IHCP *banner page*

INDIANA HEALTH COVERAGE PROGRAMS BR201548 DECEMBER 1, 2015

IHCP clarifies provider enrollment revalidation requirements

Pursuant to federal law, all providers enrolled with the Indiana Health Coverage Programs (IHCP) prior to January 1, 2012, must meet enrollment revalidation requirements by the end of 2015. The Centers for Medicare & Medicaid Services (CMS) has directed states to disenroll any provider who fails to revalidate by the deadline. Providers must revalidate in a timely manner.

Providers should receive letters reminding them to revalidate at 90 days and again at 60 days before their revalidation due date. If you received a revalidation letter, please follow the instructions provided to ensure that you are not at risk of disenrollment. Providers that did not receive a revalidation letter but who have not yet revalidated their IHCP enrollment should log on to Web interChange and select the **Provider Profile** option to view a list of providers with revalidation dates between now and the end of the year. If you are on the list, your revalidation date is approaching.

Providers who have received letters or who are on the list should proceed with the revalidation process by visiting the Complete an IHCP Provider Packet web page at indianamedicaid.com. To find instructions and a link to the appropriate provider application packet, select the provider type that applies from the left navigation panel.

Providers that do not revalidate will be disenrolled from the IHCP and required to submit a new application to reenroll in the program. Disenrollment will prevent a provider from being reimbursed by the IHCP. Further, there is no provider enrollment application fee for enrollment revalidation at this time. However, effective January 1, 2016, an application fee will be required for certain revalidations as it is now for new enrollments. Affected provider types can avoid the application fee associated with revalidations by completing their revalidations before the end of the year.

For questions regarding this information or if you are unsure whether you have revalidated, please contact Customer Assistance at 1-800-577-1278.

Patient residence required on pharmacy claims

The Indiana Health Coverage Programs (IHCP) *Banner Page* *BR201508* announced that mandatory completion of the *Patient Residence* (384-4X) field on all pharmacy claims for IHCP members would be effective April 1, 2015. Due to the system modifications required, this change was not implemented in the pharmacy claims processing system as planned. The system modifications have since been completed

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and this change will be implemented effective January 1, 2016. The following changes will apply to all pharmacy claims:

- A value of "1 = Home," previously not used by the IHCP, has been added as a valid entry in the *Patient Residence* field.
- A value of "0 = Not Specified" will no longer be accepted as a valid entry in the *Patient Residence* field.
- Pharmacy claims will reject if the *Patient Residence* field is blank or contains an invalid entry.

These changes have been reflected in pages 1–3 of the *Companion Guide: NCPDP Version D.0 Transaction Payer Sheet*, accessible via the Pharmacy Services quick link at indianamedicaid.com.

The *Patient Residence* field is used by pharmacies to communicate to the IHCP whether a member is a resident of a long-term care (LTC) facility. Patient residence values drive the following:

- Number of allowable dispensing fees when a member is in an LTC facility
- Elimination of copays when a member is in an LTC facility
- Adjudication of claims for services that are reimbursed per diem in an LTC facility and not separately billable to the IHCP
- Appropriate retro-Drug Utilization Review (DUR) screening

It is the responsibility of the pharmacist or pharmacy dispensing the prescription or adjudicating the claim to ensure that the *Patient Residence* field is populated correctly. The use of this field in claims adjudication is subject to pharmacy audit.

Please direct questions about this article to the OptumRx Clinical and Technical Help Desk by calling toll-free 1-855-577-6317.

FSSA clarifies age limit for Child Mental Health Wraparound program

The Indiana Family Social Service Administration (FSSA) clarifies that services under the Child Mental Health Wraparound (CMHW) program, operated by the Division of Mental Health and Addiction (DMHA), may be provided up to a member's 18th birthday (see Indiana Administrative Code *405 IAC 5-21.7-5(a)(1)*). CMHW services provided on or after the member's 18th birthday are not reimbursable through Indiana Medicaid.

If the member no longer meets the level of need, or is otherwise deemed ineligible for CMHW services, as noted in *405 IAC 5-21.7-8,* the wraparound facilitator and team should work together with the member and the member's family to develop and implement a transition plan. The transition plan is intended to assist the member in moving from CMHW services to community-based services appropriate for the member's current level of need. Providers should facilitate transition to avoid gaps in service. For more information on the policies and procedures of the CMHW program, please see the *Child Mental Health Wraparound Services Program Provider Manual* available on the Manuals page at indianamedicaid.com.

Correction regarding inappropriate denials of nursing facility claims for HIP members

The Indiana Health Coverage Programs (IHCP) Banner Page *BR201545* incorrectly stated that an eligibility issue caused nursing facility claims for Healthy Indiana Plan (HIP) members to deny inappropriately. The eligibility issue described in this publication related only to Hoosier Care Connect (HCC) member claims processed between April 1, 2015, and October 28, 2015. **HIP member claims were not affected.**

QUESTIONS?

If you have questions about this publication, please contact Customer Assistance at 1-800-577-1278.

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