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Indiana Health Coverage Programs

Monthly News

Provider Monthly Newsletter

NL200604 **April 2006**

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Abbreviations in this Newsletter

ACN	attachment control number
ACS	Affiliated Computer Services
AVR	Automated Voice Response
BSR	Biller Summary Report
CCF	Claim Correction Form
CDT	Current Dental Terminology
CHIP	Children's Health Insurance Plan
CMHC	community mental health center
CMS	Centers for Medicare & Medicaid Services
COB	coordination of benefits
COBA	Coordination of Benefits Agreement
COBC	Coordination of Benefits Contractor
DUR	Drug Utilization Review
EDI	electronic data interchange
EDS	Electronic Data Systems
EDT	electronic data transfer
EFT	electronic funds transfer
FMAC	Federal Maximum Allowable Cost
FUL	Federal Upper Limits
HCBS	home- and community-based services
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMS	Health Management Services
ICD-9	International Classification of Diseases, 9th Revision
ICES	Indiana Client Eligibility System
IFSSA	Indiana Family Social Services Administration
IHCP	Indiana Health Coverage Programs
MAC	maximum allowable cost
MCO	Managed Care Organization
MHS	Managed Health Service
MRN	Medicare Remittance Notice
OMPP	Office of Medicaid Policy and Planning
PA	prior authorization
PBM	Pharmacy Benefits Manager
PCCM	Primary Care Case Management
PMP	primary medical provider
PNCC	Prenatal Care Coordination
POS	place of service
ProDUR	Prospective Drug Utilization Review
RFA	Request for Approval
SUR	Surveillance and Utilization Review
TOB	Type of Bill
TPL	third party liability

Provider News

New Bulletins on the IHCP Web Site

A complete list of bulletins is available on the IHCP Web site at www.indianamedicaid.com/ihcp/Publications/bulletin_results.asp.

The following are bulletins posted to the IHCP Web in March:

- *BT200604* – Prenatal Care Coordinator Forms and PNCC Program.
- *BT200605* – Billing Requirements and Prior Authorization Criteria for Genetic Testing for Breast and Ovarian Cancer
- *BT200606* – Change to the Preferred Drug List
- *BT200607* – Final Medicare Hospice Rules Effective January 23, 2006 and Medicaid Hospice Authorization Changes
- *BT200608* – Annual *Medicaid Select* member bulletin
- *BT200609* – Notice of Privacy Practices member bulletin

As new bulletins are posted to the IHCP Web site, IHCP E-mail Notifications are sent to subscribers. To learn more about this feature and subscribe to it visit http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

System Maintenance Announcement

EDS will perform system maintenance on Sunday, April 9, 2006, from 7 p.m. until 11:59 p.m., EDT. The following systems will be **unavailable** during that time:

- AVR
- Batch electronic claim submission
- Omni eligibility system
- POS pharmacy claim submission
- Web interChange

> *Make sure the appropriate business offices and software vendors are notified of this scheduled downtime.*

Questions about this system maintenance announcement should be addressed to the EDS EDI Solutions Help Desk at (317) 488-5160, Indianapolis local area, or 1-877-877-5182.

The 835 Electronic Remittance Transaction

Beginning April 1, 2006, the 835, Electronic Remittance Transaction will return a unique control number for each transaction, regardless of payment. Prior to April 1, 2006, the TRN02, Check/EFT Trace Number contained the text, *NO PAYMENT*, and a date and time stamp that was specific to the minute. If a trading partner had multiple claims with $0 payment reported on the 835, the TRN02 values would be identical. Per the *835 – Health Care Claim Payment/Advice Transaction, Version 4010 Implementation Guide and the 4010A1 Addenda* TRN02 field description, *This number must be unique within the sender/receiver relationship*.

To correct this issue, the IHCP will send the Transaction Set Control Number also found in the ST02 segment instead of a time stamp in TRN02. The IHCP creates a unique control number for each transaction sent to a trading partner, so duplicate TRN02 values should no longer be created. The full TRN02 value for a $0 payment 835 will be, *NO PAYMENT-YYYYMMDDXXXXXXXXX*, where YYYYMMDD is the date the transaction is created and XXXXXXXXX is the Transaction Set Control Number.

Direct questions about this article to the Electronic Solutions Help Desk at (317) 488-5160, in the Indianapolis local area, or 1-877-877-5182, or by e-mail at INXIXElectronicSolution@eds.com.

Type of Bill Code Set Update

This article provides clarification about updates to the TOB code set published in the IHCP banner page *BR200601* dated January 3, 2006.

The IHCP updated the *Type of Bill Information* document in Web interChange to include all TOB codes that are available for use per the *UB-92 Editor*. The IHCP does not cover all codes. The new document lists the *Type of Bill Code*, *Description*, *Processing Decision* indicator (*Accept*, *Deny*) and *Claim Type*.

This article is to notify IHCP providers of a change in IHCP coverage of TOB 731 and the 22X series.

- TOB code 731 is now valid and covered by the IHCP for crossover C and outpatient claim types.
- TOB codes for the 22X series are now valid and covered for crossover A claim types.
- Inpatient claim type is valid, however, not a covered TOB for the IHCP.

