IHCP Provider

Monthly News

October 2009

Indiana Health Coverage Programs

http://www.indianamedicaid.com

What's New Inside!

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Common Abbreviations

ACN	Attachment Control Number
ADA	American Dental Association
ASC	Ambulatory Surgical Centers
AVR	Automated Voice Response
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
CPS	Child Protective Services
CPT	Current Procedural Terminology
DCS	Department of Child Services
DFR	Division of Family Resources
DME	Durable Medical Equipment
EDI	Electronic Data Interchange
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EVS	Eligibility Verification Systems
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability & Accountability Act
HP	Hewlett Packard
ICN	Internal Control Number
IHCP	Indiana Health Coverage Programs
LPI	Legacy Provider Identifier
MAC	Maximum Allowable Cost
MAR	Management and Administrative Reporting
MCO	Managed Care Organization
MHS	Managed Health Services
MRO	Medicaid Rehabilitation Option
NDC	National Drug Code
NOA	Notice of Action
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NTIOL	New Technology Intraocular Lenses
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claim Committee
OMPP	Office of Medicaid Policy and Planning
PA	Prior Authorization
PMP	Primary Medical Provider
PRTF	Psychiatric Residential Treatment Facility
RA	Remittance Advice
RBMC	Risk-Based Managed Care
SSN	Social Security Number
SUR	Surveillance and Utilization Review
TIN	Tax Identification Number
TPL	Third-Party Liability
VAN	Value-Added Network

All Providers

New Bulletins on the IHCP Web Site

The following bulletins were recently posted to the Indiana Health Coverage Programs (IHCP) Web site:

- *BT200931* – Notification of Pregnancy (NOP) Inquiry Search Function
- *BT200932* – Changes to the Preferred Drug List
- *BT200933* – Hospice, Home and Community-Based Services, and Medicaid Home Health Services

A complete list of bulletins is available on the IHCP Web site at http://provider.indianamedicaid.com/news,-bulletins,-and-banners/bulletins.aspx. E-mail notifications are sent to subscribers as new bulletins are posted. To subscribe, visit the IHCP Web site at http://provider.indianamedicaid.com/ihcp/mailing_list/default.asp and click **Open New Account**.

To access the Explanation of Benefits (EOB) codes from the IHCP Web site, click **Provider Services** and then click **EOB Descriptions**. Follow the directions at the top of the EOB Web page to print or download the EOB list.

Recent Updates to the *IHCP Provider Manual*

The following chapters of the *IHCP Provider Manual* have been updated:

- *Chapter 1 – General Information*
- *590 Program Provider Manual*

EDS Changes Name to HP

In August 2008, Hewlett-Packard (HP) acquired EDS, fiscal agent for the Indiana Health Coverage Programs. On Wednesday, September 23, 2009, the HP business unit of EDS changed its name to HP Enterprise Services in most locations across the country and around the world.

How will that affect healthcare providers in Indiana? You probably won't notice many changes. You'll begin to see the HP logo or the HP Enterprise Services name on correspondence. You'll begin to receive emails from an @hp.com email address rather than an @eds.com address. And you'll hear the HP name when calling the Customer Assistance Center.

Provider Termination Process – No Claim Activity in 18 Months

On October 1, 2009, HP Enterprise Services began a process of mailing termination letters to Medicaid providers that have not submitted claims for payment within the past 18 months. Providers have 30 days from the date of the letter to notify HP to retain their eligibility. The following providers are exempt from the systematic termination: out-of-state providers, state hospitals, waiver providers, school corporations, primary medical providers (PMP), and National Provider Identifier (NPI) billing default providers. The benefits of this termination process include a truer representation of the IHCP provider population, including density; more accurate reporting; and less returned and undeliverable mail.

Annual Update of the International Classification of Diseases

The annual update of the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is effective for the IHCP beginning October 1, 2009. The new, revised, and discontinued codes may be viewed at http://www.cms.hhs.gov/ICD9ProviderDiagnosticCodes/07_summarytables.asp#. To ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA), the 90-day grace period no longer applies to ICD-9-CM updates. Providers must use the appropriate ICD-9-CM diagnosis and procedure codes that are valid for the date of service. Codes not valid for dates of service deny. The new ICD-9-CM diagnosis and procedure codes are billable and reimbursable October 1, 2009.

The ICD-9-CM diagnosis codes in Table 1 will be added to Table 8.28 – Emergency Department Diagnosis Codes – in the *IHCP Provider Manual*,

Chapter 8, Section 2. These codes are effective for dates of service on or after October 1, 2009.

