Rhode Island Medicaid Program

PROVIDER*update*

Volume 323 December 2019

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In addition to the *Provider Update*, you will also receive any updates that relate to the services you provide.

PROVIDER*update*

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RI Medicaid Customer Service Help Desk for Providers

Available Monday—Friday
8:00 AM-5:00 PM
(401) 784-8100
for local and long distance calls
(800) 964-6211
for in-state toll calls

Attention Clearing Houses, Billing Agencies, and Providers

A Reminder on How to Manage your Covered Providers:

ERA Received by Clearinghouse/Vendors
Providers who have moved their business to a new clearinghouse/vendor will need to contact the original clearinghouse/vendor to be removed as a covered provider, before the new enrollment can be completed. The provider must contact the existing clearinghouse/vendor and ask them to remove their association.

The original clearinghouse/vendor should log into the Healthcare Portal. Under the Covered Provider section of the Trading Partner Profile screen, access the details for a specific provider by either clicking Display Covered Providers, which will display all, or search for a specific provider using the Provider ID and ID Type.

Select the plus sign (+) next to the NPI of the specific provider. Uncheck the boxes for the 835 and 277 and select the save button.

Once this is completed, the new clearinghouse/vendor may complete the process to add the covered provider, and select the 835/277 transactions. They will then complete the ERA enrollment form.

Note: To ensure continuous receipt of the 837/277U, the new billing entity must add the provider as a covered provider and complete the ERA enrollment form before the cut-off date of the financial cycle.

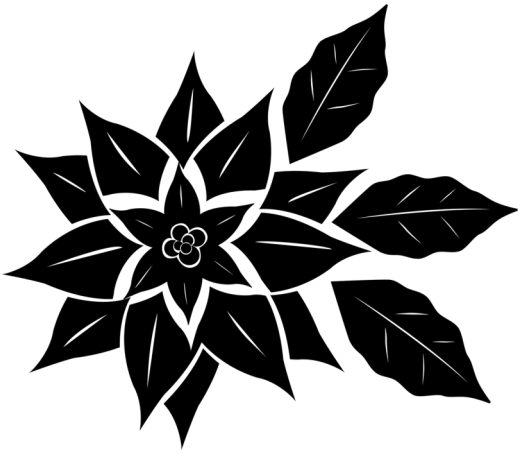
Medicaid Guidelines for ADA Code D9410

D9410* House call / Extended Care Facility Call
Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate procedure codes for actual services performed.

**The D9410-House/Extended Care Facility Call procedure code must be billed with a reimbursable Medicaid service and cannot be billed alone.*

Mobile services provided by fee-for–service providers to nursing home residents may only be reimbursed for one visit per day, per facility, per provider. Providers may not bill the D9410-House/ Extended Care Facility Call for each recipient seen during a single nursing home visit even when a reimbursable Medicaid Service is being rendered to multiple recipients.
For each nursing home visit, please add the D9410 to ONE claim being billed for a reimbursable service.

Mobile dental providers who bill fee-for–service, cannot bill the D9410 for nursing home visits related to procedures whose payment is considered all-inclusive. i.e. impressions, try-in, adjustments, related to the fabrication of dentures.



Happy Holidays!

Incorrect RUG Scores

As previously communicated, a change in the MDS data has resulted in many recipient's RUG scores changing to the default value of AAA. While some of these changes may be legitimate, most are in error.

DXC is working on determining a final solution, however DXC will be taking the following action with this weekend's Nursing Home Adjustment cycle which will be reflected in your 11/29/19 Remittance Advice:

Roll back all RUG scores calculated as AAA after 09/30/19 to their prior value, if the prior value is not AAA
Mass Adjust all impacted claims that paid in the November payment cycle that paid on November 15, 2019

As a result, the majority of you who were paid for claims as AAA will now receive re-adjudicated payments using the RUGs score prior to October 1. We understand that this new payment may not be the final amount based on the ultimate RUGS score. However, we believe this is the best course of action to ensure that more accurate payments are made promptly as we work to complete our RUGS testing.

When we have concluded testing on our complete solution, we will communicate with you all again, including a plan to reprocess any remaining claims.

