B A N N E R P A G E

B R 2 0 0 9 3 3 A U G U S T 1 8 , 2 0 0 9

All Providers

Eligibility Inquiry for Presumptive Eligibility

EDS has identified an issue related to eligibility inquiry for presumptive eligibility (PE) members that makes it appear that women are not eligible for PE in the Eligibility Verification Systems (EVS). This occurs only when the member had prior Medicaid coverage and if alternate methods of identification are used (for example, name and date of birth or Social Security number).

To avoid this problem, providers are encouraged to use the PE "550" RID number to verify eligibility for women who state they have PE coverage. Providers who do not have the PE "550" RID number can contact EDS customer assistance at (317) 655-3240 or 1-800-577-1278 to obtain the PE "550" RID number.

Prior Authorization for Hysterectomy

Provider bulletin BT200208, dated February 19, 2002, states that effective April 5, 2002, the prior authorization (PA) requirement was eliminated for specific hysterectomy codes. The codes are Current Procedural Terminology (CPT®[1]) codes 58200 – Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s); 58285 – Vaginal hysterectomy, radical; 59525 – Subtotal or total hysterectomy after cesarean delivery. Indiana Code 405 IAC 5-28-9 indicates that a hysterectomy is subject to prior authorization (PA). Effective July 1, 2009, the PA requirement will be reactivated for these procedure codes.

Presumptive Eligibility: Selecting a Primary Medical Provider and a Managed Care Organization

When a qualified provider (QP) facilitates the completion of the PE Application for Pregnant Women, the QP must provide a telephone for the applicant to contact the enrollment broker, MAXIMUS, to choose her primary medical provider (PMP) and managed care organization (MCO). The applicant must make these selections the same day she applies for PE. The QP cannot influence the selection process in any way. MAXIMUS will explain the selection process and identify women who are exempt from choosing PMPs and MCOs.

Once the selection of the PMP and MCO is made, the member has the right to change her selection at any time during her PE period by contacting MAXIMUS. The QP who performs the PE enrollment process will be paid for the services provided the day of the application, even if the member chooses a different doctor as her PMP.

Presumptive Eligibility Process

QPs must ensure that all the following steps are completed the same day a PE applicant is in the provider's office:

1. Verify pregnancy via a professionally administered pregnancy test.
2. Verify eligibility using Web interChange.
3. Access the PE Member Application via Web interChange.
4. Complete and submit the PE Member Application.

[1] CPT® is a registered trademark of the American Medical Association.

5. Give the PE applicant the PE determination letter.
6. If the PE applicant is approved for PE, she must contact the enrollment broker to choose her PMP and MCO. The PE applicant's selections must be written on the PE determination letter.
7. The QP must have the PE applicant verify all the information on the Hoosier Healthwise Application, sign the application, and fax it to the appropriate Division of Family Resources (DFR) office or the Documentation Center for Modernized Counties. QPs should also include a statement of pregnancy.

All the above steps must be completed on the same day the member is in the provider's office. Failure to complete the PE application and have the member contact the enrollment broker will result in termination of PE for the member and no reimbursement for the services provided by the QP.

Mental Health Quality Advisory Committee Utilization Edits

On June 19, 2007, the Mental Health Quality Advisory Committee's (MHQAC's) recommended utilization edits for mental health medications were implemented (refer to provider bulletin BT200709, dated May 3, 2007). The utilization edits are reviewed quarterly, and the additions in Table 1 will be made **August 28, 2009**.

Table 1 – First-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Venlafaxine HCl 37.5mg tab OSM 24 Oral	1/day
Venlafaxine HCl 75mg tab OSM 24 Oral	2/day
Venlafaxine HCl 150mg tab OSM 24 Oral	1/day
Venlafaxine HCl 225mg tab OSM 24 Oral	1/day

The additions and updates in Table 2 will be made **September 11, 2009**.

