Monthly News

Indiana Health Coverage Programs

www.indianamedicaid.com

Provider News NL200410 October 2004

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Frequently Used Acronyms

AAA	Area Agency on Aging
AVR	Automated Voice Response
CMS	Centers for Medicare & Medicaid Services
CPT	Common Procedural Terminology
DFC	Division of Family and Children
DME	Durable Medical Equipment
FQHC	Federally Qualified Health Center
HCE	Health Care Excel
HCPCS	Healthcare Common Procedure Coding System
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act
IAC	Indiana Administrative Code
IDOA	Indiana Department of Administration
IFSSA	Indiana Family and Social Services Administration
IHCP	Indiana Health Coverage Programs
IPAS	Indiana Pre-admission Screening
LOC	Level of Care
MCO	Managed Care Organization
MDS	Minimum Data Set
NDC	National Drug Code
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PAS	Pre-admission Screening
PCCM	Primary Care Case Management

Provider News

PA for Respigam and Synagis

HCPCS code J1565 *Injection, respiratory syncytial virus immune globulin, intravenous, 50mg*, CPT code 90379 *Respiratory syncytial virus immune globulin (RSV-IGIV), human, for intravenous use*, and CPT code 90378 *Respiratory syncytial virus (RSV) immune globulin, for intramuscular use, 50mg* all require PA. These codes represent the RSV immune globulin product only and not the administration of the product. The IHCP has discovered that Indiana*AIM* did not accurately indicate that PA was required for these codes. This is not a change in policy, as Respigam (J1565 and 90379) and Synagis (90378) have required PA since April 15, 2002, as described in IHCP provider bulletin *BT200210*. PA criteria for Respigam and Synagis can also be found in banner pages *BR200239* and *BR200240*. Indiana*AIM* has been updated to require PA for these codes beginning with the upcoming RSV season, effective October 1, 2004.

Physicians, hospitals, and clinics that provide Respigam or Synagis products in an office or outpatient setting may bill for the immune globulin product using the appropriate code and claim format. A pharmacy, or any of the previously listed provider types dually enrolled as a pharmacy, must submit claims for Respigam and Synagis using the NDC on the drug claim form. In addition, providers are reminded that it is not appropriate for those solely enrolled as DME suppliers to submit claims for Respigam or Synagis using either of these methods.

PA requests for the provision of either Respigam or Synagis that are billed using J1565, 90379, or 90378 must be requested from the HCE PA Department. The HCE PA Department can be contacted by calling 1-800-457-4518 or (317) 347-4511. It is recommended that providers submitting PA requests to HCE attach the ACS Synagis request form, which is available on the IHCP Web site. If Respigam or Synagis is being provided by a pharmacy provider, the claim must be submitted using the NDC, and PA must be requested from ACS State Healthcare. Providers may contact ACS at 1-866-879-0106. As previously stated, pharmacy providers must submit claims for Respigam or Synagis using the NDC on the drug claim form.

Respigam and Synagis treatments are only approved during the RSV season. Respigam administration can be performed in a clinic, physician's office, or a hospital. Synagis administration is permitted in any setting where intramuscular injections are appropriate, including home administration. The approval period is from October 1 through April 30 of the following year. As stated in previous publications, approval will consist of a total of six doses and administration of a seventh dose will require a separate PA. Refer to banner pages *BR200239* or *BR200240* for PA criteria.

Providers who previously provided Respigam or Synagis to IHCP members using procedure codes J1565, 90379, or 90378 may be subject to post-payment review. Patient records must document medical necessity for the provision of Respigam or Synagis. In addition, treatment provided outside of the typical RSV season of October 1 through April 30 of the following year will be subject to investigation and possible recoupment of IHCP reimbursement.

Home Infusion and Enteral Therapy

This article provides information about reimbursement policies for home infusion therapy and enteral therapy services. A recent review of claims has indicated that providers are inappropriately billing for these services.