Table 1 – ICD-9-CM Diagnosis Codes **Effective for Dates of Service on or after October 1, 2009** (**additions** to Table 8.28 – Emergency Department Diagnosis Codes – of the *IHCP Provider Manual*)

416.2	453.50	453.51	453.52	453.6	453.71	453.72
453.73	453.74	453.75	453.76	453.77	453.79	453.81
453.82	453.83	453.84	453.85	453.86	453.87	453.89
488.0	488.1	569.87	670.10	670.12	670.14	670.20
670.22	670.24	670.30	670.32	670.34	670.80	670.82
670.84	768.70	768.71	768.72	768.73	779.31	779.32
779.33	779.34	784.42	789.7	799.21	799.22	799.23
799.24	799.25	799.29	813.46	813.47	832.2	969.00
969.01	969.02	969.03	969.04	969.05	969.09	969.70
969.71	969.72	969.73	969.79	995.24	E830.7	E831.7
E832.7	E833.7	V87.32				

The ICD-9-CM diagnosis codes in Table 2 will be removed from Table 8.28 – Emergency Department Diagnosis Codes – in the *IHCP Provider Manual*, *Chapter 8*, *Section 2* (invalid for dates of service on or after October 1, 2009). These codes are no longer valid.

Table 2 – ICD-9-CM Diagnosis Codes **Invalid for Dates of Service on or after October 1, 2009** (**deletions** from Table 8.28 – Emergency Department Diagnosis Codes – of the *IHCP Provider Manual*)

453.8	488	768.7	779.3	784.5	799.2	969.0
969.7						

The ICD-9-CM diagnosis codes in Table 3 will be added to Table 8.82 – High Risk Pregnancy ICD-9-CM Diagnosis Codes – in the *IHCP Provider Manual*, *Chapter 8*, *Section 4*. These codes are effective for dates of service on or after October 1, 2009.

Table 3 – ICD-9-CM Diagnosis Codes **Effective for Dates of Service on or after O*ctober 1, 2009*** (**additions** to Table 8.82 – High Risk Pregnancy ICD-9-CM Diagnosis Codes – of the *IHCP Provider Manual*)

488.0	488.1	621.34	621.35	V60.81	V60.89	V61.07
V61.08	V61.23	V61.24	V61.25	V61.42		

The ICD-9-CM diagnosis codes in Table 4 will be removed from Table 8.82 – High Risk Pregnancy ICD-9-CM Diagnosis Codes – in the *IHCP Provider Manual*, *Chapter 8*, *Section 4* (invalid for dates of service on or after October 1, 2009). These codes are no longer valid.

Table 4 – ICD-9-CM Diagnosis Codes **Invalid for Dates of Service on or after October 1, 2009** (**deletions** from Table 8.82 – High Risk Pregnancy ICD-9-CM Diagnosis Codes – of the *IHCP Provider Manual*

488	V60.8					

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 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 timeframe and insert a six-month period, as indicated in Senate Bill 266.

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 was reactivated for these procedure codes.

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

Eligibility Verification for Presumptive Eligibility

Eligibility can now be verified for Presumptive Eligibility (PE) members using name and date of birth, Social Security number, Medicare ID, or Medicaid ID.

As stated in *BR200933*, HP identified an issue related to eligibility inquiry for 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). This issue has been resolved.

Web interChange, Omni, and Automated Voice Response (AVR) display the eligibility information for the date requested. If the inquiry is made for a date of service during the PE period, and the member has not been transitioned to Hoosier Healthwise, EVS will show the PE eligibility for that date of service. If the inquiry is made by the PE "550" Recipient Identification Number (RID) for a date of service after the member is eligible for Hoosier Healthwise, EVS displays only the Hoosier Healthwise eligibility, but does not display the new Hoosier Healthwise "10_99" RID number. Providers are encouraged to use the name and date of birth or Social Security number to verify eligibility and to obtain the new RID number for that date of service. When the name and date of birth or Social Security number is used for eligibility inquiry, the current open Medicaid segment displays whether the member is eligible for PE or Hoosier Healthwise.

Primary Care, Vision, Dental, Behavioral Health, and Hearing Providers

Early and Periodic Screening, Diagnosis, and Treatment: Preventive Services for Children and Adolescents

The Office of Medicaid Policy and Planning (OMPP) wants to increase the number of children receiving age-appropriate preventive care services. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is the foundation for Medicaid-enrolled children, and this article focuses on preventive services for children and adolescents enrolled in Hoosier Healthwise and *Care Select*.

The objectives of the EPSDT Program are:

- To increase the number of members who are up-to-date with their childhood immunizations
- To increase the number of members receiving an initial health examination
- To increase the number of members receiving a preventive care/well visit examination
- To promote interaction between member and provider by developing and coordinating preventive services
- To encourage members to take a more active role in managing their health

The OMPP has selected quality measures for a pay-for-performance program that provides incentive payments to health plans serving members in Hoosier Healthwise and *Care Select* programs. Pay-for-performance creates an incentive-based payment structure.

Table 5 outlines **some** of the pay-for-performance measures in the Hoosier Healthwise (HHW) and *Care Select* (CS) programs.