Table 2 – Second-quarter 2009 MHQAC Utilization Edits

Name of Medication and Strength	Utilization Edit
Bupropion HBR 348mg tab SR 24H oral	1/day
Bupropion HBR 522mg tab SR 24H oral	1/day
Alprazolam 0.25mg ODT	4/day
Alprazolam 0.5mg ODT	4/day
Alprazolam 1mg ODT	4/day
Alprazolam 2mg ODT	4/day
Seroquel XR 150mg tablet	1/day
Cymbalta 60mg capsule	2/day
Lexapro 20mg tablet	2/day
Venlafaxine XR 150mg capsule	2/day

Claims for "Returned-to-Stock" Prescriptions
Claims that have been billed to and paid by the program for prescriptions that have been filled but not received by the member or the member's representative must be reversed within 15 calendar days of the date of service. The date of service is considered "day 1." This policy is effective September 11, 2009.

Returned Medications
State laws IC 25-26-13-25(h) and (i); 856 IAC 1-21-1 allow for the return of medications from long-term care (LTC) facilities under certain circumstances to the pharmacy that dispensed the medications.

> Note: Medications returned to the dispensing pharmacy that are put back in stock for redispensing must be credited to the program within 30 days of being returned to the pharmacy.

To credit the program, providers must submit a credit request for the amount of the returned medication, less any applicable dispensing fee. This amount is applied against future payments. The credited amount is posted to the provider Remittance Advice, and totals on the Provider 1099 Summary Report are adjusted. Chapter 11: Paid Claim Adjustment Procedures in the IHCP Provider Manual contains specific procedures for crediting the program for returned medications.

The Indiana Health Coverage Programs (IHCP) requires that both the LTC pharmacy and LTC facilities document the medications being returned and credited to the program. Both providers are also required to document any medications being destroyed. Providers should have a log outlining the prescription number, name of medication, date the medication was returned and credited or destroyed, quantity returned and credited or quantity destroyed, and, if the medication was destroyed, to whom it was returned for destruction. The pharmacy auditing contractor, Prudent Rx, will verify compliance with these requirements. LTC pharmacies and LTC facilities found to be noncompliant will be referred to the Indiana Medicaid Fraud Control Unit (IMFCU).

The IHCP Moves to Paperless Remittance Advices September 1

The IHCP goes paperless September 1, 2009. Are you prepared? Have you signed up for Web interChange so that you have uninterrupted access to your Remittance Advices (RAs)? Be sure to sign up for Web interChange today, so you can access your RAs. Remember – it takes seven to 10 business days for the Web interChange approval process. Providers can expect to see their first RAs on the Web site September 7.

As of September 1, 2009, the IHCP will no longer print and mail provider RAs generated by EDS, banner pages, bulletins, or newsletters (including the Drug Utilization Review Board newsletters). These publications will only be available online.

To keep informed of current communications and policy updates, providers must enroll in the IHCP's E-mail Notifications at http://www.indianamedicaid.com/ihcp/mailing_list/default.asp. Providers who are already enrolled should verify that their e-mail addresses are correct.

Paper checks that are mailed with the current RAs will continue to be mailed after September 1, 2009, for providers not enrolled in electronic funds transfer (EFT).

Instructions for how to access RAs on Web interChange qre included in the August 2009 provider newsletter – see NL200908.

Claim Correction Forms
Currently, Claim Correction Forms (CCFs) are included with paper RAs. Effective September 1, 2009, the IHCP will no longer print CCFs. Providers can resubmit denied claims with corrections through the existing claims billing process.

For more information, see page 3 of the August provider newsletter NL200908, "Action Required to Access Remittance Advices after September 1, 2009," and bulletin BT200912, "Implementation of Paperless Provider Communications," dated May 19, 2009.

Hospitals

Care Select ER, Outpatient Treatment, and Inpatient Admissions Notification

The Indiana Care Select program is a care management program designed to create a medical home for Medicaid members who are aged, blind, disabled, wards of the court, or foster children. Care Select strives to provide complete and holistic care coordination for all its members.