When billing for home infusion and enteral therapy services, the following three components are billed separately:

- All supplies, equipment, and enteral therapy billed by DME providers must be on a CMS-1500 claim form or 837P transaction using the appropriate HCPCS code.
- For services provided in the home by an RN, LPN, or home health aide, the HHA must bill on the UB-92 claim form or 837I transaction using the appropriate revenue and HCPCS code combination.
- Compound drugs or any drugs or biologicals used in parenteral therapy provided by a pharmacy must be billed on a drug claim form or other electronic media to the pharmacy claims processing vendor using the appropriate NDC.

If an HHA is enrolled as a home health agency, pharmacy, and DME provider, they must bill all three components of home infusion or enteral therapy using the proper billing form and the appropriate codes. An HHA that is dually enrolled as a pharmacy provider **must** submit all compound drugs and any drugs used in parenteral therapy on a drug claim form using the appropriate NDC.

> *Note: Claims for parenteral therapy containing drugs that are billed on the CMS-1500 or 837P transaction by an HHA, dually enrolled as a pharmacy, are subject to post payment audit and recoupment.*

Additionally, it was recently discovered that HCPCS S-codes for home infusion and enteral therapy were incorrectly indicated as billable in Indiana*AIM* beginning in 2002, and providers may have been reimbursed inappropriately for services billed under these codes. The IHCP does not routinely use HCPCS S-codes when other national codes are available for the same services. HCPCS S-codes for home infusion therapy and enteral therapy are not reimbursable by the IHCP, with the exception of S9349 *Home tocolytic infusion therapy.* Refer to Chapter 8 of the *IHCP Provider Manual* which has instructions for billing home tocolytic therapy. Providers are reminded that they must separately bill the appropriate national codes, using the proper billing format, to receive reimbursement for services described in HCPCS S-codes for home therapy, including home infusion and enteral therapy.

Additional information about reimbursement policies and procedures can be found in Chapter 8 of the *IHCP Provider Manual*.

Direct questions about this information to EDS customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Medicaid Behavioral/Physical Health Coordination Form

In 2004 a multidisciplinary task force consisting of mental health advocates, managed care organizations, primary health care providers, the community mental health system, academics, and state officials met to discuss methods for improving the communication between behavioral health and physical health providers.

The task force began with the belief that the exchange of information between physical and behavioral health care providers is essential for safe, effective coordination of care. To facilitate this exchange of information, the task force developed the *Medicaid Behavioral/Physical Health Coordination Form*. It is the hope of the task force that providers will use the form to assist with the sharing of information, thus increasing the coordination of care between the two health care systems. This form can be completed by either a behavioral or physical health provider and faxed or mailed to the other provider or providers caring for the patient. The receiving practitioner will complete the rest of the form and return the results to the initiating provider. Both providers can attach the form to the patient's medical record.

One concern raised during the development of this form was a provider's legal ability to exchange this information. Both HIPAA *(45 CFR Part 164.501, .502*, and *.506*) and state law (*IC 16-39-2-6(a)(1))* permit the flow of patient information between providers as necessary to coordinate and manage the provision of health care, even without patient authorization. While obtaining patient consent is always desirable, lack of patient consent is only a legal concern if the provider is a federally assisted alcohol or drug program, because *42 CFR Part 2.51* requires the existence of a medical emergency before an unconsented disclosure between providers can be made.

This form is available on the Web sites for Hoosier Healthwise (www.healthcareforhoosiers.com), *Medicaid Select* (www.medicaidselect.com), and the IHCP (www.indianamedicaid.com).

The following organizations are committed to using this form to enhance the coordination of physical and behavioral health care:

- AmeriChoice
- Division of Mental Health and Addiction
- Harmony Health Plan
- Indiana Council of Community Mental Health Centers, Inc.
- InteCare
- NAMI
- Managed Health Services
- Mental Health Association of Indiana

- MDwise
- OMPP
- Regenstrief Institute

A copy of this form is included as an attachment on the last page of this newsletter.

Anthem Midwest Clearinghouse no Longer Accepting IHCP Claims

Effective November 1, 2004, Anthem Midwest clearinghouse will no longer accept IHCP claims. Providers using Anthem EDI as their clearinghouse to send IHCP claims must choose a different software developer or clearinghouse. The EDI Solutions page of the IHCP Web site at http://www.indianamedicaid.com contains a list of approved software vendors and clearinghouses.

Direct questions about this information to the EDI Solutions help desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182.

