



*"People
helping people
help
themselves"*

Mitchell E. Daniels, Jr., Governor
State of Indiana

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OCTOBER 4, 2006
EDS ANNUAL PROVIDER WORKSHOP
MEDICAID PRIOR AUTHORIZATION
FROM THE CASE MANAGER'S POINT OF VIEW

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GOALS AND OBJECTIVE OF THE TRAINING DOCUMENT

The purpose of this presentation is to explain the important elements and criteria that constitute Medicaid Prior Authorization while providing case managers the necessary road map to navigate the Medicaid Prior Authorization Process. This presentation is to address Medicaid Prior Authorization from the case manager's point of view. The agenda will include:

1. A Review of IHCP Eligibility Concerns That Impact HCBS Waiver and Medicaid Prior Authorization
2. A Review of Funding Streams That Impact HCBS Waiver and Medicaid Prior Authorization
3. An Overview of Medicaid Prior Authorization for Traditional Services
4. State Regulations That Specify Services/Supplies That Do Not Require Prior Authorization
5. State Plan Services That Do Require Medicaid Prior Authorization
6. Recommended Process To Request the Medicaid Prior Authorization for Traditional Medicaid Services
7. Medicaid Home Health Services under State Plan
 - a. Discussion of Respite Care
 - b. Discussion of Home Health Aide/Attendant Care
8. Medicare Part D Information

Note: All references to the Indiana Administrative Code in this presentation were obtained at www.accessindiana.com. You should check this site for the most current version of the regulations.

IHCP ELIGIBILITY CONCERNS

(Reference Sources: Chapter 2 and 4, IHCP Provider Manual)

1. The Medicaid provider agreement specifies that providers should check eligibility on a regular basis. Upon accepting a client, the case manager should always check IHCP eligibility using one of the eligibility verification systems.
2. Case managers and providers should check eligibility on a regular basis as Medicaid eligibility is subject to change at any time for a particular member. Recommended business practice is to check eligibility at the time of a referral, at the time of admission, and at the 1st and 15th day of the month to ensure that the member is still IHCP eligible or whether other eligibility considerations have arisen.
3. **Managed Care Consideration:** If the member is enrolled in one of the managed care programs, the case manager or provider should immediately contact the caseworker to have the member disenrolled from managed care. Once there is a level of care on IndianaAIM, the member should not be auto-enrolled into managed care. Waiver providers will not be reimbursed for service dates that the member is auto-enrolled into managed care.
4. **Waiver Level of Care:** If the member has no waiver level of care (LOC), initiate the process and then forward the information to the OMPP to enter into IndianaAIM.
5. **Waiver Authorization:** After level of care is entered onto IndianaAIM, the waiver case manager is responsible for completing a Plan of Care/Cost Comparison Budget (POC/CCB), which results in an approved Notice of Action (NOA). The NOA details the services and number of units to be provided, the name of the authorized provider, and the approved billing code with the appropriate modifiers. This data is transmitted to IndianaAIM and is stored in the prior authorization database. *Claims for waiver services will deny if no authorization exists on the database or if a code other than the approved code is billed.*

Providers are not to render or bill waiver services without an approved Notice of Action.

It is the responsibility of each provider to contact the case manager in the event the services as authorized or rendered do not meet the definition and parameters of the services approved on the NOA.

The Medicaid eligibility verification systems will specify if a member has a waiver level of care. The case manager can also contact EDS Customer Assistance at (317)655-3240 or 1-800-577-1278.

IHCP ELIGIBILITY CONCERNS

(Reference Sources: Chapter 2 and 4, IHCP Provider Manual)

6. **QMB Also v. QMB-Only:** Federal law requires that State Medicaid programs pay Medicare premiums, coinsurance and deductibles for certain elderly and disabled persons. These persons are designated as Qualified Medicare Beneficiaries (QMBs). The IHCP pays Medicare deductibles, coinsurance and the Part B premium for QMBs. Therefore only services covered by Medicare are reimbursable by Medicaid. Claims received for Medicare non-covered services will deny when the services are rendered to a QMB-Only member. The member is responsible for paying medical supplies, equipment, and services not covered by Medicare.

QMB-only members can also be enrolled in the IHCP as a spend-down member. It is important to note that until that individual meets their spend-down for the month the member is still eligible for coverage as a QMB-Only under the restrictions noted in the prior paragraph. On the service date the member meets his/her spend-down, the individual's eligibility status changes to QMB-Also with spend-down and that individual becomes eligible for IHCP-covered services.

