B A N N E R P A G E

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All Providers

Correction to Manual Pricing Article

EDS has obtained rates from the Medicare Fee-for-Service Payment files on the Centers for Medicare & Medicaid Services (CMS) Web site (http://www.cms.hhs.gov/home/medicare.asp) for the five Healthcare Common Procedure Coding System (HCPCS) codes listed in Table 1. These codes are currently manually priced based on information submitted with the claim. The new rates are effective December 1, 2006. The effective date and information published about code J2353 supersedes the information published in banner page *BR200652*.

Table 1 – Manual Pricing – New Rates,
Effective for Dates of Service On or After December 1, 2006

HCPCS Code	Code Description	Rate Effective for Dates of Service On or After December 1, 2006
L1510	THKAO, STANDING FRAME	$957.56
86336	INHIBIN A	$21.47
L3002	FOOT INSERT, REMOVABLE, MOLDED TO PATIENT MODEL, PLASTAZOTE OR EQUAL, EACH	$130.03*
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG	Remains manually priced.
A4349	MALE EXTERNAL CATHETER, WITH OR WITHOUT ADHESIVE, DISPOSABLE, EACH	$2.02

* This rate corrects the rate shown in *BR200652*, *BR200701*, *BR200703*, and *NL200701*.

Timeline for Revised Paper Claim Forms

The following information does not apply to providers rendering services in the risk based managed care (RBMC) delivery system. These providers should contact the managed care organization (MCO) with whom they are contracted for information about paper claim form transition.

The National Uniform Claim Committee (NUCC), the National Uniform Billing Committee (NUBC), and the American Dental Association (ADA) have revised the layouts of the institutional, professional, and dental paper claim forms. The current institutional *UB-92* claim form will be replaced with the institutional *UB-04*. The current professional *CMS-1500* health insurance claim form will be revised to the 08-05 version. The ADA dental claim form will be replaced with *J400D*. The EDS pharmacy claim forms will be revised to include National Provider Identifier (NPI) information. The pharmacy claim forms will be available May 16, 2007**, and may be obtained from the *Forms* page of the IHCP Web site at http://www.indianamedicaid.com/ihcp/Publications/forms.asp. Links to the other new claim forms will be added to the IHCP Web site *Forms* page according to the start date listed in Table 2.

The IHCP will transition to the new paper claim forms with the timelines noted in Table 2. During the transition period, both old and new claim forms will be accepted. All claim forms will have a transition period, except the Pharmacy claim form. Table 2 outlines the transition period and cutover dates for each type of paper claim form.

***The availability date of the pharmacy claim forms is changed to allow providers additional time to familiarize themselves with the forms.*

Table 2 – Timeline Revised Paper Claim Forms

Current Form	New Form	Transition Period (Old and New Forms Accepted)		Only New Forms Accepted (Cutover Date)
		Start Date	End Date	
CMS-1500	08-05	February 15, 2007	March 31, 2007	April 1, 2007
UB-92	UB-04	April 1, 2007	May 22, 2007	May 23, 2007
ADA 2000	ADA 2006	April 15, 2007	May 22, 2007	May 23, 2007
Pharmacy	Pharmacy	No Transition Period		May 23, 2007

Contact Information: Providers with questions about this article should contact Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

Medicaid and Medicare Providers and COBA

The Coordinator of Benefits Contractor (COBC), General Health, Inc. (GHI), advised EDS that it will only process the Indiana Medicaid eligibility files used to identify dual-eligible members every two weeks, not weekly. This may prevent Medicare claims from crossing over to Medicaid for new Medicaid members during the first two weeks of Medicaid eligibility.

CMS advises providers to allow 15 business days after receipt of Medicare's payment before submitting a claim to a supplemental payer. If a paper submission is required; submit the claim along with the official Medicare remittance notice (MRN), or HIPAA electronic 835 Remittance Advice as outlined in the *Companion Guide: 835 Remittance Advice Transaction* available on the IHCP Web site at http://www.indianamedicaid.com/ihcp/TradingPartner/tp_companion_guides.asp.

Claim Disputes and Resubmissions with MCOs

Hoosier Healthwise MCOs have a requirement in their contract with the State that they must have a claim dispute resolution process for their providers. Providers who are contracted with the MCOs have a claim appeal process outlined in their contracts.

