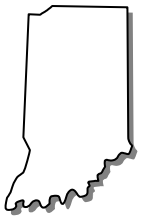

P R O V I D E R B U L L E T I N

B T 2 0 0 9 3 7 N O V E M B E R 1 7 , 2 0 0 9

To: Prescribing Providers and Pharmacy Providers

Subject: Pharmacy Benefit Consolidation Effective January 1, 2010

Overview

As advised in Indiana Health Coverage Programs (IHCP) provider bulletin *BT200929*, dated August 26, 2009, the Office of Medicaid Policy and Planning (OMPP) will assume responsibility for the administration of the Hoosier Healthwise (HHW) managed care organizations (MCOs) and Healthy Indiana Plan (HIP) pharmacy benefits for claims with dates of service of January 1, 2010, or later. In *BT200929*, this change was referred to as "carve out," but for this and future publications, the change will be referred to as "pharmacy benefit consolidation." This change includes processing all outpatient pharmacy claims and managing pharmaceutical services for drugs and some drug-related medical supplies and medical devices (identified in Table 1) provided by enrolled IHCP pharmacy or durable medical equipment providers as fee-for-service (FFS). As a result of this change, HP Enterprise Services will process HHW pharmacy claims currently processed by Anthem, MDwise, or Managed Health Services (MHS) and HIP pharmacy claims currently processed by Anthem Blue Cross/Blue Shield or MDwise.

The FFS pharmaceutical benefit is comprehensive, and is defined by the State Plan and approved by the Centers for Medicare & Medicaid Services (CMS). Members will utilize the *Indiana Medicaid Preferred Drug List* (PDL), which represents a subset of the overall FFS pharmaceutical benefit and the Over-the-Counter (OTC) Drug Formulary. The HIP pharmaceutical benefit, in general, will follow the FFS PDL. With regard to coverage of OTC drugs for HIP members, *only* those OTC drugs listed on the PDL are covered. HIP members do not have coverage for other OTC drugs on the OTC Drug Formulary. Providers should refer to the most current PDL for any differences that may apply. All other capitated services, including procedure-coded drugs billed by entities other than IHCP-enrolled pharmacy providers, most medical supplies and medical devices (that is, those not referenced in Table 1), DME, and enteral or oral nutritional supplements, will remain the responsibility of the HHW and HIP health plans.

Member Communications

A member notice will be mailed December 1, 2009. For a copy of the letter, please refer to Pharmacy Benefit Consolidation Member Notices after December 1, 2009.

Current HHW and HIP Pharmacy Prior Authorizations

Existing pharmacy prior authorizations (PA) for HHW and HIP health plan members will be systematically converted to the FFS claims processing system and honored through their expiration date. This process will be completed prior to January 1, 2010, but it may be necessary for providers to obtain another PA for some of these items.

Expanded Call Center Hours

Effective January 1, 2010, the Affiliated Computer Services (ACS) Clinical Call Center and the HP Pharmacy Services Point of Sale Help Desk will have expanded hours. Tables 2 through 12 in this bulletin provide updated contact information and hours of operation related to the pharmacy benefit consolidation changes.

Member Copays

HIP members will **not** have a copay for drugs.

Presumptive Eligibility (PE) members will **not** have a copay for drugs.

HHW members who pay a monthly premium (Package C members) will have a $3 copay for each generic drug and a $10 copay for each brand drug.

HHW members who do not pay a monthly premium (Package A and B members) will follow the same $3 copay requirements as other FFS members, as outlined in *405 IAC 5-24-7*:

(1)The copayment shall be paid by the recipient and collected by the provider at the time the service is rendered. Medicaid reimbursement to the provider shall be adjusted to reflect the copayment amount for which the recipient is liable.

(2) In accordance with *42 CFR 447.15*, the provider may not deny services to any eligible individual on account of the individual's inability to pay the copayment amount. Under *42 CFR 447.15*, this service guarantee does not apply to an individual who is able to pay, nor does an individual's inability to pay eliminate his or her liability for the copayment.

