



INDIANA HEALTH COVERAGE
PROGRAMS PROVIDER MANUAL

Chapter 1: General Information

Chapter 1: Revision History

Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
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Document Version Number	Revision Date	Reason for Revisions	Revisions Completed By
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Version 10.0	March 4, 2010 Policies and procedures as of January 1, 2010	Semiannual Update <ul style="list-style-type: none"> • Changed EDS references to HP • Added Presumptive Eligibility for Pregnant Women section • Added home medical services to the list of services not considered self-referral services under the Care Select section • Updated the Risk-Based Managed Care Service Carve-Outs section • Updated the Self-Referral Services section • Added Healthy Indiana and Presumptive Eligibility for Pregnant Women subsections under Delivery Systems • Updated the Customer Assistance Telephone Numbers and Addresses section • Updated the Claim and Check Submission Addresses section • Updated the Local County Offices of the Division of Family Resources section • Updated the Contractors section • Updated the Customer Assistance section 	HP Provider Relations and Publications Units

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Section 1: Introduction

Indiana Health Coverage Programs

This provider manual is the primary reference for submitting and processing Indiana Health Coverage Programs (IHCP) claims, prior authorization (PA) requests, and other related documents. This manual contains detailed instructions for claims submission and is the first referral source for answers to policy and procedure questions.

The IHCP receives federal and state funds to reimburse providers for reasonable and necessary medical care for people meeting eligibility requirements. Each state administers its own program within broad federal guidelines. In Indiana, the Indiana Family and Social Services Administration (IFSSA) Office of Medicaid Policy and Planning (OMPP) administers the IHCP. A copy of the Medicaid Covered Services and Limitations Rule, which is published in the Indiana Administrative Code (IAC) at 405 IAC 5, can be accessed at <http://www.state.in.us/legislative/iac/title405.html>. Rules for other programs administered by the IHCP are also published in the IAC:

- Hoosier Healthwise Package C located in 407 IAC 1, 407 IAC 2, and 407 IAC 3
- Medical Review Team (MRT) located in 405 IAC 2-2-3
- Pre-Admission Screening and Resident Review (PASRR) located in 405 IAC 1-14.6
- Other programs

Additional information on services is available in the IAC, which is published online at <http://www.state.in.us/legislative/iac/>.

Visit the IHCP Web site at <http://www.indianamedicaid.com> for additional program information, such as banner pages, bulletins, newsletters, and a complete version of the *IHCP Provider Manual*. Also located on the IHCP Web site are the IHCP Companion Guides, Web interChange electronic data interchange (EDI) information, IHCP fee schedules, provider enrollment application and maintenance forms, program contact information, schedules of events, general program updates, prior authorization forms, and links to other Web sites.

How to Use this Manual

Specific topics are covered in each chapter of the *IHCP Provider Manual*. For example, member eligibility is covered in [Chapter 2](#) and PA is covered in [Chapter 6](#). Some chapters may appear to contain similar information, but the information is in a different context and is related specifically to that chapter.

Manual Revisions

Throughout the year, changes to the IHCP are published in provider bulletins, provider newsletter articles, and banner page articles. These documents are posted on the IHCP Web site. Changes are captured and inserted into the provider manual at each revision. To ensure that they are aware of any new information that is posted to the Web site, providers should subscribe to receive IHCP E-mail Notifications by going to http://www.indianamedicaid.com/ihcp/mailling_list/default.asp.

Locating Information

Providers can refer to the [General Table of Contents](#) to locate major information. The *General Table of Contents* contains a list of chapters in the manual. Individual chapter tables of contents provide expanded subsection information, including the specific page number within the chapter.

The indexes located at the end of each chapter and at the back of the manual are available to help readers find specific information.

Supplemental Provider Manuals

Supplemental provider manuals are available for subprograms of the IHCP that have unique requirements. Supplemental provider manuals are available for download from the IHCP Web site at <http://www.indianamedicaid.com>, by calling Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278, or by submitting a request in writing to HP Written Correspondence at P. O. Box 7263, Indianapolis, IN 46207-7263. Supplemental provider manuals include the following programs:

- HealthWatch Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program
- Hospice
- Medicaid Rehabilitation Option (MRO)
- 590 Program
- Home and Community-Based Services Waiver Provider Manual
- Qualified Provider Presumptive Eligibility Manual

Managed care organizations (MCOs) and care management organizations (CMOs) also produce provider manuals. Contact the appropriate MCO or CMO to obtain necessary provider manuals. See [Section 2](#) of this chapter for MCO and CMO contact information.

Ordering Manuals

All *IHCP Provider Manuals* are available online at <http://www.indianamedicaid.com>. Providers may also request copies of the *IHCP Provider Manual* on CD-ROM at no charge. Providers may request one paper copy at no expense.

To obtain additional copies of the provider manual, send a request in writing to the following address:

**HP Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263**

The following applies to paper and CD-ROM copy orders of the *IHCP Provider Manual*:

- Enrolled IHCP providers can purchase an additional paper copy for \$105 per copy.
- Enrolled IHCP providers can request CD-ROM copies at no additional charge.
- Nonproviders can purchase paper copies for \$105 per copy.
- Nonproviders can purchase CD-ROMs for \$20.
- Providers should make checks payable to EDS.

Suggestions

Comments and suggestions are important in making the provider manual practical, relevant, and user-friendly. Please forward comments and suggestions about the *IHCP Provider Manual* to the following address:

Provider Manual Suggestions
HP Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263

Programs Overview

This section introduces and provides a high-level overview of the IHCP and associated benefit packages.

The OMPP has categorized benefits into the following programs:

- 590 Program
- Traditional Medicaid
- Hoosier Healthwise
- *Care Select*
- Healthy Indiana Plan (HIP)
- Presumptive Eligibility for Pregnant Women

590 Program

The 590 Program allows for processing claims for services provided off-site to members who are residents of State-owned facilities under the direction of the IFSSA Division of Mental Health and Addiction (DMHA) and the Indiana State Department of Health (ISDH).

Providers can verify eligibility for the 590 Program using the eligibility verification systems (EVS). See [Chapter 3](#) for more information about EVS options.

Detailed information about the 590 Program is included in the *590 Program Provider Manual*, which is available online at:

http://www.indianamedicaid.com/ihcp/Manuals/Other/590_Program_Provider_Manual.pdf.

