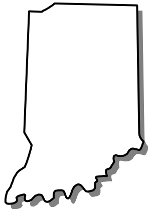


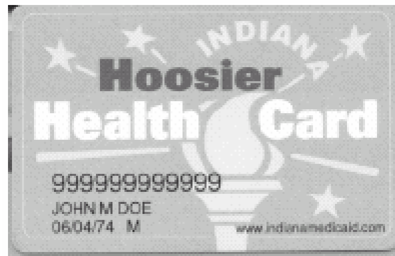
BANNER PAGE

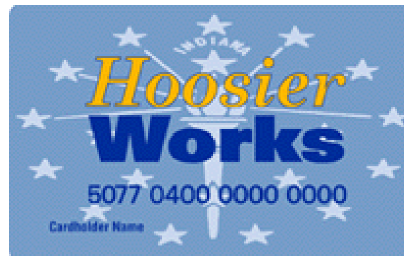
BR200707 FEBRUARY 13, 2007

All Providers

Hoosier Health Card

This message is to alert providers that when providing services to Indiana Health Coverage Programs members, that they should be viewing the member's **Hoosier Health Card** to get the appropriate 12-digit recipient identification (RID) number for billing. Instead of providing their **Hoosier Health Card**, some members have been giving their Hoosier Works card, which is used for food purchases or to access cash benefits for TANF recipients. Providers should remember to verify the member's eligibility at each visit. This will help ensure that they have the correct information for billing their services. Providers that fail to verify eligibility are at risk of claims being denied due to member ineligibility or coverage limitations.





Reporting Your NPI at the 2007 IHCP First Quarter Workshop Sessions

During the 2007 Indiana Health Coverage Programs (IHCP) First Quarter Workshop sessions, workstations will be available for providers to report their NPI to IHCP using the NPI Reporting Tool. Providers who have already obtained their NPI and have received the NPI notification letter from EDS may use the workstations to report their NPI to the IHCP via the NPI Reporting Tool. To report your NPI you must have the following available:

- The NPI notification letter (mailed from EDS) that includes the password needed to access the NPI Reporting Tool.
- The reporting provider's tax identification number or social security number.
- Taxonomy codes associated with each IHCP current provider number being reported.
- Contact name, telephone number, and e-mail address.
- The NPI of the provider(s) and the NPI of all rendering providers affiliated with the group, if applicable.

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 1.

The IHCP will transition to the new paper claim forms with the timelines noted in Table 1. 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 1 outlines the transition period and cutover dates for each type of paper claim form.

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

Table 1 – 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 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, grievance, 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 that 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.

All Pharmacy and Prescribing Providers

State Maximum Allowable Cost Update

Table 2 – **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 3 – 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
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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