As stated in *BR200601*,

- If a provider submits a claim with a valid TOB using Web interChange or an 837I transaction, but the TOB is non-covered by the IHCP, the claim will be adjudicated and denied with *Edit 594 – Type of Bill non-covered by IHCP*.

- If a provider submits a claim using Web interChange with an invalid TOB, the provider will receive an error message that states, *Type of bill is not valid for this claim type*.
- If the provider submits a claim with an invalid TOB using the 837I transaction, the claim file will be rejected with error code *272 – Invalid TOB*. This information is reported to the provider or vendor on the BSR.

The updated TOB document is available from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Forms/Type_of_Bill_Table.pdf.

Medicare Denied Details for Crossover Claims Processing

This article provides clarification to information published in the IHCP banner page *BR200551* dated December 20, 2005, about "Denied Service Lines on Crossover Claims." Effective March 21, 2006, changes have been made in the way Medicare Part B crossover claims (medical or outpatient) are processed in Indiana*AIM*.

Web interChange now allows providers to enter denied service lines for crossover claims. These details will process and deny with *Edit 593 – Medicare denied details*.

Crossover A Claims Submitted through Web interChange

For crossover A claims, providers may report COB adjustment information at the header and detail, but this information must appear at the header for claims adjudication. If only detail COB adjustment information is present, it is not recognized by Web interChange

Crossover B (Medical) Claims Submitted through Web interChange

For crossover B claims, providers must report COB adjustment information at the detail level. If COB adjustment information appears at the header and detail, then the sum of the detail must equal the header amount. If they are not equal, the user receives an error stating, "The header and detail crossover amounts are not equal."

Crossover C (Outpatient) Claims Submitted through Web interChange

For crossover C claims, providers may report COB adjustment information at the header or detail level. If COB adjustment information appears at the header and detail, then the sum of the detail must equal the header amount. If they are not equal, the user receives an error stating, "The header and detail crossover amounts are not equal."

837I Crossover A Claims Submitted through EDI

COB adjustment information can be reported at the header and detail level but must be present at the header for claims adjudication. If header COB adjustment information is not present, then BSR 280 is sent back to the provider stating, "Crossover A claims must contain crossover amounts (Medicare paid, deductible, coinsurance, and blood deductible amounts) at the header level." If header and COB adjustment information **do not** balance, the claim is still processed.

Note: Provider specialties 260, 261, and 264 continue to report COB adjustment information at the header level as the IHCP has excluded this specialty from the modification.

837I Crossover C Claims Submitted through EDI

COB adjustment information can be reported at the header and detail but must be present at the detail for claims adjudication. If header and detail COB adjustment information is present, then they must balance. If they do not balance, then BSR 277 is sent back to the provider stating, "Crossover adjustment amounts (deductible, coinsurance, and blood deductible amounts) at the detail do not balance with the header crossover adjustment amounts."

837P Crossover B Claims Submitted through EDI

COB adjustment information can be reported at the header and detail level. If COB adjustment information is present at the header and detail level, then the sum of the detail must be equal to the header. If they do not balance, then BSR 277 is sent back to the provider stating, "Crossover adjustment amounts (deductible, coinsurance, and blood deductible amounts) at the detail do not balance with the header crossover adjustment amounts."

Complete information about EDI reports is published in the *Companion Guide: Electronic Data Interchange Reports and Acknowledgements* located on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/CompanionGuides/EDI_Reports.pdf.

More information about COBs can be found by clicking on the **FAQ** menu option on Web interChange at https://interchange.indianamedicaid.com/Administrative/logon.asp.

Reporting Personal Injury Claims

Providers should notify the EDS TPL Casualty Department if a request for medical records is received from an IHCP member's attorney about a personal

injury claim, or if information is available about a personal injury claim being pursued by an IHCP member. When notifying the TPL Casualty Department, include the IHCP member's name, member identification number, date of injury, insurance carrier information, and attorney name, phone number, and address, if available.

The TPL Casualty Department prepared a form for use when submitting this information; however, use of this form is not required. The *Provider TPL Referral Form*, Attachment 4 of this newsletter, is also available on the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp under *Third Party Liability (TPL) Forms*.

Complete this form and send it to the TPL Casualty Department by e-mail at INXIXTPLCasualty@eds.com, by facsimile at (317) 488-5217, or by U.S. Mail to the following address:

EDS TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7262

The EDS TPL Casualty Department may be contacted by telephone at (317) 488-5046 in the Indianapolis local area, or 1-800-457-4510.

TPL Credit Balance Project

HMS is partnering with EDS to collect credit balances owed to the IHCP. Quarterly, HMS mails letters and credit balance worksheets to select providers notifying them that the date for refunding credit balances is 60 days from the date of the letter. Providers must reply promptly to these notices. Providers may have credit balances subtracted from future Medicaid payments, because adjustments are processed each week.

Although only selected providers receive a letter and credit balance worksheet each quarter, all providers may use this credit balance process to return overpayments.

For questions about the credit balance collection process or requests for copies of the credit balance worksheet and instructions, contact HMS Provider Relations at 1-877-264-4854. The credit balance worksheet and instructions can be downloaded from the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp.