Traditional Medicaid

The Traditional Medicaid program provides services to nonmanaged care members on a fee-for-service (FFS) basis. The types of members associated with Traditional Medicaid under the standard plan may include the following:

- Qualified Medicare beneficiary (QMB)
- Wards of the State
- Foster children
- Spend-down

- Waiver
- Long-term care (LTC)
- Emergency Services Only (Package E)

Detailed information about Traditional Medicaid is included in [Chapter 2](#) of this manual.

Hoosier Healthwise

Hoosier Healthwise provides coverage to children, pregnant women, and low-income families. This program encompasses the following four member eligibility packages:

- Package A – Standard Plan
- Package B – Pregnancy Coverage Only
- Package C – Children’s Health Insurance Plan (CHIP)
- Package P – Presumptive Eligibility for Pregnant Women

Detailed information about Hoosier Healthwise is included in [Chapter 2](#) of this manual.

Care Select

The *Care Select* program is designed to improve the member’s health status; enhance quality of life; improve client safety, client autonomy, and adherence to treatment plans; and control fiscal growth. The *Care Select* program replaced the *Medicaid Select* program through a phased-in plan with a completion date of March 1, 2008. The following IHCP members are covered by the *Care Select* program:

- Aged
- Blind
- Physically and mentally disabled
- Members receiving adoption assistance
- Members in the waiver program
- Medicaid for Employees with Disabilities (M.E.D. Works) participants
- Wards not Title IV-E eligible under 18
- Ward and foster children under 18
- Former foster children

Detailed information about *Care Select* is included in [Chapter 2](#) of this manual.

Healthy Indiana Plan

The Healthy Indiana Plan (HIP) is a program sponsored by the state of Indiana that provides more affordable healthcare choices to thousands of otherwise uninsured individuals throughout Indiana. HIP provides health insurance for uninsured adult Hoosiers between the ages of 19 and 64 whose income is up to 200 percent of the federal poverty level (FPL), and who are not otherwise eligible for Medicaid. Unlike many other government-sponsored programs, parents and childless adults can participate. Eligible participants must be uninsured for at least six months and cannot have access to employer-sponsored health insurance. Participants are required to make minimal contributions toward coverage based on their income.

The Enhanced Services Plan (ESP) is a special plan for some HIP enrollees with certain high-risk medical conditions. The ESP is administered by the Indiana Comprehensive Health Insurance Association (ICHIA). HIP applicants are screened for complex medical conditions, such as cancer, human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS), hemophilia, transplants, and aplastic anemia. Questionnaires are sent to medical professionals to validate the high-risk conditions and qualify members. HIP enrollees, who qualify, are assigned to the ESP. The ESP provides all HIP benefits in addition to comprehensive disease management services. Affiliated Computer Services (ACS) processes medical claims for the ESP. HP processes the pharmacy claims. Contact information can be found in [Section 2](#) of this chapter.

Presumptive Eligibility for Pregnant Women

Presumptive Eligibility (PE) for Pregnant Women is a process to provide coverage to women while the Hoosier Healthwise Application is under review by the Division of Family Resources (DFR). This program began July 1, 2009.

Women found to be presumptively eligible will have coverage for ambulatory prenatal services while the application and determination process for Hoosier Healthwise/Medicaid is completed. Providers will be reimbursed for covered services provided during the PE period, beginning on the date that a qualified provider (QP) determines the woman to be presumptively eligible. The woman's Hoosier Healthwise/Medicaid eligibility determination will subsequently be completed by the DFR.

Enrollment centers that are not qualified providers for the PE program can assist pregnant women by helping them complete and submit Hoosier Healthwise (HHW) Applications and providing a referral to a qualified provider. However, it is critical that only *one* HHW Application be submitted for a member.

Delivery Systems

The following sections describe IHCP delivery systems.

Fee-for-Service

The FFS delivery system reimburses providers on a per-service basis. Providers bill the IHCP claims processing contractor, HP, for services rendered to members in programs subject to FFS.

Note: The IHCP Fee Schedule can be downloaded for free from the IHCP Web site at <http://www.indianamedicaid.com>. To obtain a paper copy of the IHCP Fee Schedule, make checks payable to EDS for \$43 to the following address:

***HP Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263***

The IHCP Fee Schedule contains a complete list of Current Procedural Terminology (CPT[®]) and Healthcare Common Procedure Coding System (HCPCS) codes and includes indicators specific to each code, such as program coverage, anesthesia base units, reimbursement, and prior authorization. Users can search the online version by code or keyword.

CPT[®] is registered trademark of American Medical Association.

Care Select

Care Select is similar to Traditional Medicaid in that payments for care are made on an FFS basis. In addition, a per-member, per-month administration fee is paid to primary medical providers (PMPs) with the exception of rural health clinics and Federally Qualified Healthcare Centers.

Care Select operates as an FFS delivery system with a gatekeeper approach. Providers submit claims to HP for processing. PMPs in this program contract with CMOs through an addendum to the *IHCP Provider Agreement*. *Care Select* members are linked to a PMP who provides or authorizes most medical care. If the PMP is not providing the care, the service may require PMP authorization.

Some services are exempt from PMP authorization. The following services are known as self-referral services and do not require PMP authorization for payment:

- Chiropractic services
- Community mental health services and services under the mental health rehabilitation option
- Dental services
- Family planning services
- Home and community-based services
- Mental health services (by provider type and specialty)
- Methadone maintenance (refers to the drug *methadone*, not methadone treatment programs)
- Nonsurgical ophthalmology services
- Pharmacy services
- Podiatry services
- Services rendered for the treatment of a true medical emergency
- Transportation services
- Vision care services (optometry services and eyeglasses)
- HIV/AIDS targeted case management services
- Immunizations
- Diabetes self-management

The following services are not considered self-referral services. However, they do not require the PMP certification code for payment:

- Pathology services
- Laboratory services
- Radiology services
- Anesthesia services
- Physical therapy services
- Occupational therapy services
- Respiratory therapy services
- Speech therapy services
- Home health services

- Durable medical equipment and home medical equipment services

Note: Although the two-digit PMP certification code is not required for the outpatient hospital services listed above, after May 23, 2008, the PMP's National Provider Identifier (NPI) continues to be required for claim reimbursement. These services include outpatient therapies, as well as radiology, pathology, and laboratory when performed in an outpatient hospital setting.

