms with typed data have several advantages over black-ink claim forms:

- Accuracy: Red-ink claim forms are scanned and the data is read by optical character recognition (OCR) software rather than manually keyed. The result is fewer data-entry errors. Statistics from the software vendor show 99.9 percent error-free scanning.
- Speed: Because they require less human intervention, claims are processed faster. Other states that have implemented red-ink claim forms have decreased the days a paper claim is in process by 90 percent.
- Improved cash flow: Faster, more accurate processing means that claims are paid faster.

Black-ink Claim Forms

Black-ink claim forms are still accepted and will be processed within the required time frames for paper claims. Because they require more human interaction, black-ink claim forms take the most time to adjudicate.

The 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 information and to recommend peers and colleagues who are not currently enrolled in the IHCP. Contact information for provider field consultants is listed on page 15 of this newsletter.

Clarification of W-9 and Home or Legal Address

IHCP Provider Profiles have four address fields that contain provider information. The four address fields are as follows:

- The Service Location, which is the Billing Provider Office Location where services are performed or claim documentation is kept
- The Pay To address, which is where checks and remittance advices are sent
- The Mail To address, which is where correspondence and communications such as provider bulletins and newsletters are sent
- The Home Office, which is the legal address for the provider. The Home (Legal) Address appears to cause a lot of confusion, based on the number of documents Provider Enrollment returns to providers.

What does the Home Address represent on a provider's enrollment profile, and on the enrollment or maintenance forms?

- The Home (Legal) Address is the legal address where all 1099 information and any other legal or tax information is sent.
- The Home (Legal) Address must match the address on the W-9 form Provider Enrollment has on file for you.
- The Home (Legal) Address must be the same on every location using the same federal employer identification number (FEIN), Social Security number (SSN), or taxpayer identification number (TIN), which includes additional service locations or even other provider numbers (LPIs) using the same FEIN, SSN, or TIN.
  - Do not submit a different address on the W-9 for additional service locations.
  - If you submit a different address than what is on file for the original W-9, Provider Enrollment will return the submission or enter the W-9 address on file in the Home Address field.
- The Home (Legal) Address is not where your checks or remittance advices (RAs) are sent. Checks and RAs are sent only to the Pay To address on your provider profile.
- Large corporations having multiple provider numbers under one TIN or FEIN are going to have one W-9 on file with one legal address listed; therefore, all Home Addresses under the same taxpayer identification number must be updated when making a change to the Home Office.

Reprocessing Medical Claims for Carved-out Services

The services listed below are not typically included in the coordination by the Restricted Card Program (RCP). These services are carved out and do not require a written referral unless the member is going to receive prescriptions from the provider. On October 19, 2008, a modification was made to ensure that claims billed by these provider specialties process in accordance with the policy:

- Behavioral health
- Chiropractic services
- Dental services
- Diabetes self-management training services
- Family planning services
- HIV/AIDS targeted case management services
- Home healthcare

- Hospice
- Podiatric services
- Transportation
- Vision care (except surgery)
- Waiver services

EDS will systematically reprocess medical claims for these carved-out services with dates of service November 1, 2007, through November 21, 2008, that denied for Explanation of Benefits 7502 – *Recipient Locked in to a Specific Provider*. Reprocessed claims appeared on February 3, 2009, Remittance Advice statements.

Max Fee Pricing for Contraceptive Supplies

The IHCP has established rates for two Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1. These codes are currently manually priced, based on information submitted with the claim. The new rates are effective April 1, 2009.

Table 1 – Max Fee Pricing – New Rates Effective for Dates of Service on or After April 1, 2009

HCPCS Code	Code Description	Rates Effective for Dates of Service on or After April 1, 2009
A4267	Contraceptive supply, condom, male, each	$0.43
A4268	Contraceptive supply, condom, female, each	$2.36

Enrollment on the Web

In December 2008, EDS implemented enrollment on the Web for brand-new providers (billing and group providers only). Indiana is one of the first states to offer prospective providers the opportunity to enroll in the IHCP using a Web-based tool. The Web-based tool guides providers through entering required information for their IHCP enrollment type. When EDS receives the Web application and supportive documentation, the enrollment is finalized using newly developed automated processes.

As of January 15, 2009, Provider Enrollment has received 24 enrollment submissions from the Web. Providers find the tool very user friendly. EDS has been documenting questions from providers using the tool and want to provide future users with information to help them use the tool.