Table 5 – Pay-for-Performance Measures

Program	Measure	Level I (25% Bonus)	Level II (75% Bonus)	Level III (100% Bonus)
HHW	Six or more visits in the first 15 months of life	56.6% (50th percentile nationally)	64.4% (75th percentile nationally)	75.2% (90th percentile nationally)
HHW	One or more well-child visits for children ages 3 to 6 years of age	67.5% (50th percentile nationally)	74.9% (75th percentile nationally)	79.9% (90th percentile nationally)
HHW	One or more well-child visits for adolescents (12 to 21 years of age)	Not applicable	51.4% (75th percentile nationally)	58.9% (90th percentile nationally)
CS	Annual dental visit – children ages 3 to 20 years	>50%	>55%	>60%
CS	One or more well-child visits for adolescents (12 to 21 years of age)	35.3% (25th percentile nationally)	42.1% (50th percentile nationally)	64.4% (75th percentile nationally)

Working Together Toward Preventive Health Care

The OMPP and the managed care organizations/care management organizations (MCOs/CMOs) work with Hoosier Healthwise and *Care Select* providers to promote healthy opportunities and reward members for participation. While the focus of the pay-for-performance measures is well-child exams, the OMPP encourages providers to take the extra steps to complete an EPSDT exam. EPSDT exams are reimbursed at a higher rate, as described in Table 6.

Hoosier Healthwise
Hoosier Healthwise risk-based managed care (RBMC) participants who enroll with a primary medical provider (PMP) in the RBMC network are also enrolled with an MCO that coordinates most medical services. Contracted MCOs assume financial risk for developing and managing a healthcare network that arranges for or provides Hoosier Healthwise covered services. The state pays the MCO a monthly capitation fee for each enrolled member. The MCOs have programs that encourage both members and providers to maintain ongoing well-child healthcare.

Anthem
To ensure the effectiveness of the EPSDT Program and the Initial Health Assessment, Anthem offers the following programs that are scheduled to provide interventions to members:

- Anthem uses automated monthly calls to remind the parents/guardians of members about:
  - The importance of the immunization schedule in the first 18 months of life
  - Annual preventive care/well visit for members 2 to 20 years of age
  - Initial health visit – all newly enrolled members
- Additionally, the following monthly reminder cards are mailed to parents/guardians of members:
  - Immunization schedule for 3 months, 6 months, 12 months, 15 months
  - Well-infant/child exams at 9 months, 18 months, 30 months, 42 months, 54 months, 66 months, and 78 months
  - Annually for children 2 to 20 years of age, in the month before their birthday
  - Initial Health Assessment for all newly enrolled members

Anthem Members Get a Free Reward for Practicing Good Health
Providers can also encourage parents/guardians of members to take advantage of health-plan incentives available to members that maintain regular well-child appointments.

All children who receive all appropriate **immunizations** in the first 12 months or at 24 months, and members who receive a **well-child exam** between 36 and 48 months, or between 48 and 60 months, qualify for a reward.

- Members receive one reward for each age level
- Members have a choice of reward: Childproofing Kit, First-Aid Kit, or Workout bag

Providers verify which of the services were delivered, and members mail the reward form to Anthem to receive their choice of reward. Reward forms can be obtained through Anthem by calling 1-888-232-9613.

MDwise
MDwise uses mailings to members to encourage well-child care. These mailings include highlights of preventive milestones that encourage the member's parent/guardian to plan for well-child visits.

- New parents receive magnetic picture frames that include easily accessible reminders of the health checkups recommended for newborn to 15 months of age.
- NURSE on-call postcards are mailed to parents/guardians of children 3-6 years of age and adolescents.

MDwise providers can also benefit financially when they reach targets for well-child exams:

- The MDwise Reach Out for Quality (ROQ) program incentivizes the MDwise integrated delivery systems by tying 4 percent of their capitation payments to improvements in Health Plan Employer Data and Information Set (HEDIS) measures.
- All three well-child measures in Table 5 are included in ROQ.
- Each MDwise delivery system has provider quality bonuses consistent with contracted physicians.

Managed Health Services (MHS)
Managed Health Services (MHS) offers many programs to support its members and providers in seeking preventative care:

- Step into Wellness: MHS members who see their doctor within 90 days of joining MHS and complete the Step into Wellness coupon (included in the MHS member handbook) receive a gift. Members can also contact MHS to request a coupon.
- Start Smart for your Baby®: All expecting MHS members receive a "Welcome to the Start Smart for Your Baby®" letter and educational materials. Booklets for tracking the series of prenatal activities are also included. Members can return these booklets for a $10 gift card. Members can contact member services at 1-877-647-4848 for additional assistance during pregnancy.

- MHS has a competitive, primary care-focused pay-for-performance program for contracted providers.
- MHS partners with PMPs across Indiana to ensure that MHS members who have not received their preventive care visits are educated on the importance of the primary care physician/patient relationship, and members are encouraged to seek needed visits and services.