Provider Bulletin BT200527 Automation of Spend down can be viewed on the Indiana Medicaid website at www.indianamedicaid.com. Here is a brief note on how automated spend-Down affects QMBs:

- Medicaid is responsible for all coinsurance and deductible amounts for the member so these amounts will not credit spend-down
- Non-crossover claims will credit spend-down based on spend-down policy, such as Dental services.
- Members who are eligible for QMB, but elect to NOT have the State pay their premiums, are treated as regular Medicare and Medicaid dually-eligible.
- The Medicare deductible amounts for claims incurred by these members credit spend-down

NOTE: Case managers need to check Section 2: Member and Eligibility Services of the IHCP Provider Manual for more information. The manual can be viewed at www.indianamedicaid.com.

REVIEW OF FUNDING STREAMS

CMS requires that a HCBS waiver member exhaust all services on the State Plan before utilizing HCBS waiver services. HCBS waiver programs are considered funding of last resort and have a closed funding stream.

The following list provides the hierarchy of funding streams for ease of reference with HCBS waiver programs and the CHOICE program are the funding streams of last resort.

1. Private Insurance/Medicare
2. Medicaid State Plan Services
3. HCBS Waiver Programs
4. CHOICE (100% State Dollars) ***

***See BT200527 Automated Spend-down, page 3 regarding CHOICE

Issue 1: As a funding stream of last resort, HCBS waiver case managers must ensure that all other revenue streams are exhausted before utilizing waiver services.

Issue 2: Medicaid Home Health Prior Authorization Requests must specify if there are other caregiving services received by the member, including, but not limited to services provided by Medicare, Medicaid waiver programs, CHOICE, vocational rehabilitation, and private insurance programs. The number of hours per day and the days per week for each services must be listed. (BT 200237, July 2002 release date).

MEDICAID PAYMENT IN FULL AND HCBS WAIVER PROGRAM

Reprint from April 2006 IHCP Newsletter Article

This newsletter is meant to summarize information that is already available to HCBS case managers and providers in the IHCP Provider Manual and the IHCP Provider Agreement with regards to hierarchy of funding streams when a HCBS waiver case manager submits a Request for Approval to Authorize Services (RFA) to the Medicaid Waiver Unit. The IHCP Provider Manual (March 2005) and the IHCP Provider Agreement may be located at the IHCP website at www.indianamedicaid.com. Requests made by case managers for the HCBS waiver program to pay the difference between the Medicaid allowable amount and the private pay rate rather than accepting Medicaid reimbursement as payment in full is the issue of this newsletter article. The HCBS waiver program may not pay the difference between the Medicaid allowable amount for a product or service and the private pay rate. The following pertinent excerpts from the IHCP Provider Manual and the IHCP provider agreement are included below.

According to Chapter 2, Section 3 of the IHCP Provider Manual, waiver programs cover a variety of Home and Community-Based Services (HCBS) not otherwise reimbursed by the IHCP. The IHCP has always noted that Indiana Medicaid is the payor of last resort when there are other funds available; however, HCBS waiver funds are a closed funding stream so waiver budgeted dollars are considered the payor of last resort after Medicaid dollars have been exhausted. HCBS Waiver Case Managers and HCBS waiver providers are reminded that the following hierarchy of funding streams must be exhausted prior to requesting an RFA: Private Pay/Medicare and Medicaid.

Furthermore, the IHCP provider agreement outlines the following consistent with the statement in the previous paragraph:

12. To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time to time, as well as all provider bulletins and notices. Any amendments to the provider manual, as well as provider bulletins and notices, communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when mailed to the billing Provider's current "mail to" address on file with IFSSA or its fiscal agent.

18. To accept payment as payment in full the amounts determined by IFSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid or CHIP covered services provided to Medicaid or CHIP members (recipients). Provider agrees not to bill members, or any member of a recipient's family, for any additional charge for Medicaid or CHIP covered services, excluding any co-payment permitted by law.

30. To cooperate with IFSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.

Questions regarding this newsletter article may be directed to the EDS Customer Assistance Line at (317)655-3240 or 1-800-577-1278. Question regarding Medicaid Prior Authorization may be directed to Health Care Excel, Inc. Prior Authorization Unit at (317)347-4511 or 1-800-457-4518. Questions regarding the Request for Request for Approval to Authorize Services (RFA) may be directed to Waiver Services at (317) 232-0049.