Instructions on Page 1 Will Help

It is very important to read all the instructions on the first page. EDS has been asked to give passwords and enrollment keys (login names), but we do not have that information. You are given this information when you first access the tool; you must write it down when you start using this tool and save it for future reference. We do not store this information and cannot give it to you.

Please remember you cannot use the Web enrollment tool to do the following:

- Enroll a new service location for an already-enrolled (existing) provider.
- Enroll a new rendering provider if the group is already enrolled (an existing provider).

Please refer to the Frequently Asked Questions available on the Web enrollment tool for more information about Web enrollment. In addition, here are additional questions we have been asked since the tool was put to use:

Question: Can I use the tool to enroll a new service location or a new rendering provider?

Answer: No. At this time, the tool is available only for brand-new billing or group providers. If you are a new group, you can enroll new rendering providers with your group or link already-enrolled providers with your group. If you want to enroll a new service location, you must submit a paper application. You cannot use the Web tool to add new service locations or new rendering providers.

Question: What do I enter on C.1 – my business name or my personal name – and what address am I supposed to use in this section?

Answer: C.1 is for the personal information of the owners of the company; therefore, you choose *personal* and enter the owner's name; the rest of the information fields requested are for the person you are listing as the owner. That means the address is the person's address and not the business address, and the SSN information is what belongs to the owner, not the company.

However, if the business is a not-for-profit business, you would enter the business name and address, and the business federal employer identification number (FEIN). On schedule C.3, you would list the board of directors with their personal information (personal names, SSNs, and personal address information).

Question: When do you click on the "Personal" versus the "Business" button for addresses?

Answer: Choose *Personal* when you are entering your own information, and *Business* when entering the business information. You must always complete the personal information for the owners of the business; if it is a not-for-profit business, you enter the business information on Schedule C.1 and the personal information for the board of directors on C.3.

Question: Is the beginning date for licensure the original date the license was granted or the current licensure period?

Answer: Either beginning date is acceptable.

Question: I am enrolling as a group, and I am the single owner of the corporation. Am I required to give my personal information, such as name, address, and Social Security number on the C Schedule?

Answer: Yes. If yours is a for-profit business, you must enter your personal name as the owner, your personal address, and your Social Security number on Schedule C.1; or on Schedule C.3 if yours is a not-for-profit business.

Question: What paperwork do I need to mail in after I have completed and submitted my application?

Answer: The paperwork you submit as an addendum must include the printout with the attachment tracking number (ATN) on it; supporting documentation needed for your provider type and specialty will be given to you at the end of the process. Required supporting documentation depends on provider type and specialty. For example, waiver providers need to send copies of their certification letters from the Family and Social Services Administration (FSSA); for-profit transportation providers need to send copies of their Motor Carrier Service certifications; and all providers must submit W-9s.

Question: What signatures do I need for the C schedules? Do I need to submit the signatures with the addenda?

Answer: No, you do not need to submit signatures with the addenda. When you accept the agreement online, you are agreeing to have signatures in your possession for all the persons whose SSNs are listed on any of the C schedules. The signatures show these people agreed to allow you to send us their SSNs.

Please note: It is the responsibility of the providers who submit enrollment information to maintain appropriate records to support the information entered on the application using the Web enrollment tool.