Please continue to contact Marlene Lamoureux at marlene.lamoureux@dxc.com or 401-784-3805 with any additional questions or concerns.

Electronic Data Interchange (EDI) Updates

ATTENTION TRADING PARTNERS:

There is a plan to update our current Sybase Translator to the OXi SaaS translator in the Fall of 2019. The teams working on this project expect a seamless transition for providers. No action is required on your part at this time. But, along with the new translator, we will be upgrading the current 277U transaction from 3070 to 5010 version 005010X228. We will be sending out a new RI Companion guide in the near future.

ATTENTION CLEARINGHOUSES:

Future code modifications will impact automated script users. We require users who submit claims automatically to please email riediservices@dxc.com and identify yourselves as automated script users. These users will then be contacted for testing purposes at a later date. Please note that automated script users who fail to identify themselves as such may experience errors after the OXi SaaS transition occurs.

ATTENTION PROVIDER ELECTRONIC SOLUTION (PES) USERS:

All users should be using PES 2.10. See upgrade instructions here. PES users should be aware that a new version of PES will be available in the Fall of 2019.

Pharmacy Claim Edit for Unit of Use/Package Size

This edit has been activated in Production effective May 1, 2019. It has been fully validated to be working as intended.

EOHHS introduced in May a Pharmacy Claim Edit for Unit of Use/Package Size to ensure pharmacy providers are billing pharmacy claims with an accurate metric quantity based on the unit of use package size. The edit impacts Medicaid Fee For Service, ADAP and RIPAE. If a point of service (POS) pharmacy claim is submitted with metric units that are not an exact match or multiple of the NDC's package size, the claim will deny with the following message "**Units billed for NDC do not conform to package size"**. Examples of products are single units of use such as inhalers, eye drops and single use packaged items.

Examples:

- PremPro, The package unit size is 1 and contains 28 tablets. If a pharmacy billed for 30 units, the claim would deny. The claim should be submitted with a metric quantity of 28.
- ProAir HFA, The metric package unit size is an 8.50 gram inhaler. If a pharmacy dispensed two inhalers and billed 18 grams, the claim would deny. The claim for two inhalers should be billed as 17 grams.

If you have questions, please contact customer service at 401-784-8100 and for in-state toll calls, 800-964-6211.

FYI:

The application fee
to enroll as a Medicaid provider is $586.00
as of January 1, 2019.

See more information regarding providers who may be subject to application fees here.

Updated: Claims Processing and Payment Schedule

See information regarding when claims are due and when EFT payments will be made from July 2019 to July 2020.

Click here to view 2020 Financial Calendar!

Information re: PASSR for Nursing Home and Hospice Providers

In order for nursing home claims and hospice room and board claims to pay, a Pre-Admission Screening and Resident Review (PASRR) must be completed.

This is an evaluation process that is mandated by the Nursing Home Reform Act under the Omnibus Budget Reconciliation Act of 1987. A Level I PASRR is required for all applicants to Medicaid certified nursing facilities, regardless of the payor. A Level II Evaluation and Determination must be completed prior to admission if a serious mental illness and/or intellectual disability or related condition is identified through the Level I screening. This requirement excludes Eleanor Slater Hospital, The Tavares Pediatric Center and RICLASS facilities.

In late June 2019 RI Bridges will begin to send an indicator of "Y" (for yes) to indicate that this screening has been completed or "N" (for no) to indicate the screening has not been completed. This indicator will be viewable on the eligibility page on the Health Care Portal. If the PASRR is set to "N" for the dates of service being submitted on the claim, the claim will go into suspense and be denied if the PASSR is not updated to a Y for the dates of service on the claim.

DXC will be working with EOHHS to add the PASSR indicator of Y to all previously approved recipients. Claims processing will begin to utilize this indicator for all claims submitted after June 24, 2019.

The PASSR indicator will be available for viewing in the Health Care Portal after June 27, 2019.

