I M P O R T A N T I N F O R M A T I O N

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To All Providers:

- The paper copy price of the *Indiana Health Care Coverage Programs Provider Manual* recently increased to $121.60 per copy. All providers are entitled to one CD-ROM copy and one paper copy of the manual at no charge. Providers must request copies of the manual in writing and include a check for $121.60 for each **additional** paper copy. To avoid misapplication of payment and to ensure requests process accurately, write **IHCP Provider Manual** on the check memo line. Mail **all** publication requests to the following address:

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

  Table 1.1 indicates the charge and additional information needed for each IHCP publication requiring payment.

Table 1.1 – IHCP Request Charges and Locations

Publication	Charge	Additional Information
IHCP Provider Manual	$121.60 per paper copy No charge to providers for CD-ROM copies ($20 per CD-ROM for non-providers)	• Attach documentation for the request • Write *IHCP Provider Manual* on the check memo line
IHCP Fee Schedule	$43	• Attach documentation for the request • Write *IHCP Fee Schedule* on the check memo line
Remittance Advice Older Than One Year	$.10 per page	• Attach documentation stating the RA date being requested (including provider number and location) • Write *Remittance Advice Copy* on the check memo line

- This clarifies information for peptic acid disease drugs published in bulletin *BT200148*, implementing the Indiana Rational Drug Program (IRDP). Prior authorization (PA) is required for therapeutic doses of an acid suppression agent beyond an acute treatment period of 90 days. The criteria for peptic acid drugs were effective January 7, 2002, and include H2 antagonists above maintenance dosing, sucralfate, and all proton pump inhibitors. PA for these drugs is to encourage a step-down process. Requests for PA will not be reviewed until April 7, 2002, after the first 90-day period is complete. Every subsequent 90-day period authorization will only be granted for the next lower dose of medication or frequency until a maintenance dosing of an H2 antagonist is achieved. Certain diagnoses may exempt a patient from this step-down requirement as outlined in *BT200148*.
- Hoosier Healthwise managed care information is now available on the www.indianamedicaid.com Web site. Visit the new pages for information about managed care contacts, frequently asked questions (FAQs), forms, primary medical provider (PMP) enrollment and disenrollment guidelines and much more, as well as up-to-date information concerning the mandatory Managed Care Organization (MCO) transition in certain Indiana counties. Just click the **Dr. Hoosier owl** to access the information.
- The *Claims Correction Form* (CCF) has been modified to allow additional space to describe requested information. This change begins with the RA dated February 5, 2002. This increased description helps providers determine the information that should be forwarded to EDS to complete adjudication of claims in a CCF status.
- Following is an update to an article originally printed September 25, 2001, in *BR200139*.

  Edit 0232 – Rendering physician number is not in valid format, was inactivated for all crossover claims on July 7, 2000. EDS identified some duplicate claim payments made after that date. *Edit 0232* was reactivated effective September 14, 2001, to prevent additional duplicate payments. A systematic mass adjustment was finalized January 15, 2002, to recoup affected claims paid from July 7, 2000, through September 14, 2001. The adjustments denied because the Medicare information was not on file at the time of original claim adjudication. EDS is reviewing all crossover claims denied for *edit 0232* during this mass adjustment. If the correct Medicare information is now on the provider file, EDS will systematically reprocess the claim. Claims identified for reprocessing will appear on the RA dated February 19, 2002.

  If EDS does not have the correct Medicare information on file for both rendering and billing providers, the denied adjustments will not be reprocessed. The provider must resubmit the crossover claim on paper or by using Provider Electronic Solutions. Additionally, future claims received from Medicare will not automatically crossover for Medicaid adjudication.

To Long Term Care Providers:

- Effective January 8, 2002, the color of paper used for the *Indiana Pre-Admission Screening Program* (PAS/PASRR) *Assessment Determination State Form 707 (R/2-98)/Form 4B* changed from blue to beige because the U.S. Postal Service machines no longer read the paper color. Applicants and nursing facilities will now receive the *PAS Form 4B* on beige paper.

To All Home Health Providers:

- This clarifies the information that must be submitted with a written PA request for home health services, or that can be requested as written documentation to supplement telephone requests for PA. According to 405 IAC 5-16-3, the following information must be submitted:
  - Estimate of the costs for the required services as ordered by the physician and set out in the written plan of treatment. The cost estimate must be provided on or with the plan of treatment and signed by the attending physician. The cost estimate must reflect the cost estimate of each service, plus the overhead rate for the time period requested, on the plan of treatment.
  - Caregiver(s) available to provide care for the member including consideration of whether the caregiver works outside the home or attends school outside the home. A copy of the caregiver's work schedule from the employer or the class schedule from the school must be submitted with the PA request.
  - Whether the member works or attends school outside the home including what assistance is required.

  Refer questions to the Health Care Excel (HCE) Prior Authorization Department at (317) 347-4500.

To All Dental Providers:

- Bulletin *BT200003*, published January 14, 2000, clarified the policy for coverage of dentures and partials. The **Prior Authorization of Dentures and Partials** section, under **Exclusions and Limitations** states the following:

  > **Relines and Repairs – Laboratory relines** (D5750-D5761), **repair to dentures** (D5510 and D5520) and **repairs to partial dentures** (D5610-D5660) are covered only when the reline or repair will extend the useful life of a medically necessary denture or partial that is six (6) or more years old. PA is required for adults. In order to be approved, the PA request should indicate the individual is eligible for a new prosthesis, but a repair or reline will extend the useful life of the existing prosthesis.
  >
  > **Partials for Replacement of Anterior Teeth Only** – Requests for partial dentures that replace anterior teeth only will not be approved. Anterior tooth replacement will be considered purely an aesthetic or cosmetic concern and not medically necessary.

  According to *BT200003*, the IHCP will not approve or pay for repairs to partial dentures not meeting the guidelines nor will repairs to anterior teeth of partial dentures for adults be reimbursed. The bulletin is available on the www.indianamedicaid.com Web site. Direct questions to the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis area and 1-800-577-1276 outside the Indianapolis area or contact the HCE Medical Policy Department at (317) 347-4500.
- *Z5155, SQ/IM/oral administration of sedation and monitoring,* will be end-dated and made non-covered effective March 29, 2002. This code was replaced by dental procedure code *D9248*, (non-intravenous conscious sedation) effective for dates of service January 1, 2000, and later. Non-intravenous conscious sedation includes appropriate monitoring, as defined by the *Current Dental Terminology (CDT-3) Users Manual*, version 2000, published by the *American Dental Association*.
- The Comprehensive oral examination (D0150) and Detailed and extensive oral evaluation – problem focused, by report (D0160) codes are limited to reimbursement once a lifetime, per provider, per member. Once a provider uses D0150 or D0160 for an initial exam (new patient), the provider must bill a periodic exam code for the next oral examination. Periodic oral exams are limited to one per six months for members under 21 years old and to one per year for members 21 years old or older. If a provider submits either D0150 or D0160 more than once for a member, the claim denies with explanation of benefits (EOB) code 6226 – Comprehensive or Detailed and extensive oral evaluations are limited to one per lifetime.

To All Physicians, Nurse Practitioners, Clinics, Federally-Qualified Health Clinics, and Rural Health Clinics:

- Effective February 1, 2002, the $2.90 administration fee included in office administered injectable drug codes was removed. Exemptions to this revised policy include vaccines and toxoids that continue to include the $2.90 administration fee. Refer to bulletin *BT200151* for details about this revised policy.