Provider Profile Maintenance Using Web interChange

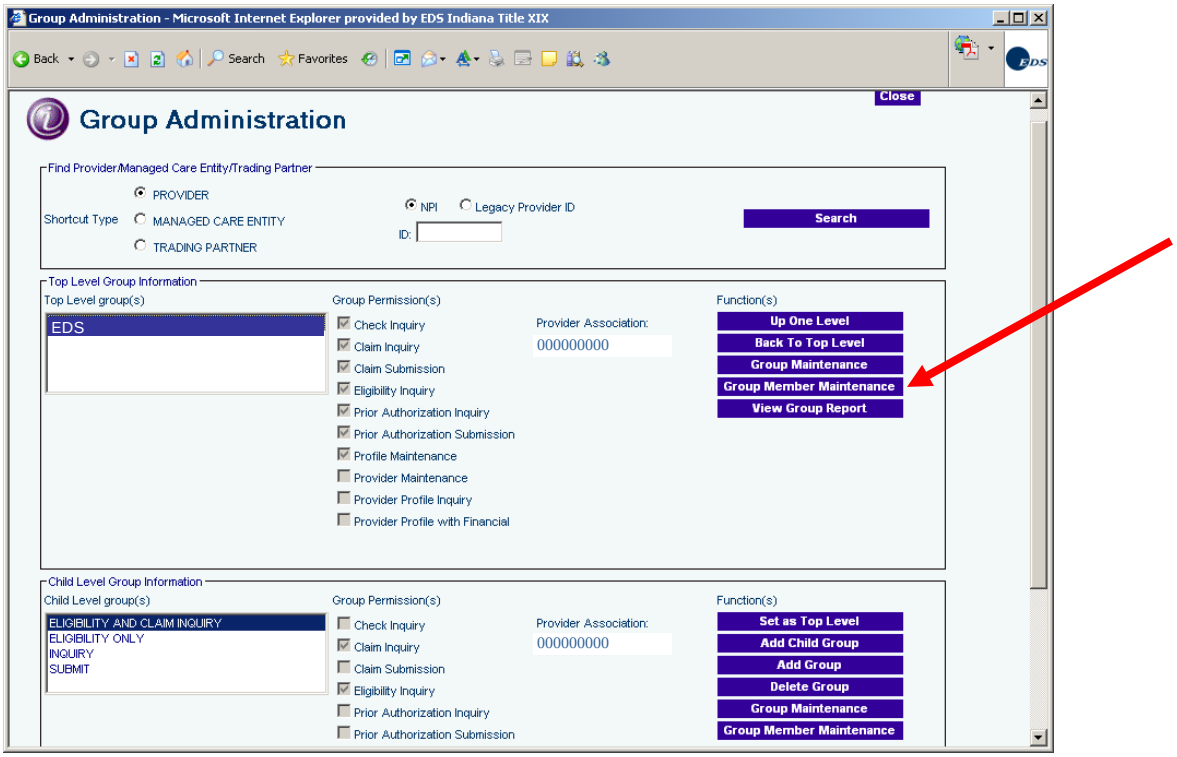
Providers can also change the addresses on their service locations, mail-to locations, and pay-to locations. However, changing the Home Office/Legal Address requires a new W-9 with the new address, so these change requests must be submitted to EDS using the Provider Maintenance form. In addition, if you are a provider who has been certified at a specific service location (license issued with a specific location identified on the license), such as a home health provider or a nursing facility provider, you must contact the Indiana State Department of Health (ISDH) to change the service location identified on your license before making any changes to your profile on Web maintenance. EDS must have the new license with the updated address, along with a certificate and transmittal form (C&T) from the ISDH, before we can make the change.

Providers can maintain their specialties and electronic funds transfer (EFT) information using the Profile Maintenance feature on Web interChange, as well, because these changes do not require supportive documentation. Using Web interChange to update your provider profile makes the task quick, easy, and secure. You must be a Web interChange administrator, and you must give yourself provider maintenance rights to edit your provider profile through Web interChange.

