All PROVIDERS

**Open Enrollment Period For Medicaid MCOS And Connect Care Choice Ends May 31, 2012**

On an annual basis, Medicaid’s RIte Care, Rhody Health Partners (RHP), and Connect Care Choice (CCC) programs conduct open enrollment which allows RIte Care members to switch health plans, and RHP and CCC members to switch programs or health plans. In April, letters were mailed to RIte Care, Rhody Health Partners, and Connect Care Choice members. Members excluded from this mailing were those enrolled in Extended Family Planning, Foster/Substitute Care, Adoption Subsidy or Chafee/Post Foster Care, Medicare, those with verified comprehensive commercial coverage including RIte Share, those living in a long-term setting or a Skilled Nursing Facility, and those who are Medically Needy or QMB. The Open Enrollment period ended May 31, 2012. Enrollment in the new health plan or program will be effective July 1, 2012.

**Rhode Island Medical Assistance HIPAA 5010**

Rhode Island is now compliant with CMS requirements for the 5010 & NCPDP D.O standards. As of February 18th, 2012, we no longer accept 4010 transactions. At this time, we are only accepting the 5010 format for the following transaction sets:

- 837P, I and D – Professional, Institutional and Dental
- 270 and 271 – Eligibility Inquiry and Response
- 277U – Unsolicited – Health care claim status
- 835 – Health care payment and remittance advice
- NCPDP D.O. – POS Retail Pharmacy Drug and Professional Services

If you are a Provider Electronic Solutions software user (PES) you should be using the most current version of 2.06. If you have not already upgraded to version 2.06, the newest version can be found at:

[http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/HIPAA/ElectronicDataInterchange/ProviderElectronicSolutions/tabid/363/Default.aspx](http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/HIPAA/ElectronicDataInterchange/ProviderElectronicSolutions/tabid/363/Default.aspx)

Claims submitted in a 4010 format will not be accepted for processing. If you need any assistance upgrading to version 2.06 or becoming 5010 compliant, please contact our EDI Coordinator Mary Jane Nardone at 401-784-8014 or mary-jane.nardone@hp.com.
Welcome to Medicaid- New Provider E-Learning Course

In an effort to assist new and existing providers with navigating the Rhode Island Medical Assistance Program, HP Enterprise Services has created a “Welcome to Medicaid” E-Learning Course. This course intends to empower providers with increased knowledge so that they can more easily resolve common questions and billing difficulties. In this course, we review key information about the RI Medical Assistance Program, including provider responsibilities, basic billing procedures, recipient eligibility, and utilizing the Executive Office of Health and Human Services (EOHHS) website.

You may access this course by visiting the Executive Office of Health and Human Service website at www.dhs.ri.gov. In the left margin, click on “Provider Services,” followed by “Customer Service.” The “Welcome to Medicaid” course is located at the bottom of the page, under “Links.”

In-Plan Oral Health Benefits

The following procedures are part of the managed care in-plan oral health benefits including Rite Care and Rhody Health Partners. Claims for these services should be billed to the respective plans.

These benefits are included in the capitated benefit and are the responsibility of the Managed Care Health Plan to provide or arrange. The following services will be paid for by the Managed Care Health Plans: (1) Services to diagnose and treat an Oral Health Condition in either an inpatient or an outpatient hospital setting, or (2) Services to diagnose and treat an Emergency Oral Health Condition in a hospital emergency department and (3) Medically necessary oral surgery services as described below.

OTHER SURGICAL PROCEDURES

D7260 Oroantral fistula closure
D7261 Primary closure of sinus perforation
D7270 Tooth reimplantation and/or stabilization of accidentally or evulsed displaced tooth and/or alveolus
D7285 Biopsy of oral tissue – hard (bone, tooth)
D7286 Biopsy of oral tissue - soft
D7287 Exfoliative cytological sample collection
D7288 Brush biopsy- transepithelial sample collection
D7291 Transseptal fiberotomy/ supra crestal fiberotomy, by report

