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To All Providers:

- The Office of Medicaid Policy and Planning (OMPP) will implement Hoosier Healthwise mandatory risk-based managed care (RBMC) enrollment across all Indiana counties in 2005. This will transition current Prime*Step* Hoosier Healthwise managed care members from Primary Care Case Management (PCCM) into enrollment with a local managed care organization (MCO) in the RBMC delivery system.

  Primary medical providers (PMPs) in the affected counties can choose to contract with one of the Hoosier Healthwise MCOs. Prime*Step* PMPs who switch to one of the MCOs before the final transition date will retain their current Hoosier Healthwise members. Specialists, hospitals, and ancillary providers may have various MCO arrangements depending on factors such as how many of the MCO's members may be served by the provider, or how many MCOs are serving their region. The transition schedule, regional map, questions and answers, and additional detailed information on the transition can be found in IHCP provider bulletin *BT200506*, which is available at www.indianamedicaid.com.

  The OMPP will conduct a series of public meetings about the transition to mandatory RBMC for the Hoosier Healthwise Program. The meeting's agenda will include an overview of the transition process, individual MCO presentations, and the opportunity to ask questions of the MCOs. The details of upcoming scheduled meetings on the transition to mandatory RBMC are as follows:

  1) Wayne County Area Public Meeting: May 10, 2005, at Reid Hospital Auditorium (1401 Chester Blvd. Richmond, Ind.). The meeting will be held from noon to 1 p.m.

  2) Tippecanoe County Area Public Meeting: June 7, 2005, at the Kathryn Weil Center for Education, 415 N. 26th St., Ste. 400, Lafayette, Indiana. The meeting will be held from noon to 1 p.m.

- The Indiana Health Coverage Program (IHCP) has discovered a discrepancy in the pricing of Healthcare Common Procedure Coding System (HCPCS) code J0587, Botulinum toxin Type B, per 100 units. This discrepancy has resulted in the overpayment of claims for this service. The pricing has been changed from $462.50 per 100 units to the correct rate of $9.25 per 100 units. On June 15, 2005, EDS will perform a mass adjustment on all affected paid claims for HCPCS code J0587 from January 1, 2002, through April 5, 2005. Providers should direct questions to customer assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278. Should you disagree with this mass adjustment, request an administrative review by writing to the following address: **EDS - Administrative Review, Written Correspondence, P.O. Box 7263, Indianapolis, IN 46207-7263**. You should explain why you disagree and include copies of all pertinent documentation. The administrative review process is set forth in more detail in Chapter 10, Section 6 of the *IHCP Provider Manual*.

- This article updates information published in IHCP provider bulletin *BT200323*, dated May 1, 2003, regarding changes in chiropractic services. Effective January 1, 2005, services that meet the50 unit limitation will post a new explanation of benefit (EOB) *6099, Reimbursement is limited to no more than 50 chiropractic services per member per calendar year. These services could include up to five (5) office visits and spinal manipulation treatments, or physical medicine treatments.* Because the chiropractic limitation is applied on a calendar year basis, providers are reminded to bill these services for each calendar year on a separate line item when multiple units for a procedure code span one calendar year to the next.

To Home and Community Based Services Waiver Providers:

- This article refers to home and community based waiver claims that denied for overlapping Hoosier Healthwise and *Medicaid Select* PCCM enrollment from January 1, 2003, through May 31, 2004. Waiver services incurred from January 1, 2003, through May 31, 2004, that denied for the following edits were systematically reprocessed the week of April 11, 2005: Hoosier Healthwise PCCM edits 342, 343, and 1011, and *Medicaid Select* PCCM edits 1042, 1043, and 1044. Waiver providers do not need to resubmit affected claims. Remittance advice (RA) statements will reflect the reprocessing of these claims, identifiable as Region 80, the week of April 18, 2005. Claims may still deny for reasons unrelated to the edits described above. Reprocessing does not apply to services provided to members in the RBMC program during the stated time frame.

To All Pharmacy Providers:

- This article is to remind pharmacy providers that refund checks for pharmacy adjustments only should be made payable to and sent to: ACS State Healthcare – Indiana Adjustments, P.O. Box 201376, Dallas, TX 75320-1376.

To all Dental Providers:

- This article is a reminder about the prior authorization (PA) and post-payment review requirements for partial dentures for the IHCP. The 2005 Annual HCPCS update included two new codes for flexible base partial dentures. Procedure codes *D5225, Maxillary partial denture – flexible base* and *D5226, Mandibular partial denture – flexible base* are covered, are effective January 1, 2005. Complete and partial

dentures require prior authorization for members 21 years and older. Prior authorization for dentures is subject to medical necessity. Eight posterior teeth in occlusion, four maxillary and four mandibular teeth in functional contact with each other, are considered adequate for functional purposes. Providers must submit PA requests for members 21 years and older on the *IHCP Prior Authorization Dental Request Form*. For members younger than 21 years old no prior authorization is required; however, the provider must maintain documentation to support the services and type of denture or partial provided. Providers are responsible for maintaining supporting documentation within the member's medical record for members of all ages. The following types of partial dentures are covered by the IHCP. Please refer to the *IHCP Provider Manua*l for information about coverage of complete dentures.

- Acrylic partial dentures, D5211 and D5212, are covered when medically necessary based on the PA criteria.
- Cast metal partial dentures, D5213 and D5214, are only covered for members with facial deformity due to congenital, developmental, or acquired defects. The need for a cast metal partial must be documented in the member's medical record for all members, and the PA request for members 21 years and older must include specific reasons for the request.
- Flexible base partial dentures, D5225 and D5226, are only covered for members with a facial deformity due to congenital, developmental, or acquired defects (such as, cleft palate conditions) that require the use of a flexible base partial instead of an acrylic or cast metal partial. The need for a flexible base partial must be documented in the member's medical record for all members, and the PA request for members 21 years of age and older must include specific reasons for the request.

As a reminder, dentures and partials are subject to the $600 annual dental cap for members 21 years and older. Please refer to the *IHCP Provider Manual, Chapter 8*, for more information about billing procedures for members that exceed the $600 annual cap. The reimbursement rates for partials are listed in Table 1. Cast metal and flexible base partials are currently manually priced; however, effective June 6, 2005, the max fees listed in Table 1 apply to cast metal and flexible base partials. The rates for acrylic partials have not changed.

Table 1 – IHCP Maximum Reimbursement Rates for Partial Dentures

CDT-5 Code	Description	Max Fee Members ages 0 through 20 years	Max Fee for Members ages 21 years and older
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests, and teeth)	$656.00	$328.00
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests, and teeth)	$788.25	$333.00
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$656.00	$328.00
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests, and teeth)	$788.25	$333.00
D5225	Maxillary partial denture – flexible base (including any clasps, rests, and teeth)	$656.00	$328.00
D5226	Mandibular partial denture – flexible base (including any clasps, rests, and teeth)	$788.25	$333.00

In addition, effective June 6, 2005, CDT-5 procedure codes *D7111, Extraction, coronal remnants – deciduous tooth* and *D7288, Brush biopsy – transepithelial sample collection* will be subject to the maximum fees listed in Table 2. These codes were previously manually priced.

Table 2 – Reimbursement Rates for D7111 and D7288

CDT-5 Code	Description	Max Fee as of June 6, 2005
D7111	Extraction, coronal remnants – deciduous tooth	$72.25
D7288	Brush biopsy – transepithelial sample collection	$35.00