OVERVIEW OF MEDICAID PRIOR AUTHORIZATION (PA)

Medicaid prior authorization is the process whereby the IHCP authorizes services under the Traditional Medicaid Program. Medicaid prior authorization is distinguished from Waiver Authorization on page 3 of this document.

1. Health Care Excel (HCE) is Indiana Medicaid's PA Contractor
HCE Telephone Numbers: 1-800-457-4518; (317)347-4511
2. The primary objective of PA is to serve as a utilization management measure
3. Indiana Administrative Code (IAC) 405 IAC 5 provides the rules for PA process. The following rules are particularly helpful:
 - a. Rule 3. Prior Authorization
 - b. Rule 7. Administrative Review and Appeals.
4. The PA Department processes approximately 5,000 PA requests per week. These requests include DME, Home Health Services, Therapies, Specific Dental Services (Dentures), Certain Surgeries, and all out of state services.
5. Reference Sources Regarding Medicaid Prior Authorization
 - Chapter 6, IHCP Provider Manual available at www.indianamedicaid.com
 - IHCP Prior Authorization Forms available at www.indianamedicaid.com
 - IHCP Fee Schedule can be found on the home page at www.indianamedicaid.com .

6. Recommended Submission Time-frame for PA Requests: 30 Days before the requested start of care date
7. HCE Review Time: HCE has 10 working days to review the PA request. The date of receipt is included count in the 10 working days.
8. Provider and Member Notification: The *Indiana Review and Authorization Request Decision Form* is automatically generated by IndianaAIM. A copy of the form goes to the provider and another copy goes to the member.
9. Determinations may reflect one of the following:
 - **Approved**
the request was approved as submitted by provider
 - **Modified**
the request was approved but not as originally submitted by provider
 - **Denied**
the request was denied for not meeting medical necessity, as a non-covered service or for failure to submit additional information on a suspended PA request within the 30 calendar day time-frame
 - **Suspended**
additional information needed to render a decision provider has 30 day calendar to submit additional information or the PA will automatically deny

10. **Checking Status of a PA Request:** A provider may use automated voice response (AVR) to check the status of a PA request. AVR may be reached at (317)692-0819 or 1-800-738-6770. Instructions on how to use AVR are available in Section 3 of the IHCP Provider Manual.

11. Appropriate Denials: The Waiver Specialist may approve Services under the waiver program if the denial on the PA notice is due to the individual not meeting medical necessity under Traditional Medicaid or the service is a Medicaid non-covered service. ***Waiver Services will not be approved for failure to submit additional information on a suspended prior authorization request.***

**STATE PLAN SERVICES REQUIRING PA
PROVIDER TYPES WHO MAY SUBMIT PA REQUESTS
NAVIGATING THE MEDICAID PA PROCESS**

Medicaid Services Requiring PA	Provider Types Who May Request PA
Durable Medical Equipment (DME)	MD must request DME and submit PA
Home Health Services	Home Health Provider
Hospice	Hospice Provider
Outpatient Therapies	Doctor of Medicine
Out of State Services	Chiropractor
Psychiatric Inpatient Admissions	Psychologist (Health Service Providers in Psychology)
Rehabilitation Inpatient Admissions	Doctor of Osteopathy
Transportation Services	Transportation Provider
Certain Medical Procedures	Optometrist
	Podiatrist
Dentures, Orthodontics	Dentists

RECOMMENDATION: A case manager should first determine if a service can be obtained under the State Plan (Traditional Medicaid) before using waiver services. If the service is covered under the Medicaid State Plan, the case manager should contact a professional or agency from the appropriate provider type to obtain Medicaid PA for the required service. Once the provider type has obtained the PA Decision Form, provider can submit that information to the case manager. Then the case manager can develop the POC/CCB accordingly and submit to the Waiver Specialist with any appropriate attachments as required by the Medicaid waiver program.

For example, the case manager contacts a Medicaid-enrolled home health agency to assess the HCBS waiver member. The home health agency assesses the member and submits a Medicaid PA Request for skilled nursing, home health aide or therapy services. The PA Decision Form is sent to the member and the provider of service who submitted the request. Once the PA Decision Form is received, the home health agency provides to the case manager. The case manager submits the POC/CCB to the waiver specialist with any appropriate attachments as required by the Medicaid waiver program.

