IHCP Provider

Monthly News

September 2009

Indiana Health Coverage Programs

http://www.indianamedicaid.com

What's New Inside!

- Action Required to Access Remittance Advices
- Present on Admission Indicator for Hospital-acquired Conditions Is Effective October 1, 2009
- Register Now for the October IHCP Seminar in Indianapolis

Welcome to your first paperless IHCP Provider Newsletter! For more information, please refer to the article on page 3 – "Action Required to Access Remittance Advices."

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 and Periodic Screening, Diagnosis, and Treatment
EVS	Eligibility Verification Systems
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

All Providers

New Bulletins on the IHCP Web Site

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

- *BT200923* – Home Health Rates for State Fiscal Year 2010
- *BT200924* – Direct Deposit of Supplemental Assistance for Personal Needs Payments
- *BT200925* – Medical Record Documentation Guidelines and Appropriate Provider Qualifications and Supervision
- *BT200926* – National Provider Identifier Mandate
- *BT200927* – Automation of Pharmacy Prior Authorization for Fee-for-Service Claims
- *BT200928* – Present on Admission Indicator for Hospital Acquired Conditions
- *B T200929* – "Carve Out" of the Managed Care and Healthy Indiana Plan (HIP) Pharmacy Benefits – Effective January 1, 2010
- *BT200930* – 2009 Indiana Health Coverage Programs Provider Seminar

A complete list of bulletins is available on the IHCP Web site at http://provider.indianamedicaid.com/news,-bulletins,-and-banners/bulletins.aspx. E-mail notifications are sent to subscribers as new bulletins are posted. To subscribe, visit the IHCP Web site at http://provider.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.

Recent Updates to the *IHCP Provider Manual*

The following chapters of the *IHCP Provider Manual* have been updated:

- *Chapter 2 – Member Eligibility*
- *Chapter 9 – Pharmacy Services*

Action Required *Now* to Access Remittance Advices

The implementation date for paperless provider communications is ***now*** – September 1, 2009. Be sure to sign up for Web interChange **today**, so you can access your electronic Remittance Advices (RAs). Remember – it takes seven to 10 business days for the Web interChange approval process.

After September 1, 2009, the IHCP no longer prints and mails provider Remittance Advices (RAs) generated from EDS, banner pages, bulletins, or newsletters (including the Drug Utilization Review Board newsletters). These publications are only available online. The final paper RA was mailed September 1. The first paperless RA will be available September 7.

The paper checks that are mailed with current RAs will continue to be mailed for providers not enrolled in Electronic Funds Transfer (EFT).

Effective September 1, 2009, the IHCP has also ceased printing *Claim Correction Forms*. Providers can resubmit denied claims with corrections through the existing claims billing process.

Providers gain the following advantages by going paperless:

- Quicker access to your IHCP communications
- Ability for multiple people within your organization to access the communications
- Reduced risk of sensitive information going to the wrong entity
- Paperless RAs are not limited to the pay-to address, as current paper RAs are.
- Less office file storage for banner pages, bulletins, and newsletters
- Ability to print and save copies of the communications to your personal electronic storage device for future reference

How to Sign Up

- To sign up for **Web interChange**, go to https://interchange.indianamedicaid.com, and click the link under **First Time Here?**
- To sign up for **IHCP E-mail Notifications**, go to http://provider.indianamedicaid.com/ihcp/mailing_list/default.asp, choose **Open New Account**, and follow the online instructions.

- E-mail notifications will be the only method used to let you know of the publication of new banner pages, bulletins, and newsletters.

Accessing Paperless RAs Through Web interChange – Three Easy Steps

As of September 7, 2009, paperless RAs may be accessed on Web interChange:

Step 1 – From the Web interChange Home page, on the left-side menu, select **Check/RA Inquiry**. On the Check/RA Inquiry page, enter the desired search criteria and click **Submit**; a list of checks and RAs (most recent first) displays. See Figure 1.

- The link to download the RA displays regardless of check availability.
- If no check was issued in conjunction with the RA, the check number displays as "000000000."
- The Provider/National Provider Identifier (NPI) fields populate based on the user's security.

Step 2 – Click on the PDF icon to the right of the page (in the Download RA column).