(3) The amount of the copayment will be three dollars ($3) for each covered drug dispensed.

The pharmacy provider shall collect a copayment for each drug dispensed by the provider and covered by Medicaid.

The following pharmacy services are exempt from the copayment requirement:

(1) Emergency services provided in a hospital, clinic, office, or other facility equipped to furnish emergency care.

(2) Services furnished to individuals less than eighteen (18) years of age.

(3) Services furnished to pregnant women if such services are related to the pregnancy or any other medical condition that may complicate the pregnancy.

(4) Services furnished to individuals who are inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions.

(5) Family planning services and supplies furnished to individuals of childbearing age.

Note:	42 CFR 447.15 *mandates that a provider may not refuse to provide services to a recipient who cannot afford the copayment. IHCP policy is that the member remains liable to the provider for the copayment, and the provider may take action to collect it. The provider may bill the member for that amount and take action to collect the delinquent amount in the same manner that the provider collects delinquent amounts from private pay customers. Providers may set office policies for delinquent payment of incurred expenses including copayments. The policy must apply to private pay patients as well as IHCP members. The policy should reflect that the provider will not continue serving a member who has not made a payment on past due bills for "X" months, has unpaid bills exceeding "Y" dollars, and has refused to arrange for or not complied with a plan to reimburse the expenses. Notification of the policy must be done in the same manner that notification is made to private pay customers. In accordance with* 407 IAC 3-10-3.

Member Identification Numbers and Cards

HIP members will be receiving new member identification (ID) cards. If HIP members do not receive their new ID cards by March 31, 2010, they should contact member services at their health plan. Refer to the Billing Information below for details about claims submission.

Note:	*The recipient identification (RID) number may be on the back of the identification card.*

All HHW members will continue to use their current member ID number and card.

HHW and HIP and Pharmacy Benefit Administration

The HHW and HIP health plans will receive pharmacy claim files from HP, the State's fiscal agent, on a daily basis. The plans will also have real-time access to pharmacy claims through a Web portal. Timely access to this information will allow the plans to perform care management activities.

The administrators of all plans will work closely with OMPP pharmacy staff in the evaluation and presentation of recommendations to the Drug Utilization Review (DUR) Board, the Therapeutics Committee, and the Mental Health Quality Advisory Committee.

Billing Information

For outpatient pharmacy claims with dates of service prior to January 1, 2010, please refer to the Claim Adjustments and Reversals section in this bulletin. For outpatient pharmacy claims with dates of service prior to January 1, 2010, please refer to the Claim Adjustments and Reversals section in this bulletin.

The HHW and HIP health plans remain responsible for the following services:

- Procedure-coded drugs billed by entities other than IHCP-enrolled pharmacy providers
- Medical supplies and medical devices not included in Table 1
- DME
- Enteral or oral nutritional supplements

Days Supply

Claims billed to HHW and HIP health plans prior to January 1, 2010, should not be submitted with a shortened days supply. All prescriptions should be dispensed with the allowable days supply as permitted by each plan prior to January 1, 2010.

Example: A prescription written for a 30 days' supply submitted on December 20, 2009, should not be submitted with a quantity sufficient for only 11 days, but should be submitted with a quantity sufficient for a 30 days' supply.

Beginning January 1, 2010, please use the following claim forms to submit paper claims:


drugclm.doc


compound_drug_form.doc

These forms are also posted at http://provider.indianamedicaid.com/general-provider-services/forms.aspx.

Outpatient Pharmacy Claims

Outpatient pharmacy claims dispensed by an IHCP-enrolled pharmacy provider and with dates of service prior to January 1, 2010, must be submitted to the HHW and HIP health plans. Outpatient pharmacy claims dispensed by a Medicaid-enrolled pharmacy provider and with dates of service on or after January 1, 2010, must be submitted to the FFS pharmacy benefit (BIN 610467). Any claims submitted to the HHW or HIP health plans with dates of service on or after January 1, 2010, will be denied by HHW or HIP. The pharmacy provider will receive a text message indicating the claim needs to be submitted to BIN 610467.