EDI Information on the IHCP Web Site

The IHCP Web site contains information for providers and EDI software developers about upcoming IHCP system updates. In the *EDI Solutions* section, the *What's New For Providers* and *What's New For EDI Vendors* pages contain important system update information.

Providers should contact their software developers to ensure that they are aware of this part of the Web site and the important EDI information. Software developers should view this site regularly to ensure that their systems are updated and tested for the most current system changes.

It is the provider's and software vendor's responsibility to monitor the EDI updates, and to make and test necessary changes to their system. Failure to monitor the EDI updates and make appropriate changes could result in unexpected outcomes such as claims rejecting for noncompliance, 835 electronic remittance information displaying differently than expected, or providers not being able to view updated eligibility information.

Direct questions about this information to the EDI Solutions help desk at (317) 488-5160 in the Indianapolis local area or 1-877-877-5182 or by email at inxixtradingpartner@eds.com.

Annual ICD-9-CM Code Updates

The annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is effective October 1, 2004. The ICD-9-CM diagnosis and ICD-9-CM procedure codes are billable and reimbursable effective October 1, 2004. To ensure HIPAA compliance, the 90-day grace period will no longer apply to the ICD-9-CM updates. Providers are to use the diagnosis and procedure codes valid for the date of service. Direct questions about this information to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Dental Services

Package E Dental Services

Providers must verify eligibility prior to rendering services to IHCP members. It is important to verify eligibility prior to each visit, as eligibility can change or be terminated at any time. It has come to the attention of the IHCP that dental providers may have received inappropriate reimbursement for services rendered to Package E members.

Chapter 2 of the *IHCP Provider Manual* describes the different eligibility categories within the IHCP. Hoosier Healthwise Package E members are eligible only for services to treat an emergency medical condition(s). The *Omnibus Budget Reconciliation Act (OBRA) of 1986* defines an emergency medical condition as follows:

A medical condition of sufficient severity (including severe pain) that the absence of medical attention could result in placing the member's health in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of an organ or part.

Preventive treatments such as sealants, prophylaxis, and fluoride treatments do not meet the definition of an emergency medical condition. Those providers identified as having received inappropriate reimbursement for Package E members will be subject to investigation and possible recoupment if the services provided do not meet the definition of an emergency medical condition.

Version 5.0 of the *IHCP Provider Manual*, *Chapter 8, page 233* states that field 53 of the ADA dental claim form must be used to specify if the services performed were for emergency care. Field 53 is a required field. Providers must indicate *Yes* for emergency care rendered to Package E members. All services are subject to post-payment review and documentation must support medical necessity for the services performed.

Direct questions about this information to EDS customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

DME Services

PA Criteria for Coverage of Cranial Remolding Orthosis

The IHCP has determined that HCPCS code S1040 is the most appropriate code for billing cranial molding helmets for members with cranial asymmetry. HCPCS code S1040 will be covered by the IHCP when medically necessary, with PA, retroactively, effective July 1, 2004, at a max fee of $1480.11. Effective immediately, providers must discontinue requests for HCPCS codes L1499, L0100, or E1399 for cranial molding helmets. These requests will be denied, and any claims paid for cranial molding helmets with these codes after November 1, 2004, will be subject to recoupment.

The IHCP considers HCPCS code S1040 for cranial remolding orthosis to be medically necessary for members between four and 24 months of age with benign positional plagiocephaly, plagiocephaly with torticollis, brachycephaly, dolichocephaly, and scaphocephaly due to conditions such as in utero or intra partum molding, premature or multiple births, and supine positioning. The prescription for the cranial remolding orthosis must be signed by a pediatrician, a general surgeon with a specialty in pediatrics, a pediatric surgeon, a craniofacial surgeon or a craniofacial anomalies team member. The medical necessity and PA criteria must be documented in the patient's chart by the prescribing physician. The PA form must be signed by the prescribing physician, but may be submitted by the DME supplier.

The following PA criteria must be met for the cranial remolding orthosis to be considered for approval for members between the ages of four and 12 months of age.

1. Documentation must be submitted that shows the member received a minimum of a two month trial of aggressive repositioning and stretching exercises recommended by the American Academy of Pediatrics and has failed to improve.

