PROVIDER *news*

INDIANA HEALTH COVERAGE PROGRAMS NL201106 JUNE 2011

Doing business with Medicaid

Eligibility Verification Systems (EVS) to include ARCH and CHIP/Package A information

Disproportionate share hospitals (DSH) are hospitals that serve a disproportionate number of Medicaid and low-income patients. Certain aid categories are **excluded** from the Medicaid days used to determine a hospital's DSH eligibility. Specifically, aid categories known as CHIP (Children's Health Insurance Program) and ARCH (Assistance to Residents in County Homes) are excluded from DSH eligibility calculations.

Currently, the CHIP and ARCH aid categories are displayed in EVS as "Member is Eligible for Package A Standard Plan" and "Member is Eligible for Traditional Medicaid," respectively. Please note, however, that the EVS aid category for CHIP (MA9) includes some CHIP members with credible insurance or third-party liability (TPL) who are classified as Medicaid for DSH eligibility purposes and **are** eligible for inclusion in the DSH eligibility calculations. To allow hospitals to identify these members for DSH eligibility calculation purposes, the EVS will be updated effective June 29, 2011, to include additional information for members eligible under the CHIP and ARCH aid categories. As shown in the table on the next page, EVS will indicate to providers whether a

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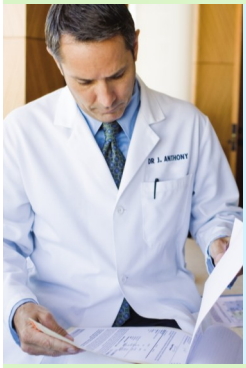
member in the MA9 aid category is classified as CHIP (**not eligible** for inclusion in DSH eligibility calculations) or Medicaid (**eligible** for inclusion in DSH eligibility calculations). The Web interChange eligibility information screen will be changed in accordance with the following table.

EVS: Is MA9 member CHIP or Medicaid?

Aid Category/Title	Current EVS Response	New EVS Response
AR 5 (ARCH for Aged)	Member is Eligible for Traditional Medicaid	Member is Eligible for Traditional Medicaid for ARCH
AR 6 (ARCH for Blind)	Member is Eligible for Traditional Medicaid	Member is Eligible for Traditional Medicaid for ARCH
AR 7 (ARCH for Disabled)	Member is Eligible for Traditional Medicaid	Member is Eligible for Traditional Medicaid for ARCH
MA 9 (CHIP1)	Member is Eligible for Package A – Standard Plan	Member is Eligible for Package A (CHIP)
MA 9 (MCHIP) Member has Credible TPL	Member is Eligible for Package A – Standard Plan	Member is Eligible for Package A (Medicaid)

These modifications will also be made in the Automated Voice Response (AVR), OMNI, and electronic 270/271 eligibility verification systems. These changes will allow hospitals to more readily identify CHIP and ARCH members to be excluded from DSH eligibility data. **This change is to facilitate reporting for DSH hospitals. It is not intended to affect eligibility verification by any other provider type**.



HIPAA 5010 testing ends this month

Phase 2 of vendor testing for Health Insurance Portability and Accountability Act (HIPAA) 5010/ National Council for Prescription Drug Programs (NCPDP) D.0 ends June 30, 2011. Be sure your software vendor, clearinghouse, or billing service is testing or has been scheduled for testing. If you have questions, contact the EDI Solutions Service Desk at 1-877-877-5182; at (317) 488-5160; or at INXIXTradingPartner@hp.com.

Sign up now for second-quarter workshops

The Indiana Health Coverage Programs (IHCP) is offering free quarterly provider workshops. Sessions for Medicaid 101, IHCP Updates, and Provider Enrollment are available. Sessions are also scheduled for *Care Select* Provider Issues and Resolutions, a behavioral health roundtable, updates from managed care entities (MCEs), and questions-and-answers. For more information and to register, visit indianamedicaid.com (General Provider Services > Provider Education).

Medicaid reimbursement for medically necessary infant formula

Clarification for Hoosier Healthwise (HHW) providers about how and when to request prior authorization (PA) for medically necessary infant formula

The Indiana Administrative Code (*405 IAC 5-24-09*) outlines Medicaid requirements for coverage of infant formula benefits. Food supplements, nutritional supplements, and infant formulas are covered only when no other means of nutrition is feasible or reasonable.

Very young children enrolled in Medicaid requiring specialized infant formulas can receive their formula as a covered benefit through Medicaid. Medicaid providers must determine that the infant formula is medically necessary for it to be considered for coverage, and PA is required in some cases. Providers must coordinate with the appropriate entity when seeking approval for Medicaid coverage of infant formula.

If the eligible Medicaid member is assigned to Traditional Medicaid on the date of service, ADVANTAGE Health Solutions℠ is responsible for processing the required PA. Information about obtaining PA through ADVANTAGE can be found on the Prior Authorization page at indianamedicaid.com.