In line with the goals for Care Select, it is essential for the care management organizations (CMOs) to be notified when a Care Select member receives services in a hospital setting, inclusive of the emergency room, outpatient surgery, or inpatient care. Effective October 1, 2009, providers who serve Care Select members in a hospital setting should notify the members' CMOs, so the appropriate care coordination can take place.

The hospital staff is responsible for checking member eligibility upon treatment or admittance to the facility. Providers who use Web interChange to check member eligibility will see a Care Select Notification button appear for Care Select members only. Within 48 hours of a member's treatment or admission to a facility, hospital staff will click the **Care Select Notification** button and enter the following information in the space provided:

- Date of treatment
- Type of treatment
- Presenting signs, symptoms, and/or diagnoses

Once the hospital staff clicks **Save** and the CMO has subsequently been notified, the CMO will assess the nature of the visit for follow-up. If the member's situation appears to be complex or additional details are needed for case management, the CMO's care manager will contact clinical personnel at the hospital. The CMO will work with the hospital staff to notify the member's primary medical provider (PMP) and other key physicians on the member's case.

The CMOs will be responsible for contacting hospital discharge planning staff, as appropriate, to offer assistance in discharge planning, to obtain treatment plans and the necessary details to assist with facilitation of appropriate care and resources upon discharge. Providers are encouraged to contact each CMO to communicate the appropriate contact person or department within each facility Please see Table 3 for specific contact information.

Table 3 – CMO Contact Information for Notification Efforts

Care Select CMO	ADVANTAGE^{SM} Care Select	MDwise Care Select
Voice Option	1-866-868-2093	1-866-440-2449 (Options 5, 3)
Fax Option	1-877-761-4227	1-877-822-7189
Secure E-mail	ACSHN@aetna.com	NA
Electronic File Transfer	NA	1-866-440-2449 (Option 1)

Community Mental Health Center Providers

Revised Version of BT200925 Has Been Posted to the IHCP Web Site

A revised version of BT200925, Medical Record Documentation Guidelines and Appropriate Provider Qualifications and Supervision, which was originally published July 22, 2009, has been posted to the IHCP Web site. The revised bulletin explains that the bulletin was issued in response to Office of Inspector General's (OIG) findings related to documentation and provider qualifications within the Medicaid Rehabilitation Option (MRO) program. This bulletin is not related to the proposed changes to the MRO program and is solely in response to previous OIG findings.

Hospice Providers

Hospice Rate Update

IHCP Provider Bulletin BT200917, dated June 16, 2009, announced updates to hospice rates for claims with dates of service October 1, 2008, through September 30, 2009.

Hospice claims with revenue codes 651, 652, 655, and 656 that are affected by the revised rates were scheduled to be systematically mass adjusted and appear the week of July 20, 2009; they appeared the week of August 4, 2009.

Provider Workshops

Addition!

The third-quarter provider workshops feature a session on Presumptive Eligibility for Pregnant Women and Notification of Pregnancy, two new programs that began July 1, 2009. The Presumptive Eligibility session runs from 2:40-4:45 p.m. This information did not appear on the paper registration form included in the July newsletter, NL200907. Providers are encouraged to register online instead of using the paper registration form. Workshop registration is available at http://www.indianamedicaid.com/ihcp/index.asp. Click on **Provider Services** > **Educational Opportunities** > **Workshop Registration**.

Third-quarter Workshops

The IHCP is offering quarterly provider workshops free of charge. Topics include Hoosier Healthwise open enrollment; Care Select; Early and Periodic Screening, Diagnosis, and Treatment (EPSDT); a managed care and Healthy Indiana Plan (HIP) roundtable; blood lead testing; and Presumptive Eligibility/Notification of Pregnancy. Workshop agendas, dates, registration deadlines, and locations are online at http://provider.indianamedicaid.com/general-provider-services/provider-education/workshop-registration.aspx. You may register by using the registration form printed in the IHCP provider newsletter. For more information about the workshops, please contact the workshop line at (317) 488-5072.