Exercises should include at least four of the following activities:

- Alternating back and side sleeping
- Supervised *tummy time*
- Rearranging the crib relative to the primary light source
- Limiting time spent in a supine position
- Limiting time in strollers, carriers, swings and strollers
- *Rotating chair* activity
- Neck motion exercises

And **one** of the following (2-6).

2. Moderate to severe positional plagiocephaly, with or without torticollis, documented by an anthropometric asymmetry greater than 6 mm in the measurement of the cranial base, cranial vault, or orbitotragial depth.
3. Brachycephaly documented by a cephalic index two standard deviations above or below the mean (approximately 78 percent).
4. Scaphocephaly or dolichocephaly in premature or breech infants with a cephalic index significantly less than 78 percent.
5. Further correction of asymmetry for members after surgical treatment of craniosynostosis will be considered on a case-by-case basis.
6. Moderate to severe residual plagiocephaly after surgical correction of plagiocephaly. Documentation of medical necessity must be provided by the pediatric neurosurgeon or craniofacial surgeon who performed the corrective procedure.

Treatment of members 12-24 months old with severe plagiocephaly and who are considered to have a reasonable likelihood of continued skull growth will be considered for approval on a case-by-case basis. Documentation of medical necessity must be provided by a pediatric neurosurgeon, craniofacial surgeon, or craniofacial anomalies team member. The member must have a documented trial of repositioning and stretching exercises as

described in criteria 1 to be considered for approval.

The following are contraindications to receiving a cranial remolding orthosis:

- Members greater than 24 months old
- Unmanaged Hydrocephalus
- Craniosynostosis

Direct questions about this article to the HCE Medical Policy department at (317) 347-4500.

DME Provider Code Set

Effective November 1, 2004, a *DME Provider Code Set* will be implemented. Claims submitted by DME providers will be subject to edit 1012 – *Rendering provider specialty not eligible to render procedure code*. The development of the *DME Provider Code Set* does not involve any policy change, but instead identifies procedure codes that are appropriate for reimbursement by DME providers. Providers must ensure that they are enrolled under the correct provider specialty with the IHCP. For additional information about provider enrollment, refer to Chapter 4 of the *IHCP Provider Manual*, contact a provider field representative, or contact the EDS Provider Enrollment Unit at 1-877-707-5750. Enrolled providers billing within current IHCP guidelines should not experience difficulty with claim adjudication associated with the implementation of these code sets.

The code sets will be available on the IHCP Web site prior to implementation. These code sets are subject to change and will be updated accordingly on the IHCP Web site based on annual and quarterly HCPCS updates and policy changes. Providers should monitor the Web site for changes to the code sets. Reimbursement will continue to be subject to current applicable policies, edits, or audits. Direct questions about this information to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Nursing Facility Services

Process Changes in Pre-admission Screening Determinations and Related *Form 450B* and *OMPP 450B SA/DE*

This article provides information about changes to the pre-admission screening determination process for admissions to nursing facilities and the procedures for *Form 450B* and *OMPP 450B SA/DE.*

Transfer of Pre-admission Screening Determination Authority

In April 2004, the OMPP initiated a pilot project to transfer the responsibility for the nursing facility IPAS determinations in Area 8 (Marion County and surrounding counties) from the OMPP to the CICOA. It is anticipated that effective June 1, 2004, the IPAS determinations for all Indiana nursing facilities will be transferred to the local AAA.

This change is in the determination process only. There is no change in the IPAS application and screening process. However, to streamline the determination process for nursing facility admissions subject to IPAS, the AAAs will make the official determination on behalf of the State as follows:

- The AAA will issue the *Form 4B Indiana's Pre-Admission Screening Program (PAS/PASRR) Assessment Determination* for all Medicaid and Medicaid pending individuals and private pay individuals on behalf of the OMPP.
- **If the applicant is on Medicaid, is in the nursing facility, and is approved for nursing facility care with Medicaid as the primary payer, the AAA will transmit this information to the OMPP to enter the LOC in Indiana*AIM* and issue a completed form *450B SA/DE*.** After the nursing facility receives the *4B* from the AAA, the OMPP will generate a *450B SA/DE* form within two weeks. Providers should not submit any documentation prior to receiving the OMPP generated *450B SA/DE* form if the requirements listed above are met.
- If the applicant is pending Medicaid, Medicaid is not the primary payer (Medicare, or other third party is the primary payer), or the individual is not yet in a nursing facility, the AAA will issue the *Form 4B* and the *OMPP 450B SA/DE* to approve the admission. The *Effective Medicaid Reimbursement Dates* box on the *OMPP 450B SA/DE* will be blank. This means that no LOC has been entered in Indiana*AIM*. The *OMPP 450B SA/DE* issued by the AAA will be processed the same as *the OMPP 450B SA/DE* issued by OMPP. If the applicant is being approved for only a short-term PAS admission in the nursing facility, the *Form 4B* and *OMPP 450B SA/DE* will note the following:

  This individual has been approved for a short-term nursing facility stay. If Medicaid is the primary payer, there will be no Medicaid reimbursement for NF per diem after (specified date). If this individual continues to require nursing facility level of care past the approved date regardless of payer source, e.g., Medicare, Medicaid, private pay, the facility must submit a new Form 450B *to OMPP with documentation to support continued placement in the facility.*

  If the nursing facility does not submit additional documentation prior to the date specified on the *Form 4B*, reimbursement stops. It is the nursing facility's responsibility to ensure that additional documentation is submitted.
- If the applicant is denied nursing facility level of care, the denial *Form 4B* and *OMPP 450B SA/DE* will be issued by the AAA.

> *Note: Both the computer-generated* Form 4B *and* OMPP Form 450B SA/DE *issued by the AAA are white, not beige as has been issued by OMPP. However, the OMPP will now accept either the white or the beige forms as the official forms if computer generated by the AAA or the OMPP.*

***Resubmission of Computer-Generated* 450B SA/DE *When Resident Becomes Medicaid Eligible to Expedite Data Entry of Nursing Facility LOC in Indiana*AIM

- There is no change in the procedure described in IHCP provider bulletin *BT200002* dated March 31, 2000, for individuals who become Medicaid eligible following the issuance of the computer-generated *OMPP 450B SA/DE*.
- If the individual becomes eligible for Medicaid reimbursement as the primary payer of the nursing facility per diem within 90 days of the *OMPP 450B SA/DE* issuance date, the facility should complete the computer generated *OMPP 450B SA/DE* as necessary (for example RID, admission date, Medicare from/through dates) and submit the *OMPP 450B SA/DE* to OMPP for entry of LOC into Indiana*AIM*.
- If the facility is going to be submitting the *450B SA/DE* to the OMPP for entry of LOC in Indiana*AIM* when the resident becomes Medicaid eligible, the facility must verify that the resident is enrolled in traditional Medicaid and is not enrolled in managed care. Eligibility can be verified using AVR, OMNI, or Web interChange. Institutional LOC cannot be entered in Indiana*AIM* for retroactive Medicaid reimbursement if the resident is enrolled in Hoosier Healthwise/*Medicaid Select* (IHCP managed care programs). In any given month, managed care enrollment can occur at either the first or 15th of the month. Therefore, the provider should continue to verify IHCP coverage status at the beginning and the middle of each month until the provider has received the completed *450B SA/DE* documenting that LOC has been entered in Indiana*AIM* (*Effective Medicaid Reimbursement Date* box is completed by the OMPP). It is the provider's responsibility to ensure that the resident is disenrolled from the Hoosier Healthwise/*Medicaid Select* program in a timely manner if the provider is expecting traditional Medicaid reimbursement for the per diem.
- In April 2004 the 450Bs that were submitted to the OMPP for Medicare *to* and *from* dates were not processed by the Level of Care Unit within the OMPP. The reason the forms were not processed was due to the new policy effective July 1, 2004, which does not require submission of Medicare stays. The OMPP will no longer require providers to submit short *450B SA/DE* forms strictly for Medicare stays. After an LOC has been established, the OMPP does not require notification of the Medicare stay. If the patient was admitted to the nursing facility as a Medicare stay, that information must be submitted on a *450B SA/DE* form.
- The OMPP is requiring providers to submit *450B SA/DE* forms for hospitalization stays 15 days or longer where discharge procedures have taken place. Short term hospital stays less than 15 days do not require the provider to submit a *450B SA/DE* form.