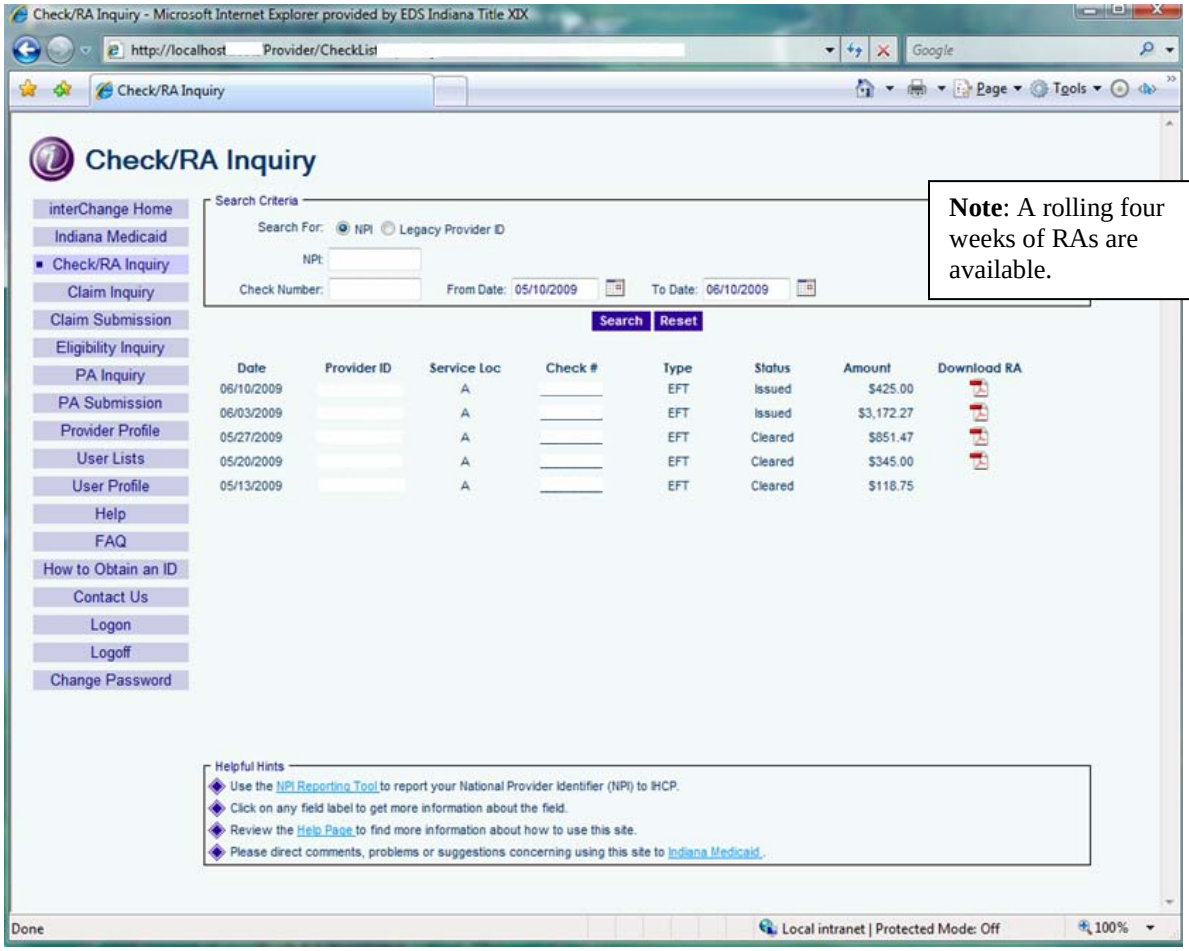

Figure 1 – Example of Check/RA Inquiry Display for Providers

A PDF of the RA opens in a new window. Downloaded RAs have a Family and Social Services Administration (FSSA) watermark. If users wish to save copies of RAs for their records, they can use the "Save a Copy" feature of Adobe Acrobat Reader. RAs can also be printed from Adobe Acrobat Reader.

Step 3 – If the desired RA is not displayed, change the search criteria at the top of the Check/RA Inquiry page.

Please keep in mind that once posted, an RA will only be available in Web interChange for four weeks.

National Provider Identifier Update

To help providers obtain timely claims payment without having to resubmit denied claims due to National Provider Identifier (NPI) edits, all claims submission media (paper, Web interChange, and electronic data interchange or EDI) will be updated effective October 1, 2009, to allow only NPI entry for healthcare providers. Non-healthcare, atypical providers, including all Home and Community-Based Services (HCBS) waiver providers, will continue to submit their Legacy Provider Identifier (LPI) numbers. Claims received on or after October 1, 2009, will be rejected if healthcare providers do not submit their NPIs on the claims. Non-healthcare, atypical providers will continue to bill using their Legacy Provider Identifiers (LPIs). All healthcare providers must report their NPIs on all claims and establish a one-to-one match with the service location where the patient was treated, or the claim will be rejected.