State Plan can be found at www.indianamedicaid.com.

SERVICES THAT DO NOT REQUIRE PRIOR AUTHORIZATION

1. 405 IAC 5-19-18 Noncovered Durable Medical Equipment
2. 405 IAC 5-29-1 Noncovered Services
3. Van or Automobile Modifications
4. Home Modifications That Make Equipment Work
5. Any lift that is special or adaptive, such as a ceiling mounted lift
6. Under the Medicaid Home Health Services, the following services are NOT covered:
 - Homemaker
 - Chore services
 - Sitter/companion services
 - Respite
 - Transportation Services – *transportation services must through a Medicaid transportation provider*

Note: The handout materials include a copy of the relevant sections of the Indiana Administrative Code (IAC) for your ease of reference, but it is highly recommended that you use the website at www.accessindiana.com when checking these references since the IAC is subject to change. It is your responsibility as a case manager to stay up to date with all the relevant federal, state and local regulations and all IHCP publications.

405 IAC 5-19-18 Noncovered durable medical equipment

Sec. 18. The following equipment is not covered by Medicaid:

- (1) Equipment that basically serves comfort or convenience functions, for example, the following:
 - (A) Elevators.
 - (B) Stairway elevators.
 - (C) Posture chairs, for example, a cardiac chair or geri chair.
 - (D) Portable whirlpool pumps.
- (2) Physical fitness equipment, for example, an exercycle.
- (3) First aid or precautionary type equipment, for example, the following:
 - (A) Preset portable oxygen units.
 - (B) Spare tanks of oxygen.
- (4) Self-help devices, for example, reachers or padded cutlery.
- (5) Training equipment.
- (6) Cosmetic equipment, for example, sun lamps.
- (7) Adaptive or special equipment, for example, the following:
 - (A) Quad controls for automobiles.
 - (B) Automobile or van wheelchair lifts.
 - (C) Room air conditioners or filtering devices.
- (8) Air fluidized suspension beds, for example Clinitron.
- (9) Corrective features built into a shoe, such as heels, lifts, or wedges, for recipients twenty-one (21) years of age or older.
- (10) Supportive foot devices or orthotics for the foot.
- (11) Orthopedic shoes except under the following conditions:
 - (A) When an integral part of a leg brace.
 - (B) For a recipient with severe diabetic foot disease.

Note: As the Indiana Administrative Code(IAC) is subject to change, you should review these sections of the IAC at www.accessindiana.com for the most current version.

405 IAC 5-29-1 Noncovered Services

Sec. 1. The following services are not covered by Medicaid.

- (1) Services that are not medically *[sic]* reasonable or necessary as defined in this article.
- (2) Services provided outside the scope of a provider's license, registration, certification, or other authority to practice under state or federal law.
- (3) Experimental drugs, treatments, or procedures, and all related services.
- (4) Any new product, service, or technology not specifically covered in this article. The product, service or technology will remain a noncovered product, service, or technology until such time as the office authorizes the coverage of the product, service, or technology. This subdivision does not apply to legend drugs.
- (5) Personal comfort or convenience items, including, but not limited to, television, radio, or telephone rental.
- (6) Services for the remediation of learning disabilities.
- (7) Treatments or therapies of an educational nature.
- (8) Experimental, radiological or surgical or other modalities and procedures, including but not limited to, the following:
 - (A) Acupuncture.
 - (B) Biofeedback therapy.
 - (C) Carbon dioxide five percent (5%) inhalator therapy for inner ear disease.
 - (D) Hyperthermia.
 - (E) Hypnotherapy.
- (9) Hair transplants.
- (10) Fallopian tuboplasty (reanastomosis of the fallopian tubes) for infertility or vasovasostomy (reanastomosis of the vas deferens). *[sic]* . This procedure is only covered with disease.
- (11) Augmentation mammoplasties for cosmetic purposes.
- (12) Dermabrasion surgery for acne pitting or marsupialization.
- (13) Rhinoplasty or bridge repair of the nose in the absence of a significant obstructive breathing problem.
- (14) Ostoplasty for protruding ears unless one (1) of the following applies to the case:
 - (A) Multifacted *[sic]* craniofacial abnormalities due to congenital malformation or maldevelopment for example, Pierre Robin Syndrome.
 - (B) A recipient has pending or actual employment where protruding ears would interfere with the wearing of required protective devices.
- (15) Scar removals or tattoo removals by excision or abrasion.
- (16) Ear lobe reconstruction.
- (17) Removal of keloids caused from pierced ears unless one (1) of the following is present:
 - (A) Keloids are larger than three (3) centimeters.
 - (B) Obstruction of the ear canal is fifty percent (50%) or more.
- (18) Rhytidectomy.
- (19) Penile implants.
- (20) Perioneoplasty for sexual dysfunction.
- (21) Reconstructive or plastic surgery unless related to disease or trauma deformity.
- (22) Sliding mandibular osteotomies unless related to prognathism or micrognathism.
- (23) Blepharoplasties when not related to a significant obstructive vision problem.

