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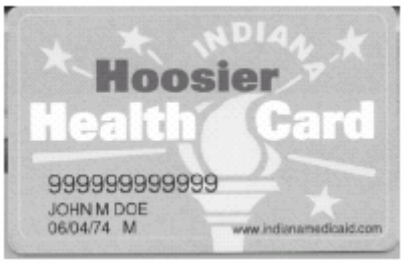
All Providers

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.



Receipt of 1099s

If you have not received your 1099, not as a result of an address change, but due to it being lost in the mail, please contact Customer Assistance at 1-800-577-1278 or 317-655-3240. Providers that need to update their address must submit the appropriate forms to update their provider information to:

Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

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 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 the table below.

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 First Steps Providers

First Steps Providers 1099s

We apologize, but due to an oversight, First Steps providers' 1099s for 2006 did not include January payments. You will soon be receiving another 1099 for payments received in January 2006. This information will also be reported to the IRS as usual. If you have not received your 1099 due to an address change, please submit the appropriate forms to update your provider information to:

Provider Enrollment
P.O. Box 7263
Indianapolis, IN 46207-7263

All Pharmacy and Prescribing Providers

State Maximum Allowable Cost Update

Effective **April 6, 2007**, State MAC rates for the following drugs will be **added** as listed below in Table 2.

Table 2 – Additions to the State MAC Rates for Legend Drugs

Drug Name	State MAC Rate	Drug Name	State MAC Rate
ALPRAZOLAM XR 0.5 MG TABLET	0.78490	GABAPENTIN 400 MG TABLET	0.33560
ALPRAZOLAM XR 1 MG TABLET	0.97960	GLIPIZIDE-METFORMIN 5/500 MG TABLET	0.78160
ALPRAZOLAM XR 2 MG TABLET	1.31740	LAMOTRIGINE 25 MG DISPER TABLET	2.66120
ALPRAZOLAM XR 3 MG TABLET	1.96920	LEFLUNOMIDE 10 MG TABLET	0.84200
AZITHROMYCIN 100 MG/5 ML SUSPENSION	1.78060	MEDROXYPROGESTERONE 150 MG/ML INJECTIBLE	49.40800
AZITHROMYCIN 600 MG TABLET	7.20740	OCTREOTIDE ACET 0.2 MG/ML VIAL INJECTIBLE	44.17980
CEFPROZIL 250 MG TABLET	2.69450	RIBAVIRIN 200 MG TABLET	2.42620
CEFPROZIL 500 MG TABLET	5.53370	VENLAFAXINE HCL 37.5 MG TABLET	1.63320
CEFTRIAXONE 10 GM VIAL INJECTIBLE	52.81200	VENLAFAXINE HCL 75 MG TABLET	1.84160
DIDANOSINE 200 MG DR CAPSULE	4.45560	ZIDOVUDINE 300 MG TABLET	0.55780
FENOFIBRATE 200 MG CAPSULE	2.11140	ZONISAMIDE 25 MG CAPSULE	0.34620
FEXOFENADINE HCL 30 MG TABLET	0.45830	ZONISAMIDE 50 MG CAPSULE	0.65780
GABAPENTIN 300 MG TABLET	0.21320		

Effective **April 6, 2007**, State MAC rates for the following drugs will be **decreased** as listed below in Table 3

Table 3 – Decreases to the State MAC Rates for Legend Drugs

Drug Name	State MAC Rate	Drug Name	State MAC Rate
BENZTROPINE MES 1 MG TABLET	0.06749	PROMETHAZINE 25 MG SUPPOSITORY	0.55975
LEVOTHYROXINE 50 MCG TABLET	0.11637	SIMVASTATIN 5 MG TABLET	0.42040
LEVOTHYROXINE 75 MCG TABLET	0.12627	SIMVASTATIN 10 MG TABLET	0.09000
LEVOTHYROXINE 112 MCG TABLET	0.19296	SIMVASTATIN 20 MG TABLET	0.12480
LEVOTHYROXINE 175 MCG TABLET	0.23934	SIMVASTATIN 40 MG TABLET	0.13693
MOMETASONE FUROATE 0.1% CREAM	0.53387	SIMVASTATIN 80 MG TABLET	0.21733
NYSTATIN 100,000 UNIT/GM POWDER	0.53650	SPIRONOLACTONE 25 MG TABLET	0.19931
OMEPRAZOLE 20 MG CAPSULE	0.59809	TAMOXIFEN 10 MG TABLET	0.15887

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.