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To All Providers:

- The passage of *House Enrolled Act (HEA) 1325* has created some confusion. Some advocates and industry representatives have been disseminating information that Prior Authorizations and other clinical edits on behavioral health drugs covered through the Hoosier Healthwise Managed Care Organizations (MCO) are invalid as of July 1, 2005. However, that information is inaccurate.

HEA 1325 confers upon the Mental Health Quality Assurance Committee the responsibility to make recommendations to the Office of Medicaid Policy and Planning (OMPP) regarding access to behavioral health drugs through the Indiana Medicaid program. The OMPP has the ultimate responsibility for implementing any restrictions with the advice of the Committee. The Mental Health Quality Assurance Committee is currently being assembled in accordance with the guidelines set forth in *HEA 1325*.

Until the committee is formed and the OMPP issues guidance regarding access to behavioral health drugs by Hoosier Healthwise members in the Risk-Based Managed Care program, all MCO preferred drug lists (PDL) clinical edits will remain in effect.

To Community Mental Health Centers and Mental Health Providers:

- This notification clarifies requirements regarding supervision of outpatient mental health or Medicaid Rehabilitation Option (MRO) services, as set out in *405 IAC 5-20-8* and *405 IAC 5-21-6*.

The supervising physician, psychiatrist, or Health Service Provider in Psychology (HSPP) must see the patient during the intake process or review the medical information obtained by the mid-level practitioner, and must approve the initial treatment plan within seven days. Providers have requested clarification about IHCP policy regarding services provided within the first seven days of intake, but prior to the treatment plan being approved. The following scenario is provided to illustrate the concern.

A case manager or mid-level mental health provider assesses the member on Day 1. Based on this assessment, a treatment plan is developed and services are initiated on Day 3. The HSPP reviews and approves the treatment plan on Day 7. Can the provider bill for services that were provided on Days 3, 4, 5, and 6, prior to the treatment plan being signed?

The Office of Medicaid Planning and Policy (OMPP) has determined that it is appropriate for outpatient mental health and MRO providers to bill for medically necessary services that are provided prior to the approval of the treatment plan, as long as the treatment plan is signed within seven days of intake. If the treatment plan is not signed within seven days of intake, providers may not bill for services provided after day 7, until the treatment plan is signed.

To All Crossover Part B Providers:

- System modifications were implemented in May 2005 for claims that were billed with a modifier type indicating “processing” or “pricing” and paid incorrectly. The billing provider number was erroneously populated in the rendering provider number field on crossover claim submissions, causing the system to process claims and pay an incorrect rate. Not all claims that were billed with a processing or pricing modifier were affected.

For claims that processed between October 1, 2003, and June 3, 2005, a mass adjustment will be performed on or after **August 30, 2005**, for incorrectly paid claims only. In the event you feel that your claim was paid

incorrectly and it was not included in the mass adjustment, you may submit your own adjustment request for consideration.

Administrative Review and Appeal

The mass adjustment amounts will be reflected in the weekly remittance advice (RA) and will be assigned to region 56. Providers who disagree with the adjustments may request an administrative review by writing to the following address:

**EDS – Administrative Review
Written Correspondence
PO Box 7263
Indianapolis, IN 46207-7263**

The request should include an explanation of the reason for disagreement and include copies of all pertinent supporting documentation. Refer to *Chapter 10, Section 6* of the *IHCP provider Manual* for more information about the administrative review and appeal process.

To All Dental, Medical Review Team, and Pre-admission and Screening Resident Review Providers:

- The Indiana Health Coverage Programs (IHCP) identified a high number of claim denials for edit *1008 – rendering provider must have an individual number*. This error occurs when a provider submits a billing group number in the detail line. Per the *IHCP Provider Manual*, all group providers must use their rendering provider numbers. Providers should follow the guidelines below:
 - **Group provider using a paper claim** – Enter the group number and location code(s) in field 44 for dental providers on the ADA dental claim form and field 33 on the CMS-1500 claim form for Medical Review Team (MRT) providers. Enter the individual rendering number(s) in the Administrative column adjacent to each detail submitted for dental providers on the ADA dental claim form and in field 24K for MRT providers on the CMS-1500 claim form.
 - **Group provider using Web interChange** – Enter the group number and location code in the provider number field. Enter the individual rendering number in the rendering provider field.
 - **Individual billing provider using a paper claim** – Enter the individual billing number and location code in field 44 on the ADA dental claim form or field 33 on the CMS-1500 claim form for MRT providers. Enter the individual billing number in the Administrative column adjacent to each detail submitted on the ADA dental claim form or field 24K on the CMS-1500 claim form for MRT providers.
 - **Individual billing provider using Web interChange** – Enter the individual billing number and location code in the provider number field. Enter the individual billing number in the rendering provider field.

