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All Providers

Prior Authorization Transition from HCE

Beginning November 1, 2007, the prior authorization (PA) function will transition from Health Care Excel (HCE) to the entities identified in Table 1.

Table 1 – Prior Authorization Transition

PA Entities	Program	Contact Information
ADVANTAGE Health Solutions, Inc. SM	Traditional Medicaid, Medicaid Select, Hoosier Healthwise Carve-Outs (RBMC)	P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720
ADVANTAGE Health Solutions, Inc. SM	*Care Select* - Care Management Organization (CMO)	P.O. Box 80068 Indianapolis, IN 46280 1-800-784-3981
MDwise	*Care Select* - Care Management Organization (CMO)	P.O. Box 44214 Indianapolis, IN 46244-0214 1-866-440-2449

The aforementioned information was originally published in Indiana Health Coverage Programs (IHCP) provider bulletin *BT200723*. It is important for all providers to understand that this change impacts *all* IHCP providers requesting PA. Providers must contact the member's Care Management Organization (CMO) regarding PA and restricted card services when a member is enrolled in the *Care Select* program. The correct CMO can be verified using one of the available Eligibility Verification Systems (EVS). If an EVS does not identify specific CMO information, then the provider must determine the IHCP program with which the member is associated.

Please note that based on the above table, ADVANTAGE Health Solutions SM plays multiple roles in the PA process. The organization will process PA for *Care Select* members who are assigned to a primary medical provider (PMP) contracted with their organization and will *also* process PA requests for members who are assigned to Traditional Medicaid, *Medicaid Select,* and Hoosier Healthwise carve-out services (RBMC) when the member is not in *Care Select.* (*Care Select* does not have carve-out services.) Because ADVANTAGE Health Solutions is processing PAs in two different capacities, they have designated two separate P.O. Boxes for submitting PA requests. It is important for providers to ensure that PA requests are mailed to the correct P.O. Box for the applicable program.

HCE will accept new and updated PA requests through October 31, 2007. After this date, HCE's PA telephone and fax numbers will be disconnected. HCE can still be contacted at 317-347-4500 for information about PAs that were submitted to HCE. Providers must submit all PA requests to the appropriate PA vendor on or after November 1, 2007. Providers may choose to hold any new PA requests and determine member eligibility on November 1 to ensure that the PA request is mailed to the appropriate PA vendor for review.

Provider Enrollment Forms Notice

Provider Enrollment implemented new IHCP applications and profile maintenance (update) forms effective September 27, 2007. Forms are available at http://www.indianamedicaid.com/ihcp/index.asp. Old forms will not be accepted for processing on or after January 1, 2008. Any previous version of the applications and maintenance forms submitted for processing after that date will be returned to providers with a request for completion and submission of a current form.

CPT Code 86701 HIV-1

Claims for Current Procedural Terminology (CPT) code 86701, HIV-1 that are denying for EOB 4208, *The procedure code billed is invalid with your CLIA certification on file*, will be systematically adjusted or reprocessed and will begin appearing on remittance advice (RA) statements dated October 16, 2007.

V5266, Battery for Use in Hearing Device

There is a clarification to the billing requirements for Healthcare Common Procedure Coding System (HCPCS) code V5266, *Battery for use in hearing device.* The IHCP designates one unit of code V5266 to represent four batteries; therefore, when submitting claims to the IHCP for reimbursement, providers are to report one unit of V5266 for each package of four batteries supplied.

CPT Code 83655 – Assay of Lead

The IHCP will reprocess or mass adjust professional claims that were denied or processed incorrectly for providers who submitted claims for CPT code 83655 - *Assay of Lead* with dates of service on or after July 1, 2004. Providers who are CLIA waived certified may have received denials for error code 4208 - *Invalid CLIA certification/procedure code combination* in relation to CPT code 83655. The reprocessed and mass adjusted claims began appearing on remittance advice (RA) statements dated October 9, 2007.

Billing Requirements for Lead Testing

There is a new billing requirement for lead testing in the office setting. The coverage and reimbursement rate for code 83655 is expanded to include tests administered using filter paper and handheld testing devices in the office setting. The following new procedure codes and modifier combinations are effective December 1, 2007.

Table 1 – New Codes for Lead Testing

Procedure Code	Description	Reimbursement Rate
83655 U1	Assay of lead, using filter paper	$10.00
83655 U2	Assay of lead, using handheld testing device	$5.00
83655	Assay of lead (venous blood)	$16.72*

**Note: Coverage and reimbursement of 83655 are not being changed.*

Modifications to Duplicate Logic

For claims and replacements received on or after September 27, 2007, the Indiana*AIM* system duplicate logic has been modified for Medical, Medical Crossover Part B, Outpatient, Outpatient Crossover C, and Home Health claim types. Dental claims have been excluded from this change. The system enhancements are for claim processing to read all five characters of HCPCS/CPT code, in addition to a HCPCS/CPT code that includes modifiers as part of the procedure (such as 99600 TD-Home Health visit, RN) instead of the first three characters of the procedure code billed.