Risk-Based Managed Care

The State has mandated risk-based managed care (RBMC) enrollment for members eligible for Hoosier Healthwise. MCO members who qualify for hospice care, long-term institutional Level of Care, or waiver Level of Care are disenrolled from Hoosier Healthwise and placed in Traditional Medicaid. In addition, some Level of Care members may be eligible for the *Care Select* program. Detailed information about *Care Select* is included in [Chapter 2](#) of this manual.

All providers rendering services to Hoosier Healthwise members must enroll with the IHCP and one or more of the managed care organizations. This provision also includes out-of-state providers.

In RBMC, the State pays the MCO a monthly capitation fee for members enrolled with the MCO. This capitation fee covers the costs of care for most covered services incurred by Hoosier Healthwise members enrolled in the MCO network. Each MCO maintains its own provider and member services units. Each MCO pays claims, performs PA, and is responsible for subrogation activities. Providers should contact the MCO for specific claims payment and PA policies and guidelines.

Risk-Based Managed Care Service Carve-Outs

The MCO is responsible for the delivery and payment of most care for its members; however certain services are not paid by the MCO. The following carved-out services are the financial responsibility of the State and billed directly or indirectly to HP for reimbursement as FFS:

- Dental services rendered by providers enrolled in an IHCP dental specialty
 - These specialties are endodontist, general dentistry practitioner, oral surgeon, orthodontist, pediatric dentist, periodontist, pedodontist, and prosthodontist
 - Services provided by a school corporation as part of a student's individualized education plan (IEP)
- Pharmacy services
- MRO services and psychiatric residential treatment facility (PRTF) services
- MCOs must provide care coordination services and associated services related to MRO and PRTF services including, but not limited, to transportation.

Self-Referral Services

The MCO reimburses for the following self-referral services that do not require PMP referral:

- Chiropractic services
- Immunizations
- Family planning services
- HIV/AIDS targeted case management services

- Podiatry services
- Services rendered for the treatment of a true medical emergency
- Eye care services (except eye care surgical services)
- Diabetes self-management services rendered by a chiropractor, podiatrist, optometrist, or psychiatrist outside the MCO network or to an IHCP-enrolled provider as a referral from one of these provider specialties
- Behavioral Health Services, such as mental health, psychiatric, substance abuse, and chemical dependency services
- The MCO mental health providers to which the member may self-refer within the provider network are the following:
 - Outpatient mental health clinics
 - Community mental health clinics
 - Psychiatrists (Services provided in a PRTF are excluded from the MCO's responsibility)
 - Psychologists
 - Certified psychologists
 - Health services providers in psychology (HSPP)
 - Certified social workers
 - Certified clinical social workers
 - Psychiatric nurses
 - Independent practice school psychologists
 - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center

Members may self-refer *outside the MCO network* to psychiatrists only.

PMP referral is not the same as PA. Contact the appropriate MCO to determine if the service or procedure requires program PA. Refer to [Chapter 6](#) of this manual for *Prior Authorization*.

Healthy Indiana Plan

For claims submitted to HP, providers must follow billing procedures as outlined in this manual . Billing procedures and details on noncovered services can be found in [Chapter 8: Billing Instructions](#) and [Chapter 2: Member Eligibility and Benefit Coverage](#) of the *IHCP Provider Manual*, which is located at <http://www.indianamedicaid.com/ihcp/Publications/manuals.htm>.

Presumptive Eligibility for Pregnant Women

It is imperative that qualified providers verify eligibility to determine eligibility for presumptively eligible women each date of service before administering services in order to receive payment. Providers can use any of the three eligibility verification systems (EVS) to verify eligibility: Web interChange, Omni, or the Automated Voice Response system.

During the PE period, providers will send claims for a presumptively eligible woman to the appropriate MCO using the member's 550 identification number. It is important to use the appropriate pregnancy-related diagnosis for claims and the pregnancy indicator for pharmacy claims. Transportation will be provided for a PE member as long as it is pregnancy- and or emergency-related. Inpatient, Hospice, Long Term Care, abortions, sterilizations and hysterectomy services are not covered under PE. These services may be covered if the patient becomes fully eligible for Medicaid.

While the member is on presumptive eligibility, the provider should bill using the PE RID that begins with the digits 550. Once the Hoosier Healthwise application process has been completed, if the woman is approved, the provider will then submit claims using the woman's Hoosier Healthwise RID, which begins with 10 and ends with 99. If the member is approved for Hoosier Healthwise and the provider submits a claim using the PE RID (starting with 550), the claim will deny and the provider must resubmit the claim using the correct RID. If a member receives retroactive eligibility for Medicaid, the provider must bill using the Hoosier Healthwise RID and not the PE RID.

Section 2: Telephone and Address Directory

Customer Assistance Telephone Numbers and Addresses

Table 1.1 lists contact information for customer assistance for different entities supporting the Indiana Health Coverage Programs (IHCP).

Table 1.1 – Customer Assistance Telephone Numbers and Addresses

Name	Contact Information
ACS (Affiliated Computer Services) Prior Authorization (PA) for Prospective Drug Utilization Review (ProDUR) and Preferred Drug List for Pharmacy claims	ACS Clinical Call Center Pharmacy PA: 1-866-879-0106 Fax: 1-866-780-2198
ACS Drug Rebate	ACS Indiana Drug Rebate P.O. Box 2011332 Dallas, TX 75320-1332
ACS Healthy Indiana Plan Enhanced Services Pan	Medical Services: 1-866-674-1461 or (317) 614-2032 P.O. Box 33077 Indianapolis IN 46203-0077
ADVANTAGE Health SolutionsSM - Care Select	Member Services: 1-800-784-3981 Provider Services: 1-866-504-6708 Medical PA: 1-800-784-3981 Fax: 1-800-689-2759 Web site: http://www.advantageplan.com/
ADVANTAGE Health SolutionsSM – FFS (PA)	1-800-269-5720 7:30 a.m. to 6 p.m. (Eastern Time) Monday through Friday (including holidays) ADVANTAGE Health Solutions – FFS P. O. Box 40789 Indianapolis, IN 46240 Medical PA Fax: 1-800-689-2759 To obtain the <i>Certification - Plan of Care for Inpatient Psychiatric Hospital Services / Determination of Medicaid Eligibility Form (I261A)</i> , go to www.fssa.in.gov . On the left side of the page, select Aging, below that select For Providers, then select Forms. The Prior Authorization form is also available under the Forms menu at: www.indianamedicaid.com .