Pertinent documentation to evaluate medical appropriateness should be included when this code is reported.
### SURGICAL EXCISION OF REACTIVE INFLAMMATORY LESIONS (SCAR TISSUE OR LOCALIZED CONGENITAL LESIONS)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7410</td>
<td>Excision of benign lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>D7411</td>
<td>Excision of benign lesion diameter greater than 1.25 cm</td>
</tr>
<tr>
<td>D7412</td>
<td>Excision of benign lesion, complicated</td>
</tr>
<tr>
<td>D7413</td>
<td>Excision of malignant lesion up to 1.25 cm</td>
</tr>
<tr>
<td>D7414</td>
<td>Excision of malignant lesion greater than 1.25 cm</td>
</tr>
<tr>
<td>D7415</td>
<td>Excision of malignant lesion, complicated</td>
</tr>
<tr>
<td>D7440</td>
<td>Excision of malignant tumor - lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>D7441</td>
<td>Excision of malignant tumor - lesion diameter greater than 1.25 cm</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal of benign odontogenic cyst or tumor-lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal of benign odontogenic cyst or tumor-lesion diameter greater than 1.25 cm</td>
</tr>
<tr>
<td>D7460</td>
<td>Removal of nonodontogenic cyst or tumor-lesion diameter up to 1.25 cm</td>
</tr>
<tr>
<td>D7461</td>
<td>Removal of nonodontogenic cyst or tumor-lesion diameter greater than 1.25 cm</td>
</tr>
<tr>
<td>D7465</td>
<td>Destruction of lesion(s) by physical or chemical methods, by report</td>
</tr>
<tr>
<td></td>
<td>Pertinent documentation to evaluate medical appropriateness should be included when this code is reported</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis –(maxilla or mandible)</td>
</tr>
<tr>
<td>D7472</td>
<td>Removal of torus palatines</td>
</tr>
<tr>
<td>D7473</td>
<td>Removal of torus mandibularis</td>
</tr>
<tr>
<td>D7485</td>
<td>Surgical reduction of osseous tuberosity</td>
</tr>
<tr>
<td>D7490</td>
<td>Radical resection of maxilla or mandible</td>
</tr>
</tbody>
</table>

### SURGICAL INCISION

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
</tr>
<tr>
<td>D7511</td>
<td>Incision and drainage of abscess-intraoral soft tissue-complicated</td>
</tr>
<tr>
<td></td>
<td>(include drainage of multiple fascial spaces)</td>
</tr>
<tr>
<td>D7520</td>
<td>Incision and drainage of abscess-extraoral soft tissue</td>
</tr>
<tr>
<td>D7521</td>
<td>Incision and drainage of abscess- extraoral soft tissue- complicated</td>
</tr>
<tr>
<td></td>
<td>(includes drainage of multiple fascial spaces)</td>
</tr>
<tr>
<td>D7530</td>
<td>Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue</td>
</tr>
<tr>
<td>D7540</td>
<td>Removal of reaction-producing foreign bodies-musculoskeletal system</td>
</tr>
<tr>
<td>D7550</td>
<td>Partial ostectomy/sequestrectomy for removal of non-vital bone</td>
</tr>
</tbody>
</table>
D7560  Maxillary sinusotomy for removal of tooth fragment or foreign body

TREATMENT OF FRACTURES – SIMPLE

D7610  Maxilla - open reduction (teeth immobilized, if present)
D7620  Maxilla - closed reduction (teeth immobilized, if present)
D7630  Mandible - open reduction (teeth immobilized, if present)
D7640  Mandible - closed reduction (teeth immobilized, if present)
D7650  Malar and/or zygomatic arch - open reduction
D7660  Malar and/or zygomatic arch - closed reduction
D7670  Alveolus –closed reduction, may include stabilization of teeth
D7671  Alveolus-open reduction, may include stabilization of teeth
D7680  Facial bones - complicated reduction with fixation and multiple surgical approaches

TREATMENT OF FRACTURES - COMPOUND

D7710  Maxilla - open reduction
D7720  Maxilla - closed
D7730  Mandible - open reduction
D7740  Mandible - closed reduction
D7750  Malar and/or zygomatic arch - open reduction
D7760  Malar and/or zygomatic arch - closed reduction
D7770  Alveolus - open reduction stabilization of teeth
D7771  Alveolus, closed reduction stabilization of teeth
D7780  Facial bones - complicated reduction with fixation and multiple surgical approaches

REDUCTION OF DISLOCATION AND MANAGEMENT OF OTHER TEMPOROMANDIBULAR JOINT DYSFUNCTIONS

Procedures which are an integral part of a primary procedure should not be reported separately.

