

Rhode Island Executive Office of Health and Human Services
Medicaid Program



RI Medicaid

Community Health Workers

July 2023
Version 2.0

**Rhode Island Executive Office of Health and Human Services
Medicaid Program**

Revision History

Version	Date	Sections Revised	Reason for Revisions
1.0	July 2022	All Sections	Newly Created
1.0	December 2022	General Policy	Update
2.0	July 2023	Recommendation Requirement; Settings for Services; Collateral Services; New Patient Definition; Information Needed for Claim Submission; General Policy and Claims Guidelines; and Appendix. New sections added for Intake Activities/Calls; Billing for Services in a Group Setting	Update with additional details

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Introduction

The Rhode Island Executive Office of Health and Human Services (EOHHS) partners with Gainwell Technologies as its Fiscal Agent to process the state's Medicaid Program claims, to enroll and train providers, and perform other duties to fulfill State and Federal requirements. EOHHS has the sole responsibility for formatting program policy and procedures.

Purpose of Coverage Policy

The purpose of this policy is to establish the rules of payment for services provided to individuals determined to be eligible for RI Medicaid. The General Rules for RI Medicaid along with this policy are to be used together to determine eligibility for services.

General Policy Requirements

The Rhode Island Medicaid Program will only reimburse providers for medically necessary services. The RI Medicaid conducts both pre-payment and post-payment reviews of services rendered to recipients. Determinations of medical necessity are made by the staff of the RI Medicaid Program, trained medical consultants, and independent State and private agencies under contract with the RI Medicaid.

Medical Necessity

Medicaid provides payment/allowance for covered services only when the services are determined to be medically necessary. CHW services are considered medically necessary for beneficiaries with one or more chronic health (including behavioral health) conditions, who are at risk for a chronic health condition, and/or who face barriers meeting their health or health-related social needs.

The determination of whether a beneficiary meets the medical necessity criteria for CHW services shall be based on the presence of one or more of the following:

- Diagnosis of one or more chronic health (including behavioral health) conditions;
- Presence of medical indicators of rising risk of chronic disease (e.g., elevated blood pressure, elevated blood glucose levels, etc., that indicate risk but do not yet warrant diagnosis of a chronic condition);
- Presence of known risk factors including tobacco use, excessive alcohol use, and/or drug misuse;
- Results of a social determinant of health screening indicating unmet health-related social needs;
- One or more visits to a hospital emergency department;
- One or more hospital inpatient stays, including stays at a psychiatric facility;
- One or more stays at a detox facility;
- Two or more missed medical appointments; and/or
- Beneficiary expressed need for support in health system navigation or resource coordination services.

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Who Can Provide CHW Services

1. Individuals certified by the Rhode Island Certification Board (RICB) as a CHW.
2. Individuals who have a plan for working toward RIBC certification, to be achieved within 18 months.

An organization – whether a medical practice, hospital, other healthcare organization, or a community-based organization – can enroll as a CHW Provider and submit claims to RI Medicaid. There is no RIBC CHW certification at the organizational level. Rather, an organizational CHW Provider must ensure the individuals delivering the CHW services billed to Medicaid are either certified or have a plan to become certified within 18 months.

Enrollment Guidelines

Before a provider can begin seeing RI Medicaid members, an active enrollment is required.

Providers that currently participate with RI Medicaid and who want to become a CHW provider must perform a separate enrollment for CHW services.

CHW's enrolling independently (not part of an agency) will be required to submit proof of CHW certification by the Rhode Island Certification Board (RIBC). If the CHW is not yet certified, they may enroll as a provider, but the enrollment will be limited to an 18-month certification. If the proof of certification is not submitted before the end of the 18-month period, the provider will be disenrolled.

CHW certification is not required for agencies to enroll.

In addition to enrolling as a provider, the CHW must then enroll as a Trading Partner in order to bill and receive payment.

How to Enroll

Enrollment is completed using the RI Medicaid Healthcare Portal (HCP). To access the RI Medicaid Portal, the following link should be utilized: <https://www.riproviderportal.org>.

Step-by-step enrollment instruction can be found on the portal home page. The Healthcare Portal Resource Page can be accessed using the following link: <http://www.eohhs.ri.gov/ProvidersPartners/HealthcarePortal.aspx>.