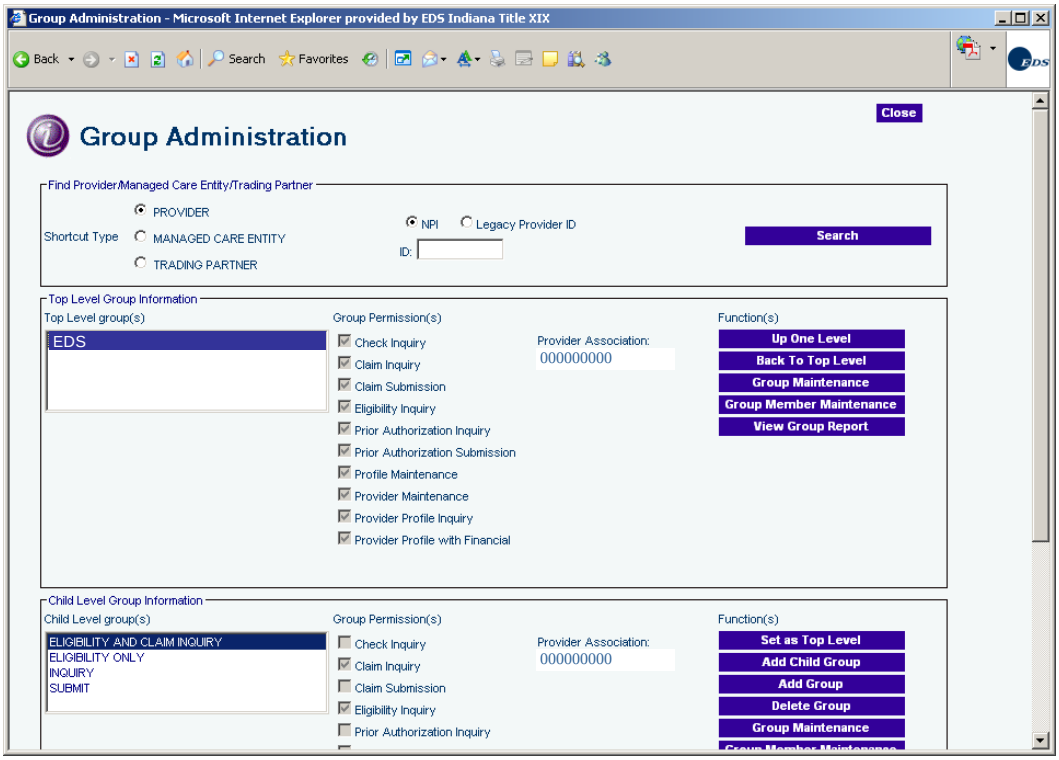
How to Give Yourself Provider Maintenance Rights

To make any changes in the Administrative Menu, you must have administrative rights. The following windows will be available to view only if you have the Administration Menu on the Web interChange home page.

Choose the Administration Menu from the home page. The first screen shot on the next page shows a group that has access to the Provider Maintenance permission, but has not selected the feature for their group. You can verify whether you have this feature by checking to see if the box next to Profile Maintenance under the Group Permissions function button has been checked.

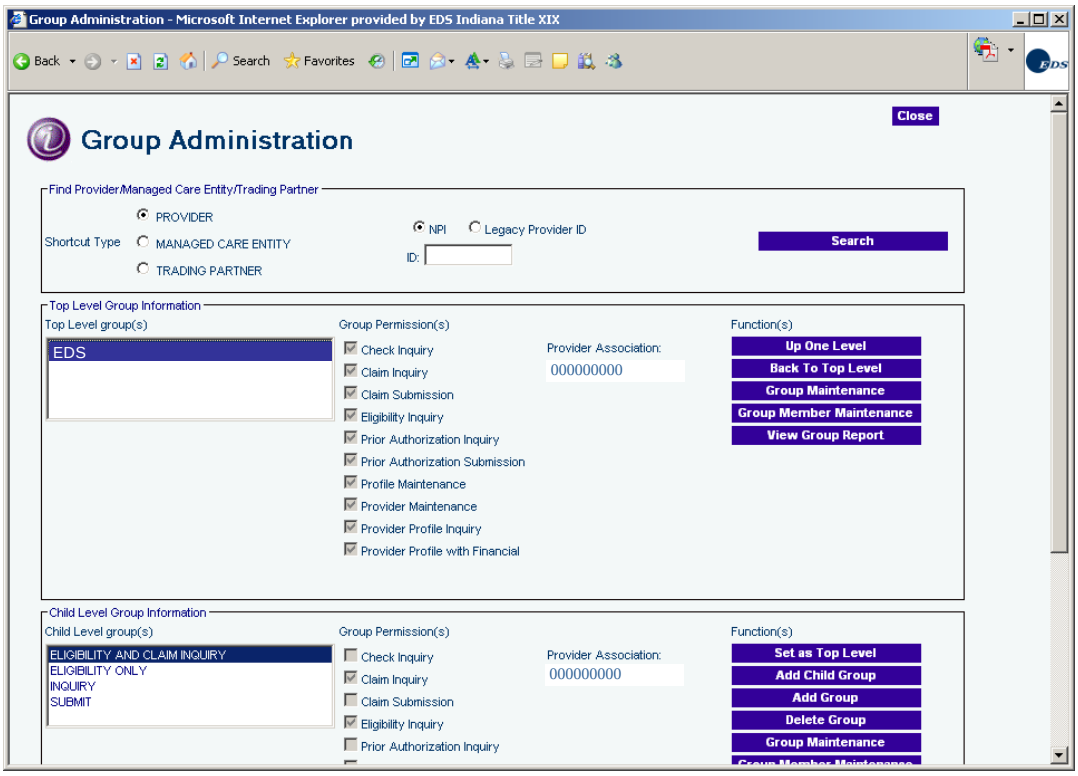


Choose the Group Maintenance function button and verify that the box has been checked next to Provider Maintenance, so you can update profile information.



