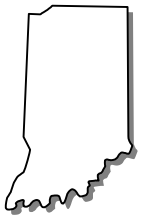

IMPORTANT INFORMATION

BR200318 MAY 6, 2003

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.

To All OMNI Users:

- The planned OMNI upgrade for the *Health Insurance Portability and Accountability Act* (HIPAA) compliant basic eligibility and benefit limitation information scheduled to begin April 30,2003, has been delayed. OMNI users should download updates between May 21, 2003, and October 15, 2003. Please refer to IHCP provider bulletin *BT200303* for more information about the download process.

To All Pharmacy Providers and Prescribing Practitioners:

- The pharmacy point of service (POS) claims processing system will experience extended downtime on the morning of Sunday May 11, 2003. Although the system is regularly not available for POS claim submission from midnight to 2 a.m. each Sunday, on May 11, 2003, the outage will be from midnight until 6 a.m. Please direct questions to the ACS Call Center at 1-866-645-8344.
- Effective April 29, 2003, the maximum allowable fees for the following medical supply products have been changed as indicated in the following table;

CDE	Description	Max Fee
A4250	Urine Test Strips Or Tablets	$17.54
A4253	Blood Glucose Test Strip	$36.72
A4352	Intermittent Urinary Catheter	$5.71
A4353	Intermittent Urinary Catheter	$9.82
A4362	Skin Barrier; Solid, 4 x 4	$2.95
A4367	Ostomy Belt	$8.34
A4373	Skin Barrier With Flange	$5.99
A4391	Ostomy Pouch, Urinary	$6.33
A4405	Ostomy Skin Barrier NPB	$4.73
A4414	Ostomy Skin Barrier	$4.26
A4455	Adhesive Remover or Solvent	$2.43
A4621	Tracheostomy Mask or Collar	$2.80
A4627	Spacer, Bag or Reservoir	$25.80
A5051	Ostomy Pouch, Closed	$2.46
A5052	Ostomy Pouch, Closed; Without Barrier	$1.44
A5055	Stoma Cap	$1.50
A5061	Ostomy Pouch, Drainable	$3.28

(Continued)

CDE	Description	Max Fee
A5063	Ostomy Pouch Drainable	$2.67
A5073	Ostomy Pouch, Urinary	$3.17
A5102	Bedside Drainage Bottle	$28.25
A5112	Urinary Leg Bag; Latex	$32.75
A5073	Pouch, Urinary	$3.17
A5119	Skin Barrier; Wipes	$7.85
A6402	Gauze, Non-Impregnated	$0.27

For a complete up-to-date fee schedule, please visit www.mslcindy.com/pharmacy/. Please direct questions to Jared Duzan at Myers and Stauffer at (800) 877-6927, (317) 846-9521, or jduzan@mslc.com.

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 are 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 Based Services (HCBS) 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