Care Select
Care Select is a care management program tasked to assist members with the coordination of their healthcare needs. Each member has a care coordinator or care manager who assists in scheduling PMP appointments, obtaining transportation, connecting the member with local resources, and identifying any other available resources the member may need for the management of their care. Members are contacted on a regular basis. The amount of contact is based upon member need.

The Office of Medicaid Policy and Planning has contracted with two CMOs, MDwise, Inc. and ADVANTAGE Health Solutions[SM], to manage the care of eligible members and ultimately improve the quality of care and health outcomes for the members.

EPSDT Billing
Medicaid-enrolled providers must furnish and document all components of the EPSDT visit in order to bill for the higher rate of reimbursement for EPSDT screens. To review a complete list of EPSDT requirements, refer to the *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Provider Manual*. In addition, Bright Futures offers helpful practice management tools focused on children's health at http://brightfutures.aap.org/index.html.

Table 6 – Coding and Reimbursement for Health Exams
(The preventive health diagnosis code V20.2 must be used as the primary diagnosis.)

Type of Visit	CPT® Codes	ICD-9-CM Codes	Reimbursement
EPSDT Visit Provide preventive care following the EPSDT guidelines and documenting the components of the screening to allow for a higher level of reimbursement. Includes: Developmental testing of infant or child, immunizations appropriate for age, initial and subsequent routine newborn check, and routine vision and hearing.	**Preventive Visits** 99381-99385 – Initial/New Patient 99391-99395 – Established Patient **Evaluation and Management** 99201-99205 – New Patient 99211-99215 – Established Patient	V20.2 – Routine infant or child health check Use additional International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM) codes to identify special screening examinations performed.	Yes. EPDT visits must be billed with V20.2 **and** one of the Current Procedural Terminology (CPT) codes listed. These visits are eligible for additional reimbursement. Reimbursement: • Initial/New Patient, EPSDT $75 • Established Patient, EPSDT $62
Well-Child Visit Provide and document preventive care at any visit. Include age-appropriate medical history, physical exam, and health education. A comprehensive prenatal visit can also	**Preventive Visits** 99381-99385 – Initial/New Patient 99391-99395 – Established Patient **Prenatal Care** 59425 and 59426	V70.0 or V70.3 – V70.9 or V20.2 (see EPSDT Visit above)	Additional reimbursement is available only if the ICD-9 code is V20.2 – refer to the EPSDT Visit explanation. Reimbursement (if billed with V70.0 or V70.3-V70.9): • Initial/New Patient, Well-child: $63-$69 • Established Patient, Well-

Type of Visit	CPT® Codes	ICD-9-CM Codes	Reimbursement
meet the requirements for a well-child visit.			child: $50-$56 • Prenatal Care Visit: $40-$43
Sick Visit plus EPSDT Visit (two visit codes)	Preventive visit code **and** 99203-99215 w/modifier –25	V20.2 must be used as the **primary** diagnosis for the appropriate preventive visit. The appropriate presenting diagnosis must also be included with the CPT code for the sick visit.	Yes. Sick visits depend on complexity and doctor/patient relationship Reimbursement: • $19-$65
Refer to the IHCP Fee Schedule at www.indianamedicaid.com for more information and specific reimbursement rates.			

When a member presents to a provider for a sick visit and his/her records indicate the need for an updated EPSDT visit, physicians can include services for both visits and **bill two visit codes for reimbursement of both services on the same day**. Providers must maintain a complete problem-focused visit exam for the presenting problem **and** a complete preventive visit documenting the EPSDT components of the screening exam within the member's health records.

Required HealthWatch/EPSDT Screenings and Referrals

Children should routinely be screened for vision, hearing, and dental problems during EPSDT exams. There are additional age-appropriate screenings that should be provided, including developmental and mental health screenings. Refer to the *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Provider Manual* for additional information regarding recommended screenings.

Vision

Undetected vision problems occur in 5 to 10 percent of preschool children. The most serious of these problems are strabismus (cross eyed, or one eye looking out) and amblyopia (lazy eye). Both disorders can be detected by age three. Early screening and intervention programs can prevent lifelong visual impairments. Providers must perform a vision screening as part of the EPSDT visit at the ages specified in Table 7, with follow-up referrals as necessary. Screenings are not separately reimbursable; however, the EPSDT visit is reimbursed at an enhanced rate.

Table 7 – IHCP HealthWatch/EPSDT Vision Periodicity and Screening Schedule
Adapted from the American Academy of Pediatrics (AAP) Guidelines

Age of Child	Subjective (S) or Objective (O)	Services Required or Recommended
Up to 3 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
3 to 5 years	O	Annual objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.
6, 8, 14, 16, and 18 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
10, 12, and 20 years	O	Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.