Claims for pharmacy-dispensed **Synagis** must be submitted to HP as a pharmacy claim in National Council for Prescription Drug Programs (NCPDP) format, effective January 1, 2010.

Drug-Related Medical Supplies and Medical Devices

As a result of drugs being reimbursed on an FFS basis, some drug-related medical supplies and medical devices will also be reimbursed on an FFS basis. Table 1 lists drug-related medical supplies and medical devices that will be paid for by the FFS medical benefit for all HHW and HIP health plan members for claims with dates of service on or after January 1, 2010. These claims should be billed on the CMS-1500 claim form or an 837P transaction. Services must be provided by an IHCP-enrolled pharmacy or durable medical equipment (DME) provider. This list is subject to change. Providers will be notified via an IHCP provider bulletin or other formal communication at least 45 calendar days prior to the change. Only the drug-related medical supplies and medical devices listed below are reimbursable by the FFS medical benefit. Claims submitted to the FFS, HHW, or HIP health plan pharmacy benefits with dates of service on or after January 1, 2010, will be denied.

Refer to *EDI Solutions Trading Partner Registration Procedure* and *IHCP Chapter 3: Electronic Solutions* (page 7) for instructions about how to enroll as a trading partner with the IHCP and submit these medical claims.

> *Note: Claims for supplies and devices not found in Table 1 must be submitted to the HHW and HIP health plans. Refer to the Contact Information (page 10) for the appropriate entity if you have billing questions. Durable medical equipment only providers (provider specialty 250) are reminded to follow the IHCP DME code set for appropriate billing practices, as posted on the indianamedicaid.com Web site.*

Table 1: Drug-Related Medical Supplies and Medical Devices
Submit to FFS Medical Benefit

Procedure Code	Description
A4210	*Needle free injection device*

Procedure Code	Description
A4211	*Supplies for self administered injection*
A4245	*Alcohol wipes, per box*
A4206	*Syringe with needle; sterile, 1cc or less, each*
A4207	*Sterile 2cc, each*
A4208	*Sterile 3cc, each*
A4209	*Sterile 5cc or greater, each*
A4213	*Syringe, sterile, 20cc or greater, each*
A4215	*Needle, sterile, any size, each*
A4233	*Replacement battery, alkaline (other than J cell), for use with medically necessary home blood glucose monitor owned by patient, each*
A4234	*Replacement battery, alkaline, J cell, for use with medically necessary home blood glucose monitor owned by patient, each*
A4235	*Replacement battery, lithium, for use with medically necessary home blood glucose monitor owned by patient, each*
A4236	*Replacement battery, silver oxide, for use with medically necessary home blood glucose monitor owned by patient, each*
A4244	*Alcohol or peroxide, per pint*
A4250	*Urine test or reagent strips or tablets (100 tablets or strips)*
A4253	*Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips*
A4256	*Normal, low, and high calibrator solutions/chips*
A4258	*Lancet device*
A4259	*Lancets, per box of 100*
A4261	*Cervical cap for contraceptive use*
A4266	*Diaphragm for contraceptive use*
A4267*	*Contraceptive supply, condom, male, each*
A4268*	*Contraceptive supply, condom, female, each*
A4269*	*Contraceptive supply, spermacide (e.g., foam, gel), each*
A4627	*Spacer, bag or reservoir, with or without mask, for use with metered dose inhaler*
A7018	*Water, distilled, used with large volume nebulizer, 1000 ml*
E0607	*Home blood glucose monitor*
E2100	*Blood glucose monitor with integrated voice synthesizer*
E2101	*Blood glucose monitor with integrated*

Procedure Code	Description
	lancing/blood sample
S8101	*Holding Chamber or spacer for use with an inhaler or nebulizer; with mask*
S8100	*Holding chamber or spacer for use with an inhaler or nebulizer without mask*

**Not covered by Healthy Indiana Plans*

FFS Billing Information for Procedure-Coded Drugs

The *Federal Deficit Reduction Act of 2005* mandates that the IHCP require submission of national drug codes (NDCs) on claims submitted with certain procedure-coded drugs. The requirement for the NDC submission was implemented August 1, 2007, for professional claims and July 1, 2008, for institutional outpatient claims.

