



I M P O R T A N T I N F O R M A T I O N

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To All Providers:

- Beginning in April, Pediarix, current procedural terminology (CPT) code 90723- *DTAP-HEP B-IPV Vaccine*, is available from the Vaccines For Children (VFC) Program, for members 18 years old or younger. For dates of service on or after May 1, 2003, the Indiana Health Coverage Programs (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.
- The 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.
- 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.

To All Waiver Providers:

- The Office of Medicaid Policy and Planning (OMPP) has contracted with EDS to review approved waiver services providers. The purpose of these reviews is to ensure adherence to the requirements of the respective waivers. Starting in May 2003, EDS and staff from the Bureau of Quality Improvement Services (BQIS) will review for the developmentally disabled (DD) waivers. Providers will be notified two weeks in advance of a scheduled survey and the providers will participate in an entrance meeting with both EDS and BQIS staff. The goal of this is to reduce intrusiveness to business operations and individuals receiving services.

After the entrance meeting, EDS review teams will perform the following functions:

- Examine the member's approved plan of care and the case manager's and provider's related documentation
- Verify the delivery of services billed to the IHCP
- Meet with a sample of members in the home setting to ensure that the services meet the needs of the member and to review the member's eligibility for waiver services

Staff from the BQIS will complete the *BQIS Provider Standards Agency Survey* after the entrance meeting. This survey has been sent to all providers and it is important that providers are familiar with this document so that they prepared. Providers must present documentation of the services they are approved to provide, demonstrate applicable policies and procedures as identified in *460 IAC 6*, and provide personal files relating to the provision of health care coordination services, behavioral support services, and case management services, as applicable. Providers must make available employee files and the evidence of the internal quality assurance and quality improvement system. Approximately two weeks after the completion of this survey, BQIS staff will return to complete the *Residential Services and Supports* survey. The *Residential Services and Supports* survey will involve some of the same individuals that EDS used in its sample.

The OMPP appreciates provider cooperation while implementing the Family and Social Services Divisions of Disability, Aging, and Rehabilitative Services (FSSA/DDARS) quality assurance and quality improvement initiatives. Please direct questions to Ellen McClimans by telephone at (317) 234-2708 or by e-mail at nmcclimans@fssa.state.in.us.

- 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

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.

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