Name	Contact Information
Anthem-Hoosier Healthwise	Claims: 1-888-232-9613 Member Services: 1-866-408-6131 Member TTY: 1-866-408-7188 Member Fax: 1-866-408-7087 Medical PA: 1-866-408-7187 Medical PA Fax: 1-866-406-2803 Provider Services: 1-866-408-6132 Provider Fax: 1-866-408-7087 Transportation: 1-800-508-7230 Transportation TTY: 1-866-910-1603 Transportation Fax: (317) 291-9446 Web site: http://www.anthem.com
Anthem Blue Cross and Blue Shield Healthy Indiana Plan	Member Services: 1-800-553-2019 Provider Inquiry 1-800-345-4344 P.O. Box 37010 Louisville, KY 40233-7180 Medical PA: 1-866-398-1922
HP Administrative Review	HP Written Correspondence Unit P.O. Box 7263 Indianapolis, IN 46207-7263
HP Automated Voice Response (AVR) System	(317) 692-0819 in the Indianapolis local area or 1-800-738-6770 Seven days per week, 24 hours per day Eligibility, Benefits, Claim Status
HP Casualty (subrogation)	INXIXTPLCasualty@hp.com HP Third Party Liability Unit P. O. Box 7262 Indianapolis, IN 46207-7262
HP Customer Assistance	(317) 655-3240 in the Indianapolis local area or noncontiguous states 1-800-577-1278 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday (except holidays) The toll-free number is available to providers located throughout Indiana, Michigan, Ohio, Kentucky, and Illinois.
HP Electronic Solutions Help Desk	(317) 488-5160 in the Indianapolis local area or 1-877-877-5182 8 a.m. to 5 p.m. (Eastern Time) Monday through Friday (except holidays) INXIXElectronicSolution@hp.com
HP Forms Request	HP Forms Request P. O. Box 7263 Indianapolis, IN 46207-7263 Forms are available online at http://www.indianamedicaid.com .

Name	Contact Information
HP Member Hotline	(317) 713-9627 in the Indianapolis local area or noncontiguous states 1-800-457-4584 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday (except holidays) The toll-free number is available in Indiana, Michigan, Ohio, Kentucky, and Illinois.
HP Pharmacy Services Point of Service (POS) Help Desk	(317) 655-3240 in the Indianapolis local area or noncontiguous states 1-800-577-1278 Option 2 8 a.m. to 8 p.m. (Eastern Time) Monday through Friday (except holidays) 10 a.m. to 6 p.m. Saturday The toll-free number is available in Indiana, Michigan, Ohio, Kentucky, and Illinois. INXIXPharmacy@hp.com
HP Premium Collection Services M.E.D. Works Hoosier Healthwise Package C	8 a.m. to 6 p.m. (Eastern Time) Monday through Friday (except holidays) M.E.D. Works Payment Line 1-866-273-5897 M.E.D. Works Premium Payment Mailing Address: P. O. Box 946 Indianapolis, IN 46206-946 Package C Payment Line: 1-866-404-7113 Package C Premium Payment Mailing Address: P. O. Box 3127 Indianapolis, IN 46206-3127
HP Privacy Unit	P.O. Box 7260 Indianapolis, IN 46207
HP Third Party Liability (TPL)	(317) 488-5046 in the Indianapolis local area or noncontiguous states 1-800-457-4510 Fax: (317) 488-5217 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday (except holidays) The toll-free number is available in Indiana, Michigan, Ohio, Kentucky, and Illinois. HP Third Party Liability Unit P.O. Box 7262 Indianapolis, IN 46207-7262

Name	Contact Information
HP Waiver Provider, Enrollment and NPI	1-877-707-5750 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday (except holidays) HP Provider Enrollment P.O. Box 7263 Indianapolis, IN 46207-7263
HP Written Correspondence	HP Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
Healthy Indiana Plan	1-877-438-4479 http://www.hip.in.gov/
IHCP Surveillance and Utilization Review (SUR)	(317) 347-4527 in the Indianapolis local area or 1-800-457-4515 8 a.m. to noon and 1 p.m. to 5 p.m. (Eastern Time) Monday through Friday (except holidays) IHCP Surveillance and Utilization Review P.O. Box 531700 Indianapolis, IN 46253-1700
IHCP Web Site	http://www.indianamedicaid.com
Managed Health Services (MHS)	Claims, Member Services, Medical PA/Medical Management, Provider Services, and Nursewise: 1-877-MHS-4U4U or 1-877-647-4848 Web site: http://www.managedhealthservices.com
MAXIMUS Administrative Services, Inc. – Enrollment Broker	1-866-963-7383, Option 3 for Providers (<i>Care Select</i>) http://www.indianacareselect.com 1-800-889-9949, Option 3 for Providers (Hoosier Healthwise) http://www.healthcareforhoosiers.com <u>1-877-438-4479 (Healthy Indiana Plan)</u> www.HIP.in.gov
MDwise – Care Select	Member and Provider Services 1-866-440-2449 Member Services Fax: 1-877-822-7188 Medical PA: 1-866-440-2449 Fax: 1-877-822-7186 Web site: http://www.mdwise.org
MDwise – Hoosier Healthwise	Claims, Member Services, Medical PA/Medical Management, and Provider Services: (317) 630-2831 or 1-800-356-1204 Web site: http://www.mdwise.org

Name	Contact Information
MDwise Healthy Indiana Plan	Member and Provider Services: 1-877-822-7196 or (317) 822-7196 Fax: 1-877-822-7192 or (317) 822-7192 P.O. Box 44236 Indianapolis, IN 46244-0236 Medical Claims P. O. Box 33049 Indianapolis, IN 46203 Payor ID: MDWIS Behavioral Health Claims/HIP P.O. Box 33049 Indianapolis, IN 46203 Payor ID: MDWIS
Medical Policy	Questions regarding IHCP medical policy should be directed to HP Written Correspondence. HP Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263
Myers and Stauffer (M&S)	9265 Counselors Row, Suite 200 Indianapolis, IN 46240 Help desk: 1-800-591-1183 Fax: (317) 571-8481 www.mslc.com
Provider and Member Concern Line (Fraud and Abuse)	(317) 347-4527 in the Indianapolis local area or 1-800-457-4515 8 a.m. to noon. and 1 p.m. to 5 p.m. (Eastern Time) Monday through Friday (except holidays)

Claim and Check Submission Addresses

Table 1.2 lists the addresses to submit claims and Table 1.3 lists the addresses to submit checks.