Refer to Provider Bulletins *BT200703*, dated January 30, 2007; *BT200713*, dated May 29, 2007; and *BT200908*, dated March 12, 2009, for more detailed information. An updated list of the procedure codes that require an NDC is available from the *Provider Services* tab on the IHCP Web site. Click **Procedures That Require an NDC** from the drop-down menu to access the list.

As stated above, HHW and HIP health plans remain responsible for procedure-coded drugs billed to the HHW and HIP health plans by entities other than IHCP-enrolled pharmacy providers.

Claim Adjustments and Reversals

HHW and HIP health plans will accept claim adjustments and reversals submitted by pharmacy providers through March 31, 2010. HHW and HIP health plans are still responsible for all claims with dates of service prior to January 1, 2010. Refer to the *Contact Information* section of this bulletin for the appropriate entity to contact with billing questions.

Web interChange

In 2010, prescribers will have *real-time* access to patient profiles online via Web interChange. Online profiles will contain information about their patient's pharmacy claims, where the prescriptions were filled, and what other prescribers are being utilized. Please refer to future provider bulletins for details and implementation dates.

Current Pharmacy Policies and Procedures and Pharmacy Benefit Consolidation

The information provided below is a subset of all existing pharmacy policies and procedures that apply to all pharmacy claims paid by the FFS pharmacy benefit effective for pharmacy claims with dates of services on or after January 1, 2010. For more complete information on the FFS Pharmacy Benefit, refer to *Chapter 9* of the *Indiana Health Coverage Programs Provider Manual* and provider bulletins and banner pages at http://www.indianamedicaid.com/ihcp/index.asp.

Indiana Medicaid Boards and Committees

The Indiana Medicaid DUR Board was created as a result of federal (OBRA '90) and State law (*IC 12-15-35*), and acts as an advisory body to the OMPP on various clinical matters related to the pharmacy benefit. Specific duties of the board are listed at *IC 12-15-35-28*. For more information about the DUR Board, including meeting dates and times, refer to http://provider.indianamedicaid.com/provider-specific-information/pharmacy/boards-and-committees/drug-utilization-review-(dur)-board.aspx.

The Therapeutics Committee, a subcommittee of the DUR Board, evaluates therapeutic classes based upon clinical (first) and fiscal (second) considerations. The Therapeutics Committee makes recommendations to the DUR Board regarding the content of the PDL. The DUR Board reviews the PDL in its entirety twice annually. For more information about the Therapeutics Committee, including meeting dates and times, refer to www.indianapbm.com.

The Mental Health Quality Advisory Committee (MHQAC) is a result of *HEA 1325* and was implemented to develop guidelines and programs that would allow open and appropriate access to mental health medications. The MHQAC provides educational materials to prescribers and pharmacy providers concerning the appropriate use of mental health medications. For more information about the MHQAC, including meeting dates and times, refer to http://provider.indianamedicaid.com/provider-specific-information/pharmacy/boards-and-committees/mental-health-quality-advisory-committee-(mhqac).aspx.

Preferred Drug List (PDL)

Refer to http://www.indianamedicaid.com/ihcp/index.asp or www.indianapbm.com under Pharmacy Services.

Prospective Drug Utilization Review (ProDUR)

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 28).

Retrospective Drug Utilization Review (Retro-DUR)

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 32).

Early Refill

An early refill is defined as any claim in which less than 75 percent of the medication should have been utilized at the time the claim for the refill is submitted. A prior authorization will be required for the claim to pay.

Maintenance Medications

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 38).

Mandatory Generic Substitution/Brand Medically Necessary

Refer to *IHCP Chapter 9 – Pharmacy Services* (pages 16 and 37).

Emergency Supply Provision

Please refer to http://www.indianapbm.com/emergencySupply.htm for additional information.

Over the Counter Drug Formulary

Any over the counter (OTC) drug covered by the IHCP must be on the state of Indiana OTC Drug Formulary. The OTC Drug Formulary can be viewed at http://in.mslc.com/StateMacServices.aspx.