For most current version of the IAC, check www.accessindiana.com

MEDICAID HOME HEALTH PA REQUESTS

1. Resources: The following IAC sites and IHCP publications provide an overview of the Medicaid PA documentation requirements for Medicaid Home Health.
 - Rule 16 Home Health Agency
 - Rule 22 Nursing and Therapy Services
 - BT 200117
 - BT 200237
2. Twenty-four hour care is not provided under Medicaid Home Health.
3. Federal regulations at *42 CFR 440.70* and state regulations at *405 IAC 1-4.2-3* require that home health services be provided to a member at his place of residence.
4. Definition of Medicaid Home Health
 - Home health services include the services that are provided to the member in his place of residence as ordered by his or her physician as part of a written plan of care. HH Services may be offered for the following reasons: (1)Care and Treatment of an acute or chronic condition (2)Rehabilitation (3)Coordination of Community services (4) To avoid prolonged or repeated hospitalizations and/or higher and more costly levels of care
5. Medicaid Home Health Covered Services include:
 - Skilled nursing services provided by an RN or LPN
 - Home health aide services
 - Physical, occupational and speech therapy services
 - Renal dialysis
 - Note: These services must be performed in the member's place of residence to be eligible for Medicaid reimbursement; however, Medicaid will authorize on a case by case basis for a home health aide or nurse to accompany a member to school or to a training workshop.

6. Home Health Agency Services---Limitations
 - Prescribed or ordered in writing by a physician
 - Provided in accordance with a written plan of treatment developed by the attending physician
 - Intermittent or part-time
 - Health-related nursing. Homemaker, chore services, and sitter companion services not covered. ***Respite and transportation services not allowed under the Medicaid Home Health Program.***

7. Medicaid’s Definition of Medical Necessity: “Medically reasonable and necessary service” as used in this title means a covered service that is required for the care or well being of the patient and is provided in accordance with generally accepted standards of medical or professional practice. **Source: 405 IAC 5-1-17**

8. Medicare Homebound Status versus Medicaid Homebound Status
 - (A) Medicare Homebound Definition

Normally unable to leave home. Leaving home takes considerable and taxing effort. *A person may leave home for medical treatment or short, infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services.* A need for adult day care does not keep you from getting home health care for other medical conditions.
Source: Medicare Glossary (CMS)

 - (B) Medicaid Homebound Definition

BT 200120 (May 14, 2001)-Defining Homebound Status specified that “providers are being notified that home health agencies will be out of compliance if they deny services to a Medicaid member based on the Medicare definition of homebound.

Medicaid members may work and attend school outside of the home.

9. Waiver Respite services versus Medical Necessity Under Medicaid Home Health

- (A) Respite is to provide short-term, temporary relief of the unpaid primary caregiver. Respite nursing under the Medicaid waiver program is only to be used when the individual requires skilled services.
- (B) Do NOT use the word respite or respite nursing when submitting a PA request for Medicaid Home Health. Respite is NOT covered under Traditional Medicaid. HCE will need to appropriately suspend a request for additional information. ***This will delay the PA process and POC/CCB process for the member.***
- (C) For an individual with a documented medical need, Traditional Medicaid may provide home health aide or Skilled Nursing Services while the primary caregiver is completing a ***non-respite*** type of activity (i.e. working, sleeptime). The Medicaid PA should be a request for Home Health Aide or Skilled Nursing services depending on the individual's level of need. Paint a clinical picture for HCE to determine medical necessity.
- (D) Documentation on Medicaid Home Health PA
 - (1) Medical need
 - (2) Description of activity the care provider will be doing during the period of service (i.e. sleeping, working)
 - (3) Plan of Treatment
 - (4) Estimate of Costs for services as set out in plan of treatment
 - (5) Number and availability of nonpaid caregivers that assist in the care of the member
 - (6) Number of members receiving home health services in a single household
 - (7) Number of hours of service per day
 - (8) Number of visits per day
 - (9) Number of days per week the service is to be provided
 - (10) Other personal care services in the home such as HCBS waiver or CHOICE with notation of frequency and scope these services are provided