Three data elements are used for the standard NPI crosswalk:

- Billing NPI
- Billing taxonomy code
- Billing provider office location ZIP Code + 4 on file in Indiana*AIM*

For more information, see *BT200926*, dated August 19, 2009.

Coverage of Image-guided Robotic Linear Accelerator Stereotactic Radiosurgery – Healthcare Common Procedure Coding System Codes G0339 and G0340

Effective December 1, 2008, the Indiana Health Coverage Programs (IHCP) began providing coverage of image-guided robotic linear accelerator-based stereotactic radiosurgery (SRS). This service is billable through the Healthcare Common Procedure Coding System (HCPCS) Code G0339 – *Image-guided robotic linear accelerator-based stereotactic radiosurgery, complete course of therapy in one session, or first session of fractionated treatment*; and through code G0340 – *Image-guided robotic linear accelerator-based stereotactic radiosurgery, delivery including collimator changes and custom plugging, fractionated treatment, all lesions, per session, second through fifth sessions, maximum five sessions per course of treatment*. Providers that received denials for dates of services on or after December 1, 2008, with error code 520 – *Invalid revenue code/ procedure code combination* for the HCPCS codes above may resubmit those claims.

Mental Health Quality Advisory Committee 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 provider bulletin *BT200709*, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions in Table 1 will be made **August 28, 2009**.

Table 1 – First-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Venlafaxine HCl 37.5mg tab OSM 24 Oral	1/day
Venlafaxine HCl 75mg tab OSM 24 Oral	2/day
Venlafaxine HCl 150mg tab OSM 24 Oral	1/day
Venlafaxine HCl 225mg tab OSM 24 Oral	1/day

The following additions and updates will be made **September 11, 2009**.

Table 2 – Second-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Bupropion HBR 348mg tab SR 24H oral	1/day

Name of Medication and Strength	Utilization Edit
Bupropion HBR 522mg tab SR 24H oral	1/day
Alprazolam 0.25mg ODT	4/day
Alprazolam 0.5mg ODT	4/day
Alprazolam 1mg ODT	4/day
Alprazolam 2mg ODT	4/day
Seroquel XR 150mg tablet	1/day
Cymbalta 60mg capsule	2/day
Lexapro 20mg tablet	2/day
Venlafaxine XR 150mg capsule	2/day

Claims for "Returned-to-Stock" Prescriptions
Claims that have been billed to and paid by the program for prescriptions that have been filled but not received by the member or the member's representative must be reversed within 15 calendar days of the date of service. The date of service is considered "day 1." This policy is effective September 11, 2009.

Returned Medications
State laws *IC 25-26-13-25(h) and (i)*; *856 IAC 1-21-1* allow for the return of medications from long-term care (LTC) facilities under certain circumstances to the pharmacy that dispensed the medications.

> *Note: Medications returned to the dispensing pharmacy that are put back in stock for redispensing must be credited to the program within 30 days of being returned to the pharmacy.*

To credit the program, providers must submit a credit request for the amount of the returned medication, less any applicable dispensing fee. This amount is applied against future payments. The credited amount is posted to the provider Remittance Advice, and totals on the Provider 1099 Summary Report are adjusted. *Chapter 11: Paid Claim Adjustment Procedures* in the *IHCP Provider Manual* contains specific procedures for crediting the program for returned medications.

The IHCP requires that both the LTC pharmacy and LTC facilities document the medications being returned and credited to the program. Both providers are also required to document any medications being destroyed. Providers should have a log outlining the prescription number, name of medication, date the medication was returned and credited or destroyed, quantity returned and credited or quantity destroyed, and, if the medication was destroyed, to whom it was returned for destruction. The pharmacy auditing contractor, Prudent Rx, will verify compliance with these requirements. LTC pharmacies and LTC facilities found to be noncompliant will be referred to the Indiana Medicaid Fraud Control Unit (IMFCU).

UB-04 Paper Claim Form Locator 17 – Patient Status Codes

Table 3 includes the current patient status codes that are valid for UB-04 paper claim forms, form locator 17, as well as upcoming changes. Providers are reminded to refer to the most current edition of the Uniform Billing Editor for proper use of patient status codes.