The process for claims disputes with non-contracted providers is outlined in *405 IAC 1-1.6*. This rule requires the provider to attempt to informally resolve the matter before submitting a formal claim appeal. If the provider disagrees with the MCO's determination regarding a claim, the informal process must begin by a provider submitting a written objection to the MCO within 60 days after the provider's receipt of written notification of the MCO's determination. Formal appeals of a denial of payment for services must be submitted to the MCO within 60 days after the provider's receipt of the written notification of the MCO's determination resulting from the informal claim dispute process.

Claims are considered to be a resubmitted when the provider files a corrected claim. Examples of claim resubmissions include correcting coding, submitting missing documentation, adjusting units of service, and updating third party liability (TPL) information. Providers should regularly and promptly review the remittance advice received from the MCO to preserve their ability to meet any applicable timeframes to address potential claims issues. Resubmission of a corrected claim does not constitute an informal claim dispute or appeal and should not be subject to the 60 day filing limit for a claim dispute or appeal. However, providers should follow each MCO's process for resubmitting corrected or adjusted claims to ensure proper adjudication of the resubmitted claim.

Filing Grievances and Appeals for MCO Members

The Federal Medicaid Managed Care rules require MCOs to have a grievance process, an appeal process, and access to the State's fair hearing system. The federal rules and the MCO's contract with the State outlines the various requirements of the grievance system. The *Code of Federal Regulations (CFR) 438.400* defines action, *g*rievance and appeal, as follows:

"(a)(3) Section 1932(b)(4) requires Medicaid managed care organizations to establish internal grievance procedures under which Medicaid enrollees, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance.

(b) *Definitions.* As used in this subpart, the following terms have the indicated meanings:

Action means--

In the case of an MCO or PIHP--

1) The denial or limited authorization of a requested service, including the type or level of service;
2) The reduction, suspension, or termination of a previously authorized service;
3) The denial, in whole or in part, of payment for a service;
4) The failure to provide services in a timely manner, as defined by the State;
5) The failure of an MCO or PIHP to act within the timeframes provided in Sec. 438.408(b); or
6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.

Appeal means a request for review of an action, as ``action'' is defined in this section.

Grievance means an expression of dissatisfaction about any matter other than an action, as ``action'' is defined in this section"…

The subject of the grievance must be something for which the member has a reasonable expectation that action will be taken to resolve or reconsider the matter expressed. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights.

Grievances must be filed with the MCO within 60 days of the event which prompted the grievance. The decision regarding the resolution of the grievance may be appealed but the appeal must be filed with the MCO within 30 days of the decision.

Indiana Health Maintenance Organization (HMO) law (*IC 27-13-10.1*) allows a member or member's representative to request an external independent review of an appeal of certain MCO decisions, such as an adverse utilization determination, adverse determination of medical necessity, or determination that a proposed service is experimental, made by an MCO. The request for external review must be filed with the MCO within 45 days of the determination being appealed.

MCO members may file an appeal with the Family and Social Services Administration (FSSA) Hearings and Appeals Office only after the interim appeal processes available through the MCO have been exhausted. In accordance with *405 IAC 1.1*, appeals to the FSSA Hearings and Appeals Office must be filed within 30 days of the action being appealed.

Clarification to Bulletin *BT200630* - New 2007 Healthcare Common Procedure Coding System Codes

The *Replacement Code* information for procedure code *D1205 – Topical application of fluoride (including prophylaxis)-adult* as published in bulletin *BT200630*, dated December 29, 2006, is clarified as shown in Table 4. The replacement procedure codes are for members 13 years of age or older for prophylaxis and for members 1-20 years of age for topical fluoride treatments. For members 12 years of age or younger, use the appropriate procedure code combination.

Table 3 – **Deleted** 2007 HCPCS Codes,
Effective for Dates of Service On or Before December 31, 2006

Procedure Code	Description	Replacement Code
D1205	TOPICAL APPLICATION OF FLUORIDE (INCLUDING PROPHYLAXIS)-ADULT	D1110-PROPHYLAXIS – ADULT (Age 13-999 Years) *D1203-TOPICAL APPLICATION OF FLUORIDE-CHILD (Age 1-20 Years) *No coverage for topical application of fluoride for members older than 20 years of age.

Contact Information: Direct questions about this article to Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

All Durable Medical Equipment Providers

Correction to Power Wheelchairs Article

The billing information for procedure code E1230 as published in *BR200650, BR200701,* and *NL200701,* is updated as shown below.

Pending final review of the expanded power wheelchair codes, providers should continue to bill using the following existing codes and fee schedule amounts. Prior authorization (PA) is required for power wheelchairs and accessories. Refer to existing provider notifications for current PA requirements.