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 21).

Note: For HIP members, only those OTC drugs listed on the PDL are covered. HIP members do not have coverage for other OTC drugs on the OTC Drug Formulary.

Maximum Allowable Cost Programs

Providers can access http://in.mslc.com/ for more information. In addition, users may access the Myers and Stauffer Web site through the State MAC Program link located in the Pharmacy Links under the Pharmacy Services tab at http://www.indianamedicaid.com.

Suspended Compound Claims

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 33).

Tamper Resistant Prescription Pads (TRPPs)

After January 1, 2010, outpatient pharmacy claims that were previously paid by HHW or the HIP health plans will now be paid by the FFS pharmacy delivery system and will be subject to the TRPP requirements.

Refer to *BT200929*, dated August 26, 2009, and *IHCP Chapter 9 – Pharmacy Services* (page 17) for additional information regarding TRPP requirements.

Pharmacy Audits

Prudent Rx is contracted with the state of Indiana to provide pharmacy audit services to the OMPP. After January 1, 2010, outpatient pharmacy claims that were previously paid by HHW or the HIP health plans will now be paid by the FFS pharmacy delivery system and will be subject to the Prudent Rx pharmacy audit processes.

Refer to *IHCP Chapter 9 – Pharmacy Services* (page 33).

Manuals

Information pertaining to the IHCP manuals can be found at http://www.indianamedicaid.com. Links to the manuals are available under the Publications button, http://provider.indianamedicaid.com/general-provider-services/manuals.aspx

Prior Authorization Forms

Refer to http://provider.indianamedicaid.com/general-provider-services/forms.aspx under Pharmacy Forms.

Contact Information

Pharmacy Prior Authorization Requests and Preferred Drug List Inquiries

Table 2 – PA Requests and PDL Inquiries for All IHCP and HIP Members

Vendor	Phone Number	FAX Number	Hours of Operation
ACS (Affiliated Computer Services) Clinical Call Center	1-866-879-0106	1-866-780-2198	Effective January 1, 2010 M – F: 8 a.m. – 8 p.m. Saturday and some holidays (New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas): 10 a.m. – 6 p.m.

Note: Pharmacy Prior Authorization Forms can be found at Indiana Medicaid Prior Authorization Forms under Pharmacy Forms.

Note: The Preferred Drug List (PDL) can be found at www.indianamedicaid.com or www.indianapbm.com under Pharmacy Services.

Note: The Over-the-Counter OTC Drug Formulary can be found at OTC Drug Formulary.

Pharmacy Claims Processing Inquiries

Table 3 – Pharmacy Claims Processing Inquiries for All IHCP and HIP Members

Vendor	Phone Number	E-mail	Hours of Operation
HP Enterprise Services Pharmacy Services Point of Sale (POS) Help Desk	1-800-577-1278 or (317) 655-3240 for local; Option 1 for Pharmacy	INXIXPharmacy@hp.com	Effective January 1, 2010 M – F: 8 a.m. – 8 p.m. Saturday: 10 a.m. – 6 p.m. Closed state holidays

Note: The IHCP Provider Manual *can be found at IHCP Provider Manual.*

Eligibility, Benefits, Claim Status

Table 4 – Questions About Eligibility, Benefits, Claim Status for All IHCP and HIP Members

Vendor	Phone Number	Local Phone Number	Hours of Operation
HP Enterprise Services Automated Voice Response (AVR) System	1-800-738-6770	(317) 692-0819	Seven days per week, 24 hours per day

Pharmacy Auditing Inquiries

Table 5 **–** Pharmacy Auditing Inquiries for All IHCP and HIP Members

Vendor	Phone Number/FAX Number	E-mail	Hours of Operation
Prudent Rx via HMS	Ph: 1-866-642-0622 FAX: 1-310-642-1701	audit@prudentrx.com	M – F: 11 a.m. – 8 p.m.