Update to 2006 Annual HCPCS Codes

The CMS released corrections to the 2006 Annual HCPCS Update, published in provider bulletins *BT200528* and *BT200601*. The following tables list corrections to the 2006 new and deleted codes. These corrections are effective retroactively to January 1, 2006. Providers can access the 2006 Annual HCPCS new and deleted code updates on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/providerCodes/providerCodes.asp.

Reinstated Codes, Effective January 1, 2006

Table 4.1 lists codes that CMS initially deleted in the 2006 Update, but have now determined to be valid codes. These codes remain active in the Indiana*AIM* claims processing system, so that providers can bill and be reimbursed appropriately for these services.

Replacement Codes, Effective January 1, 2006

Table 4.2 lists codes CMS deleted in the 2006 Update. In Table 4.2 the *Replacement Code* column shows the corrected replacement code(s).

Table 4.1 – Corrections to the New and Deleted 2006 HCPCS Codes, Effective January 1, 2006

Procedure Code	Description	PA Requirements	Modifiers	Program Coverage
E1239	Power wheelchair, pediatric size, not otherwise specified	Yes		Covered for all programs
J7317	Sodium hyaluronate, per 20 to 25 mg dose for intra-articular injection			Covered for all programs
J7320	Hylan G-F 20, 16 mg, for intra-articular injection			Covered for all programs

Table 4.2 – Corrections to the Deleted 2006 HCPCS Codes, Effective January 1, 2006

Procedure Code	Description	Replacement Code
15342	Application of bilaminate skin substitute/neodermis; 25 sq cm	15170, 15175, 15340, 15360, 15365
15343	Application of bilaminate skin substitute/neodermis; each additional 25 sq cm (list separately in addition to code for primary procedure)	15171, 15176, 15341, 15361, 15366
21493	Closed treatment of hyoid fracture; without manipulation	Use appropriate Evaluation and Management code
21494	Closed treatment of hyoid fracture; with manipulation	Use appropriate Evaluation and Management code
31585	Treatment of closed laryngeal fracture; without manipulation	Use appropriate Evaluation and Management code
31586	Treatment of closed laryngeal fracture; with closed manipulative reduction	Use appropriate Evaluation and Management code
37730	Ligation and division and complete stripping of long and short saphenous veins	37718, 37722
76375	Coronal, sagittal, multiplanar, oblique, 3-dimensional and/or holographic reconstruction of computed tomography, magnetic resonance imaging, or other tomographic modality	76376, 76377
92330	Prescription, fitting, and supply of ocular prosthesis (artificial eye), with medical supervision of adaptation	Use appropriate Evaluation and Management code
92335	Prescription of ocular prosthesis (artificial eye) and direction of fitting and supply by independent technician, with medical supervision of adaptation	Use appropriate Evaluation and Management code
92510	Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing, therapeutic services) with or without speech processor programming	92601, 92602, 92603, 92604, 92630, 92633
99311	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a problem focused interval history; a problem focused examination; medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Physicians typically spend 15 minutes at the bedside and on the patient's facility floor or unit.	Use appropriate Evaluation and Management code
99312	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: an expanded problem focused interval history; an expanded problem focused examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Physicians typically spend 25 minutes at the bedside and on the patient's facility floor or unit.	Use appropriate Evaluation and Management code
99313	Subsequent nursing facility care, per day, for the evaluation and management of a new or established patient, which requires at least two of these three key components: a detailed interval history; a detailed examination; medical decision making of moderate to high complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Physicians typically spend 35 minutes at the bedside and on the patient's facility floor or unit.	Use appropriate Evaluation and Management code

(Continued)

Table 4.2 – Corrections to the Deleted 2006 HCPCS Codes, Effective January 1, 2006

Procedure Code	Description	Replacement Code
K0670	Addition to lower extremity prosthesis, endoskeletal knee shin system, microprocessor control feature, stance phase only, includes electronic sensor(s), any type	L5858

2006 January Quarterly HCPCS Codes Update

The CMS released the 2006 January Quarterly HCPCS codes update. The update includes HCPCS C codes used for services paid by the Medicare Outpatient Prospective Payment System, and HCPCS G codes used to report Medicare-approved demonstration project services. These codes are not used by the IHCP and are non-covered in Indiana*AIM*.

COBA Information

Effective March 2006, the CMS is consolidating the Medicare claims crossover process. CMS has chosen a single entity, the COBC to handle crossing supplemental claims to supplemental payers including Medicaid. Therefore; the IHCP has signed a COBA initiative to allow the COBC to transmit claims information for processing. Providers will notice the results of the consolidation by the second week of April 2006. The COBC will cross over HIPAA-compliant claims. Crossover-denied details will cross over indicating denied status.

COBA Implementation

This section explains a major change in the way crossover claims are processed. Crossovers are medical claims that must be processed first by Medicare, then by Medicaid. The federal government is making a major change in their method of crossover processing in March 2006. If your technical staff or billing personnel follow these instructions, it may speed up your reimbursements for these claims. Failure to follow these instructions may cause the system to deny claims that would otherwise pay. Review the following article for the technical details.