- *E1230 – Power operated vehicle (three- or four-wheel no highway)*, specify brand name and model number, max fee price of $1807.16 for NU and $171.02 for RR.

Contact Information: Direct questions about this article to Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

All Medical Review Team Providers

Edits 2029 and 2037

On January 12, 2007, EDS implemented system modifications that now deny Medical Review Team (MRT) claims that are submitted for members who do not have eligibility on file for the dates of services submitted on the claim. Providers who experience denials for edits *2037 – Member not on file for non-IHCP program*, or *2029 – Non-IHCP member ineligible for dates of service*, and who have approval from the County Office, Division of Family Resources (DFR), must submit their claim either on paper and attach the DFR letter requesting the services be performed, or electronically with an attachment. The date of the DFR letter must be the same as or earlier than the date of service indicated on the claim.

Contact Information: Direct questions about these claims to Customer Assistance at (317) 655-3240 in the Indianapolis area, or toll free at 1-800-577-1278.

All Pharmacy and Prescribing Providers

National Drug Codes Deleted from the Medicaid Drug Rebate Master File

CMS has determined that the products in Table 4 do not meet the definition of a covered outpatient drug. CMS is therefore deleting the National Drug Code (NDC) from the Medicaid Drug Rebate (MDR) master file as of the effective dates in Table 4. As a result of this determination by CMS, these NDCs are not reimbursable in the Indiana Medicaid fee-for-service pharmacy program.

Table 4 – National Drug Code Deleted from the Medicaid Drug Rebate Master File

NDC	Description	Effective Date	NDC	Description	Effective Date
00121-0530	Ferrous Sulf. Liq	10/1/2006	24385-0528	Ferrous Sulf Slow	10/1/2006
00182-1201	Ferrous Sulf. Elixir	10/1/2006	24385-0630	Ferrous Sulf Soln Drops	10/1/2006
00182-4028-01	Ferrous Sulf Tab	10/1/2006	24385-0875	Ferrous Sulf Iron Tabs	10/1/2006
00182-4028-10	Ferrous Sulf Tab	10/1/2006	49483-0008	Ferrous Sulf	10/1/2006
00182-4028-89	Ferrous Sulf Tab	10/1/2006	50383-0630	Ferrous Sulf Soln Drops	10/1/2006
00182-4029	Ferrous Sulf Tab	10/1/2006	50383-0778	Ferrous Sulf Elixir	10/1/2006
00182-4030	Ferrous Sulf Tab	10/1/2006	52569-0466	Ferrous Sulf Blister Pack	10/1/2006
00182-4082	Ferrous Gluconate Tab	10/1/2006	52735-0019	Vit Ferrous Sulf	10/1/2006
00182-4476	Slow Fe	10/1/2006	52735-0360	FP Ferrous Sulf Slow	10/1/2006
00245-0061	Ferrous Gluconate Tab	10/1/2006	54738-0091	Ferrous Sulf Tab	10/1/2006
00245-0108-01	Ferrous Sulf Enteric Coated Tab	10/1/2006	54838-0001	Ferrous Sulf Elixir	10/1/2006
00245-0108-10	Ferrous Sulf Enteric Coated Tab	10/1/2006	54838-0002	Ferrous Sulf Drops	10/1/2006

Table 4 – National Drug Code Deleted from the Medicaid Drug Rebate Master File

NDC	Description	Effective Date	NDC	Description	Effective Date
00472-1465	Ferrous Sulf Elixir	10/1/2006	59743-0801	Ferrous Sulf Tab	10/1/2006
00536-0650	Ferrous Sulf Elixir	10/1/2006	60258-0182	Ferrous Fumerate	10/1/2006
00536-3478	Ferrous Sulf	10/1/2006	60432-0057	Ferrous Sulf Drops	10/1/2006
00574-0508	Ferrous Gluconate	10/1/2006	60432-0066	Ferrous Sulf Elixir	10/1/2006
00574-0608	Ferrous Gluconate EC	10/1/2006	62107-0044	Ferrous Sulf	10/1/2006
00603-0179	Ferrous Sulf	10/1/2006	63739-0102	Ferrous Sulf	10/1/2006
00603-0762	Ferrous Sulf Drops	10/1/2006	63739-0259	Ferrous Sulf	10/1/2006
00603-0763	Ferrous Sulf Elixir	10/1/2006	63868-0682	Ferrous Sulf	10/1/2006
00677-0069	Ferrous Gluconate	10/1/2006	00904-5118	Pediatric Electrolyte Fruit Flavor	1/1/2007
00677-0070	Ferrous Sulf	10/1/2006	00904-5119	Pediatric Electrolyte Bubblegum	1/1/2007
00677-0071	Ferrous Sulf	10/1/2006	00904-5276	Pediatric Electrolyte Grape Dyed	1/1/2007
00677-0527	Ferrous Sulf	10/1/2006	00904-7659	Pediatric Electrolyte Soln Unflavored	1/1/2007
00677-0990	MultiFerrous Folic	10/1/2006	00904-7660	Pediatric Electrolyte Soln Fruit Flavor	1/1/2007
17714-0024	Ferrous Sulf Tab	10/1/2006	00904-7850	Pediatric Electrolyte Bubblegum	1/1/2007
24385-0137	Iron Tabs, Ferrous Sulf	10/1/2006	66977-0222	Oramagicrx	1/1/2007

