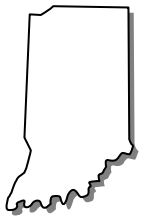

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All Providers

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 Indiana Health Coverage Programs (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 time frame and insert a six-month period, as indicated in *Senate Bill 266*.

Eligibility Verification for Presumptive Eligibility

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

As stated in *BR200933*, EDS identified an issue related to eligibility inquiry for presumptive eligibility (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**.

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,*

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

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 will be reactivated for these procedure codes.

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 1 for specific contact information.

Table 1 – 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	N/A
Electronic File Transfer	N/A	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**.