Table 1.2 – Claim Submission Addresses

Claims	
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P.O. Box 2011332 Dallas, TX 75320-1332	Anthem Hoosier Healthwise (RBMC) P.O. Box 6144 Indianapolis, IN 46209-9210 Anthem Healthy Indiana Plan (HIP) P.O. Box 37180 Louisville, KY 40233-7180
HP 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	HP Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265

Claims	
<p>HP Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259</p>	<p>Claims Attachment Cover Sheet http://www.indianamedicaid.com/ihcp/Forms/Claims_Attachment_Cover_Sheet.pdf When an 837 or Web interChange claim transaction requires the submission of additional documentation, providers can submit the documentation as a paper attachment. Additional information can be found in Chapter 8 of the manual.</p>
<p>HP CMS-1500 Claims P.O. Box 7269 Indianapolis, IN 46207-7269</p>	<p>HP Dental Claims P.O. Box 7268 Indianapolis, IN 46207-7268</p>
<p>HP Home Health Claims P. O. Box 7271 Indianapolis, IN 46207-7271</p>	<p>HP Inpatient Hospital Claims P. O. Box 7271 Indianapolis, IN 46207-7271</p>
<p>HP Institutional Crossover Claims P.O. Box 7271 Indianapolis, IN 46207-7271</p>	<p>HP Long-Term Care Claims P. O. Box 7271 Indianapolis, IN 46207-7271</p>
<p>HP Medical Crossover Claims P.O. Box 7267 Indianapolis, IN 46207-7267</p>	<p>HP Outpatient Claims P.O. Box 7271 Indianapolis, IN 46207-7271</p>
<p>HP Pharmacy Administrative Review/Pharmacy Claims P.O. Box 7263 Indianapolis, IN 46207-7263</p>	<p>HP Pharmacy Claim Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265</p>
<p>HP Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268</p>	<p>HP UB-04 Claims P.O. Box 7271 Indianapolis, IN 46207-7271</p>
<p>HP Waiver Programs Claims P.O. Box 7269 Indianapolis, IN 46207-7269</p>	<p>Managed Health Services (MHS) Hoosier Healthwise (RBMC) P.O. Box 3002 Farmington, MO 63640-3802</p>
<p>MDwise Healthy Indiana Plan Medical Claims Address: P.O. Box 33049 Indianapolis, IN 46203-0049</p> <p>Behavioral Health Claims Address: CompCare/MDwise P.O. Box 33049 Indianapolis, IN 46203-0049</p>	<p>MDwise Hoosier Healthwise (RBMC) Claims address varies depending on delivery system. See contact information at http://www.mdwise.org/hoosierhealthwise/providers/docs/hhprov-quickcontact.pdf. www.mdwise.org</p>
<p>HIP Enhanced Services Plan Medical Claims Address: P.O. Box 33077 Indianapolis, IN 46203-0077</p> <p>Pharmacy Claims Address: P.O. Box 7268 Indianapolis, IN 46207-7268</p>	

Table 1.3 – Check Submission Addresses

Checks Only	
IHCP Refunds HP Refunds P.O. Box 2303, Department 130 Indianapolis, IN 46206-2303	IHCP Refunds – Pharmacy HP Pharmacy Refunds P.O. Box 2303, Department 130 Indianapolis, IN 46206-2303
Uncashed IHCP Checks HP Finance Department 950 North Meridian Street, Suite 1150 Indianapolis, IN 46204-4288	

Local County Offices of the Division of Family Resources

Problem Resolution

Providers unable to resolve problems involving caseworkers or supervisors should contact the Family and Social Services Administration (FSSA) Call Center or the local Division of Family Resources (DFR) office. For a directory of local DFR offices, go to <http://www.in.gov/fssa/dfr/2999.htm>. The telephone number for the FSSA Call Center is 1-800-403-0864. This number also serves as the fax number for the Document Center. The address for the Document Center is:

FSSA Document Center
P.O. Box 1810
Marion, IN 46952

If a director does not respond to the complaint to the provider's satisfaction, the provider can write a letter providing facts to the deputy director of the Division of Family Resources (DFR) at the following address:

MS03
Deputy Director
Division of Family Resources
Family and Social Services Administration
402 West Washington Street W392
Indianapolis, IN 46204

Providers should specify in the letter their attempts made to resolve the problem. This information is also available on the Web at <http://www.in.gov/fssa/>.

Section 3: Civil Rights Requirements

Civil Rights

All programs, services, and benefits administered, authorized, and participated in by the Indiana Family and Social Service Administration (IFSSA) or the Indiana State Department of Health (ISDH), its subgrantees, contractors, subcontractors, providers, or other participants are operated in accordance with the nondiscriminatory requirements pursuant to *Title VI of the Civil Rights Act of 1964*. The Office of Medicaid Policy and Planning (OMPP) adheres to *Section 504 of the Rehabilitation Act of 1973*, as amended, the *Age Discrimination Act of 1975*, and where applicable, the *Omnibus Budget Reconciliation Act (OBRA) of 1981*. This means that the following is observed:

"No person or persons shall on the grounds of race, color, national origin, handicap, age, sex or religion, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program, service or benefit advocated, authorized or provided by this Office."

According to a 1988 opinion by the Department of Justice, individuals with acquired immunodeficiency syndrome (AIDS) and individuals with asymptomatic human immunodeficiency virus (HIV) infection are protected under *Section 504 of the Rehabilitation Act of 1973* as "qualified handicapped persons."

If a provider receives a complaint of an alleged violation of the *Civil Rights Act*, the provider must advise the OMPP of the complaint. Within 10 working days from the date the provider receives notification of a civil rights violation complaint, the provider must send a copy of the complaint to the following address:

**Civil Rights Plan Coordinator
Office of Medicaid Policy and Planning
402 West Washington Street, Room W382
Indianapolis, IN 46204**

Each provider must display the *Civil Rights Compliance Policy Statement Sheet* received with this provider manual. See Figure 1.1 on the following page.

