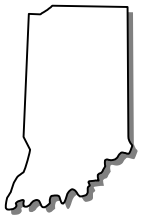

IMPORTANT INFORMATION

BR200316 APRIL 22, 2003

To All Providers:

- The Indiana Health Coverage Programs (IHCP) has received inquiries about copayment requirements for mentally retarded/developmentally disabled members who are eligible for waiver services and live independently in the community. IHCP members who are living in the community and are not inpatients in hospitals, nursing facilities, intermediate care facilities for the mentally retarded, or other medical institutions **are responsible** for the normal copayments for IHCP services.
- This is to correct coding information published in provider bulletin *BT200207*. This bulletin indicated that *Z5902—Care coordination postpartum assessment or outcome* was end-dated and replaced by current procedural terminology (CPT) code *99502—Home visit for newborn care and assessment*. However, Z5902 should not be replaced by CPT code 99502, but by CPT code *99501—Home visit for postnatal assessment and follow-up care*. Also note that Z5902 was incorrectly listed in the bulletin as Z5092.
- Beginning in April, Pediarix, CPT code *90723- DTAP-HEP B-IPV Vaccine*, is available from the Vaccines For Children (VFC) Program. For dates of service on or after May 1, 2003, the IHCP will begin reimbursing providers for the lesser of the provider's charge or the VFC administration rate of $8, for CPT code 90723. Claims billed with a date of service from January 1, 2001, through April 30, 2003, will continue to be reimbursed at a rate of $176.91.
- Due to a processing error, Medicare Part B claims without an invoice attached that were billed for dates of service prior to July 1, 2002, and denied for manual pricing will be reprocessed and paid. Payments for these claims should appear on the remittance advice (RA) dated April 22, 2003.
- Providers must always verify IHCP member eligibility on the date they provide services. If the eligibility system indicates a member is a 590 Program member, the provider should verify the facility where the member resides or resided. If the member is identified as a 590 Program member and the member no longer resides in a facility, the provider should consider the member fee-for-service and notify the EDS 590 provider representative at (317) 488-5182. The provider should give the provider representative the following information:
  - The provider's name and telephone number
  - The 590 Program member's name and member identification (RID) number
  - The name of the facility in which the member resided

  If a member resides in a facility, all claims less than $150 must be billed to the facility where the member resides. All claims more than $500 must be prior authorized by Health Care Excel (HCE), and then be submitted to EDS for processing. Send all 590 claims of more than $150 to the following address:

  EDS 590 Program Claims
  P.O. Box 7270
  Indianapolis, IN 46207-7270

To All Dental Providers:

- Some dental providers received duplicate claim payments between January 2, 1999, and January 2002. Providers effected by this overpayment received a letter in October 2002, that announced the overpayment and asked providers to refund the overpayment amount. Adjustments on all effected claims that have not been refunded to the IHCP will begin the week of April 21, 2003, and will show up on the April 29, 2003, RA.

To All Providers in Parke, Putnam, Hendricks, Hamilton, Tipton, Howard, Cass, Carroll, White, Tippecanoe, Warren, Clinton, Benton, Fountain, Montgomery, Boone, and Vermillion Counties

- On Friday May 16, 2003, Chris Kern, EDS provider relations consultant, will present an IHCP 101 workshop for all **NEW** providers and billing agents for the aforementioned counties. The IHCP 101 workshop will be held on the second floor of the Howard Community Hospital billing office at 3611 S. Reed Rd. Handouts will be provided to all attendees. Seating for the workshop will be reserved based on the order in which requests are received. There will be a morning and an afternoon IHCP 101 session (two sessions covering the same material). The first session will be from 8:30 a.m. to 11:30 a.m. The second session will be from 1 p.m. to 4 p.m. Seating is limited to 40 spaces per session and two individuals per provider number. To sign up for a session, please contact Chris Kern at (317) 488-5326 and indicate the morning or afternoon session, contact name, and telephone number. An EDS Provider Relations representative will call to confirm the attendees and session. No confirmations letters will be mailed. You must confirm your registration with the Provider Relations representative who returns your call. The registration deadline is April 25, 2003.

Note: If the morning session is full, all other attendees will be added to the afternoon session.

To All Pharmacy Providers and Prescribing Practitioners:

Note: The information in this banner is not directed to those providers rendering services in the risk-based managed care (RBMC) delivery system.

- At the March 28, 2003, drug utilization review (DUR) Board meeting, the Over the Counter (OTC) Drug Formulary was expanded to include oral electrolyte replenishing solutions. In the past, these products were understood to be, and considered by the IHCP as supply items, as opposed to drugs. Given that it was recently determined that the products are OTC drugs, they have been added to the OTC Drug Formulary. Please note that only drug products from a rebating manufacturer will be reimbursed. Currently, the participating manufacturers of electrolyte replenishing solutions are: Abbott Labs, Bergen Brunswig; Brite Life; Goldline Drug; Ivax/Goldline; Leader; Major Pharm; MJ Nutritional; Pan American; Reese Chemical; Ross Labs; Rugby; and Select Brand. The state maximum allowable charge (MAC) rate for oral electrolyte replenishing solutions is $0.00472 per ml. The effective date for the addition to the OTC Drug Formulary is May 5, 2003. The products remain reimbursable under the program in the interim.
- Effective April 8, 2003, the maximum allowable fees for the following medical supply products have been changed as indicated in the following table:

Code	Item Name	New Price
A4360	Colostomy Set	$0.95
A4253	Blood Glucose Test	$35.00
A5061	Pouch, Drainable	$2.72
A5055	Stoma Cap	$1.32
A4406	Ostomy Skin Barrier	$7.35
A5063	Ostomy Pouch Drainable	$2.23
A4362	Skin Barrier; Solid, 4 X	$2.71
A4373	Skin Barrier With Flange	$5.09
A5052	Pouch, Closed	$1.22
A5073	Pouch, Urinary	$3.14
A5123	Skin Barrier; With Flange	$3.51
A4250	Urine Test Strips	$14.62

Please direct any questions to Jared Duzan at Myers and Stauffer at (800) 877-6927, (317) 846-9521, or jduzan@mslc.com.

To All Waiver Providers:

- The purpose of this Home and Community Services (HBCS) Waiver update is to clarify the HCBS Waivers standards and rule promulgation.

  The *Final Rule Title 460 IAC 6* Division of Disability, Aging and Rehabilitative Services is in effect for the Autism, Developmental Disability, and Support Services HCBS Waivers effective January 1, 2003. In addition, the documentation standards are in effect, and were published in provider bulletin *BT200305*. For the Aged and Disabled, Traumatic Brain Injury, Medically Fragile Children, and Assisted Living Waivers, the Bureau of Aging and In Home Services is in the process of rule promulgation. This rule will be separate from the *Title 460 Rule* and will be forthcoming.

  All HCBS Waivers providers are subject to and should be in compliance with the following IHCP IAC guidelines:
  - *405 IAC 1-1-4* – Denial of claim payment
  - *405 IAC 1-1-5* – Overpayments made to providers; recovery
  - *405 IAC 1-1-6* – Sanctions against providers
  - *405 IAC 1-5-1* – Medical records; contents and retention
  - *405 IAC 5-1* – General Provisions
  - *405 IAC 5-2* – Definitions
  - *405 IAC 5-4* – Provider Enrollment
  - *IC 12-15-13-3* – Appeal Procedures
  - *Indiana Health Coverage Programs Provider Manual*
  - All IHCP Home and Community Based Waiver bulletins
  - All DDARS Waiver bulletins