Right Choices Program (Lock-in/Restricted Card) Provider Inquiries

Table 6 – Provider Services Inquiries for Right Choices Program

Vendor	Provider Services Phone Number	Web Site	Hours of Operation
ADVANTAGE Health Solutions – all IHCP and HIP members excluding MDwise *Care Selec*t	1-800-784-3981	www.advantageplan.com	M – F: 8 a.m. – 6 p.m.
MDwise – *Care Select*	1-866-440-2449	www.mdwise.org	M – F: 8 a.m. – 6 p.m.

Member Services

Table 7 – Member Services Inquiries Regarding Pharmacy or Dental Claims for All IHCP Members and Pharmacy for HIP Members

Vendor	Member Services Phone Number	Web Site	Hours of Operation
HP Enterprise Services Member Services Hotline	1-800-457-4584	Not available	M – F: 8 a.m. – 6 p.m.

Table 8 – Member Services Inquiries that Are Non-Pharmacy Related

Vendor	Member Services Phone Number	Web Site	Hours of Operation
Anthem – HHW	1-866-408-6131	www.anthem.com	M – F: 7 a.m. – 8 p.m.
MDwise – HHW	1-800-356-1204	www.mdwise.org	M – F: 8 a.m. – 6 p.m.
MHS (Managed Health Services) – HHW	1-877-647-4848	www.managedhealthservices.com	M – F: 8 a.m. – 6 p.m.
ACS HIP – ESP	1-866-674-1461	www.onlinehealthplan.com/hipesp/	M – F: 8 a.m. – 4 p.m.
Anthem – Healthy Indiana Plan	1-800-553-2019	www.anthem.com	M – F: 7 a.m. – 8 p.m.
MDwise – Healthy Indiana Plan	1-877-822-7196	www.mdwise.org	M – F: 8 a.m. – 6 p.m.

Table 9 – Member Services Inquiries for Right Choices Program

Vendor	Member Services Phone Number	Web Site	Hours of Operation
ADVANTAGE Health Solutions – FFS and *Care Select*	1-800-784-3981	www.advantageplan.com	M – F: 8 a.m. – 6 p.m.

Vendor	Member Services Phone Number	Web Site	Hours of Operation
MDwise – *Care Select*	1-866-440-2449	www.mdwise.org	M – F: 8 a.m. – 6 p.m.

Drug and Drug Related Supply Prior Authorization Requests Inquiries

Table 10 – Drug and Drug Related Supply PA Request for IHCP and HIP Members

Vendor	Provider Services Phone Number	Web Site	Hours of Operation
ADVANTAGE Health Solutions – FFS	1-800-269-5720	www.advantageplan.com	M – F: 7 a.m. – 7 p.m.

Medical Services (Non-Pharmacy or Drug and Drug Related Supply) Inquiries

Table 11 – Medical Services (Non-Pharmacy or Drug and Drug Related Supply) Inquiries

Vendor	Provider Services Phone Number	Web Site	Hours of Operation
HP Enterprise Services – FFS	1-800-577-1278 or (317) 655-3240 for local; Option 2	http://www.indianamedicaid.com	M – F: 8 a.m. – 6 p.m.
Anthem – HHW	1-866-408-6132	www.anthem.com	M – F: 7 a.m. – 8 p.m.
MDwise – HHW	1-800-356-1204	www.mdwise.org	M – F: 8am – 6 p.m.
MHS (Managed Health Services) – HHW	1-877-647-4848	www.managedhealthservices.com	M – F: 8 a.m. – 6 p.m.
ACS HIP – ESP	1-877-707-5750	www.onlinehealthplan.com/hipesp/	M – F: 8 a.m. – 4 p.m.
Anthem – Healthy Indiana Plan	1-800-345-4344	www.anthem.com	M – F: 7 a.m. – 8 p.m.
MDwise – Healthy Indiana Plan	1-877-822-7196	www.mdwise.org	M – F: 8 a.m. – 6 p.m.
ADVANTAGE Health Solutions – *Care Select*	1-866-504-6708	www.advantageplan.com	M – F: 7 a.m. – 7 p.m.
MDwise – *Care Select*	1-866-440-2449	www.mdwise.org	M – F: 8 a.m. – 6 p.m.