> *Note: Patient status code changes are in bold type in Table 3.*

Table 3 – UB-04 Claim Form Locator Descriptions

Form Locator	Narrative Description/Explanation
17*	**STATUS** – Enter the code indicating the member discharge status as of the ending service date of the period covered on this bill. **Required for inpatient and long-term care (LTC).**
Patient Status Codes	
Code	**Description**
01	Discharged to home or self-care, routine discharge
02	Discharged or transferred to another short-term general hospital for inpatient care
03	Discharged or transferred to skilled nursing facility (SNF)
Code	**Description**
04	Discharged or transferred to an intermediate care facility (ICF)
05	**Discharged or transferred to a designated cancer center or children's hospital. New description effective September 30, 2009, for claims with discharge dates on or after April 1, 2008.**
06	Discharged or transferred to home under care of organized home health services organization
07	Left against medical advice or discontinued care
08	**Discharged or transferred to home under care of a home intravenous provider. Patient status code 08 will be changed from active to inactive effective for claims received on or after September 30, 2009, for claims with discharge dates on or after October 1, 2005.**
20	Expired
30	Still a patient
43	Discharged or transferred to a federal healthcare facility
50	Discharged to hospice – home
51	Discharged to hospice – medical facility
61	Discharged or transferred within this institution to hospital-based Medicare swing bed
62	Discharged or transferred to another rehabilitation facility including discharge planning units of hospital
63	**Discharged or transferred to a long-term care hospital (long-term care facility changed to long-term care hospital), effective for date of receipt September 30, 2009**
64	Discharged or transferred to a nursing facility – Medicaid-certified but not Medicare-certified
65	Discharged or transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital (effective April 1, 2004)
66	Discharged or transferred to a critical access hospital (effective January 1, 2006)
70	**Discharged or transferred to another type of healthcare institution not defined elsewhere in code list. Effective September 30, 2009, for claims with discharge dates on or after April 1, 2008. (This was previously the 05 description.)**

Patient Transfers
Special payment policies apply to transfer cases paid using the diagnosis-related group (DRG) methodology. The receiving hospital, or transferee hospital, is reimbursed according to the DRG or level-of-care (LOC) methodology, whichever is applicable. Transferring hospitals are reimbursed a DRG-prorated daily rate for each day, not to exceed

the full DRG amount. The IHCP calculates the DRG daily rate by dividing the DRG rate by the average length of stay. The full payment to the transferring hospital is the sum of the DRG daily rate, the capital *per diem* rate (up to the DRG average length of stay), and the medical education *per diem* rate (up to the DRG average length of stay). Transferring hospitals are eligible for outlier payments.

To ensure accurate reimbursement, the appropriate discharge status code of 02, 05, 62, 63, 65, 66, and 70 must be placed in the UB-04 form locator 17 on the claim form. (See Table 3 for effective dates.)

Presumptive Eligibility: Selecting a Primary Medical Provider and a Managed Care Organization

When a qualified provider (QP) facilitates the completion of the Presumptive Eligibility (PE) Application for Pregnant Women, the QP must provide a telephone for the applicant to contact the enrollment broker, MAXIMUS, to choose her primary medical provider (PMP) and managed care organization (MCO). The applicant must make these selections the same day she applies for PE. The QP cannot influence the selection process in any way. MAXIMUS will explain the selection process and identify women who are exempt from choosing PMPs and MCOs.

Once the selection of the PMP and MCO is made, the member has the right to change her selection at any time during her PE period by contacting MAXIMUS. The QP who performs the PE enrollment process will be paid for the services provided the day of the application, even if the member chooses a different doctor as her PMP.

Presumptive Eligibility Process

Qualified providers (QPs) must ensure that all the following steps are completed the same day a presumptive eligibility (PE) applicant is in the provider's office:

1. Verify pregnancy via a professionally administered pregnancy test.
2. Verify eligibility using Web interChange.
3. Access the PE Member Application via Web interChange.
4. Complete and submit the PE Member Application.
5. Give the PE applicant the PE determination letter.
6. If the PE applicant is approved for PE, she must contact the enrollment broker to choose her primary medical provider (PMP) and managed care organization (MCO). The PE applicant's selections must be written on the PE determination letter.
7. The QP must have the PE applicant verify all the information on the Hoosier Healthwise Application, sign the application, and fax it to the appropriate Division of Family Resources (DFR) office or the Documentation Center for Modernized Counties. QPs should also include a statement of pregnancy.

