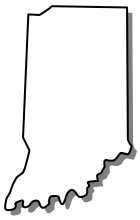

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All Providers

Current Procedural Technology Codes No Longer Subject to Site-of-Service Reduction

For claims with dates of service on or after January 1, 2005, Current Procedural Technology (CPT®) codes 43280 – *Laparoscopy, Surgical, Esophagogastric Fundoplasty (for example, Nissen, Toupet Procedures)* and 47562 – *Laparoscopy, Surgical; Cholecystectomy* will no longer be subject to the site-of-service reduction. Claims with dates of service on or after January 1, 2005, will be systematically mass adjusted and will appear on the April 14, 2009, Remittance Advice.

Individual Cases of Varicella (Chickenpox) Are Now Reportable

As of December 12, 2008, all primary cases of varicella (chickenpox) are reportable to the local health department under *410 IAC 1-2.3-47*. Healthcare providers should report all individual cases of chickenpox to the local health department within 72 hours for investigation by department staff. Cases of varicella should be reported to the local health department using the Report of Confidential Communicable Diseases Form available at http://www.in.gov/isdh/files/43823.pdf.

The complete revised Communicable Disease Control Rule is available at http://www.in.gov/legislative/iac/T04100/A00010.PDF?

Managed Care Providers

Managed Care Organization and Provider Contract Indemnification

The Hoosier Healthwise and Healthy Indiana Plan (HIP) contractual agreements with the State include language that requires the managed care organizations (MCOs) to ensure that subcontractors indemnify and hold harmless the state of Indiana from claims and suits caused by an act or omission of the contractor or subcontractors.

The requirement to indemnify the State created concern within the provider community and has prevented some providers from signing agreements with the Hoosier Healthwise MCOs and HIP insurers.

In response to this concern, the Indiana Office of Medicaid Policy and Planning (OMPP) issued a memo in February 2008 to the Hoosier Healthwise MCOs indicating that indemnification of the State language was no longer required in Hoosier Healthwise provider agreements. The OMPP maintains the same position with regard to HIP insurers and will formally modify the HIP contract to reflect these requirements.

The OMPP maintains the position that this indemnification clause is required in all contracts between the MCO and another prepaid health plan, physician-hospital organization, and any entity that performs delegated activities related to the State MCO contract, as well as between MCOs and any administrative entities not involved in the actual delivery of medical care. Thus, a medical provider is not defined as a subcontractor for this purpose.

If you have any questions about this article, please contact the health plans with which you are contracted.

Dental Providers

Billing Member Claims for Dental Emergency Services

When billing dental claims for "Emergency Services Only" members, it is required that "Emergency" is noted in form locator 2 on the American Dental Association (ADA) 2006 dental claim form, or that the emergency indicator is marked "yes" for 837D and Web interChange transactions. This is in addition to billing emergency codes from Table 1 in Bulletin *BT200839*, dated October 21, 2008. Using a code from Table 1 on the claim does not eliminate the need for providers to document "Emergency" on the claim form or electronic transaction.

Claims submitted without "Emergency" noted in form locator 2 and the appropriate emergency procedure code will deny with the explanation of benefits (EOB) code 2047 – *Package E Members Eligible for Dental Emergency Services Only*.

Dental Workshop Scheduled for April

EDS Provider Relations is offering workshops for the dental provider community. This is an excellent opportunity to become more familiar with Medicaid dental policies, procedures, and billing tools and methodology. Details about the workshops are below:

April 8, 2009, 1 p.m.-5 p.m.
Union Hospital
Landsbaum Center, Classroom 2
1433 6½ Street
Terre Haute, IN 47804

April 13, 2009, 8 a.m.-noon
Floyd Memorial Hospital
1950 Bono Rd.
New Albany, IN 47150

The agenda includes the following:

- National Provider Identifier (NPI) information and updates
- Dental billing and rendering provider information
- Working with the dental cap
- Dental policies
- Live demonstration and discussion of all facets of Web interChange
- An extensive question-and-answer period

Providers may enroll in the workshop at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp. If you have questions, please call the workshop line at (317) 488-5072.

CA-PRTF Grant Providers

Mass Reprocessing of Claims for CA-PRTF Grant Service Providers

Claims submitted for Community Alternatives to Psychiatric Residential Treatment Facilities (CA-PRTF) services that have previously denied for error code 1047 – *Certification Code Missing – Care Select* and error code 1049 – *Care Select Member's PMP is Missing* were reprocessed the week of March 24, 2009.

Chiropractic Providers

Medicare Chiropractic Billing Guidelines

Effective April 1, 2009, the IHCP will deny the procedure codes listed below when billed by a chiropractor, specialty 150, to bill Medicare primary for dually eligible Medicaid members. Medicaid will be processing a mass adjustment for these services paid as Medicaid primary on a future Remittance Advice (RA). Additional information will be forthcoming concerning the time period.

Medicare covers the following manipulation procedure codes for chiropractors (specialty 150):

- 98940 – *chiropractic manipulative treatment, spinal one to two regions*
- 98941 – *chiropractic manipulative treatment, spinal three to four regions*
- 98942 – *chiropractic manipulative treatment, spinal five regions*

Vision/Durable Medical Equipment/Home Medical Equipment Providers

Use Modifier U8 When Billing for Replacement Frames and Lenses

Effective December 31, 2008, the Centers for Medicare & Medicaid Services (CMS) end-dated modifier RP – *replacement and repair*, as announced in provider bulletin *BT200843*, dated December 30, 2008. Vision providers must use modifier U8 when billing for replacement frames and lenses when medical necessity guidelines are met or when replacement is necessary because of loss, theft, or damage beyond repair. Modifier RP should not be used for dates of service on or after January 1, 2009. Vision, durable medical equipment (DME), or home medical equipment (HME) providers that billed with the RP modifier for dates of service on or after January 1, 2009, must adjust claims to correct the modifier. Refer to *Chapter 11* of the *IHCP Provider Manual* for additional information on the paid claim-adjustment options and process.

Provider Workshops

Note:	The Federally Qualified Health Center and Rural Health Clinic Workshop originally scheduled for January 28, 2009, at Daviess Community Hospital in Washington, Indiana, was cancelled because of inclement weather. The seminar has been rescheduled for April 29, 2009. Topics include how to check eligibility, how to file a claim, how to bill services, what causes claims to deny, and more. For more information, please contact the workshop line at (317) 488-5072.

Second-quarter Workshops Are Here!

The IHCP is offering quarterly provider workshops free of charge. Topics include the IHCP Family Tree, electronic transactions, presumptive eligibility and notification of pregnancy, Hoosier Healthwise open enrollment, a managed care roundtable, and more. Workshop agendas, dates, registration deadlines, and locations are online at http://www.indianamedicaid.com/ihcp/ProviderServices/workshops.asp. You may register online or by using the registration form printed in the newsletter. For more information about the workshops, please contact the workshop line at (317) 488-5072.

Contact Information

If you have questions about the articles published in this banner page, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278, unless otherwise noted.

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