Submission of a New* Form 450B *to Request Extended Stay Following a Short-term PAS Approval

The *Form 4B* and *450B SA/DE* issued by the OMPP or the AAA may authorize only a short-term Medicaid covered stay in the nursing facility for individuals requiring time-limited nursing facility services including but not limited to rehabilitative services.

- If the individual continues to require Medicaid covered care in the nursing facility past the date approved on the *Form 4B* and *450B SA/DE*, the nursing facility must submit a new *Form 450B* or a short *450B SA/DE* to the OMPP for authorization of the extended care.
- The facility must also submit documentation with the new *Form 450B* to support the need for ongoing nursing facility services. Supportive documentation includes but is not limited to the following:
  - Nurses' notes
  - Physician progress notes
  - Therapy notes and evaluation
  - Social service notes
  - Most recent MDS
- When the OMPP issues the determination about the request for extended care in the nursing facility, the *OMPP 450B SA/DE* will provide the appeal rights should the individual disagree with the OMPP LOC decision for the extension.

Direct questions about this information to the local PAS Agency, Bhinder Hare, (317) 232-2036, bhare@fssa.state.in.us; or Nancy Hopkins, (317) 232-4359, nhopkins@fssa.state.in.us.

Vision Services

HCPCS Code Changes for Eyeglass Lenses

The IHCP is implementing coverage changes to four HCPCS codes for eyeglass lenses. The changes described in this article are effective December 1, 2004.

High Index Lenses

The following codes for high index lenses will be non-covered, effective December 1, 2004:

- *V2782–Lens, index 1.54 to 1.65 plastic or 1.60 to 1.79 glass, excludes polycarbonate, per lens*
- *V2783–Lens, index greater than or equal to 1.66 plastic, or greater than or equal to 1.80 glass, excludes polycarbonate, per lens*

Specialty Occupational Lenses

HCPCS code *V2786–Specialty occupational multi-focal lens, per lens* will be non-covered, effective December 1, 2004. This lens is an occupational tool, and not a medically necessary daily-wear eyeglass lens.

Scratch Resistant Coating

HCPCS code *V2760–Scratch resistant coating, per lens* will be non-covered, effective December 1, 2004.

Polycarbonate Lenses

The IHCP has developed specific criteria for polycarbonate lenses to ensure that they are used only for medically necessary conditions that require additional ocular protection for members. Effective December 1, 2004, HCPCS code *V2784–Lens, polycarbonate or equal, any index, per lens* will remain covered when a corrective lens is medically necessary if one of the following criteria is met:

- Member has carcinoma in one eye and the healthy eye requires a corrective lens.
- Member has only one eye which requires a corrective lens.
- Member has had eye surgery and still requires the use of a corrective lens.
- Member has retinal detachment or is post-surgery for retinal detachment and requires a lens to correct a refractive error of one or both eyes.
- Member has a cataract in one eye or is post-cataract surgery and requires a lens to correct a refractive error of one or both eyes.
- Member has low vision or legal blindness in one eye with normal or near normal vision in the other eye.
- Other conditions deemed medically necessary by the optometrist or ophthalmologist. These conditions must be such that one eye is affected by an intractable ocular condition and the polycarbonate lens is being used to protect the remaining vision of the healthy eye.

In all of these situations, one or both eyes must be affected by an intractable ocular condition. The polycarbonate lens will only be covered to protect the remaining vision of the healthy eye when it is medically necessary to correct a refractive error. Patient charts must support medical necessity. The IHCP will monitor use of these lenses on a post-payment review basis.

Billing Members for Non-Covered Services

If a service is non-covered by the IHCP, the member must understand, before receiving the service, that the service is not covered by the IHCP, and that the member is responsible for the service charges. The provider must maintain documentation, such as a waiver, in the member's file to confirm that the member voluntarily chose to receive the service knowing that the service was non-covered by the IHCP. If a member requests a non-covered enhancement to a basic service and a separate code exists for the enhancement, the member can be charged for the enhancement and the IHCP will reimburse for the basic service. If the IHCP covers a portion of the service code, the difference between the provider usual and customary charge and the IHCP maximum reimbursement amount cannot be billed to the member (for example, balance billing).