Pharmacy Spotlight

Meeting Schedule:

Pharmacy and Therapeutics Committee

Drug Utilization Review Board

The next meeting of the
Pharmacy & Therapeutics Committee (P&T)
is scheduled for:
Date: December 17, 2019
Registration: 7:30 AM
Meeting: 8:00 AM
Location: DXC Technology
301 Metro Center Blvd.,
Suite 203
Warwick, RI 02886
Click here for agenda

The next meeting of the
Drug Utilization Review (DUR) Board
is scheduled for:
Date: December 17, 2019
Meeting: 10:30 AM
Location: DXC Technology
301 Metro Center Blvd.,
Suite 203
Warwick, RI 02886

Click here for agenda

2019 Meeting Dates:
April 9, 2019
June 4, 2019
September 10, 2019
December 17, 2019

Medicare ID Project

As part of changes related to the CMS New Medicare ID card project, some changes will be observed to the following MMIS reports.

Three TPL billing reports (the Inpatient, Outpatient, and Part B Professional Billing) are being changed to relabel the field 'Medicare HIC' to now be 'Medicare ID'. The new Medicare Beneficiary ID (MBI) will be listed when it is known to the MMIS, otherwise the Health Insurance Claim Number (HICN) will be displayed as is the case today. After the January 1, 2020 dual processing (MBI or HICN as the primary Medicare identifier) cut-off, these reports will only display the MBI information. This change will be observed in the August, 2019 report generation.

Additionally, the electronic Remittance Advice report will display either the MBI or the HICN in the TPL section of the report (in the field labeled 'Medicare ID'). After the 1/1/2020 cutoff, the RA will only display the MBI in the Medicare ID field. This change will be observed in the August 24 financial cycle.

Pharmacy Update—Pain Management

The Department of Health continues to receive questions about the requirement of ICD-10 codes for controlled substance prescriptions. Below are questions and answers regarding ICD-10 codes on controlled substance prescriptions. Also below, is a link to more FAQs about Pain Management on the Department of Health website.

Documenting International Classification of Diseases (ICD) 10 Diagnosis Code(s) on Controlled Substance Prescriptions

1. **Why is the documentation of ICD-10 diagnosis codes on all controlled substances prescriptions required?**

The requirement for prescribers to provide a diagnosis code on a patient's prescription allows pharmacists to understand why the controlled substance is being dispensed. Pharmacists are able to use this information to have follow-up conversations with prescribers and patients to ensure that patients are being treated with the appropriate medication. This is a requirement for all clinicians with a Controlled Substance Registrations (CSR), including dentists, physicians, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), optometrists, midwives, podiatrists, and veterinarians. The ICD-10 code(s) must be entered in a visible location on the prescription.

2. **Where can dentists and other clinicians who typically do not work with ICD-10 codes find the appropriate diagnosis code?**

The most common dental ICD-10 codes are:

- K01: impacted teeth
- K04: pulpal and periapical diseases
- K05: periodontal diseases
- K08: loss of teeth (This code could be used for implant placement or another pre-prosthetic surgery.)

For dentists, it is sufficient to document the three-character code–the category code–when documenting a diagnosis on a prescription. For example, the three-character code of **K01** supplies sufficient information to indicate a diagnosis of **Embedded and Impacted Teeth**. To find a more specific diagnosis code, prescribers can visit the World Health Organization's (WHO) comprehensive list of ICD-10 codes.

3. **If the prescriber cannot find an appropriate ICD-10 code or if the prescriber's profession does not typically use ICD-10 codes, how should the patient's diagnosis be indicated on the prescription?**

In these specific cases, the patient's diagnosis should be written legibly in a visible location on the face of the prescription.

4. **Does the ICD-10 code have to be documented in the medical record, too?**

RIDOH does not require a prescriber to record an ICD-10 code in the patient's medical record.

5. **If a prescriber omits the ICD-10 code, can pharmacists take verbal orders from the prescriber for the code, or does a new prescription need to be issued?**

A verbal order from the prescriber can be obtained to fulfill the requirement for the ICD-10 code. Dentists and veterinarians do not use ICD 10 codes and may write the diagnosis on the prescription in place of the ICD 10 code.

http://health.ri.gov/publications/frequentlyaskedquestions/PainMgmtRegs.pdf

Covered Outpatient Drugs Rule Changes to Pharmacy Reimbursement

As part of regulatory rules defined by the Covered Outpatient Drugs (COD) Rule, EOHHS is implementing changes to the reimbursement algorithm. Medicaid Fee for Service (FFS) pharmacy claims reimbursement algorithm will include the CMS National Average Drug Acquisition Cost (NADAC) price point and the pharmacy professional fee will be $7.90 for recipients residing in a facility and $8.96 residing at home.