With the implementation of COBA, the COBC automatically crosses over claims to the IHCP based on the eligibility information the IHCP submits to the COBC. The IHCP submits eligibility files to the COBC weekly. The COBC processes eligibility files within five days of receipt and provides a detail-level report to IHCP. If there are discrepancies in reporting, the IHCP internally coordinates with ICES to resolve.

The COBC only submits crossover claims in the 837 Institutional and 837 Professional formats. Providers can help ensure proper adjudication of the crossover claims by providing the information needed by the IHCP when submitting claims to Medicare. The 837 transactions provide the capability of submitting the IHCP provider number (billing and rendering) in addition to the Medicare provider numbers. Refer to the IHCP *Companion Guide: 837 Institutional Claims and Encounters Transaction* and *Companion Guide: 837 Professional Claims and Encounters Transaction* for the instructions regarding submission to Medicare with the IHCP required information. These Companion Guides are located at http://www.indianamedicaid.com/ihcp/TradingPartner/tp_companion_guides.asp

For crossover claims to pass preadjudication and pay, providers must supply information needed by the IHCP for adjudication. The following information must be submitted in the 837 transaction.

- Medicaid provider ID must be included on the claim to Medicare
- Member first and last name
- Medicaid member ID number
- COB Loop with the IHCP pertinent information (use *70035* as the Payer ID for the IHCP)
- The following information, if applicable:
  - Other payer (COB) adjudication information for payers *other* than Medicaid and Medicare
  - Rendering provider ID
  - Referring provider ID
  - Pregnancy indictor
  - Referral number
  - Attending physician state license number
  - Operating physician state license number
  - Other provider state license number
  - Modifiers used by IHCP for processing

The IHCP Payer ID in the COB Loop is important when transmitting the claim electronically to Medicare. Include a COB Loop for the IHCP-required information with Payer ID *70035*.

The 837 transaction allows providers to submit claims with the specifications outlined in Table 4.3.

Table 4.3 – 837 Transaction Specifications

Specification	Explanation
Number of details	• UB* service lines increase to 450. • Medical claims service lines increase to 50.
Modifiers	• UB claims can include as many as four modifiers. • Medical claims can include as many as four modifiers.
ICD-9 Diagnosis Codes	UB claims can submit as many as 27 diagnosis codes. • This includes the admit diagnosis, primary diagnosis, E-code, and 24 additional codes. • Medical claims can include as many as eight diagnosis codes at the claims level and four diagnosis indicators per service line.
Units	UB and medical claims expand the length of the unit field to ten digits, including three decimal places.
Dollar amounts fields	UB and medical claims expand the length of the dollar field to ten total digits, including two decimal places. • This applies to all dollar amount fields.
Patient account number	UB and medical claims allow as many as 20 characters for the account number.
ICD-9 Procedure Codes	UB claims allow as many as 25 ICD-9 procedure codes and corresponding dates.
Type of bill	UB claims allow four characters.
Occurrence Codes and span dates	UB claims allow as many as 12 occurrence codes and corresponding dates.

* UB is a standard term used for institutional claims.

CMS advises providers to allow 15 business days after receipt of Medicare's payment before submitting a claim to a supplemental payer. If a paper submission is required; submit the claim along with the official MRN or HIPAA electronic 835 Remittance Advice as outlined in the *Companion Guide: 835 Remittance Advice Transaction*.

The COBA initiative does not impact providers submitting crossover claims via Web interChange.

New Edit for COBA

A new edit has been created, *0592 – Medicare denied detail*. This eliminates the need for providers to adjust the claim.

The COBC has provided the IHCP with a list of Medicare contractors that can provide claims adjudication and crossover through their processing systems. A list of these contractors is available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/Misc_PDF/Medicare_Payer_IDs.pdf.

For more details, visit the CMS Web site at http://www.cms.hhs.gov/COBGeneralInformation/.

Contact Information

Direct questions about electronic transactions processing to EDS Electronic Solutions Help Desk, (317) 488-5150, in the Indianapolis local area, or 1-877-877-5182.

IHCP E-mail Notifications Program

On January 17, 2006, EDS and the IHCP launched the IHCP E-Mail Notifications program. This program automatically issues e-mails to subscribers when IHCP publications and announcements are posted to the IHCP Web site.

This service is **free** and available to both providers and non-providers. To subscribe to the service, visit the IHCP Web site at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

On the *IHCP E-mail Notifications* page, click the **Open New Account** button, complete the profile information, and select the publications for e-mail notifications. You will receive a *SUBSCRIPTION REQUEST* e-mail with instructions and a link to activate your subscription. You must follow the link in the e-mail to activate your registration. Once your subscription is activated you will receive a *WELCOME!* e-mail to verify the activation. You may subscribe or

unsubscribe at any time. Each notification e-mail contains a link for updating your subscription profile or unsubscribing to the service.

Publications are posted to the Web site on Tuesdays and Thursdays of each week. For a period of time *both* e-mail notifications and paper copies of the publications will be provided.