If the eligible Medicaid member is enrolled in Hoosier Healthwise (HHW) on the date of service, which is most often the case with young children, the member's managed care entity (MCE) is responsible for approving Medicaid coverage of the infant formula. Each MCE has developed its own policy and procedure for how medical necessity for infant formula must be documented and approval obtained. The table on the next page clarifies the steps to follow for each MCE.

While awaiting authorization, the Women, Infants and Children (WIC) program will provide *a supplemental amount of exempt infant formula or medical food*. Under federal regulation (*USDA 7 CFR Ch. II (1-1-10 Edition*), to receive this WIC benefit, members must obtain *documentation of a qualifying condition from a healthcare professional licensed to write medical prescriptions*. Please note that members should be referred to WIC only as a secondary provider. Medicaid becomes the primary provider once approval as a covered benefit is granted.

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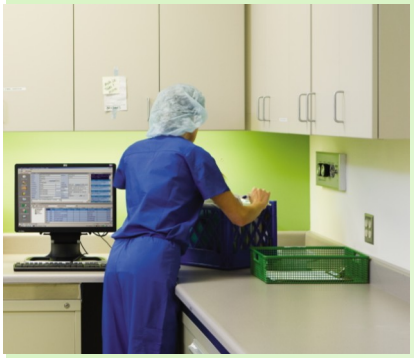
HHW MCE steps for establishing medical necessity and obtaining Medicaid approval for infant formula

Steps	Anthem	Managed Health Services (MHS)	MDwise
Step 1. Physician determines medical necessity	Physician must provide a prescription or a completed Certificate of Medical Necessity: Parenteral or Enteral Nutrition (located at indianamedicaid.com under Forms) to the durable medical equipment (DME) or home care formula provider. Physician can use the online provider finder tool at anthem.com or call 1-866-408-6131 for assistance in finding a network formula provider. Physician's office must verify that the formula provider is able to fill the order for the specific formula and supply member's current address for delivery. Members may be referred to Anthem Case Management.	Physician completes a Certificate of Medical Necessity: Parenteral or Enteral Nutrition (located at indianamedicaid.com under Forms). Physician's office sends this information to a DME/formula provider.	Physician provides documentation supporting the medical necessity of the formula, including office notes, labs, growth charts, etc.
Step 2. Justification is provided to the MCE	No approval is required by network DME or home care formula providers. Non-network DME or home care formula providers must call 1-866-408-7187 for approval.	DME/formula provider contacts MHS for prior authorization by phone at 1-877-647-4848 and faxes Certificate of Medical Necessity: Parenteral or Enteral Nutrition form to MHS at 1-866-912-4245.	Physician submits request for approval of coverage for infant formula to the member's MDwise delivery system entity using the Universal Prior Authorization Form (located at indianamedicaid.com under Forms). Providers should call the medical management department of the member's delivery system with questions or for assistance.
Step 3. What to expect	Requests for approval are typically addressed within three to four days. **Approval:** Requests by non-network DME or home care formula providers are reviewed, and the physician and the DME or home care formula provider receive verbal and written notification. The formula provider will determine method of delivery to the member. **Denial:** The non-network DME or home care formula provider, the ordering physician, and the member receive verbal and written information explaining the denial, the right to appeal, and the appeal process.	All requests are reviewed against the IAC; if they do not appear to qualify, they are referred to a physician for review. MHS auto-approves if the member is less than one year old, or if the request is for G tube-fed members. **Approval:** MHS faxes approvals to the DME formula provider. The DME/formula provider determines method of formula delivery to the member. **Denial:** The DME/formula provider is notified by phone of denial or partial approval. The DME/formula provider, the member, and the physician receive written notification of denial or partial approval. Denials are subject to appeal.	An approval or denial decision is made within two business days of receiving all necessary information. **Approval:** MDwise delivery system entity sends approved PA to the physician, along with the name and contact information of the approved DME/formula provider. (As warranted by the physician, MDwise may send the approved PA directly to the DME/formula provider.) The DME/formula provider has a one month's supply of infant formula delivered to the member. **Denial:** A denial letter outlining the appeal process is sent to the physician and the member.
Contact information if you have questions	Providers and members can call the Customer Care Center at 1-866-408-6131.	Providers and members can call 1-877-647-4848.	Providers can call the medical management department of the member's delivery system. Members can call MDwise Customer Service at 1-800-356-1204.