(Screenings not separately billable)

Hearing
The most critical period for learning language is in the first two years of life. If hearing problems are not detected until after this time, lost ground in language development may never be fully regained. Screening tests vary according to age. The appropriate test must be provided as part of the EPSDT visit. The early detection of hearing loss is an urgent duty of any physician caring for young children. Treatment has the best results when infant hearing loss is identified and intervention begins before the child reaches 6 months of age.

Table 8 describes the intervals of the subjective and objective screening schedule. For additional guidance, refer to the *HealthWatch Early and Periodic Screening, Diagnosis, and Treatment Provider Manual*. Providers must perform a hearing screening as part of the EPSDT visit at the ages specified in Table 8, with follow-up referrals as necessary. Screenings are not separately reimbursable; however, the EPSDT visit is reimbursed at an enhanced rate.

Table 8 – IHCP HealthWatch/EPSDT Hearing Periodicity and Screening Schedule
Adapted from the American Academy of Pediatrics (AAP) Guidelines

Age	Screening
Newborn	Subjective screening, by history; to be performed on patients at risk
2-4 days, by 1 month, 2, 4, 6, and 9 months visits	Subjective screening, by history
12 months to 4 years visits	Range during which an objective screening may be provided, with objective screening, by standard testing method is recommended at age 4 years.
5-year visit	Objective screening, by standard testing method
6- and 8-year visits	Subjective screening, by history
10-, 12-, and 18-year visits	Objective screening, by standard testing method, not to be duplicated if screened within the school system.*
14-, 16-, and 20-year visits	Subjective screening, by history

* *Hearing tests are given by the Department of Education in grades one, four, seven, and 10. Screening efforts should not be duplicated unless the child is at risk and the situation warrants rescreening. Screening results from the school or verbal confirmation by the parent should be documented in the patient's medical records.*

Dental
The OMPP adopted the American Academy of Pediatric Dentistry (AAPD) periodicity and screening in 2008. Providers must perform a dental screening as part of the EPSDT visit at the ages specified in Table 9, with follow-up referrals to a dental provider, as necessary. Dental providers should also follow this schedule for prevention and treatment of childhood dental problems.

Table 9 – IHCP HealthWatch/EPSDT Dental Periodicity and Screening Schedule
Adapted from the American Academy of Pediatric Dentistry (AAPD) guidelines

Dental Services	6-12 months	12-24 months	2-6 years	6-12 years	>12 years
Clinical oral examination [1,2] to include:	■	■	■	■	■
Assess oral growth and development [3]	■	■	■	■	■
Caries-risk assessment[4]	■	■	■	■	■
Radiographic assessment[5]	■	■	■	■	■
Prophylaxis and topical flouride[4,5]	■	■	■	■	■
Anticipatory guidance/counseling[6]	■	■	■	■	■
Injury prevention counseling[7]	■	■	■	■	■
Counseling for nonnutritive habits[8]	■	■	■	■	■
Counseling for speech/language development	■	■	■		
Substance abuse counseling				■	■
Counseling for intraoral/perioral piercing				■	■
Assessment for pit and fissure sealants[9]			■	■	■
Transition to adult dental care			■	■	■
Assessment and treatment of developing malocclusion			■	■	■
Assessment and/or removal of third molars				■	■

[1] First examination at the eruption of the first tooth and no later than 12 months. Repeat every six months or as indicated by child's risk status/susceptibility to disease.

[2] Includes assessment of pathology and injuries.

[3] By clinical exam.

[4] Must be repeated regularly and frequently to maximize effectiveness.

[5] Timing, selection, and frequency determined by child's history, clinical findings, and susceptibility to oral disease.

[6] Appropriate discussion and counseling should be an integral part of each visit for care.

[7] Initially play objects, pacifiers, car seats; then, while learning to walk, sports and routine play, including the importance of mouth guards.

[8] At first, discuss the need for additional sucking: digits versus pacifiers; then, the need to wean from the habit before malocclusion or skeletal dysplasia occurs. For school-aged children and adolescent patients, counsel regarding any existing habits such as fingernail biting, clenching, or bruxism.

[9] For caries-susceptible primary molars, permanent molars, premolars, and anterior teeth with deep pits and fissures; placed as soon as possible after eruption.

Prescribing Providers and Pharmacy Providers

Automation of Pharmacy Prior Authorization for Fee-for-Service Claims

Overview
On November 1, 2009, the fee-for-service (FFS) pharmacy program will implement an automated prior authorization (PA) tool known as SmartPA™. SmartPA™ executes real-time prior authorization decisions by utilizing highly sophisticated clinical PA edits supported by the member's medical and pharmacy claims data. SmartPA™ will result in quicker PA determinations for fee-for-service Medicaid members, with less intervention on the part of both pharmacy and prescribing providers. SmartPA™ has the capability to allow certain prescriber specialties to bypass designated PA requirements.