Once you check the box, click **Submit** and you will receive the following message:

On the Group Maintenance screen you will see all options selected:

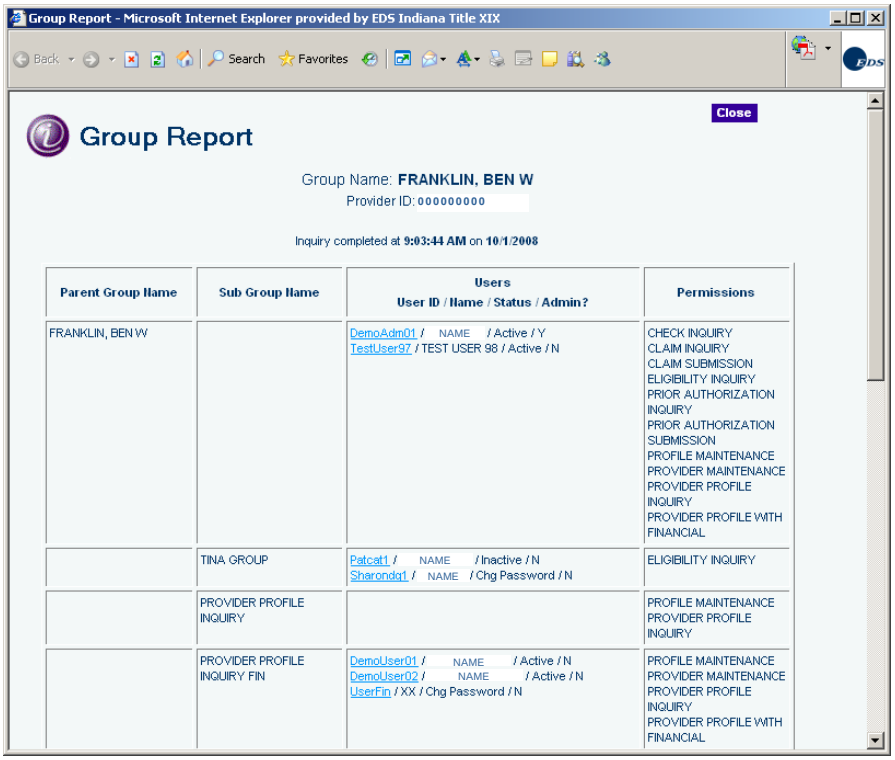


Please note: Administrators must be aware that all users they have placed in the Parent Group will also have Provider Maintenance permissions, which means they will be able to edit your EFT and address information. Ideally, only Web interChange administrators should be located in the Parent Group. Users should be placed in subgroups appropriate to their business needs. If you have placed users in the Parent Group, and you do not want them to have Provider Maintenance permission, you will need to put them in a different subgroup.

Please view the Group Report to determine how your users are set up and what permissions they have been given. An example of a group report appears on the next page.

If administrators need to move a user, they must put him or her in the new group first before deleting them from the original group. Deleting a user before putting him or her in the new group inactivates the user.

If you have questions about Web interChange administration or need help moving users, please view the Group Administration Help text on Web interChange Help or contact the EDS EDI Solutions help desk at 1-877-877-5182 or (317) 488-5160.



Important Note About EFT Changes

When making changes to your bank information (electronic funds transfer – EFT), it is important to note that changes made on Friday when financials run will not be effective until the next financial cycle, which means that payment will still be made to the old bank account until the next pay cycle. Please contact Provider Enrollment at 1-877-707-5750 if you need assistance.

