July 28, 1998

To All Indiana Medicaid Hoosier Healthwise PCCM Primary Medical Providers:

Starting with the July cycle, the administrative fee payments for PCCM Primary Medical Providers now match the recipients assigned on the first and fifteenth of the same month that the fees and listings are compiled and produced. Originally, the system referred to the first of the current month and the fifteenth of the previous month and paid administrative fees accordingly. Retroactive payments were completed with the June cycle.

To All Indiana Medicaid Pharmacy Providers:

This is to notify all Pharmacy Providers of changes to the Medicaid Drug Federal Upper Limit (FUL).
The following products have been deleted from the Medicaid FUL effective July 15, 1998:

Temazepam
15mg, Capsule, Oral 100
30mg, Capsule, Oral 100

Also, this is to inform all Medicaid Pharmacy Providers that there will be a delay in the August 1, 1998 effective date of the Federal Upper Limit (FUL) processing. HCFA plans to publish the next FUL listing with the effective date of September 1, 1998.

To All Providers of Risk Based Managed Care Dental Services

Effective for dates of service 8/1/98 and greater, dental provider services billed on dental claim forms are being excluded from Risk Based Managed Care. These providers should submit dental claims incurred by managed care enrollees (members of either Managed Health Services or MaxiHealth) from this timeframe to EDS for adjudication. Dental claims for dates of service prior to 8/1/98 should continue to be submitted to the appropriate Managed Care Organization (MCO).

Only dental claims billed by the appropriate provider specialties will be carved out of Managed Care. Dental specialists include: Endontists, General Dentistry Practitioners, Oral Surgeons, Orthodontists, Pediatric Dentists, Periodontists, Pedodontists, Prosthodontists, and Dental Clinics. HCFA claims and UB claims submitted by dental providers and oral health services provided by non-dental specialists (i.e. anesthesiology) are not included in this carve out and should continue to be submitted to the appropriate MCO.

The small group of enrollees in the Managed Care for Persons with Disabilities delivery system (TeamSelect) will remain under the MCO's responsibility until a later date (at the latest January 1, 1999). A future bulletin will describe these changes in further detail.

To All Indiana Medicaid Providers of Dental Services and Orthopedic Shoes:

As a result of a lawsuit, Medicaid is extending coverage for dentures, partial dentures and orthopedic shoes to all Medicaid recipients, regardless of age. These services are subject to prior authorization of medical necessity with the exception of partial or complete dentures for recipients under age 21. When billing services for recipients under age 21 for dentures (complete or partial), the procedure codes below should be utilized. For all other PA requests and billings, the existing dental or HCPCS codes would be utilized for dentures or for orthopedic shoes. Please note that coverage for dentures is effective 4/23/98 and coverage for partial dentures and orthopedic shoes is for 10/30/97.

Description of Dental Codes (for Recipients under age 21)	Local HCPCs Code	Rate
Maxillary partial denture-resin base	Z5029	656.00
Mandibular partial denture -resin base	Z5028	666.00
Maxillary partial denture-case metal framework with resin denture bases.	Z5034	Manually Priced
Mandibular partial denture-case metal framework with resin denture bases	Z5035	Manually Priced
Complete denture - maxillary	Z5027	782.50
Complete denture - Mandibular	Z5030	788.25
Removable unilateral partial denture one piece cast metal	Z5033	Manually Priced

Please note that coverage will not be available for adjustments, repairs, rebasing or religning of dentures except for recipients under age 21. Billing would continue for this age group using the existing dental codes. Also note that immediate dentures are not covered.

To All Indiana Medicaid Providers:

Banner messages for 5/12/98 and 5/19/98 listed several diagnosis codes that will bypass Third Party Liability (TPL) when the diagnosis is entered as the primary diagnosis on the claim. The diagnosis code 650 for delivery was incorrectly included in this list. The Code of Federal Regulations (CFR) at 42 CFR 433.139 (b)(3)(i) states that prenatal services and preventive pediatric services, including Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services, must be paid by Medicaid and then reimbursement must be sought from any liable third party by Medicaid. Since labor and delivery services are not included as services that must be first paid by Medicaid, they are still subject to TPL requirements.