HCBCS Waiver Case Managers and Providers

Medicaid Reimbursement as Payment in Full and the HCBS Waiver Program

This article summarizes information already available to HCBS case managers and providers in the *IHCP Provider Manual* and the *IHCP Provider Agreement* in regard to hierarchy of funding streams when an HCBS waiver case manager submits an RFA to the Medicaid Waiver Unit. The *IHCP Provider Manual* (March 2005) and the *IHCP Provider Agreement* may be located at the IHCP Web site at www.indianamedicaid.com. The HCBS waiver program may not pay the difference between the Medicaid allowable amount for a product or service and the private pay rate. The following pertinent excerpts from the *IHCP Provider Manual* and the *IHCP Provider Agreement* are included below.

According to Chapter 2, Section 3 of the *IHCP Provider Manual*, waiver programs cover a variety of HCBS not otherwise reimbursed by the IHCP. The IHCP has always noted that Indiana Medicaid is the payor of last resort when there are other funds available; however, HCBS waiver funds are a closed funding stream so waiver budgeted dollars are considered the payor of last resort after Medicaid dollars have been exhausted. HCBS waiver case managers and HCBS waiver providers are reminded that the following hierarchy of funding streams must be exhausted prior to requesting an RFA: Private Pay/Medicare and Medicaid.

Furthermore, the *IHCP Provider Agreement* outlines the following consistent with the statement in the previous paragraph:

12. To abide by the *Indiana Health Coverage Programs Provider Manual*, as amended from time to time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.
18. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.
30. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

Contact Information

Questions about information contained in this article may be directed to EDS Customer Assistance at (317) 655-3240, in the Indianapolis local area, or 1-800-577-1278.

Questions about Medicaid PA may be directed to HCE Prior Authorization Unit at (317) 347-4511, in the Indianapolis local area, or 1-800-457-4518.

Questions about the RFA may be directed to Waiver Services at (317) 232-0049.

Pharmacy Services

State MAC Legend Drug Rate Updates

Attachment 3 of this newsletter contains the updates to the State MAC rates and rate lists with effective dates for the changes.

Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 in the Indianapolis local area, or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

Medicare Prescription Drug Benefit

The IHCP continues to provide information about Medicare Part D in banner pages, the IHCP provider newsletter, bulletins, and on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp.

Accessing Program Information for Medicaid Drug Rebate and FUL

Providers may now verify a manufacturer's participation in the CMS federal Medicaid Drug Rebate Program by visiting http://www.indianapbm.com/, and selecting **Drug Rebate Labelers** from the *Pharmacy Services* menu. In addition, providers can access CMS Web site for the latest rates and information for the FUL Program by selecting **Federal Upper Limits (FUL) Program (FMAC)** from the *Pharmacy Services* menu, or by visiting http://www.cms.hhs.gov/FederalUpperLimits/. E-mail your questions to PDL@fssa.state.in.us.

Provider Workshops

2006 Second Quarter Medicaid Provider Workshops

The OMPP, CHIP, and EDS offer IHCP 2006 first quarter workshops free of charge. Sessions are offered at several locations in Indiana. Table 4.4 lists the time, session topic, and description. The schedule allows for a lunch period from noon until 1 p.m.; however, lunch is not provided. **Seating is limited in all locations**. **Registrations are processed in the order received and registration does not guarantee a spot at the workshop**. Confirmation letters are sent upon receipt of registrations. If a confirmation letter is not received, the workshop seating capacity has been reached.

All workshops begin promptly at 8 a.m., local time. General directions to workshop locations are available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp. Consult a map or other location tool for specific directions to the exact location.

Workshops are presented free of charge to providers.

Seating for the workshops is limited to two registrants per provider number.

A copy of the *Provider Workshop Registration* form is included as Attachment 2 of this newsletter. Print or type the information requested on the registration form. List one registrant per form. Fax completed registration forms to EDS at (317) 488-5376. EDS processes registrations chronologically based on the date of the workshop. A letter or fax confirming registration is sent before the workshop.

Direct questions about the workshop to a field consultant at (317) 488-5072.

For comfort, business casual attire is recommended. Consider bringing a sweater or jacket due to possible room temperature variations.

Table 4.4 – 2006 Second Quarter Workshop Session Times, Topics, and Descriptions

Time	Topic	Description
8 a.m. – 10:45 a.m.	Medicaid 101	This session provides an overview of the IHCP, eligibility verification methods, the restricted card program, managed care programs, and more. This session is ideal for new IHCP billers or those needing an IHCP refresher course.
10:45 a.m. – 11 a.m.	Break	
11 a.m. – 12 p.m.	Waiver Services	This is an educational session designed for new and current waiver providers. An overview of the new *Waiver Provider Manual* will be presented. This session is ideal for new providers to learn the processes of waiver billing, documentation, and audit criteria.
12 p.m. – 1 p.m.	Lunch Break	Lunch is not provided
1 p.m. – 1:30 p.m.	Managed Care Presented by MDwise representatives	This session is designed for MDwise to present valuable information to assist providers in the billing of their claims. A question and answer period will follow.
1:30 p.m. – 2 p.m.	Managed Care Presented by MHS representatives	This session is designed for MHS to present valuable information to assist providers in the billing of their claims. A question and answer period will follow.