Additions to MHQAC Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented (refer to *BT200709*, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions listed in Table 2 will be made March 13, 2009:

Table 2 – Additions to MHQAC Utilization Edits

Medication and Strength	Utilization Edit
D amphetamine Sulfate, 5mg/5mL solution	40mL/day
Dexedrine spansules, 5mg capsules	2/day
Dexedrine spansules, 15mg capsules	2/day
Pexeva, 40mg tablets	1/day

Pharmacy Providers

Billing Prilosec OTC™

Effective February 1, 2009, providers are advised to discontinue using the Universal Product Code (UPC) when billing Prilosec OTC. Instead, the corresponding National Drug Code (NDC) should be used for billing all claims for Prilosec OTC. If a claim is submitted with a UPC, it will be denied, and resubmission with the appropriate NDC will be requested. Please refer to Table 3 for the UPC to NDC conversion:

Table 3 – Prilosec OTC UPC to NDC Conversion

Prilosec OTC	UPC	NDC
14 count	37000035905	37000045502
28 count	37000035906	37000045503
42 count	37000035907	37000045504
28 count unit dose	37000005845	37000045505

Vaccines for Children (VFC) Providers

Update on Claims for Hemophilus Influenza B (Hib) Vaccine

In conjunction with banner page *BR200901*, dated January 6, 2009, Vaccines for Children (VFC) providers who provided Hib-containing vaccine from their private stocks to VFC-eligible children since February 1, 2008, and received only $8 (using CPT codes 90645, 90647, 90648, 90721, and 90748) will need to submit replacement claims for adjustments to receive the difference for the IHCP Medicaid rate on file. Please refer to the IHCP or managed care organization (MCO), as appropriate, for directions about submitting replacement claims to adjust these claims for reprocessing. Remember to include the invoice as an attachment for immunizations provided from your private stock. Doses provided from the VFC vaccine stock should not be billed for more than the $8 administration fee.

For IHCP claims beyond the one-year filing limit, you must attach a copy of this banner page to each claim for proper processing. For MCO claims, follow the MCO's claim-processing guidelines.

Care Select Providers

Guidelines for Billing Primary Medical Provider Care Coordination

One of the covered benefits for *Care Select* for primary medical providers (PMPs) is the care coordination conference. Care coordination conferences can occur up to twice per member per rolling calendar year (conferences will be scheduled semi-annually).

These conferences can be in person at the PMP's office or via phone conference. The care management organizations (CMOs) will coordinate with their *Care Select* PMPs to perform care coordination conferences to review members' plans of care and evaluate progress with those plans of care. PMPs or their designees (for example, nurse practitioners – NPs – or physician assistants – PAs – who work for the PMP or the PMP's employer, such as a group or clinic) are eligible to receive reimbursement from the IHCP for their participation in care coordination conferences.

To help ensure that PMPs are reimbursed appropriately, EDS has compiled billing guidelines for care coordination conferences. As a reminder, PMPs, NPs, or PAs employed by Federally Qualified Health Centers (FQHCs) or rural health centers (RHCs) are not permitted to bill and receive reimbursement for care coordination conferences because of their enhanced reimbursement from the IHCP.

Please review the following billing guidelines:

- Both the CMO and the PMP will be responsible for checking eligibility on the date of the care coordination conference.
- As with all other covered *Care Select* services, submit claims for members discussed during the care coordination conferences to EDS.
- No prior authorization is required for care coordination conferences.
- Care coordination conferences are carved out of the third-party liability requirements for *Care Select*, so providers do not need to submit claims for these services to members' private insurance companies prior to submitting them to EDS for reimbursement.
- Submit claims on a CMS-1500 claim form using the CMS-1500 paper claim format found in *Chapter 8, Section 4*, of the *IHCP Provider Manual*. Providers may also submit these claims electronically using their proprietary software or using EDS's Web interChange.
- The primary diagnosis providers should use when billing for care coordination conferences is either the member's last known diagnosis related to the member's disease state or V70.9.
- All PMPs or NPs must be linked to the billing group.
- The CMO and provider will identify, via the CMO's Bi-Annual Care Coordination Conference Checklist, potential members to be reviewed and discussed during the conference. If neither the PMP nor the CMO has issues resulting in a discussion of the member's plan of care, the

provider cannot bill for a care coordination conference for that member.