SmartPA™ ensures that the prescribed therapy meets Indiana-specific evidence-based criteria for appropriate use. If the therapy is appropriate, the claim continues through the pharmacy claims processing system. If the therapy is not appropriate, the claim is denied and the provider receives notification to contact the Affiliated Computer Services (ACS) Indianapolis Clinical Call Center. SmartPA™ is integrated with both the ACS Indianapolis Clinical Call Center and the HP pharmacy claims adjudication (PCA) system. Claim denial results when SmartPA™ edit requirements are not met.

Implementation
The Office of Medicaid Policy and Planning, based on recommendations from the Indiana Medicaid Drug Utilization Review Board, the Therapeutics Committee, and the Mental Health Quality Advisory Committee (applicable only to mental health drugs), reviews and approves the clinical edits and criteria used within SmartPA™.

Clinical edits will gradually be added to SmartPA™ as they are approved as described above. The first edit to be implemented with SmartPA™ will be the 15-day trial fill for new, atypical antipsychotic medications. Refer to Provider Bulletin *BT200805*, dated January 24, 2008, for the criteria pertaining to this edit. Providers will be notified of the implementation of future edits through HP provider bulletins and/or banner pages.

Consolidation of the Managed Care and Healthy Indiana Plan (HIP) Pharmacy Benefits – Effective January 1, 2010

Effective for claims with dates of service of January 1, 2010, and later, the Office of Medicaid Policy and Planning (OMPP) will assume responsibility for the administration of the managed care and HIP pharmacy benefits. This is referred to as a consolidation of the pharmacy benefits. All Hoosier Healthwise pharmacy claims that are currently processed by Anthem, MDwise, or Managed Health Services will be processed by the fee-for-service claims processor, HP. At the same time, HIP claims that are currently processed by Anthem/Blue Cross-Blue Shield and MDwise/AmeriChoice will also begin being processed by HP. Additional information will be provided in subsequent provider bulletins and banner pages.

Important Information – Benefit Consolidation and Tamper Resistant Prescription Pads (TRPPs)
Related to the benefit consolidation described above, we want to remind providers that all non-electronic prescriptions for fee-for-service recipients must meet applicable federal TRPP requirements. In part, this means that refills of prescriptions written for Hoosier Healthwise and HIP members prior to the January 1, 2010, benefit consolidation effective date, but that will be dispensed on or after that date, must meet TRPP requirements. As noted in prior provider communications regarding TRPPs, the Indiana Board of Pharmacy security prescription blanks meet all TRPP requirements; therefore, OMPP strongly suggests that providers obtain a supply of those prescription blanks and use them when prescribing for their Medicaid patients. Please refer to the following Medicaid bulletins for information regarding federal TRPP requirements:

- *BR200733*, dated August 14, 2007
- *BT200724*, dated September 18, 2007
- *BR200741*, dated October 9, 2007
- *BT200810*, dated February 22, 2008

Please contact HP Customer Assistance at (317) 655-3240 or 1-800-577-1278 if you have questions.

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's) 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.

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 10 for specific contact information.

Table 10 – 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)

Provider Workshops

Register Now for the October IHCP Seminar in Indianapolis!

Register now to attend the 2009 IHCP Seminar October 20-22, 2009, at the Indianapolis Marriott East. Topics include claims and billing; programs such as *Care Select*; dental, vision, and mental health; transportation and durable medical equipment (DME); Presumptive Eligibility for Pregnant Women and Notification of Pregnancy (PE/NOP); and more. There is no cost to attend. To register, go to http://www.indianamedicaid.com/ihcp/index.asp and click **Provider Services** > **Education Opportunities** > **Workshop Registration**.

Contact Information

Table 11 – Provider Relations Field Consultants

Territory Number	Provider Relations Consultant	Telephone	Counties Served
1	Jean Downs	(317) 488-5071	Jasper, Lake, LaPorte, Newton, Porter, Pulaski, Starke
2	Rhonda Rupel	(317) 488-5080	Allen, Dekalb, Elkhart, Fulton, Kosciusko, Lagrange, Marshall, Noble, St. Joseph, Steuben, Whitley
3	Tawanna Danzie	(317) 488-5197	Benton, Boone, Carroll, Cass, Clinton, Fountain, Hamilton, Howard, Miami, Montgomery, Tippecanoe, Tipton, Warren, White
4	Daryl Davidson	(317) 488-5388	Adams, Blackford, Delaware, Grant, Hancock, Henry, Huntington, Jay, Madison, Randolph, Wabash, Wayne, Wells
5	Bill Woodruff	(317) 488-5098	Marion – UB-04 Billing Providers and Dental Providers
	Mona Green	(317) 488-5309	Marion – CMS-1500 Billing Providers
6	Shantel Silnes	(317) 488-5123	Bartholomew, Brown, Clark, Dearborn, Decatur, Fayette, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Ohio, Ripley, Rush, Scott, Shelby, Switzerland, Union, Washington
7	Virginia Hudson	(317) 488-5148	Clay, Greene, Hendricks, Johnson, Lawrence, Monroe, Morgan, Owen, Parke, Putnam, Sullivan, Vermillion, Vigo
8	Ken Guth	(317) 488-5153	Crawford, Daviess, Dubois, Gibson, Knox, Martin, Orange, Perry, Pike, Posey, Spencer, Vanderburgh, Warrick
9	Tawanna Danzie	(317) 488-5197	Out-of-State
10	Relia Manns	(317) 488-5363	Presumptive Eligibility and Notice of Pregnancy for the entire State of Indiana