IHCP members who request an upgrade to a non-covered high index lens, or those members who do not meet the criteria for a polycarbonate lens,

can choose to pay for the upgrade. The IHCP will only reimburse the base code for the lens and no additional reimbursement will be made for the upgraded lens code.

More information about billing members for non-covered services is available in the *IHCP Provider Manual*, Chapter 4, Section 5.

Direct questions about this information to the HCE Medical Policy Department at (317) 347-4500.

IHCP Provider Field Consultants Effective September 14, 2004

Territory Number	Provider Consultant	Telephone	Counties Served
1	Sharon Page	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, and Starke
2	Debbie Williams	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, and Whitley
3	Jessica Ferguson (temp)	(317) 488-5197	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, and White
4	Laura Merkel (temp)	(317) 488-5356	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, and Wells
5	Relia Manns	(317) 488-5187	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, and Washington
7	Phyllis Salyers	(317) 488-5148	Clay, Greene, Johnson, Hendricks, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, and Vigo
8	Pam Martin	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, and Warrick
9	Jessica Ferguson	(317) 488-5197	Out-of-State

Field Consultants for Bordering States

State	City	Representative	Telephone
Illinois	Chicago/Watseka	Sharon Page	(317) 488-5071
	Danville	Jessica Ferguson (temp)	(317) 488-5197
Kentucky	Louisville/Owensboro	Pam Martin	(317) 488-5153
Michigan	Sturgis	Debbie Williams	(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.

Statewide Special Program Field Consultants

Special Program	Consultant	Telephone
590	Laura Merkel	(317) 488-5356
Dental	Pat Duncan	(317) 488-5101
Waiver	Mona Green	(317) 488-5152

Client Services Department Leaders

Title	Name	Telephone
Director	Darryl Wells	(317) 488-5013
Supervisor	Connie Pitner	(317) 488-5154

Note: For a map of provider representative territories or for updated information about the provider field representatives, visit the IHCP Web site at www.indianamedicaid.com.

Indiana Health Coverage Programs Quick Reference Effective September 14, 2004

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization		Pharmacy Benefits Manager
EDS Customer Assistance (317) 655-3240 1-800-577-1278	**EDS Forms Requests** P.O. Box 7263 Indianapolis, IN 46207-7263	**Indiana Drug Utilization Review Board** INXIXDURQuestions@acs-inc.com
EDS Member Hotline (317) 713-9627 1-800-457-4584	**Indiana Health Coverage Programs Web Site** www.indianamedicaid.com	**ACS PBM Call Center for Pharmacy Services/POS/ProDUR** 1-866-645-8344 Indiana.ProviderRelations@acs-inc.com
EDS OMNI Help Desk 1-800-284-3548	**HCE Prior Authorization Department** P.O. Box 531520 Indianapolis, IN 46253-1520 (317) 347-4511 1-800-457-4518	**ACS Preferred Drug List Clinical Call Center** 1-866-879-0106
EDS Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263		**PA For ProDUR and Indiana Rational Drug Program – ACS Clinical Call Center** 1-866-879-0106 fax 1-866-780-2198
AVR System (317) 692-0819 1-800-738-6770	**HCE Medical Policy Department** P.O. Box 53380 Indianapolis, IN 46253-0380 (317) 347-4500	**Indiana Pharmacy Claims/Adjustments** c/o ACS P. O. Box 502327 Atlanta, GA 31150
EDS Electronic Solutions Help Desk (317) 488-5160 1-877-877-5182 INXIXElectronicSolution@eds.com	**HCE Provider and Member Concern Line (Fraud and Abuse)** (317) 347-4527 1-800-457-4515	**Indiana Administrative Review/Pharmacy Claims** c/o ACS P.O. Box 502327 Atlanta, GA 31150
EDS Provider Enrollment/Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	**HCE SUR Department** P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 1-800-457-4515	**Drug Rebate** ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332
EDS Third Party Liability (TPL) (317) 488-5046 1-800-457-4510 Fax (317) 488-5217	**EDS Administrative Review** Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	**To make refunds to IHCP for pharmacy claims send check to:** ACS State Healthcare – Indiana P.O. Box 201376 Dallas, TX 75320-1376