Medical Services (Non-Pharmacy or Drug and Drug Related Supply) Prior Authorization Requests

Table 12 – Medical Services (Non-Pharmacy or Drug and Drug Related Supply) PA Requests

Vendor	Medical Services Phone Number	Web Site	Hours of Operation
FFS Medical Claims/EDI Solutions Help Desk	1-877-877-5182	n/a	M – F: 8 a.m. – 5 p.m.
ADVANTAGE Health Solutions – FFS	1-800-269-5720	www.advantageplan.com	M – F: 7 a.m. – 7 p.m.
Anthem – HHW	1-866-408-7187	www.anthem.com	M – F: 8 a.m. – 5 p.m.
MDwise – HHW	1-800-356-1204	www.mdwise.org	M – F: 8 a.m. – 6 p.m.
MHS (Managed Health Services) – HHW	1-877-647-4848	www.managedhealthservices.com	M – F: 8 a.m. – 12 p.m.; 1 p.m. – 5 p.m.
ACS HIP – ESP	1-866-674-1461	www.onlinehealthplan.com/hipesp/	M – F: 8 a.m. – 4 p.m.
Anthem – Healthy Indiana Plan	1-866-398-1922	www.anthem.com	M – F: 8:30 a.m. – 5 p.m.
MDwise – Healthy Indiana Plan	1-877-822-7196	www.mdwise.org	M – F: 8 a.m. – 6 p.m.
ADVANTAGE Health Solutions – *Care Select*	1-800-784-3981	www.advantageplan.com	M – F: 7 a.m. – 7 p.m.
MDwise – *Care Select*	1-866-440-2449	www.mdwise.org	M – F: 8 a.m. – 6 p.m.

Frequently Asked Questions

1. What is pharmacy benefit consolidation?
2. What is the effective date for pharmacy benefit consolidation?
3. Where can I find information about the IHCP fee-for-service pharmacy benefit?
4. What Preferred Drug List (PDL) will be used?
5. Are there services that are excluded from the pharmacy benefit consolidation?
6. Will members need to change pharmacies due to the pharmacy benefit consolidation?
7. What if a member has a pharmacy prior authorization with his or her plan? Will the member need a new prior authorization?
8. What are the medication copayments for fee-for-service claims?
9. Will members receive new identification cards?

1. What is a pharmacy benefit consolidation?

The OMPP will assume responsibility for the administration of the HHW and HIP health plan pharmacy benefits.

2. What is the effective date for pharmacy benefit consolidation?

The pharmacy benefit consolidation is effective for claims with dates of service on or after January 1, 2010.

3. Where can I find information about the IHCP FFS pharmacy benefit?

Information regarding the IHCP FFS pharmacy benefit can be found at www.indianamedicaid.com under the Pharmacy Services button. Also, refer to *Chapter 9* of the IHCP Provider Manual at *IHCP Provider Manual – Chapter 9*.

4. What Preferred Drug List (PDL) will be used?

The fee-for-service PDL will be used and can be found at www.indianamedicaid.com and www.indianapbm.com under Pharmacy Services.

5. Are there services that are excluded from the pharmacy benefit consolidation?

HHW and the HIP health plans remain responsible for the following services:

- Procedure-coded drugs billed by entities other than IHCP-enrolled pharmacy providers
- Medical supplies and medical devices not included in Table 1
- Durable medical equipment

- Enteral or oral nutritional supplements

6. Will members need to change pharmacies due to the pharmacy benefit consolidation?

Members may continue to utilize the same pharmacy.

7. What if a member has a pharmacy PA with his or her plan? Will the member need a new prior authorization?

Existing pharmacy PA for HHW and HIP health plan members will be systematically converted to the FFS claims processing system and honored through their expiration date. This process will be completed prior to implementation, but it may still be necessary for providers to obtain another PA if the PA was not available for conversion.