- The Bi-annual Care Coordination Conference Checklist verifies the PMP's review regarding the plan of care. Providers are required to keep copies of Bi-annual Care Coordination Conferences Checklists for auditing and documentation.
- PMPs are limited to billing for one care coordination conference semi-annually and up to two care coordination conferences per member per rolling calendar year.
- The service code to identify billing for care coordination conferences for each *Care Select* member is 99211 SC – *Office or other outpatient visit for the evaluation and management of an established patient.* Please refer to IHCP bulletins *BT200723*, dated September 13, 2007, and *BT200804*, dated January 15, 2008, for further details.
- If the PMP's NP is in the same group or clinic as the PMP who performs the care coordination conference with the member's CMO care manager, the NP's IHCP provider number is appended to 99211 SC. If the NP is not enrolled in the IHCP, providers must append modifier SA. PAs cannot enroll in the IHCP, but can participate in the care coordination conference and be reimbursed. The care coordination service code 99211 SC must be billed, along with modifier HN or HO (use the modifier that corresponds to the PA's education level).
- Services for NPs not linked to the PMP's clinic or group will be denied because that practitioner does not participate in the same group or clinic as the member's PMP, and it will be assumed that those practitioners have no practical experience with that member and are not in a position to discuss that member's plan of care.
- The PMP, or the PMP's NP or PA, will be reimbursed by the IHCP at a rate of $40 per member per conference. PMPs (or their NPs or PAs) who refuse to participate or do not attend a scheduled care coordination conference cannot bill the IHCP for that conference.

The OMPP Completes Auto-assignment of Wards of the Court and Foster Children into Indiana *Care Select*

Effective January 15, 2009, the OMPP has completed auto-assignment of wards of the court and foster children into Indiana *Care Select*. New enrollees in the IHCP have 30 days from the date of their initial eligibility to select PMPs or be auto-assigned to *Care Select* PMPs. A *Care Select* member's guardian or caregiver can contact the member's assigned CMO to select a different *Care Select* PMP at any time.

Continuity of Care

Care Select PMPs are reminded that these new members may already be receiving care from IHCP-enrolled specialists, hospitals, ancillary providers, or their previous PMPs. A PMP who ordered services prior to the January 15, 2009, auto-assignment effective date may not be the same PMP a member is assigned to after January 15, 2009. The OMPP and the CMOs ask newly assigned PMPs to work with the member's previous PMP and other providers to ensure continuity of care. If care has already been initiated for a member, review the member's medical record and authorize the continuation of that care until the member can become an established patient with your practice. Authorize care by releasing your quarterly two-character certification code and National Provider Identifier (NPI) to these providers, so they may receive reimbursement for their services.

Additional Information

We encourage all providers to visit each CMO's Web site for additional information related to *Care Select* and the transition of wards and foster children to *Care Select*:

- MDwise *Care Select*: http://www.mdwise.org
- ADVANTAGE *Care Select*: http://www.advantageplan.com/advcareselect

See the following bulletins for additional information:

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

Contact Information

If you have questions, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278. Contact information for managed care entities (MCEs) can be found on the IHCP Provider Quick Reference at the following address: http://www.indianamedicaid.com/ihcp/Misc_PDF/Quick_Reference.pdf and also on the last page of this newsletter.

Managed Care – Hoosier Healthwise Providers

Hoosier Healthwise Open Enrollment Began March 1

To enhance continuity of care, the Hoosier Healthwise program began a phased implementation of open enrollment in the Central region effective March 1, 2009. Open enrollment is an improvement to the Hoosier Healthwise program.

Formerly, Hoosier Healthwise members could change their health plans at any time. Under open enrollment, members can change health plans only at the following times:

- Anytime during their first 90 days with a new health plan.
- Annually during their open enrollment period.
- Anytime there is "just cause."

Open enrollment does not significantly change how Hoosier Healthwise members receive services. Providers should continue to check members' eligibility before rendering services or requesting prior authorization. Additional information regarding open enrollment, just cause, and the implementation schedule are available in bulletin *BT200841*, dated November 24, 2008.

Provider Workshops

Please note: The Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Workshop originally scheduled for January 28, 2009, at Daviess Community Hospital in Washington Indiana, was cancelled because of weather. The seminar has been rescheduled for April 29, 2009. The workshop agenda includes how to check eligibility, how to file a claim, how to bill services, what causes claims to deny, and more. For more information, 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.

Remaining workshop dates, registration deadlines, and locations are listed in Table 5. Addresses of 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 14. 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, presented by EDS and the three managed care organizations (MCOs)	An introduction to open enrollment, which begins first-quarter 2009 and allows members to remain with a single managed care 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 CMOs 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**
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℠ 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		