Table 12 – Provider Relations Field Consultants for Bordering States

State	City	Provider Relations Consultant	Telephone
Illinois	Chicago/Watseka	Jean Downs	(317) 488-5071
Illinois	Danville	Virginia Hudson	(317) 488-5148
Kentucky	Owensboro	Ken Guth	(317) 488-5153
Kentucky	Louisville	Shantel Silnes	(317) 488-5123
Michigan	Sturgis	Rhonda Rupel	(317) 488-5080
Ohio	Cincinnati/Hamilton/Harrison/Oxford	Shantel Silnes	(317) 488-5123

Out-of-state providers not located in these states, or those with a designated out-of-state billing office supporting multiple provider sites throughout Indiana, should direct calls to (317) 488-5197.

Table 13 – For Provider Concerns

Name	Title	Telephone
Tina King	Provider Relations Supervisor	(317) 488-5154

Indiana Health Coverage Programs Quick Reference

Assistance, Enrollment, Eligibility, Help Desks, and Prior Authorization			
ADVANTAGE Health Solutions℠ Prior Authorization – FFS P.O. Box 40789 Indianapolis, IN 46240 1-800-269-5720 Fax: 1-800-689-2759	Automated Voice Response (AVR) System (including eligibility verification) (317) 692-0819 or 1-800-738-6770	HP Administrative Review Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	HP Customer Assistance (317) 655-3240 or 1-800-577-1278 Opt 1 = Pharmacy
HP Electronic Solutions Help Desk (317) 488-5160 or 1-877-877-5182 INXIXElectronicSolution@eds.com	HP Forms Requests P.O. Box 7263 Indianapolis, IN 46207-7263	HP Member Hotline (317) 713-9627 or 1-800-457-4584 Opt 1 = Member Services – English Opt 2 = Member Services – Spanish	HP Omni Help Desk (317) 488-5051 or 1-800-284-3548
HP TPL (317) 488-5046 or 1-800-457-4510 Fax: (317) 488-5217	HP Provider Enrollment and Waiver P.O. Box 7263 Indianapolis, IN 46207-7263 1-877-707-5750	HP Provider Written Correspondence P.O. Box 7263 Indianapolis, IN 46207-7263	IHCP Provider and Member Concern Line (Fraud and Abuse) (317) 347-4527 or 1-800-457-4515
IHCP SUR Department P.O. Box 531700 Indianapolis, IN 46253-1700 (317) 347-4527 or 1-800-457-4515	Premium Collection Services Package C Payment Line 1-866-404-7113 Package C Payment Mailing Address Hoosier Healthwise P.O. Box 3127 Indianapolis, IN 46206-3127	M.E.D. Works 1-866-273-5897 M.E.D. Works Payment Mailing Address P.O. Box 946 Indianapolis, IN 46206	
Pharmacy Services Contact Information			
ACS Drug Rebate ACS State Healthcare ACS – Indiana Drug Rebate P. O. Box 2011332 Dallas, TX 75320-1332	HP Pharmacy Services Help Desk for POS Claims Processing (317) 655-3240 or 1-800-577-1278 INXIXPharmacy@hp.com	HP Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268	HP Pharmacy Claims Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265
Pharmacy Benefit Management Inquiries PDL@fssa.in.gov	Indiana Administrative Review/Pharmacy Claims HP Pharmacy Claims Admin. Review P.O. Box 7263 Indianapolis, IN 46207-7263	PA For Pro-DUR and Preferred Drug List – ACS Clinical Call Center 1-866-879-0106 Fax: 1-866-780-2198	To make refunds to the IHCP for pharmacy claims, send check to: HP Pharmacy Refunds P.O. Box 2303, Dept 130 Indianapolis, IN 46206-2303
Enrollment Broker Helplines (MAXIMUS)	**Hoosier Healthwise Managed Care Organizations (MCOs)**		
Hoosier Healthwise http://www.healthcareforhoosiers.com 1-800-889-9949 *Care Select* http://www.indianacareselect.com 1-866-963-7383 HIP http://www.HIP.in.gov 1-877-438-4479	Anthem http://www.anthem.com Claims 1-888-232-9613 Member Services 1-866-408-6131 PA 1-866-408-7187 Fax: 1-866-406-2803 Provider Services 1-866-408-6132 Fax: 1-866-408-7087 Prospective Providers 1-800-618-3141 Fax: 1-866-408-7087 Transportation 1-800-508-7230 Pharmacy 1-866-629-1608 PA: 1-877-652-1223 PA Fax: 1-866-408-7103	MDwise http://www.mdwise.org Claims, Member Services PA/Medical Management, Provider Services, and Pharmacy (317) 630-2831 or 1-800-356-1204	Managed Health Services (MHS) https://www.managedhealthservices.com Claims, Member Services, PA/Medical Management, Provider Services, and Nursewise 1-877-MHS-4U4U or 1-877-647-4848 Pharmacy – US Script (PBM) 1-800-460-8988 Pharmacy PA 1-866-399-0928 Fax: 1-866-399-0929