(Continued)

Table 4.4 – 2006 Second Quarter Workshop Session Times, Topics, and Descriptions

Time	Topic	Description
2 p.m. – 2:30 p.m.	Managed Care Presented by Molina Healthcare, Inc. representatives	This session is designed for Molina Healthcare to present valuable information to assist providers in the billing of their claims. A question and answer period will follow.
2:30 p.m. – 2:45 p.m.	Break	
2:45 p.m. – 3:15 p.m.	Managed Care Presented by Harmony Health Plan representatives	This session is designed for Harmony Health Plan to present valuable information to assist providers in the billing of their claims. A question and answer period will follow.
3:15 p.m. – 3:45 p.m.	Managed Care Presented by CareSource representatives	This session is designed for CareSource to present valuable information to assist providers in the billing of their claims. A question and answer period will follow.

Table 4.5 lists the workshop dates, registration deadlines, and Indiana locations for each workshop.

Table 4.5 – 2006 Second Quarter Workshop Dates, Registration Deadlines, and Locations

Workshop Date	Registration Deadline	Location
Friday, June 2, 2006	Friday, May 26, 2006	Home Hospital 415 N. 26th St. Lafayette, IN 47904
Monday, June 5, 2006	Monday, May 29, 2006	Ball Memorial Hospital Auditorium 2401 University Ave. Muncie, IN 47303
Tuesday, June 6, 2006	Tuesday, May 30, 2006	Wishard Hospital Myers Auditorium 1001 W. 10th St. Indianapolis, IN 46202
Tuesday, June 13, 2006	Tuesday, June 6, 2006	Lutheran Hospital Kachmann Auditorium 7950 W. Jefferson Blvd. Fort Wayne, IN 46807
Friday, June 16, 2006	Friday, June 9, 2006	St. Joseph Regional Medical Center Educational Center 801 E. LaSalle Ave. South Bend, IN 46617
Thursday, June 22, 2006	Thursday, June 15, 2006	Bloomington Hospital Wegmiller Auditorium 601 W. 2nd St. Bloomington, IN 47403
Tuesday, June 27, 2006	Tuesday, June 20, 2006	Floyd Memorial Hospital 1850 State St. New Albany, IN 47150
Wednesday, June 28, 2006	Wednesday, June 21, 2006	Deaconess Hospital Bernard Schnacke Auditorium 600 Mary St. Evansville, IN 47747

Contact Information

Provider Field Consultants, Effective March 10, 2006

Territory Number	Provider Consultant	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke
2	Susan Bresson	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, Whitley
3	Jenny Atkins (temp)	(317) 488-5071	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	Natalie Snow	(317) 488-5356	Marion
6	Tina King	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington
7	Lori Bishop	(317) 488-5148	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
8	Cynthia Spear-Duncan	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
9	Tina King (temp)	(317) 488-5123	Out-of-State

Field Consultants for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/Watseka	Jean Downs	(317) 488-5071
	Danville	Lori Bishop	(317) 488-5148
Kentucky	Owensboro	Cynthia Spear-Duncan	(317) 488-5153
	Louisville	Tina King	(317) 488-5123
Michigan	Sturgis	Susan Bresson	(317) 488-5080
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Tina King	(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.

Member and Provider Relations Leaders, Effective March 1, 2006

Title	Name	Telephone
Director of Member and Provider Relations	Marcia Meece-Bagwell	(317) 488-5345
Provider Relations Supervisor	Phyllis Salyers	(317) 488-5154

Note: For a map of provider representative territories or for updated information about the provider field consultants, visit the IHCP Web site: http://www.indianamedicaid.com/ihcp/ProviderServices/pr_list_frameset.htm..

If you need additional copies of this newsletter, please download them from the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/newsletters.asp. To receive e-mail notifications of future IHCP publications, subscribe to the IHCP E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp.

Indiana Health Coverage Programs Quick Reference, Effective March 10, 2006

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization

AVR System (including eligibility verification) (317) 692-0819 1-800-738-6770	EDS Administrative Review Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Customer Assistance (317) 655-3240 1-800-577-1278 Opt 1 = Pharmacy, Opt 2 = First Steps	EDS Electronic Solutions Help Desk (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@eds.com
EDS Forms Requests P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Member Hotline (317) 713-9627 1-800-457-4584 Opt 1 = First Steps, Opt 2 = Pharmacy	EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	EDS Provider Enrollment/Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750
EDS Third Party Liability (TPL) (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	HCE Medical Policy Department P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	HCE Prior Authorization Department P.O. Box 531520 Indianapolis, IN 46253-1520 (317) 347-4511 or 1-800-457-4518	HCE SUR Department P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 1-800-457-4515
HCE Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 or 1-800-457-4515		IHCP Web Site www.indianamedicaid.com	

Pharmacy Benefit Manager

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 1-800-577-1278 or INXIXPharmacy@EDS.com	EDS Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268	Indiana DUR Board INXIXDURQuestions@acs-inc.com
EDS Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	Indiana Administrative Review/ Pharmacy Claims EDS Pharmacy Claims Admin. Review P.O. Box 7263 Indianapolis, IN 46207-7263	PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center 1-866-879-0106 Fax: 1-866-780-2198	To make refunds to IHCP for pharmacy claims send check to: EDS Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303

