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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 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 Medical Review Team Providers:

- This article deletes lines 2 and 3 of *Table 1 – The Medical Review Team (MRT) Procedure Codes and Fee Schedule* published in IHCP Provider bulletin BT200514 and replaces the 96100 SE U1 and 96100 SE U2 with the following:

MRT Code	Replacement Code	Description	MRT Rate
Psychological Testing / IQ Eval 1 Unit = 1 Hour Max Units: 2 Hours (Partial Unit Billing Allowed)	96100 SE	**96100**: Psychological testing (includes psychodiagnostic assessment of personality, psychopathology, emotionality, intellectual abilities, e.g., WAIS-R, Rorschach, MMPI) with interpretation and report, per hour **SE**: State and/or federally funded programs/services	$80.00 per hour

To MRT and Pre-Admission Screening and Resident Review Providers:

- This article replaces information in IHCP provider bulletins, *BT200513* and *BT200514*, for form locator 24A in *Table 2 – CMS-1500 Claim Form Locator Descriptions.* Providers **should not bill** date ranges, but should bill only for the single date of service. For example, if a provider renders services on June 30, 2005, and July 1, 2005, then the provider must bill each date of service as a separate line item on the claim. The provider **cannot bill the service on one line** using the date range of June 30, 2005, to July 1, 2005.

To Outpatient Mental Health Services Providers:

- This article is a reminder of billing procedures for outpatient mental health services that are provided by mid-level practitioners. As stated in 405 IAC 5-20-8, the IHCP reimburses physician or HSPP-directed outpatient mental health services for group, family, and individual psychotherapy when services are provided by one of the following mid-level practitioners.
  - Academy of Certified Social Workers (ACSW)
  - Advanced practice nurses under IC 25-23-1-1(b)(3), credentialed in psychiatric or mental health nursing by the American Nurses Credentialing Center
  - Independent practice school psychologists
  - Licensed marriage and family therapist
  - Psychologist with a basic certificate
  - Certified Clinical Social Worker (CCSW)
  - Certified psychologist
  - Licensed Clinical Social Worker (LCSW)
  - Licensed mental health counselor
  - Licensed psychiatric and mental health clinical nurse specialist
  - MSW
  - RN with a master's degree in nursing with a major in psychiatric and mental health nursing from an accredited school of nursing
  - These mid-level practitioners may not be separately enrolled as individual providers to receive direct reimbursement. Mid-level practitioners can be employed by an outpatient mental health facility, clinic, physician, or HSPP enrolled in the IHCP. Reimbursement is available for services provided by mid-level practitioners in an outpatient mental health facility when services are supervised by a physician or HSPP. Services rendered by mid-level practitioners must be billed using the rendering provider number of the supervising practitioner and the billing provider number of the outpatient mental health clinic or facility. The appropriate procedure code should be billed in conjunction with one of the following modifiers to indicate the type of mid-level practitioner providing the service.
  - AH – Services provided by a clinical psychologist
  - AJ – Services provided by a clinical social worker
  - HE in conjunction with SA – Services provided by a nurse practitioner or clinical nurse specialist
  - HE – Services provided by any other mid-level practitioner as addressed in the 405 IAC 5-25
  - HW – Medicaid Rehabilitation Option (MRO) services
  - Claims billed for mid-level practitioner services with these modifiers will be reimbursed at 75 percent of the IHCP allowed amount for the procedure code identified.
  - Additional information along with these billing procedures can be found in Chapter 8 of the *IHCP Provider Manual*.

To Pharmacies and Prescribing Providers:

- 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 (866) 879-0106.