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All Providers

Revisions to Bariatric Surgery Policy

Previous bariatric surgery policy reflects an age requirement of 21-65. The following stipulation has been and will continue to be utilized for members under the age of 21 for consideration of the procedure: Members younger than 21 years of age must have documentation in the medical record by two physicians who have determined that bariatric surgery is necessary to save the life of the member or restore the member's ability to maintain a major life activity defined as self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency. In addition, the member must be physically mature, as shown by sexual maturity and the closure of growth plates.

The Indiana Health Coverage Programs (IHCP) has modified the age requirement for bariatric surgery to reflect consideration of members between the ages of 18-65.

The IHCP previously required documentation by the primary care physician of the results of the physician-supervised nonsurgical weight loss program for at least 18 consecutive months, including unsuccessful weight loss or maintenance after successful weight loss. The IHCP has revised this portion of the policy to remove the 18-month time frame and insert a six-month period, as indicated in Senate Bill 266.

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.

The IHCP Moves to Paperless Remittance Advices September 1

The IHCP goes paperless September 1, 2009. Remittance Advices (RAs) dated September 1 will be printed and mailed; after that, providers can expect to see their first RAs on the Web site September 7.

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

Are you prepared? Have you signed up for Web interChange so that you have uninterrupted access to your 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.

As of September 1, 2009, the IHCP will no longer print and mail 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 are 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 1 for specific contact information.

Table 1 – 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	N/A
Electronic File Transfer	N/A	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.

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.

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