Indiana Health Coverage Programs Quick Reference

Care Select – Care Management Organizations (CMOs)		Healthy Indiana Plan (HIP) Organizations	HIP – Enhanced Services Plan (ESP) Organizations	
ADVANTAGE Health Solutions℠ http://www.advantageplan.com/ Member Services 1-800-784-3981 Provider Services 1-866-504-6708 PA 1-800-784-3981 Fax: 1-800-689-2759 P.O. Box 80068 Indianapolis, IN 46280 Hospice Member Disenrollment Fax: (317) 810-4488	MDwise http://www.mdwise.org Member Services and Provider Services 1-866-440-2449 Member Services Fax 1-877-822-7188 PA 1-866-440-2449 Fax: 1-877-822-7186 P.O. Box 44214 Indianapolis, IN 46244-0214	MDwise Healthy Indiana Plan http://www.mdwise.org Member Services and Provider Services P.O. Box 44236 Indianapolis, IN 46244-0236 1-877-822-7196 or (317) 822-7196 Fax: 1-877-822-7192 or (317) 822-7192 Medical Claims P. O. Box 33049 Indianapolis, IN 46203 Payer ID: MDWIS Behavioral Health Claims/HIP 1-800-818-6872 P.O. Box 33049 Indianapolis, IN 46203 Payer ID MDWIS Customer Service/Provider Service 1-877-822-7196 or 317-822-7196	ACS – Non-Pharmacy P.O. Box 33077 Indianapolis, IN 46203-0077 1-866-674-1461 or (317) 614-2032 Pharmacy PA ACS 1-866-879-0106 Fax: 1-877-822-7186 HP Pharmacy Claims P.O. Box 7268 Indianapolis, IN 46207-7268 1-800-577-1278 or (317) 655-3240 PA – Medical 1-877-217-7150	
Pharmacy See Pharmacy Services Contact Information above	HP Claims Providers (317) 655-3240 1-800-577-1278 Members (317) 713-9627 1-800-457-4584	Anthem Blue Cross and Blue Shield http://www.anthem.com Member Services 1-800-553-2019 Provider Inquiry 1-800-345-4344 P.O. Box 37010 Louisville, KY 40233-7180 PA 1-866-398-1922		
Paper Claim Filing				
HP 590 Program Claims P.O. Box 7270 Indianapolis, IN 46207-7270	HP Adjustments P.O. Box 7265 Indianapolis, IN 46207-7265	HP CCFs P.O. Box 7266 Indianapolis, IN 46207-7266	HP Dental Claims P.O. Box 7268 Indianapolis, IN 46207-7268	HP CMS-1500 Claims P.O. Box 7269 Indianapolis, IN 46207-7269
HP Claim Attachments P.O. Box 7259 Indianapolis, IN 46207-7259	HP Waiver Programs Claims P.O. Box 7269 Indianapolis, IN 46207-7269	HP Medical Crossover Claims P.O. Box 7267 Indianapolis, IN 46207-7267	HP Institutional Crossover/UB-04 Inpatient Hospital, Home Health, Outpatient, and Nursing Home Claims P.O. Box 7271 Indianapolis, IN 46207-7271	
Check Submission				
To make refunds to the IHCP HP Refunds P.O. Box 2303, Dept. 130 Indianapolis, IN 46206-2303	To make refunds for CA-PRTF HP/CA-PRTF Refunds P.O. Box 7247 Indianapolis, IN 46207	To make refunds for MFP HP/MFP Refunds P.O. Box 7194 Indianapolis, IN 46207	To Return Uncashed IHCP Checks HP Finance Department 950 N. Meridian St., Suite 1150 Indianapolis, IN 46204-4288	Pharmacy See Pharmacy Services Contact Information above

Restricted Card Program		
ADVANTAGE Health Solutions – FFS Attn: Restricted Card Program P.O. Box 40789 Indianapolis, IN 46240 1-800-784-3981 Fax: 1-800-689-2759	ADVANTAGE Health Solutions – *Care Select* Attn: Restricted Card Program P.O. Box 40789 Indianapolis, IN 46240 1-800-784-3981 Fax: 1-800-689-2759	MDwise – *Care Select* Attn: Restricted Card Program 1099 N. Meridian St., Suite 320 P.O. Box 44214 Indianapolis, IN 46204 1-866-440-2449 Fax: 1-877-822-7188