Hoosier Healthwise (Managed Care Organizations and PCCM) and *Medicaid Select*

CareSource Claims www.caresource-indiana.com 1-866-930-0017 Member Services 1-800-488-0134 PA 1-866-930-0017 Provider Services 1-866-930-0017	Harmony Health Plan www.harmonyhmi.com Claims 1-800-504-2766 Member Services 1-800-608-8158 TTY: 1-877-650-0952 PA/Medical Management 1-800-504-2766 Provider Services 1-800-504-2766 Pharmacy 1-800-608-8158	Managed Health Services (MHS) www.managedhealthservices.com Claims 1-800-414-9475 Member Services 1-800-414-5946 PA/Medical Management 1-800-464-0991 Provider Services 1-800-414-9475 Nursewise 1-800-414-5946 ScripSolutions (PBM) 1-800-555-8513	MDwise www.mdwise.org Claims 1-800-356-1204 or (317) 630-2831 Member Services 1-800-356-1204 or (317) 630-2831 PA/Medical Management 1-800-356-1204 or (317) 630-2831 Provider Services 1-800-356-1204 or (317) 630-2831 Pharmacy (317) 630-2831 or 1-800-356-1204
Molina Healthcare www.molinahealthcare.com Claims 1-800-642-4509 Member Services 1-800-642-4509 PA 1-800-642-4509 Provider Services 1-800-642-4509	Prime*Step* (PCCM) www.healthcareforhoosiers.com Claims - EDS Customer Assistance 1-800-577-1278 or (317) 655-3240 Member Services 1-800-889-9949, Option 1 Prior Authorization HCE: 1-800-457-4518 or (317) 347-4511 Provider Services for PMPs 1-800-889-9949, Option 3 Pharmacy – see Pharmacy Benefit Manager section above	*Medicaid Select* www.medicaidselect.com Claims - EDS Customer Assistance 1-800-577-1278 or (317) 655-3240 Member Services 1-877-633-7353, Option 1 PA HCE: 1-800-457-4518 (317) 347-4511 Provider Services for PMPs 1-877-633-7353, Option 3 Pharmacy – see Pharmacy Benefit Manager section above	

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-92 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims P.O. Box 7271 Indianapolis, IN 46207-7271	

Check Submission (Non-Pharmacy)

To make refunds to IHCP: EDS Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	To Return Uncashed IHCP Checks: EDS Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288

INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER WORKSHOP REGISTRATION

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

Medicaid 101		
☐ Lafayette, June 2, 2006	☐ Muncie, June 5, 2006	☐ Indianapolis, June 6, 2006
☐ Fort Wayne, June 13, 2006	☐ South Bend, June 16, 2006	☐ Bloomington, June 22, 2006
☐ New Albany, June 27, 2006	☐ Evansville, June 28, 2006	
Waiver Services		
☐ Lafayette, June 2, 2006	☐ Muncie, June 5, 2006	☐ Indianapolis, June 6, 2006
☐ Fort Wayne, June 13, 2006	☐ South Bend, June 16, 2006	☐ Bloomington, June 22, 2006
☐ New Albany, June 27, 2006	☐ Evansville, June 28, 2006	

MCO Presentations *(Select date and presentations)*

Lafayette, June 2, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.	Muncie, June 5, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.
Indianapolis, June 6, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.	Fort Wayne, June 13, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.
South Bend, June 16, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.	Bloomington, June 22, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.
New Albany, June 27, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.	Evansville, June 28, 2006 ☐ MDwise ☐ Harmony Health Plan ☐ Managed Health Services ☐ CareSource ☐ Molina Healthcare, Inc.

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: _____

State MAC Legend Drug Rate Updates

Changes Effective February 14, 2006

Table 4.6 – Increases to the State MAC Rates for Legend Drugs, Effective February 14, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMITRIPTYLINE HCL 50 MG TAB	0.03880	THEOPHYLLINE ER 300 MG TABLET	0.16670
CLINDAMYCIN PH 1% SOLUTION	0.09540	TRIAMCINOLONE 0.1% CREAM	0.04930
SULFAMETHOXAZOLE/TMP DS TAB	0.09450		

Changes Effective March 14, 2006

Table 4.7 – Increases to State MAC Rates for Legend Drugs, Effective March 14, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMOXICILLIN 500 MG CAPSULE	0.05694	IBUPROFEN 800 MG TABLET	0.04907
HYDROCODONE/APAP SOLUTION	0.03072		

Changes Effective March 31, 2006

Table 4.8 – Additions to the State MAC Rate List for Legend Drugs, Effective March 31, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
CALCITRIOL 1 MCG/ML SOLUTION	10.81170	FEXOFENADINE HCL 60 MG TABLET	1.24840
CEFTRIAXONE 2 GM VIAL	18.49570	GANCICLOVIR 500 MG CAPSULE	7.15980
CEFTRIAXONE 500 MG VIAL	5.45400	GLIMEPIRIDE 2 MG TABLET	0.21500
CHOLESTYRAMINE LIGHT PACKET	1.00560	GLIMEPIRIDE 4 MG TABLET	0.35640
DIDANOSINE 250 MG DR CAPSULE	5.59890	SULFADIAZINE 500 MG TABLET	1.35200
DIDANOSINE 400 MG DR CAPSULE	8.74440		