For example, prior to August 1, 2007, if a claim was billed with procedure code 82550 and procedure code 82552 for the same date of service, the second detail would have suspended for *Edit 5000 possible duplicate* because the first three characters of the procedure code were the same as the first three characters of the procedure code submitted on the first detail. Therefore, the enhancements noted above will allow the system to read all five characters billed and no longer suspend the second detail of the claim for *Edit 5000 possible duplicate.*

Please note that banner page *BR200451* dated December 21, 2004, informed providers that HCPCS codes with the same beginning alpha or numeric characters, for the same member, on the same date of service, and rendered by the same provider required special handling due to claim denials for the exact duplicate edits. As a result of the above modification to duplicate logic in the Indiana*AIM* system, claims submitted with the above criteria will no longer require special handling by the EDS provider field consultant staff or the Written Correspondence Unit. Providers can now submit claims through their normal business process.

Crossover Claims that Previously Denied for Duplicate Edits 5007 and 5008

EDS modified the claims duplicate logic for all crossover claims received on the CMS-1500 claim form. CMS-1500 crossover claims that previously denied for *Edit 5007 exact duplicate header*, and *Edit 5008 suspect dupe header* will no longer deny for these edits. Effective August 1, 2007, crossover claims billed on the CMS-1500 claim form will emulate the possible and exact duplicate logic that is currently applied to medical claims and deny for *Edit 5000 possible duplicate* and *Edit 5001 exact duplicate.*

Tamper-Resistant Prescription Pads Requirements Delay

H.R. 3668, the "TMA, Abstinence Education, and QI Programs Extension Act of 2007," was signed by President Bush September 29, 2007. In part, it establishes a six-month delay for the tamper-resistant prescription pads provisions for Medicaid prescription drugs. Those provisions were set to become effective October 1, 2007. Please refer to provider bulletin *BT200724* for details. Given the passage of H.R. 3668, the revised effective date for the tamper-resistant prescription pads requirements, as specified in provider bulletin *BT200724*, is April 1, 2008.

All Home Health and Hospice Providers

Prior Authorization Information Specific to Home Health and Hospice Providers

This banner page is meant to supplement information already provided in *BT200723 Indiana Care Select-(Medicaid Care Management for Aged, Blind and Disabled) and Prior Authorization Changes.* This banner page addresses case-specifics for Medicaid home health and hospice providers.

ADVANTAGE Health Solutions is responsible for processing prior authorization requests and updates for all Traditional fee-for-service (FFS) members. This has specific implications for FFS members enrolled in the Medicaid home health and hospice programs.

- The Medicaid home health program covers members who have a spend-down or who are dually eligible Medicare/Medicaid and do not meet Medicare home health criteria. Home health providers will be required to send all prior authorization requests to ADVANTAGE Health Solutions^{SM}-FFS.
- The Medicaid hospice program covers Medicaid-only members and dually eligible Medicare/Medicaid members residing in nursing facilities. Hospice providers will be required to send all hospice authorization paperwork to ADVANTAGE Health Solutions-FFS. The Office of Medicaid Policy and Planning (OMPP) has decided to exclude hospice members from the Care Management Organization (CMO) Plans so that hospice providers will only submit hospice authorization request to one contractor (ADVANTAGE).
- ADVANTAGE Health Solutions-FFS prior authorization contact information is as follows:

  ADVANTAGE Health Solutions-FFS
  P.O. Box 40789
  Indianapolis, Indiana 46240
  1-800-269-5720

Home health providers are reminded that members they serve may also be enrolled in one of the CMOs under Indiana *Care Select*. The contact information for prior authorization under these plans is as follows:

ADVANTAGE Health Solutions-CMO
P.O. Box 80068
Indianapolis, Indiana 46280
1-800-784-3981

MDwise-CMO
P.O. Box 44214
Indianapolis, Indiana 46244-0214
1-866-440-2449

It is imperative that home health and hospice providers continue to check Medicaid eligibility on a regular basis to monitor eligibility changes such as managed care auto-enrollment issues or changes in eligibility. It will be particularly crucial that home health providers check eligibility on a regular basis, because *Care Select* members can change enrollment from one CMO to another.

Please visit www.indianamedicaid.com for additional information related to *Care Select* and prior authorization. Home health and hospice providers may submit any questions regarding prior authorization or *Care Select* to the following e-mail address: careselect@fssa.in.gov. For questions regarding claims payment or submission or provider enrollment, please contact EDS at 1-800-577-1278. The OMPP and the Division of Aging (DA) will then prepare a frequently asked questions document if necessary.

All Home Health Providers

Home Health Claims Reimbursement

Provider bulletin *BT200716* dated June 26, 2007, announced the rule changes impacting home health rates for State fiscal year (SFY) 2008 and 2009. The rule was signed and effective July 18, 2007, for SFY 2008 rates. The OMPP received approval from the Centers for Medicare & Medicaid Services (CMS) of the State Plan amendment. The new rates are now in the Medicaid system and were effective July 18, 2007. The mass adjustment will occur beginning the week of October 8, 2007, on home health claims with dates of service on or after July 18, 2007.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll-free at 1-800-577-1278, unless otherwise noted.

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