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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 Ancillary and Medical Services Providers:

- Effective **August 2, 2005**, all providers that anticipate performing, or that perform, ancillary and medical services to Medicaid members during an inpatient stay at a State Hospital should contact the State Hospital to receive reimbursement. When patients who are enrolled in Medicaid receive services at a State Hospital, the State Hospital is responsible for all of the ancillary and medical costs incurred during the Medicaid member's stay. IHCP will deny any claim requesting reimbursement for ancillary treatment and all medical services while the Medicaid member is an inpatient at the State Hospital.

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.

  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 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.