Providers who have Administrator access in Web interChange can view their provider profiles to access a list of the rendering providers linked to the group. Providers can also call the Provider Enrollment Helpline at 1-877-707-5750 to discuss any updates that need to be made to the provider group information.

To All Federally Qualified Health Centers and Rural Health Clinics:

- Effective January 1, 2005, the following Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes 90846, 97597, 97598, D0170, D1201, D1203, D1205, D2390, D2391, D2392, D2393, D2394, D4342, D4355, D7111, D7140, and D7280 will be added as valid Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) encounter codes. Additionally, effective January 1, 2005, the following CPT and HCPCS codes are no longer valid FQHC/RHC encounters, and, therefore, will be removed from the list of valid encounter codes: 76815, 76817, 76819, 76830, 76856, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 92547, 97601, 99456, D2951, D2970, D5721, and D7281.

The valid FQHC/RHC encounter code list is reviewed annually and is available on the Myers and Stauffer Web site at www.mslcindy.com. For the 2006 annual code review, providers should submit any requests to include additional codes on the current list of valid encounter codes to Alice Rae of the Indiana Primary Health Care

Association at (317) 630-0845 or Shawna Girgis of the Indiana Rural Health Association at (812) 478-3919 by November 15, 2005. Please note that any requests received subsequent to publication of this banner page will be reviewed during the 2006 annual code review. Please direct questions about the information in this article to Tim Guerrant at Myers and Stauffer LC at (317) 846-9521.

To Pharmacies and Prescribing Providers:

- Effective **September 9, 2005**, the following drug groups will be added to the State Maximum Allowable Cost (State MAC) for legend drugs rate list.

| Drug Name | State MAC Rate |
|-------------------------------|----------------|
| CILOSTAZOL 100 MG TABLET | 0.70570 |
| GABAPENTIN 800 MG TABLET | 1.52230 |
| MOMETASONE FUROATE 0.1% CREAM | 1.1577 |
| QUINAPRIL HCL 20 MG TABLET | 0.78670 |
| QUINAPRIL HCL 40 MG TABLET | 0.93950 |

Effective **July 15, 2005**, State MAC rates for the following drugs will be increased as listed below.

| Drug Name | State MAC Rate |
|-----------------------------|----------------|
| CYCLOSPORINE 100 MG SOFTGEL | 4.25370 |
| PAROXETINE HCL 10 MG TABLET | 0.99107 |
| PAROXETINE HCL 20 MG TABLET | 0.76272 |
| PAROXETINE HCL 30 MG TABLET | 1.00320 |
| PAROXETINE HCL 40 MG TABLET | 0.88560 |
| PROMETHAZINE 25 MG TABLET | 0.38430 |
| TRETINOIN 0.01% GEL | 1.50720 |

Effective **September 9, 2005**, State MAC rates for the following drugs will be decreased as listed below.

| Drug Name | State MAC Rate |
|----------------------------------|----------------|
| CLINDAMYCIN PHOS 1% GEL | 0.41748 |
| PROMETHAZINE W/COD SYRUP | 0.02316 |
| TRIAMCINOLONE 0.1% CREAM | 0.03528 |
| OXYCODONE/APAP 7.5/325 MG TABLET | 0.92724 |
| PROMETHAZINE 25 MG SUPPOSITORY | 0.69876 |

Effective **June 24, 2005**, the State MAC rate for Bupropion SR 150mg Tab - AB2 (Zyban) will be removed. The State MAC rate for Bupropion SR 150mg Tab - AB1 (Wellbutrin) will remain active. Please direct any questions regarding the State MAC

for legend drugs to the Myers and Stauffer pharmacy unit at (317) 816-4136 or 1-800-591-1183, or e-mail at pharmacy@mslc.com.

- Effective January 1, 2006, the Centers for Medicare and Medicaid Services (CMS) is implementing a Medicare prescription drug benefit. This coverage, also known as Medicare Part D, is a new benefit to help Medicare members pay for prescription drugs.

The IHCP will provide information as it becomes available with banner pages, the IHCP provider newsletter, bulletins, and the IHCP Web site. The annual IHCP Seminar and fourth quarter provider workshops will include materials and training about the new Medicare Prescription Drug Benefit.

For more information about the Medicare Prescription Drug Benefit visit the CMS Web site at <http://www.cms.gov/medicarereform/>

- This is to advise providers that the new drug Revatio® (sildenafil citrate—Pfizer) will require prior authorization under the Traditional Indiana Medicaid pharmacy benefit. Criteria for approval of prior authorization requests is limited to the labeled indication, diagnosed pulmonary arterial hypertension to improve exercise ability. While the drug is on the Preferred Drug List, prior authorization is being required in order to prevent fraud, abuse, waste, overutilization, or inappropriate utilization, specifically due to its similarity to Viagra®, which is also a sildenafil citrate product. Please call ACS for prior authorization questions at 1-866-879-0106.

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