D7810  Open reduction of dislocation
D7820  Closed reduction of dislocation
D7830  Manipulation under anesthesia
D7840  Condylecetomy
D7850  Surgical discectomy, with/without implant
D7852  Disc repair
D7854  Synovectomy
D7856  Myotomy
D7858  Joint reconstruction
D7860  Arthrotomy
D7865  Arthroplasty
D7870  Arthrocentesis
D7872  Arthroscopy - diagnosis, with or without biopsy
D7873  Arthroscopy – surgical: lavage and lysis of adhesions
D7874  Arthroscopy – surgical: disc repositioning and stabilization
D7875  Arthroscopy – surgical: synovectomy
D7876  Arthroscopy – surgical: discectomy
D7877  Arthroscopy – surgical: debridement
D7880  Occlusal orthotic device, by report
D7899  Unspecified TMD therapy, by report
This code should be used only if a more specific code is unavailable.

REPAIR OF TRAUMATIC WOUNDS
Excludes closure of surgical incisions.

D7910  Suture of recent small wounds up to 5 cm

COMPLICATED SUTURING (RECONSTRUCTION REQUIRING DELICATE HANDLING
OF TISSUES AND WIDE UNDERMINING FOR METICULOUS CLOSURE)
Excludes closure of surgical incisions.

D7911  Complicated suture - up to 5 cm
D7912  Complicated suture - greater than 5 cm

OTHER REPAIR PROCEDURES

D7920  Skin graft (identify defect covered, location and type of graft)
D7940  Osteoplasty - for orthognathic deformities
D7941  Osteotomy – mandibular rami
D7943  Osteotomy – mandibular rami with bone graft; includes
        obtaining the graft
D7944  Osteotomy - segmented or subapical - per sextant or quadrant
D7945  Osteotomy - body of mandible
D7946  LeFort I (maxilla - total)
D7947  LeFort I (maxilla - segmented)
D7948  LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion)-without bone graft
D7949  LeFort II or LeFort III - with bone graft
D7950  Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones - autogenous or nonautogenous, by report
D7951  Sinus augmentation with bone or bone substitutes
D7955  Repair of maxillofacial soft and hard tissue defect
D7960  Frenulectomy (frenectomy or frenotomy) - separate procedure
D7963  Frenuloplasty
D7972  Surgical reduction of fibrous tuberosity
D7980  Sialolithotomy
D7981  Excision of salivary gland, by report
Pertinent documentation to evaluate medical appropriateness should be included when this code is reported
D7982  Sialodochoplasty
D7983  Closure of salivary fistula
D7990  Emergency tracheotomy
D7991  Coronoidectomy
D7995  Synthetic graft, mandible or facial bones, by report
Pertinent documentation to evaluate medical appropriateness should be included when this code is reported
D7996  Implant, mandible for augmentation purposes (excluding alveolar ridge), by report
Pertinent documentation to evaluate medical appropriateness should be included when this code is reported
D7997  Appliance removal (not by a dentist who placed appliance), includes removal of archbar
D7998  Intraoral placement of a fixation device not in conjunction with a fracture
D7999  Unspecified oral surgery procedure, by report
This code should be used only if a more specific code is unavailable.

Should you have questions please contact the plan directly.

- UnitedHealthcare of New England  1-800-587-5187 - www.uhcmedicaid.com
- Neighborhood Health Plan of Rhode Island  1-800-459-6019 - www.nhpri.org
Manually Priced Durable Medical Equipment

DME Providers are asked to remember to send a manufacturer’s invoice with prior authorization requests and paper claims submitted for items which are priced manually, for example T2028, T2029 and S5165 (or any other code where there is no set amount is found on the fee schedule). The item(s) being billed on the request/claim should be easily differentiated from any other items on the invoice by such means as an asterisk or by blacking out items not being billed. The invoice must also show if the cost on the invoice is retail or wholesale. If the item is shipped in a case, package or box, we will need clear indication of cost per unit. For example, providers might send in a copy of a catalog page indicating an item is shipped 12 units to a box. If you have any questions, please contact Jeanne Giroux, DME Provider Representative, at 401.784.8020 or at jeanne.giroux@hp.com.

Reference Laboratory

The Medical Assistance Program will reimburse for testing performed within the laboratory billing for the service or when provided by a referring laboratory where there exists a wholly owned relationship between the referring or primary laboratory. Services are considered performed by the provider when either an employee or the individual provider personally performs the service. Referred services are provided by the laboratory who performed the lab services for the primary laboratory. The part of a test performed by another lab will be reimbursed through the Medical Assistance Program to the primary laboratory and will be the responsibility of the primary laboratory provider. The primary laboratory provider is responsible to reimburse the referencing laboratory for the services performed.