Providers must comply with federal law with regard to the *Patient Self-Determination Act*, contained in the *OBRA of 1990*. This law requires that providers advise adult patients about the patient's right to determine treatment before they can no longer make healthcare decisions for themselves. The patient can express this in an *advance directive*.

**CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)
CIVIL RIGHTS COMPLIANCE POLICY STATEMENT**

The vision of the current Strategic Plan for the Centers for Medicare and Medicaid Services guarantees that all our beneficiaries will have equal access to the best health care. Pivotal to guaranteeing equal access is the integration of compliance with civil rights laws into the fabric of all CMS program operations and activities. I want to emphasize my personal commitment to and responsibility for ensuring compliance with civil rights laws by recipients of CMS funds. These laws include Title VI of the Civil Rights Act, as amended, Section 504 of the Rehabilitation Act, as amended, the Age Discrimination Act of 1975, as amended, the Americans with Disabilities Act of 1990, as amended, and Title IX of the Education Amendments of 1972, as well as other related laws. The responsibility for ensuring compliance with these laws is shared by all CMS operating components. Promoting attention to and CMS program compliance with civil rights laws are among my highest priorities for CMS, its employees, contractors, State agencies, health care providers, and all other partners directly involved in the administration of CMS programs.

CMS, as the agency legislatively charged with administering the Medicare, Medicaid and Children's Health Insurance Programs, is thereby charged with ensuring these programs do not engage in discriminatory actions on the basis of race, color, national origin, age, sex or disability.

With your help, CMS continues to ensure that persons are not excluded from participation in or denied the benefits of its programs because of prohibited discrimination.

To achieve its civil rights goals, CMS will continue to incorporate civil rights concerns into the culture of our agency and its programs, and we ask that all our partners do the same. We will include civil rights concerns in the regular program review and audit activities: collecting data on access to, and the participation of, minority and disabled persons in our programs; furnishing information to recipients and contractors about civil rights compliance reviewing CMS publications, program regulations, directives and instructions to assure support for civil rights, and working closely with the Department of Health and Human Services (DHHS), Office for Civil Rights, to initiate orientation and training programs on civil rights. CMS will also allocate financial resources, to the extent feasible, to ensure equal access, to prevent discrimination, and to assist in the remedy of past acts adversely affecting persons on the basis of race, color, national origin, age, sex or disability.

DHHS will seek voluntary compliance to resolve issues of discrimination whenever it is possible. If necessary, CMS will refer matters to the Office for Civil Rights for appropriate handling. In order to enforce civil rights laws, the Office for Civil Rights may: 1) refer matters for an administrative hearing which could lead to suspending, terminating or refusing to grant or continue Federal financial assistance; or 2) refer the matter to the Department of Justice for legal action.

CMS's mission is to assure health care security for the diverse population that constitutes our nation's Medicare and Medicaid beneficiaries, i.e., our customers. We will enhance our communication with constituents, partners and stakeholders. In so doing, we will seek input from health care providers, states, contractors, the DHHS Office for Civil Rights, professional organizations, community advocates and program beneficiaries. We will continue to vigorously assure that all Medicare and Medicaid beneficiaries have equal access to and receive the best health care possible, regardless of race, color, national origin, age, sex or disability.

Figure 1.1 – CMS Civil Rights Compliance Policy Statement

Section 4: State, County, and Contractor Responsibilities

State Responsibility

The Office of Medicaid Policy and Planning (OMPP) is the State agency responsible for administration of the Indiana Health Coverage Programs (IHCP), which requires coordination with a number of entities. This section outlines the primary agencies involved in program administration.

Local Offices of the Division of Family Resources

The Division of Family Resources (DFR) is responsible for determining eligibility for IHCP members. Following the eligibility determination, the DFR enrolls members in the program and maintains the eligibility files for the IHCP member population. A complete directory of local county offices is available on the Web at: <http://www.in.gov/fssa/df/2999.htm>.

Contractors

The OMPP contracts with a fiscal agent and other contractors to perform the day-to-day program functions associated with administration of IHCP. The current contractors and responsibilities include the following:

- HP (Fiscal Agent)
 - Claim processing and related services
 - Customer service
 - Long-term care
 - Managed care coordination
 - Provider relations
 - Third-party liability
 - Waiver programs
 - Medical policy questions – receive initial input and route to the OMPP for review
 - Prepayment review
 - Surveillance and Utilization Review services
- ADVANTAGE Health Solutions
 - Fee-for-service prior authorizations
- MAXIMUS (Enrollment Broker)
 - *Care Select* and Hoosier Healthwise member and provider helplines
 - Potential enrollee program education
 - Choice counseling for PMP health plan selection

- ACS
 - Drug rebate services
 - Pharmacy-related prior authorization
 - Pharmacy benefit manager
 - HIP – ESP medical claim processing
- Myers and Stauffer, LC
 - Rate setting
- Managed Care Organizations (MCOs) – Risk-Based Managed Care (RBMC)

Note: For more information including contact information, see [Table 1.1](#) in this chapter.

- Care Management Organizations (CMOs) – *Care Select*
 - Prior Authorization
 - Right Choices Program

Note: For more information including contact information, see [Table 1.1](#) in this chapter.

- Healthy Indiana Plan MCOs

Note: For more information including contact information, see [Table 1.1](#) in this chapter.

- Prudent Rx
 - Pharmacy-related claim audit functions
- Healthy Indiana Plan insurers

Indiana State Department of Health

The Indiana State Department of Health (ISDH) is responsible for certifying the following provider types:

- Long-term care (LTC) facilities
- Intermediate care facilities for the mentally retarded (ICFs/MR)
- Pediatric nursing facilities
- Residential care facilities
- Rehabilitation facilities
- Home health agencies
- Hospitals
- Rural health clinics (RHCs)
- Ambulatory surgical centers (ASCs)
- Laboratories
- Radiology centers (Portable X-Ray Facilities)

- End-stage renal disease (ESRD) clinics
- Hospice facilities
- Outpatient physical therapy and speech language pathology (OPT/SP) facilities
- Comprehensive outpatient rehabilitation facilities (CORF)

Providers may contact the ISDH at the following address or telephone number:

Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
(317) 233-7491

Section 5: Member and Provider Relations

General Information

HP Member and Provider Relations serves as the liaison between the provider and member communities and the Indiana Health Coverage Programs (IHCP). Member and Provider Relations offers providers avenues for resolving claims processing matters and conducting information maintenance activities.