- (E) Member and Caregiver Indicators include:
 - (1) Member has no primary caregiver and no access to other care
 - (2) Caregiver(s) has physical disability or severe physical limitations which limit ability to provide care
 - (3) Caregiver(s) has additional childcare responsibilities (3 or more under age 6, 4 or more under age 10)
 - (4) Caregiver(s) has additional special needs child(ren)
 - (5) Member requires total care 24 hours/day monitoring with “eyes-on” care needed at night – sleep time

10. Medicaid Home Health Aide Services versus Attendant Care Services

- (A) When a request for Medicaid home health aide is submitted, HCE will review the documentation to see if it supports Medicaid home health aide services under the supervision of a registered nurse versus attendant care under the HCBS waiver programs.
- (B) Medicaid home health aide must follow the training attitude and skill requirements under *42 CFR Section 484.36 Condition of Participation-Home Health Aide Services* under the Medicare home health benefit. **The Medicaid PA Unit authorizes Medicaid home health aide services.**
- (C) Attendant care services are defined under each HCBS waiver program. Case managers should look to the service definition of the respective HCBS waiver programs. **The Medicaid Waiver Unit authorizes waiver attendant care services after the case manager has exhausted all services on the State Plan.**
- (D) Attendant care skills and home health aide skills can duplicate each other; however, it is important to note that while a home health aide can perform services that an attendant can, the attendant cannot perform all the services that a home health aide can under the supervision of a registered nurse. A provider should bill for the service rendered.

(E) The Medicaid Prior Authorization Unit will determine whether a HCBS waiver member requires any Medicaid home health services and the frequency of the services based on the PA request and the clinical picture that is presented. Once the PA Notice is received for home health services, the case manager then submits a request for attendant care and other waiver services to the Medicaid Waiver Unit.

11. Primary Exception to Prior Authorization (“Code 50”)

(A) 405 IAC 5-3-12(2)

“When a recipient’s physician determines that an inpatient hospital setting is no longer necessary, but that Medicaid covered services should continue after the recipient is discharged from inpatient hospital care, such services may continue.....”

- RN,LPN, home health aide ---- 120 units within 30 days
- Therapies—120 (15 minute) units or 30 days

(B) There is a 30 day grace period on Medicaid home health services after a post hospital stay. If there is an existing PA, the agency must send in a system update form to advise of the change in status and additional units ordered.

RECOMMENDATION: Case managers are gate-keepers for the member in ensuring that the best overall plan of care is developed for the member. It is highly recommended that the case manager contact a local Medicaid-enrolled home health agency to perform the Medicaid prior authorization request on behalf of the member. Medicaid-enrolled home health agencies understand how to assess the client for medical necessity and how to navigate the PA process. Upon receipt of the PA Decision Form, the home health agency can provide a copy to the case manager.

MEDICARE PART D INFORMATION

Making Sure Dual-Eligibles Get the Drugs They Need from their Medicare Prescription Drug Plan

Thank you for helping in this difficult transition to Medicare Part D. FSSA wants to re-emphasize the proper points of contact for resolving specific situations you may encounter or may have encountered, in attempting to assist the Part D beneficiaries. We know that the Centers for Medicaid and Medicare Services (CMS) has disseminated a great amount of information, but we hope this document with contact information will assist you in helping your client contact the right office.

If you or others in your staff are assisting a dual-eligible (Medicaid and Medicare recipient), here's a list of procedures to help them resolve their Part D problem in a timely manner.