The EOHHS Drug Assistance Program claims will follow the FFS reimbursement algorithm.

These changes will take effect for claims with a date of service equal to or greater than August 1st, 2019.

Provider Revalidation: Wave 1 Concludes!

The first wave of provider revalidation concluded at the end of October. If you were notified with instructions to revalidate as a RI Medicaid provider, please make sure that you sent in all of your completed application materials.

Providers requiring revalidation:

Inpatient facilities
Outpatient facilities
Independent pharmacies
Independent labs
Ambulances
DME/prosthetic/orthotic suppliers
Nursing homes
Federally Qualified Health Centers
RICLASS
Home meal delivery services
Outpatient psychological facilities
Hospice services
Assisted living facilities
Case management services
Adult day cares
Shared living agencies
Day habilitations
Waiver case management
Personal choice/habilitation case management services
Self-directed community services

RI Medicaid provider enrollment revalidation is mandated by the Centers for Medicare and Medicaid (CMS) provider screening and program integrity rules. As such, providers are required to submit supplemental application materials.

ALL PROVIDERS must submit the following supplemental materials:

Payer's Request for Taxpayer Identification Number and Certification (see here)
Rhode Island Medicaid Disclosure Questions (see here)
Additional Federally Required Disclosure Information (see here)

Furthermore, certain provider types are required to provide additional documentation. Please visit http://www.eohhs.ri.gov/ProvidersPartners/ProviderEnrollment.aspx for more info.

Update from Rhode Island Quality Institute (RIQI)

Tracking Your Patients' CurrentCare ID Made Easy

Do you spend time trying to figure out whether or not your patients are enrolled in CurrentCare? Click the link below to view this 2-minute video podcast to learn the benefits of recording your patient's CurrentCare ID number in your own Electronic Health Record.

current care

Providers can access the Healthcare Portal directly, without going through the EOHHS website, but by going directly to the this address:

https://www.riproviderportal.org/HCP/Default.aspx?alias=www.riproviderportal.org/hcp/provider

ENTERAL NUTRITION INSTRUCTIONS for PHYSICIANS

Physicians who are prescribing Enteral Nutrition for RI Medicaid members should fill out section B of the Certificate of Medical Necessity (CMN) for Enteral Nutrition and fax it to the DME provider that will be providing the nutrition to the member. The CMN form can be found on the EOHHS website at:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/DME/CMN_enteral_and_parenteral_nutrition.pdf

The DME provider is responsible for filling out Section A of the CMN that they receive from the physician's office. The DME provider will fax the CMN with a Prior Authorization request form to:

DXC Technology
Fax: 401-784-3892

If you have any questions, please call the DXC Customer Service Helpdesk at 401-784-8100

Attention DME Providers: Updated CMNs

Effective 12/1/2019, the following Certificates of Medical Necessity (CMNs) have been updated and are available on the EOHHS website under Forms and Applications:

- Diabetic Shoes
- Enteral and Parenteral Nutrition
- CMN for Durable Medical Equipment and Supplies

The only revision to the CMN is the addition of a line for recipient date of birth (DOB). Please discard any old versions and use the updated CMNs going forward.

DME Proof of Medical Necessity

Proof of Medical Necessity is required for all services covered under this program. All prescriptions for DME, regardless of format used (e.g., CMN, Prescription pad, or letter) shall, at a minimum containing the following elements:

(1) Member name, and DOB
(2) Diagnosis code for which the DME is required
(3) Description of the DME, including quantities and any special options or add-ons:
(4) Length of need for the DME use:
(5) Name, address and NPI of the prescribing provider; and
(6) Prescribing provider's signature and date of signature. (Prescribing providers are enrolled physicians, clinical nurse specialists, certified nurse practitioner or physician assistants, within the scope of their practice as defined by state law).

All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

Proof of medical necessity should be kept on file by the supplier, and made available upon request.

See DME Provider Reference Manual here.