Member and Provider Relations comprises the following units:

- Provider Enrollment Unit is responsible for day-to-day provider enrollment activities.
- Customer Assistance Unit is responsible for answering member and provider telephone inquiries.
- Written Correspondence Unit responds to written correspondence from members and providers and performs administrative reviews and appeals as directed by the Office of Medicaid Policy and Planning (OMPP).
- Provider Relations Unit functions as the educational arm of the IHCP.

These units are described in this section.

Note: Other entities contracted with the OMPP may perform parallel functions for their provider networks. For example, each managed care organization (MCO) contracted for the Hoosier Healthwise Program maintains a provider services unit for its network providers. Each care management organization (CMO) operates a provider services unit for primary medical providers (PMPs) in the Care Select program.

Provider Enrollment

The following are key functions of the Provider Enrollment Unit:

- Provide an efficient mechanism to enroll and maintain provider profile information.
- Assess provider eligibility through verification of licensure, certification, insurance, and approval documents required for each provider type and specialty. Ensure that no provider is excluded from participation by the Office of the Inspector General (OIG), Centers for Medicare & Medicaid Services (CMS), or other federal or State agency.
- Process all provider enrollment applications and maintenance forms in an average of 30 days.
- Terminate providers who no longer meet State requirements for participation in the IHCP.
- Maintain provider files for all enrolled, denied, and terminated providers.
- Encourage provider participation by openly communicating enrollment trends to the provider field consultants for review and action.

IndianaAIM provides automated features that enable enrollment analysts to monitor enrollment activities from initial receipt of an application or maintenance form through final disposition. Enrollment procedures are discussed in [Chapter 4: Provider Enrollment, Eligibility, and Responsibilities](#).

Additional information is available on the Provider Enrollment Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/enrollment_provider.asp, and by calling the Provider Enrollment Helpline at 1-877-707-5750, from 8 a.m. to 6 p.m. (Eastern Time) Monday through Friday excluding holidays. Providers can also view their own Provider Profile with the access to the Web interChange. For more information about Web interChange, see *IHCP Provider Manual Chapter 3*. New provider groups and billing providers can enroll online at www.indianamedicaid.com.

Customer Assistance

As the front line of communications with providers, the Customer Assistance specialists quickly detect the impact of program policy and procedural changes through provider inquiries.

The Customer Assistance Unit is responsible for answering telephone inquiries about IHCP claims processing, policy, and covered services.

The Provider Customer Assistance Unit can be contacted at the following telephone numbers:

(317) 655-3240 in the Indianapolis local area or 1-800-577-1278
Option 2 Pharmacy, Option 3 Medical Provider Services

Member Services (317) 713-9627 or 1-800-457-4584

The toll-free number is available throughout Indiana (except in the 317 area code), Michigan, Ohio, Kentucky, and Illinois. Providers in noncontiguous states do not have access to a toll-free number and must use the toll number.

To assist with timely processing of inquiries, providers should consider the following guidelines when contacting the Customer Assistance Unit:

- Providers should not inquire about the status of a specific claim until at least 30 business days after submission. This is generally considered a reasonable time to process a claim. For general claim status inquiries, refer to the weekly Remittance Advice (RA), the Automated Voice Response System (AVR), or Web interChange.
- When requesting information about a claim, provide the following information:
 - Name of person calling
 - Office name
 - Provider name
 - Billing provider's 10-digit National Provider Identifier (NPI) or nine-digit Legacy Provider Identifier (LPI) with alphabetic suffix (location code) or zip code of the office location.
 - Internal control number (ICN) of the claim
 - Member name and member identification number (RID)
 - Dates of service (to include specification of the claim type, such as inpatient, outpatient, medical, dental, and so forth)
 - Amount billed
 - An outline of the question or problem
- Providers should make a note in their file of the date of the telephone call and the name of the Customer Assistance representative who handles the call. If a follow-up inquiry is necessary, this information is helpful.
- Claim status inquiry is available through the Automated Voice Response (AVR) system, HP Web interChange, and the 276/277 claim status request and response transaction. The AVR system

allows providers to use a touch-tone telephone to access pertinent claim status information. Web interChange allows providers to access claim status through the Internet. Both systems provide access 24 hours a day, seven days a week. Instructions for accessing these features are included in [Chapter 3: Electronic Solutions](#). The 276/277 claim transactions are standardized, electronic data interchange (EDI) transactions. Data is sent and received in the same format for all providers. Additional information is available in the IHCP Companion Guides, which are available at http://www.indianamedicaid.com/ihcp/TradingPartner/EDI_index.asp.

Written Correspondence

The HP Written Correspondence Unit is another link between the provider community and the IHCP. Providers should contact the Written Correspondence Unit for assistance with researching complex claims and related denials when the provider has experienced difficulty in getting claim payment. Additionally, providers can contact the Written Correspondence Unit to obtain member vision and dental benefit limit information or clarification of IHCP rules and regulations. Providers can also contact Written Correspondence to obtain a copy of previously issued RA statements.

Note: Effective September 1, 2009, there is a \$0.15 per-page charge for a paper RA.

A paper RA can be requested by calling HP Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. A Customer Assistance analyst verifies the number of pages used to calculate the correct amount to enclose with a written request. Checks must be made payable to EDS and mailed with a written request to the following address:

***HP Provider Written Correspondence
P.O. Box 7263
Indianapolis, IN 46207-7263***

Requests received without a check will be returned with a form letter asking the provider to resubmit the request with a check for the calculated amount.

Submit written inquiries using the *Written Correspondence Request* form. This form is provided free of charge to providers and can be requested at the following address:

**HP Forms Requests
P.O. Box 7263
Indianapolis, IN 46207-7263**

The *Written Correspondence Request* form is also available on the IHCP Web site at <http://www.indianamedicaid.com/ihcp/Publications/forms.asp>. The use of the *Written Correspondence Request* form ensures that the HP Written Correspondence analyst has all the information necessary to conduct thorough research.