8. What are the medication copayments for FFS claims?

HHW Package A members will follow the same $3 copay requirements as other FFS members outlined in *405 IAC 5-24-7*. HHW Package C members will have a $3 copay for each generic drug and a $10 copay for each brand drug. As in the past, HIP and PE (presumptive eligibility) members will not have a copay for drugs.

9. Will members receive new identification cards?

HIP members will receive new member ID cards. HIP members should contact their member services if they have not received their new member identification card by March 31, 2010. All HHW members will continue to use their current member card.

10. What drug-related medical supplies and devices are reimbursable by the FFS medical benefit?

Please refer to Table 1 on page 5.

11. Will the pharmacy receive a message if the claim is submitted to the wrong plan?

Any claims submitted to the HHW or HIP health plans with dates of service on or after January 1, 2010, will be denied by the HHW or HIP health plan. The pharmacy provider will receive a text message indicating the claim needs to be submitted to BIN 610467.

12. How long do I have to submit claim adjustments and reversals for claims with dates of service prior to January 1, 2010?

Claims for HHW and HIP health plan members with dates of service prior to January 1, 2010, will be available for claim adjustments and reversals through March 31, 2010. HHW and HIP health plans are responsible for all claims with dates of service on or before December 31, 2009.

13. What are the days supply limitations on maintenance and nonmaintenance medications?

Maintenance medications have a 100 days' supply limitation, while nonmaintenance medications have a 34 days' supply limitation. Refer to banner page BR200746, dated November 13, 2007, for additional information.

14. For claims with dates of service prior to January 1, 2010, what days supply and quantities should be submitted on the claims?

Claims with dates of service prior to January 1, 2010, billed to the HHW and the HIP health plans should not be submitted with a shortened days supply. All prescriptions should be dispensed with the allowable days supply as permitted by each plan prior to January 1, 2010.

Example: A claim for a prescription written for a 30 days' supply submitted on December 20, 2009, should not be submitted with a quantity sufficient for only 11 days, but should be submitted with a quantity sufficient for a 30 days' supply.

15. Do the tamper resistant prescription policies apply to HHW and the HIP claims written prior to January 1, 2010, but filled after January 1, 2010?

Due to the pharmacy benefit consolidation, HHW and HIP health plan members will receive their pharmacy services through the FFS delivery system. Federal law is that all nonelectronic prescriptions paid for by the FFS program must be written on tamper resistant prescription pads. Refills of prescriptions written for HHW and HIP health plan members prior to January 1, 2010, to be filled on or after January 1, 2010, must meet TRPP requirements. Refer to *Provider Bulletin BT200929*, dated August 26, 2009, for additional information regarding TRPP requirements.

16. Where can I find a manual relating to the IHCP?

Information pertaining to IHCP manuals can be found at www.indianamedicaid.com. Links to the manuals are available under the Publications button, http://provider.indianamedicaid.com/general-provider-services/manuals.aspx.

17. How do I contact the claims processor?

http://provider.indianamedicaid.com/media/27802/quick_reference.pdf.

18. How do I contact the pharmacy benefit manager (PBM) for prior authorization requests?

You may contact the PBM Call Center at 1-866-879-0106 or fax the appropriate prior authorization request form to 1-866-780-2198. Prior authorization forms can be found at http://provider.indianamedicaid.com/general-provider-services/forms.aspx.

19. How do I submit an appeal for a denial of a prior authorization?

Refer to *Chapter 9* (page 41) of the *IHCP Provider Manual* for the Prior Authorization Denial Appeal Process.

20. How do I submit claims for procedure-coded drugs?

Refer to *Provider Bulletins 200703*,dated January 30, 2007*; 200713*, dated May 29, 2007; and *200908*, dated March 12, 2009, for more detailed information.

21. How do I submit claims for drug-related medical supplies and medical devices?

Refer to EDI Solutions Trading Partner Registration Procedure and *IHCP Chapter 3 – Electronic Solutions* (page 7) for additional instructions about how to enroll as a trading partner with the IHCP and about how to submit these medical claims.

For a complete list of IHCP fee-for-service frequently asked questions, please refer to Indiana Medicaid FFS FAQS.