Hoosier Healthwise (Managed Care Organizations and PCCM) and *Medicaid Select*				
Harmony Health Plan www.harmonyhmi.com **Claims** 1-800-504-2766 **Member Services** 1-800-608-8158; TTY: 1-877-650-0952 **Prior Authorization/Medical Management** 1-800-504-2766 **Provider Services** 1-800-504-2766 **Pharmacy** 1-800-608-8158	**MDwise** www.mdwise.org **Claims** 1-800-356-1204 or (317) 630-2831 **Member Services** 1-800-356-1204 or (317) 630-2831 **Prior Authorization/Medical Management** 1-800-356-1204 or (317) 630-2831 **Provider Services** 1-800-356-1204 or (317) 630-2831 **Pharmacy** (317) 630-2831 1-800-356-1204	**Managed Health Services (MHS)** www.managedhealthservices.com **Claims** 1-800-414-9475 **Member Services** 1-800-414-5946 **Prior Authorization/Medical Management** 1-800-464-0991 **Provider Services** 1-800-414-9475 **Nursewise** 1-800-414-5946 **ScripSolutions (PBM)** 1-800-555-8513	**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 ACS in 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 **Prior Authorization** HCE: 1-800-457-4518 or (317) 347-4511 **Provider Services for PMPs** 1-877-633-7353, Option 3 **Pharmacy** – see ACS in 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
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	

BEHAVIORAL / PHYSICAL HEALTH COORDINATION

State Form 51856 (R / 9-04) / OMPP 0016

Family & Social Services Administration
Office of Medicaid Policy & Planning

IMPORTANT (PLEASE READ): This form may contain protected health information from the INDIANA HEALTH COVERAGE PROGRAMS (IHCP), which is intended only for the use of the individual or entity named in this form. Any unintended recipient is hereby notified that the information is privileged and confidential, and any use, disclosure or reproduction of this information is prohibited. Any unintended recipient should contact the sender immediately.

Insurer patient identification number		Date (*month, day, year*)	
Name of member		Date of birth (*month, day, year*)	
Health care provider		Behavioral health provider	
Address (*number and street*)		Address (*number and street*)	
City, state, ZIP code		City, state, ZIP code	
Telephone number ( )	Fax number ( )	Telephone number ( )	Fax number ( )
This form was filled out by			

The sharing of prescribed medication and treatment recommendations between this patient's physical healthcare provider and behavioral healthcare provider are essential for safe, effective coordination of care. Please complete the applicable section of this form and forward to the appropriate health care professional.

More information: www.indianamedicaid.com

PATIENT CONSENT

Please check if you DO NOT want the following protected health information released: ☐ **Behavioral Health** ☐ **Substance Abuse** ☐ **HIV/AIDS**

This authorization will expire on _____. I authorize the use and/or disclosure of my protected health information as described above. I understand this authorization for release of protected health information is made to confirm my wishes. I understand that I may revoke this authorization at any time by giving written notice to the person or organization that is authorized above to release information. My health care provided by _____ will not be affected if I do not sign this form. This information disclosed by this release may be re-disclosed by the recipient and may no longer be protected.

Date (*month, day, year*)

Name of provider

	Signature of member
☐ **Member declined to participate**	Signature of member

PHYSICAL HEALTH CARE PROFESSIONAL TO COMPLETE THE FOLLOWING ■ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

BEHAVIORAL HEALTH PROVIDER TO COMPLETE THE FOLLOWING ■ Medication log attached

MEDICATION	DATE STARTED	PRESCRIBED DOSAGE	Allergies to medications:
1.			
2.			Current diagnosis:
3.			
4.			Comments:
5.			
6.			

Please provide the following information regarding (*Member name*)	2. Is another appointment required? ☐ Yes ☐ No	If yes, date and time scheduled ☐ AM ☐ PM
1. Results of appointment, including any prescriptions ordered (*attach forms as necessary*)	3. Are there any special instructions for this member to follow? (*please describe*)	