All the above steps must be completed on the same day the member is in the provider's office. Failure to complete the PE application and have the member contact the enrollment broker will result in termination of PE for the member and no reimbursement for the services provided by the QP.

Hospitals

Care Select ER, Outpatient Treatment, and Inpatient Admissions Notification

The Indiana *Care Select* program is a care management program designed to create a medical home for Medicaid members who are aged, blind, disabled, wards of the court, or foster children. *Care Select* strives to provide complete and holistic care coordination for all its members.

In line with the goals for *Care Select*, it is essential for the care management organizations (CMOs) to be notified when a *Care Select* member receives services in a hospital setting, inclusive of the emergency room, outpatient surgery, or inpatient care. Effective October 1, 2009, providers who serve *Care Select* members in a hospital setting should notify the

members' CMOs, so the appropriate care coordination can take place.

The hospital staff is responsible for checking member eligibility upon treatment or admittance to the facility. Providers who use Web interChange to check member eligibility will see a *Care Select* Notification button appear for *Care Select* members only. Within 48 hours of a member's treatment or admission to a facility, hospital staff will click the *Care Select* Notification button and enter the following information in the space provided:

- Date of treatment
- Type of treatment
- Presenting signs, symptoms, and/or diagnoses

Once the hospital staff clicks **Save** and the CMO has subsequently been notified, the CMO will assess the nature of the visit for follow-up. If the member's situation appears to be complex or additional details are needed for case management, the CMO's care manager will contact clinical personnel at the hospital. The CMO will work with the hospital staff to notify the member's primary medical provider (PMP) and other key physicians on the member's case.

The CMOs will be responsible for contacting hospital discharge planning staff, as appropriate, to offer assistance in discharge planning, to obtain treatment plans and the necessary details to assist with facilitation of appropriate care and resources upon discharge. Providers are encouraged to contact each CMO to communicate the appropriate contact person or department within each facility. Please see Table 4 for specific contact information.

Table 4 – CMO Contact Information for Notification Efforts

Care Select CMO	ADVANTAGE[SM] Care Select	MDwise Care Select
Voice Option	1-866-868-2093	1-866-440-2449 (Options 5, 3)
Fax Option	1-877-761-4227	1-877-822-7189
Secure E-mail	ACSHN@aetna.com	NA
Electronic File Transfer	NA	1-866-440-2449 (Option 1)

Hospice Providers

Hospice Rate Update

IHCP Provider Bulletin BT200917, dated June 16, 2009, announced updates to hospice rates for claims with dates of service October 1, 2008, through September 30, 2009. Hospice claims with revenue codes 651, 652, 655, and 656 that are affected by the revised rates were scheduled to be systematically mass adjusted and appeared the week of August 4, 2009.

Acute Care Hospitals

Present on Admission Indicator for Hospital-acquired Conditions Is Effective October 1, 2009

Effective October 1, 2009, hospital discharge claims will require a present on admission (POA) indicator assigned to principal and secondary diagnoses to identify whether the conditions were present on admission. More information about this change is available in *BT200928*,dated August 25, 2009.

Provider Workshops

Register Now for the October IHCP Seminar in Indianapolis!

Register now to attend the 2009 IHCP Seminar October 20-22, 2009, at the Indianapolis Marriott East. Many educational topics will be offered, and there is no cost to attend. To register, go to http://www.indianamedicaid.com/ihcp/index.asp and click **Provider Services** > **Education Opportunities** > **Workshop Registration**.

The IHCP Offers Third-quarter Medicaid Provider Workshops

The IHCP is offering quarterly provider workshops free of charge – see Table 5 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 e-mailed or faxed upon receipt of registrations. If you do not receive a confirmation letter, the workshop is full.

Workshop dates and locations are listed in Table 6. Addresses of workshop locations are also available on the IHCP Web site at http://provider.indianamedicaid.com/general-provider-services/provider-education/workshop-registration.aspx.

