IMPORTANT INFORMATION

BR200247 NOVEMBER 19, 2002

To All Pharmacy Providers:

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- As a result of periodic and ongoing review of paid pharmacy claims, it was identified that some pharmacies were submitting *brand medically necessary* overrides on claims for generic drugs. This billing practice inappropriately suspended otherwise applicable maximum allowable charge (MAC) rates resulting in overpayments to providers. The overpayments will be recouped by the Office of Medicaid Policy and Planning (OMPP) and systems modifications have been made that will preclude future instances of this inappropriate billing practice.

  The mass adjustment will occur December 27, 2002, for providers that received inappropriate reimbursement for *brand medically necessary* overrides on claims for generic drugs. This mass adjustment will appear on the December 31, 2002, remittance advice (RA). Refer questions about this mass adjustment to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

- This notifies of changes to the Medicaid Drug Federal Upper Limit (FUL) to be implemented December 1, 2002.

Deletions	
Generic Name	**Dosage**
Albuterol Sulfate	EQ 2 mg Base, Tablet, Oral, 100 EQ 4 mg Base, Tablet, Oral, 100
Amantadine Hydrochloride	100 mg Capsule, Oral, 100
Baclofen	10 mg, Tablet, Oral, 100 20 mg, Tablet, Oral, 100
Hydroxyzine Pamoate	100 mg HCL, Capsule, Oral, 100
Sulfamethoxazole; Trimethoprim	200 mg/5 ml; 40 mg/5 ml, suspension, Oral 480 ml

Additions		
Generic Name	**Dosage**	**FUL Price**
Buspirone Hydrochloride	5 mg, Tablet, Oral, 100 10 mg, Tablet, Oral, 100 15 mg, Tablet, Oral, 100	$0.2964 $0.3942 $0.4470
Fluoxetine Hydrochloride	10 mg, Capsule, Oral, 100 20 mg, Capsule, Oral, 100 40 mg, Capsule, Oral, 30 20 mg/5 ml, Solution, Oral, 120 ml 10 mg, Tablet, Oral, 30	$0.5850 $0.6000 $4.0125 $0.7500 $0.6000
Lovastatin	10 mg, Tablet, Oral, 60 20 mg, Tablet, Oral, 60 40 mg, Tablet, Oral, 60	$0.7487 $1.2488 $2.3738
Oxaprozin	600 mg, Tablet, Oral, 100	$0.6758

Price Increases		
Generic Name	**Dosage**	**FUL Price**
Atenolol	25 mg, Tablet, Oral, 100 50 mg, Tablet, Oral, 100 100 mg, Tablet, Oral, 100	$0.1595 $0.0885 $0.1650
Benztropine Mesylate	0.5 mg, Tablet, Oral, 100 1 mg, Tablet, Oral, 100 2 mg, Tablet, Oral, 100	$0.1227 $0.1502 $0.1930
Doxycycline Hyclate	EQ 50 mg Base, Capsule, Oral, 50 EQ 100 mg, Base, Capsule, Oral, 50	$0.0915 $0.1287
Etodolac	400 mg, Tablet, Oral, 100	$0.3600
Metronodazole	500 mg, Tablet, Oral, 100	$0.2184
Nystatin	100,000 Units/ml, Suspension, Oral, 60 ml	$0.1757
Selenium Sulfide	2.5%, Lotion/Shampoo, Topical, 120 ml	$0.0790
Theophylline	100 mg, Tablet, Extended Release, Oral, 100	$0.1184
Thioridazine Hydrochloride	50 mg, Tablet, Oral, 100	$0.3885

To All Providers:

- The EDS Health Insurance Portability and Accountability Act (HIPAA) business unit has established an electronic mailbox now available for inquiries about HIPAA topics. EDS will respond to inquiries sent to the electronic mailbox at inxixhipaainquiries@eds.com, and will post frequently asked questions of general interest on the Indiana Health Coverage Programs (IHCP) Web site HIPAA FAQ page located at www.indianamedicaid.com.

  EDS recommends providers frequently monitor the IHCP Web site for HIPAA updates and additional information. For example, a provider who filed for the transaction and code sets extension can verify if it is a covered entity by following the link from the Resources section of the HIPAA Web page to the Centers for Medicare and Medicaid Services (CMS) Covered Entity Decision Tools Web site. The provider can use the flowcharts on that Web site to determine coverage.

- EDS identified claims paid as duplicate for edit *5008 – This is a duplicate of another claim.* This affects claim types A, B, and C. These claims will be adjusted on January 6, 2003, and appear on the January 14, 2003, RA.

To All Hoosier Healthwise MCO-enrolled Primary Medical Providers:

- Effective January 1, 2003, Hoosier Healthwise primary medical providers (PMPs) enrolled with a managed care organization (MCO) will no longer receive semi-monthly member enrollment rosters from EDS. The MCO networks currently provide, and will continue to provide, member enrollment roster information to its contracted network PMPs. The OMPP is implementing this change as a program cost control measure. This change does not affect PMPs enrolled in the Prime*Step* primary care case management program. Prime*Step* PMPs will continue to receive membership roster information from EDS on a semi-monthly basis

To All Home Health Providers:

- This supplements IHCP bulletin, *BT200117, Prior Authorization Requests for Home Health,* dated April 27, 2001, which states "…when hours on a particular prior authorization period are not used, they cannot be used as cumulative hours in the current authorization period, nor are they allowed to be carried over to the next prior authorization period." Due to exceptional situations such as nursing staff shortage, some home health agencies are missing shifts. This may cause a need for increased services on a particular day in exchange for a day that was missed. The OMPP and the Surveillance and Utilization Review (SUR) Department determined that specific documentation is needed for providers to avoid being cited for overpayment in exceptional situations. The documentation must include nurse's notes or daily progress notes explaining the exception situation, such as, the nursing staff missed prior shifts due to a nursing shortage. SUR will verify that services were not billed on the day the visit was missed. Additionally, the documentation must explain how the necessary service was rendered during the period of time that nursing or home health staff was not present and what services were rendered during the extra units of care beyond the time typically spent with the member. As with all services, a current treatment plan must be in place indicating the level and frequency of services necessary for the member. Refer questions about appropriate documentation to the SUR Department at (317) 347-4500. Questions about prior authorization should be directed to the PA Department at (317) 347-4511 in the Indianapolis local area or 1-800-457-4518.

To Pharmacy Providers and Nursing Facilities:

Note: The information referenced below is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- In accordance with federal regulations, certain pharmacy services for Medicare members in skilled nursing facilities (SNF) are reimbursed under the Medicare nursing facility per diem. Per *42 CFR Part 409.25,* Medicare pays for drugs and biologicals as post-hospital SNF care assuming it represents a cost to the facility and is furnished to an inpatient for use in the facility. Therefore, the IHCP should not be billed for the pharmacy services provided to dually eligible SNF residents during a Medicare post-hospitalization period. Drug products dispensed for these residents should be billed to the nursing facility only. During a recent review and audit of pharmacy claims, the OMPP determined some pharmacies have received payments for drug products dispensed to residents of nursing facilities that are eligible for both Medicare and Medicaid benefits when the resident was in a Medicare period of skilled care following hospitalization.

  A mass adjustment will occur December 27, 2002, for providers that received inappropriate reimbursement for drug products in these situations and will appear on the December 31, 2002, RA. Refer questions about this mass adjustment to Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.