1. Ask first to see a member card or letter from their Medicare prescription drug company or, if by phone, to have them read what it says on the card or letter.
2. Inform client to ask pharmacist to do something called an "E1" transaction to verify their Medicare plan coverage and eligibility.
3. If problem continues, tell the client to call their Medicare Prescription Drug Plan help line (company help lines are listed on the following page).
4. Refer client to the Medicare help line, 1-800-MEDICARE (1-800-633-4227) with the problem and to say the word '*agent*' to get to a Medicare representative.
5. If all the above has been tried and the issue continues to be unresolved, send very detailed information about beneficiary and the issue to the CMS Regional Office at 1-312-353-7180 or contact via e-mail at rochidmo@cms.hhs.gov. Only contact the Regional Office after all other options have failed.

Persons with Medicare, who have recently applied for Medicaid and have not yet received a Medicaid determination, should apply for Medicare Extra Help through Social Security as soon as possible, as well as select and enroll in a Medicare Prescription Drug Plan.

As of April 1, 2006, members and physicians will need to file exceptions with Part D plans for non-formulary drugs to be covered, or will need to change current drug to a therapeutically equivalent drug on the plan's formulary.

Reminder that Indiana Medicaid continues to cover drugs *excluded* by the Medicare Prescription Drug program and that are currently covered for all Medicaid members.

Visit www.indianamedicaid.com/ihcp/ProviderServices/medicareD.asp for further information about Indiana Medicaid coverage and Medicare Part D.

MEDICARE PART D INFORMATION

Making Sure Dual-Eligibles Get Their Drugs from Medicare Part D

by Jeanne LaBrecque, Director of Health Policy and Medicaid

Thank you for helping your patients during this challenging transition to Medicare Part D. Medicare and Medicaid dual eligibles are now covered by Medicare Part D for their drug coverage. Indiana Medicaid still covers prescription drugs excluded by Part D and covered by Indiana Medicaid, such as benzodiazepines, barbiturates, and over-the-counter drugs on the Medicaid OTC drug formulary.

Medicare's Part D plan transition policy allows for at least a 30-day supply of non-formulary drugs for people first enrolling in Part D and a 90-day supply for patients in long-term care facilities. Part D plans are now enforcing their formularies, which may cause problems for your patients getting their medications. The Part D transition policy is intended to provide patients with time to work with their health care providers to switch to a therapeutically appropriate formulary alternative or to request a formulary exception, based on medical necessity.

Indiana Medicaid offers some information for formulary problems you may encounter with your dually eligible Part D patients.

1. The patient or healthcare representative should call their Part D Plan to discuss any problem and ask about the drugs on the plan's formulary.
2. If the drug is not covered by their plan, the patient or pharmacist will contact your office to either change their non-formulary drug to an alternative drug on the plan's formulary or to have you request an exception with the plan to have the drug covered.
3. For other problems with Part D, refer patients to Medicare - 1-800-633-4227.
4. Providers may visit www.cms.hhs.gov for information about Medicare Part D, including the exceptions and appeals process.

<u>Medicare PDPs for duals</u>	<u>Phone Number</u>
AmeriHealth Advantage Rx	866-456-1695
Anthem Blue Cross and Blue Shield	866-803-5170
First Health Services	866-865-0662
Humana Inc.	800-281-6918
Medco Prescription Savings Plan	800-758-4574
MemberHealth (Community Care Rx)	866-684-5353
Pacificare Life and Health Insurance Company	800-797-9794
Pennsylvania Life Insurance Co.	800-698-8394
Silverscript Insurance Co.	866-235-5660
Unicare	800-928-6201
United Health Care Insurance Co. (AARP Medicare RX Plan) (United Medicare MedAdvance)	888-867-5575
Wellcare Health Plans	888-550-5252

SUMMARY OF RECOMMENDED MEDICAID PUBLICATIONS

Documents may be viewed on www.indianamedicaid.com

1. Indiana Health Coverage Programs (IHCP) Provider Manual
2. State Plan Amendment (Traditional Medicaid Services)***
3. IHCP Prior Authorization
Chapter 6, IHCP Provider Manual
4. Bulletins regarding Home Health PA & Homebound Status
 - BT 200117
 - BT 200120
 - BT 200237
5. Publications regarding DME
 - Chapter 8, IHCP Provider Manual
 - IHCP Fee Schedule***
 - BT 200130
 - BR200307
 - BT 200308
 - BT 200322
 - BT 200335
 - BT 200335
 - BT 200430
 - BR 200439

***Available as a selection option on the right hand side of the home page at www.indianamedicaid.com