Using claim notes with surgery claims



To shorten the turnaround time for processing and payment of claims and to prevent rework for you and your billing staff, follow these tips for including claim notes with surgery claims:

- In the following four surgery situations, the Indiana Health Coverage Programs (IHCP) accepts specific claim note information:
  - — Surgery payable at reduced amount when related post-operative care is paid
  - — Post-operative care within 0-90 days of surgery
  - — Pre-operative care on the day of surgery
  - — Surgery payable at reduced amount when pre-operative care is paid on the same date of service
- In the situations listed previously, the IHCP accepts the following claim note information:
  - — Information that documents the medical reason and unusual circumstances for the separate evaluation and management (E/M) visit
  - — Information that supports that the medical visit occurred due to a complication, such as cardiovascular complications, comatose conditions, elevated temperature for two or more consecutive days, medical complications other than nausea and vomiting due to anesthesia, post-operative wound infection requiring specialized treatment, or renal failure

Remember...

The best way to speed claim processing and payment is to submit claims electronically. If you are not set up to submit claims via the Web, go to Web interChange at indianamedicaid.com and click **How to Obtain a Web interChange User ID and Password**.

Pharmacy news

- If the Food and Drug Administration (FDA) labels a drug "nonapproved," the Centers for Medicare & Medicaid Services (CMS) and Indiana Medicaid will not cover the drug – even if the drug has previously been covered by state Medicaid programs. For a list of drugs recently labeled nonapproved by the FDA and noncovered by CMS, see "CMS Deleted Products" under Pharmacy Services on the Centers for Medicare & Medicaid Services page of indianamedicaid.com.

- Keep in mind that e-prescribing (writing and sending prescriptions to pharmacies electronically) demonstrates meaningful use of electronic medical health records and certified technology, which means it qualifies for reimbursement through the EHR Incentive Program. Some physicians and prescribing practitioners are already receiving reimbursement for e-subscriptions. For more information, see EHR Incentive Programs on the Centers for Medicare & Medicaid Services (CMS) Web site at cms.gov; or see "EHR Is Here!" under News and Announcements on the indianamedicaid.com home page.
- Following current Indiana law, the Indiana Health Coverage Programs (IHCP) continues to use the average wholesale price (AWP) when pricing drugs. For more information, see *405 IAC 5-24-4* – Reimbursement for legend drugs or *Chapter 9* of the *IHCP Provider Manual*.

RECENTLY PUBLISHED TO THE IHCP WEB SITE

BULLETINS

- BT201112 – Reduction in Nonhospital-Based Laboratory Reimbursement
- BT201113 – Reduction in Reimbursement for Eye Care and Eyewear
- BT201114 – Reduction in Reimbursement for Durable Medical Equipment (DME) and Prosthetics
- BT201115 – Reduction in Reimbursement for Nonhospital-Based Freestanding Dialysis Facilities
- BT201116 – Reduction in Reimbursement for Speech/Hearing Therapists and Audiologists
- BT201117 – Hearing Aid Reimbursement
- BT201118 – Reduction in Reimbursement for Medical Supplies
- BT201119 – Reduction in Reimbursement for Nursing Facilities
- BT201120 – The IHCP to Reduce Pharmacy Dispensing Fee
- BT201121 – Reduction in Reimbursement for Nonhospital-Based Radiology Providers
- BT201122 – Reduction in Reimbursement for Inpatient and Outpatient Hospital Services Extended
- BT201123 – Extension for Reduction in Reimbursement for Dental Services
- BT201124 – Extension for Reduction in Reimbursement for Nonstate-Owned Intermediate Care Facilities for the Mentally Retarded and Community Residential Facilities for the Developmentally Disabled
- BT201125 – Extension for Reduction in Reimbursement for Home Health Services
- BT201126 – Removal of Physical, Speech, and Occupational Therapy Services Limitations
- BT201127 – The IHCP Eliminates Reimbursement for Targeted Case Management

PROVIDER MANUAL UPDATES

IHCP Provider Manual – the following chapters of the manual have been updated:

- *Chapter 4 – Provider Enrollment, Eligibility, and Responsibilities*
- *Chapter 6 – Prior Authorization*
- *Chapter 14 – Long Term Care*

Electronic Health Records Incentive Program

Healthwatch/EPSDT Provider Manual

NEWS FROM RECENT BANNER PAGES

- Correction Regarding Payment of CPT Code 35638
- Changes in Global Delivery Codes
- Update: NCCI Claims Processing
- The IHCP Covers HCPCS Codes L2861 and L3891
- Updates to FQHC and RHC Encounter Codes
- Diagnosis Codes Added to HIP Pregnancy Discovery Period
- The IHCP to Cover New Modifier 33 – Preventive Service
- CPT Code Linked to Ambulatory Surgical Center Revenue Codes and Pricing Indicator
- The IHCP Clarifies Partial Hospitalization Policy
- The IHCP to Mass Adjust Outpatient Claims
- Correction Regarding Claims Denied with Modifier 50

FOR MORE INFORMATION

- Contact your Provider Relations Field Consultant
- IHCP Provider Quick Reference – a complete list of addresses, telephone numbers, and fax numbers for the IHCP and IHCP vendors