Contact Information: Direct questions about this article to Customer Assistance at (317) 655-3240 in the Indianapolis local area, or toll free at 1-800-577-1278.

State Maximum Allowable Cost Update

Table 5 – **Increase** to the State MAC Rates for Legend Drugs
Effective for Dates of Service On or After February 13, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
AMITRIPTYLINE HCL 25 MG TABLET	0.03521	HALOPERIDOL 5 MG TABLET	0.13908

Table 6 – Decreases to the State MAC Rates for Legend Drugs
Effective for Dates of Service On or After March 16, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
ALBUTEROL 0.83 MG/ML SOLUTION	0.03842	LOPERAMIDE 2 MG CAPSULE	0.07992
AMPHETAMINE SALTS 30 MG TABLET	0.25656	LORAZEPAM 0.5 MG TABLET	0.04351
BENAZEPRIL HCL 10 MG TABLET	0.08664	METFORMIN HCL 500 MG TABLET	0.05392
BENZTROPINE MES 0.5 MG TABLET	0.05724	METFORMIN HCL ER 500 MG TABLET	0.06164
CLINDAMYCIN HCL 150 MG CAPSULE	0.16308	METHYLPHENIDATE 20 MG TABLET	0.18107
CLOZAPINE 100 MG TABLET	1.19229	NAPROXEN 375 MG TABLET	0.05775
CYPROHEPTADINE 4 MG TABLET	0.12042	NAPROXEN 500 MG TABLET EC	0.19395
DESMOPRESSIN ACET 0.2 MG TABLET	3.15912	NIZATIDINE 150 MG CAPSULE	0.47798
ETH ESTRADIOL/DESOGEST 30/0.15 TABLET	0.72633	OMEPRAZOLE 20 MG CAPSULE	0.76020
GABAPENTIN 100 MG CAPSULE	0.06225	PAROXETINE HCL 10 MG TABLET	0.44987

Table 6 – Decreases to the State MAC Rates for Legend Drugs
Effective for Dates of Service On or After March 16, 2007

Drug Name	State MAC Rate	Drug Name	State MAC Rate
GABAPENTIN 600 MG TABLET	0.62320	PAROXETINE HCL 20 MG TABLET	0.50714
GLIPIZIDE ER 10 MG TABLET	0.39987	PENICILLIN VK 250 MG TABLET	0.10350
GLIPIZIDE ER 5 MG TABLET	0.19608	PRIMIDONE 50 MG TABLET	0.36936
HYDROXYZINE HCL 25 MG TABLET	0.22892	SIMVASTATIN 20 MG TABLET	3.54298
IPRATROPIUM BR 0.02% SOLUTION	0.05282	SIMVASTATIN 40 MG TABLET	3.58201
LEVOTHYROXINE 112 MCG TABLET	0.28632	SIMVASTATIN 80 MG TABLET	3.55263
LEVOTHYROXINE 175 MCG TABLET	0.33114	TEMAZEPAM 15 MG CAPSULE	0.07010
LEVOTHYROXINE 25 MCG TABLET	0.17916	TIZANIDINE HCL 4 MG TABLET	0.14152
LEVOTHYROXINE 75 MCG TABLET	0.18106	TRAMADOL HCL 50 MG TABLET	0.05588
LISINOPRIL-HCTZ 10/12.5 TABLET	0.08088	TRIAMTERENE/HCTZ 75/50 TABLET	0.03459
LISINOPRIL-HCTZ 20/12.5 TABLET	0.11208		

Contact Information: Direct questions about the State MAC for legend drugs to the Myers and Stauffer Pharmacy Unit at (317) 816-4136 in the Indianapolis local area, or 1-800-591-1183, or by e-mail at pharmacy@mslc.com.

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