Include the copies of claims and any attachments that have been submitted for payment in the past with the inquiry. Prior authorization (PA) numbers or a copy of PA decision forms should be included, as well as copies of RA statements or a print screen from the Web interChange claim inquiry screen. This information provides necessary details for denied claims and is helpful in formulating an accurate and complete response to the provider.

Incomplete Written Correspondence forms significantly hamper the ability of the HP Written Correspondence Unit to assist in resolving problems. Comprehensive information on a Written

Correspondence form with a clearly stated *Reason for Inquiry* enables the Written Correspondence analyst to research the issue and provide appropriate avenues of resolution. The more information provided about the history of a particular issue, the more easily an analyst can reach the resolution.

Written Correspondence analysts use IndianaAIM to research written inquiries. HP mails the response in a letter to the provider within 10 business days of receiving the written inquiry. Responses are assigned a letter control number (LCN) that is important for tracking and should be referred to in subsequent correspondence to the IHCP about the issue. All completed written inquiries should be sent to the following address:

**HP Written Correspondence
P. O. Box 7263
Indianapolis, IN 46207-7263**

Providers should not use the Written Correspondence Unit for claim submission, unless specifically directed to do so. The Written Correspondence analyst performs specific claim research for resolution of problems. Claims status is accessible through the AVR system at (317) 692-0819 in the Indianapolis local area or 1-800-738-6770. The AVR system allows providers to access claim status information by using a touch-tone telephone. Providers can also obtain claim status through Web interChange.

A claim status is generally available 30 days after a paper claim submission, 21 days after an electronic claim submission, and two hours after a submission through Web interChange. If claim status is not available within these time frames, the provider should take the following actions:

- Check the copies of RA statements for the particular claims
- Review the submitted claim to ensure all required information was included on the claim form
- Use Web interChange or call AVR to verify claim status using the claim inquiry option
- Resubmit the claim through normal channels

If these steps are followed, and the claim does not appear on the RA as paid, denied, or suspended, an inquiry should be submitted to the Written Correspondence Unit.

Provider Relations

HP has a team of regional provider field consultants. In addition to providing training through on-site visits, conferences, and workshops, the consultants are also available for on-site training to encourage the use of Web interChange and Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic transactions for the provider community and recruit new providers into the IHCP. The specific region assignments and contact information can be found on the <http://www.indianamedicaid.com> Web site or by calling customer assistance.

The following illustrates the key responsibilities of the HP provider field consultant:

- Work directly with the provider community to provide education and ensure program and claim processing understanding.
- Create a stable, personal relationship with the providers in their assigned geographical territory.
- Work closely with the financial managers, administrators, and business leaders of the provider community to educate about IHCP policies and objectives, assist with resolving provider issues, and conduct training seminars and on-site visits.

The information in the following section is provided to increase understanding of the key objectives of the field consultant team.

Workshops and Seminars

The provider field consultants form the educational arm of the IHCP. The field consultants, in conjunction with other program contractors, are responsible for the formulation and presentation of educational sessions about all aspects of the IHCP.

HP presents scheduled workshops each quarter throughout the year as well as an annual seminar so that the objectives and administration of the IHCP are understood throughout the provider community. Workshops are announced in IHCP provider bulletins, IHCP provider newsletters, provider association newsletters, and on the IHCP Web site at <http://www.indianamedicaid.com>. Providers may register for workshops on the IHCP Web site under Provider Services > Education Opportunities. Workshops and on-site training sessions are also arranged at the request of individual providers or provider groups.

Scheduling Details

To ensure a successful training visit or seminar, the following information is recommended to assist the field consultant in structuring the meeting or presentation to best meet the needs of the audience:

- Provider community segment attending the seminar
- Number of attendees
- Time and location of the event
- Issues to be addressed
- Point of contact, in case additional information is needed prior to the event

Avenues of Resolution

Table 1.4 is designed to provide a quick reference for providers to use when contacting Member and Provider Relations with questions about claims or programs, or clarification of a specific topic.

Table 1.4 – Provider Avenues of Resolution

Area of Member and Provider Relations	Contact Information	When to Contact
<i>Indiana Health Coverage Programs Provider Manual</i>	View or download from http://www.indianamedicaid.com To obtain additional copies of the provider manual, send a request in writing to: HP Written Correspondence P. O. Box 7263 Indianapolis, IN 46207-7263 Providers – \$105 for additional paper copies or free CD-ROM Nonproviders – \$105 for paper copies or \$20 for CD-ROM *Make check payable to EDS	Providers can refer to the <i>Indiana Health Coverage Programs Provider Manual</i> as a primary reference for claims submission and processing, prior authorization requests, and other related documents. This manual contains detailed instructions for claims submission and is the first referral source for answers to policy and procedure questions. Other Manuals: <ul style="list-style-type: none"> • <i>590 Program</i> • <i>HealthWatch/EPSDT</i> • <i>Home and Community-Based Services Waiver</i> • <i>Hospice</i> • <i>IHCP Companion Guides</i> • <i>IHCP Common Glossary</i> • <i>Medicaid Rehabilitation Option (MRO)</i> • <i>Qualified Provider <u>Presumptive Eligibility (PE) Manual</u></i>
IHCP Web Site	http://www.indianamedicaid.com	Providers can access the Web site to obtain program information, such as banner pages, provider bulletins, provider newsletters, the <i>Indiana Health Coverage Programs Provider Manual</i> and all program supplemental manuals, IHCP Companion Guides, Web interChange, program contact information, schedules of events, and general program updates.
Customer Assistance	(317) 655-3240 in the Indianapolis local area or 1-800-577-1278 Provider Enrollment and Waiver 1-877-707-5750	Providers can contact the Customer Assistance Unit for telephone inquiries about IHCP claim processing, policy, covered services, enrollment, and updates to the provider file.
Written Correspondence	HP Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	Providers can contact the Written Correspondence Unit to address specific questions about the IHCP, such as researching complex claims and related denials. Inquiries are not to be used to submit claims, but as an avenue for providers to obtain claim-specific information or help with a specific question.

Area of Member and Provider Relations	Contact Information	When to Contact
Provider Field Consultants	Consultant assignments and voice mail extensions are available at http://www.indianamedicaid.com or from Customer Assistance.	Providers can contact field consultants for explanations of the IHCP's policies and objectives, assistance in resolving issues, and setting up training seminars and on-site visits. Consultants also provide training for Web interChange and HIPAA electronic transactions.

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