Table 4.9 – Decreases to State MAC Rates for Legend Drugs, Effective March 31, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
BACLOFEN 10 MG TABLET	0.14210	METOPROLOL 50 MG TABLET	0.02960
BUSPIRONE HCL 15 MG TABLET	0.12260	MIRTAZAPINE 30 MG TABLET	0.26390
CLARITHROMYCIN 500 MG TABLET	1.32770	MORPHINE SULF 60 MG TAB SA	1.29620
ETH ESTRADIOL/DESOGEST 30/0.15 TAB	0.78170	NORTRIPTYLINE HCL 10 MG CAP	0.03620
GABAPENTIN 600 MG TABLET	1.03100	PREDNISONE 5 MG TABLET	0.02390
GABAPENTIN 800 MG TABLET	1.21460	PROMETHAZINE W/COD SYRUP	0.01620
HYDROCODONE/APAP 10/325 TAB	0.21010	RANITIDINE 150 MG TABLET	0.05020
HYDROXYZINE 10 MG/5 ML SYRUP	0.01020	TORSEMIDE 20 MG TABLET	0.36920

(Continued)

Table 4.9 – Decreases to State MAC Rates for Legend Drugs, Effective March 31, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
HYDROXYZINE PAM 50 MG CAP	0.07710	TRAMADOL HCL-ACETAMINOPHEN TAB	0.61280
KETOCONAZOLE 2% CREAM	0.52590		

Table 4.10 – Decreases to the State MAC Rates for Legend Drugs, Effective March 31, 2006

Drug Name	State MAC Rate
METOPROLOL 50 MG TABLET	0.03672

Changes Effective April 28, 2006

Table 4.11 – Additions to State MAC Rate List for Legend Drugs, Effective April 28, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMPICILLIN-SULBACTAM 3 GM VL	1.50504	POLYETHYLENE GLYCOL 3350 POWDER	0.07060
ANAGRELIDE HCL 0.5 MG CAPSULE	0.37520	PROMETHAZINE 50 MG TABLET	0.63040
D5-1/2NS/KCL 10 MEQ/L IV SOL	0.00377	QUINAPRIL/HCTZ 20/12.5 TABLET	1.01950

Table 4.12 – Decreases to State MAC Rates for Legend Drugs, Effective April 28, 2006

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMANTADINE 100 MG CAPSULE	0.28926	IPRATROPIUM BR 0.02% SOLN	0.05748
BRIMONIDINE 0.2% EYE DROP	3.02340	PERMETHRIN 5% CREAM	0.14450
CIPROFLOXACIN HCL 750 MG TAB	0.19353	PROCHLORPERAZINE 25 MG SUPP	1.17650
CYPROHEPTADINE 4 MG TABLET	0.13632	RANITIDINE 150 MG TABLET	0.04265
DIGOXIN 125 MCG TABLET	0.10488	SULFAMETHOXAZOLE/TMP DS TAB	0.08468
ECONAZOLE NITRATE 1% CREAM	0.33440	SULINDAC 200 MG TABLET	0.23447
GABAPENTIN 300 MG CAPSULE	0.34480	TRAMADOL HCL-ACETAMINOPHEN TAB	0.57873
GABAPENTIN 600 MG TABLET	0.96261	TRIAMCINOLONE 0.1% CREAM	0.04195
GABAPENTIN 800 MG TABLET	1.14227	TRIAMTERENE/HCTZ 37.5/25 CP	0.05411
HYDROCHLOROTHIAZIDE 25 MG TB	0.02316	VERAPAMIL 120 MG TABLET	0.07650
HYDROCODONE/APAP 10/500 TAB	0.15317	VERAPAMIL 120 MG TABLET SA	0.47612
OMEPRAZOLE 20 MG CAPSULE DR	0.97695		

Direct any questions regarding the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136, in the Indianapolis local area, or 1-800-591-1183, or e-mail at pharmacy@mslc.com.

Provider TPL Referral Form

Indiana Health Coverage Programs

PROVIDER TPL REFERRAL FORM

Providers: Please complete if you have received a request for medical records from an IHCP member's attorney relating to a personal injury claim or if you have information about a personal injury claim being pursued by an IHCP member.

1. Name of IHCP Member: _____
2. Member Number: _____
3. Date of Birth: _____
4. Social Security Number: _____
5. Member's Home Address: _____
6. Member's Telephone Number: _____
7. Date of Accident or Injury: _____
8. Brief Description of Accident and Injuries:

_____
_____
_____

9. Member's Attorney Name, Address, and Phone Number:

_____
_____
_____

10. Insurance Information (Name of liability insurance carrier, policy number, claim number, adjuster's name, address, and phone number)

_____
_____
_____
_____

Please send this information to the TPL Casualty Department by e-mail at INXIXCasualty@eds.com, by facsimile at (317) 488-5217, by telephone at (317) 488-5046 in the Indianapolis local area or 1-800-457-4510, or by U.S. mail to the following address:

EDS TPL Casualty Department
P.O. Box 7262
Indianapolis, IN 46207-7762

Form Number: TPL0006
Revision Date: March 2005