Register online at http://www.indianamedicaid.com. Click **Provider Services**, then **Education Opportunities**. Another registration option is the form on page 11 of this newsletter. Fax completed registration forms to EDS at (317) 488-5376. 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 5 – Third-quarter Provider Workshop Topics, Times, and Descriptions

Time	Topic	Description
8-8:45 a.m.	Hoosier Healthwise Open Enrollment, presented by EDS	This session provides an overview of the new enrollment platform that allows members to remain with a single MCO for a one-year period. The session highlights an improvement to Hoosier Healthwise and is ideal for all providers.
8:50-10:20 a.m.	*Care Select*, presented by EDS and the *Care Select* care management organizations	This session thoroughly covers the *Care Select* program. Topics include PMP rosters and how they are used; referrals to specialist and ancillary providers; identifying primary medical providers and care management organizations on Web interChange; prior authorization; the Restricted Card Program; how care coordination conferences work; billing; and more. Providers will leave with a complete understanding of the *Care Select* program. This session is ideal for all providers.
10:30-11:30 a.m.	Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), presented by EDS and the managed care organizations	This session familiarizes primary care providers with the EPSDT program, its higher reimbursement structure, program-specific billing requirements, and program goals for targeted children. The focus is on a program overview, covered services and specialties, outreach strategies, and current trends. Information about the Vaccines for Children Program and immunization registry will complete this session. This session is ideal for primary care, dental, vision, behavioral health, and hearing specialist providers.

Time	Topic	Description
11:30 a.m.- 12:30 p.m.	Lunch	
12:30-1:15 p.m.	Roundtable: Managed care and Healthy Indiana Plan (HIP), presented by representatives from the three managed care organizations and two HIP plans	The contractors for managed care and HIP provide program updates and answer questions during this roundtable session.
1:30-2:30 p.m.	Blood Lead Testing: How Are We Doing? Presented by the Indiana State Department of Health	While all Medicaid-eligible children are required to receive a blood lead test at 12 and 24 months, less than one-third receive the test. This session provides an overview of the blood lead-testing requirements set forth in the EPSDT Program, the barriers to testing, resources for testing, and reporting requirements. The session also briefly highlights the prevalence of lead hazards in the environment and the medical case management that local health departments must provide if an elevated blood lead level is identified.
2:40-4:45 p.m.	Presumptive Eligibility/ Notification of Pregnancy, presented by EDS	This session introduces a strategic new program that benefits uninsured pregnant women. Providers will learn how to participate in the new program and how to use Web interChange to help pregnant women apply for Hoosier Healthwise. The session is a must for those who treat pregnant women.

Table 6 – Dates and Locations

Workshop Date	Location
September 1, 2009	Purdue Research Park, Innovation Center Training Room, 3400 Kent Avenue, West Lafayette, IN 47906
September 3, 2009	Union Hospital, Landsbaum Center Auditorium, 1433 6½ Street, Terre Haute, IN 47804

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.

Hoosier Healthwise Open Enrollment (8-8:45 a.m.)		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 2009
***Care Select* (8:50-10:20 a.m.)**		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 2009
Early and Periodic Screening, Diagnosis, and Treatment (10:30-11:30 a.m.)		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 2009
Roundtable: Managed Care and Healthy Indiana Plan (12:30-1:15 p.m.)		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 2009
Blood Lead Testing (1:30-2:30 p.m.)		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 2009
Presumptive Eligibility (2:40-4:45 p.m.)		
☐ Elkhart, August 4, 2009	☐ Muncie, August 14, 2009	☐ Indianapolis, August 26, 2009
☐ Greensburg, August 10, 2009	☐ Fort Wayne, August 18, 2009	☐ W. Lafayette, September 1, 2009
☐ Hammond, August 12, 2009	☐ Evansville, August 20, 2009	☐ Terre Haute, September 3, 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 7 – 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, Hendricks, Johnson, 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
10	Relia Manns	(317) 488-5363	Presumptive Eligibility and Notice of Pregnancy for the entire State of Indiana

Table 8 – 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 9 – 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
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 = Member Services – English Opt 2 = Member Services – Spanish	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.in.gov	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 the 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) https://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, IN 46244-0214	MDwise Healthy Indiana Plan http://www.mdwise.org Member Services and Provider Services P.O. Box 44236 Indianapolis, IN 46244-0236 1-877-822-7196 or (317) 822-7196 Fax: 1-877-822-7192 or (317) 822-7192 Medical Claims P. O. Box 33049 Indianapolis, IN 46203 Payer ID: MDWIS Behavioral Health Claims/HIP 1-800-818-6872 P.O. Box 33049 Indianapolis, IN 46203 Payer ID MDWIS Customer Service/Provider Service 1-877-822-7196 or 317-822-7196	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 PA – Medical 1-877-217-7150	
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 the 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 Fax: 1-877-822-7188		