On the Healthcare Portal site, you find guides which include: Provider Enrollment User Guide, Trading Partner User Guide, OPR Provider User Guide, and once completed, the Community Health Worker (CHW) Guide will be located here as well.

Key Information Needed to Enroll

To enroll as a CHW Provider, you will need the following information:

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- Address Information, including postal code + 4
- Tax ID – either EIN or SSN
- Completed W-9 as an attachment, including signature
- You may also need to attach some federally required disclosures.

Because CHW services are only reimbursed through Fee For Service (FFS) Medicaid at this time, CHW Providers should select “RI Medicaid Provider – Billing Claims Directly to RI Medicaid” as the Type of Provider Enrollment.

Under “Provider Enrollment Type,” CHW Providers should select “**Atypical**”. Once the provider selects “Atypical,” the application requires that a 10-digit identifier be entered. CHW Providers should enter their 10-digit contact phone number to serve as this identifier.

CHW providers **will not** need to fill out fields for National Provider ID, License, or Taxonomy.

Trading Partner Enrollment

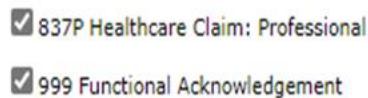
In order to submit Medicaid claims electronically, it is necessary to be enrolled as a Trading Partner. If the organization or person who will submit claims for CHW services is *already* a Trading Partner, it is not necessary to enroll again. Otherwise, it *is* necessary enroll as a Trading Partner.

To enroll as a Trading Partner, go to the Healthcare Portal at this link:

<https://www.riproviderportal.org/hcp/provider/Home/TradingPartnerEnrollment/tabid/931/Default.aspx>

Once there, follow these steps:

1. Scroll to the bottom, and on the left side of the page where it says, “Would you like to enroll as a Trading Partner?”, click on the blue link “Click Here to Enroll”. This will bring you to the Trading Partner Enrollment Application Welcome page.
2. Click Continue at the bottom of the page.
3. On the new page, complete the fields with a red asterisk in each section and select the continue button to move forward to the next page. You will enter:
 - Your Name
 - Your Tax IS/Social Security Number
 - Your contact information
 - EDI information
 - Profile information, including name, address, EDI information
4. When the next page populates displaying X12 transactions, check the 837 professional transaction and the 999 transaction as displayed below.



5. Check off online webservices as displayed below

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- Remittance Advice
- Remittance Advice Payment Amount

6. Select continue, and the Covered provider section populates. This is where you add your Provider ID, SSN, and Provider Type. The provider type for CHW Providers is MA#.
7. The next page will populate with Trading Partner Agreement. You **MUST** click on Trading Partner Agreement, then check off box to accept – type in provider name, Title -CHW, and select Submit.
8. When the next page populates, select **confirm** and then **write down the tracking number** for your trading partner enrollment. Once you have completed that, select **Exit**.

Covered Services

Health and Promotion Coaching including assessment and screening for health-related social needs, setting goals, creating an action plan, and providing information and/or coaching.

Health Education and Training for groups of beneficiaries on methods and measures that have been proven effective in preventing disease, disability, and other health conditions or their progression; prolonging life; and/or promoting physical and mental health and efficiency. Covered when the CHW provides the education/training using established training materials.

The following are examples of Health Promotion & Coaching and Health Education & Training topics:

- Injury prevention
- Addressing family violence/inter-partner violence
- Control of asthma
- Control of high blood pressure/cardiovascular disease
- Control of stress
- Control of sexually transmitted disease
- Control of toxic agents
- Diabetes prevention and control
- Chronic pain self-management
- Chronic disease self-management
- Family planning
- Immunizations
- Improvement in safety and the environmental health of housing, for example to mitigate asthma risk, risk of injury from unsafe housing, lead exposure, etc.
- Improvement in nutrition
- Improvement of physical fitness
- Occupational safety and health
- Prevention of fetal alcohol syndrome/neonatal abstinence syndrome

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- Reduction in the misuse of alcohol or drugs
- Tobacco cessation
- Promotion of preventative screenings, such as cancer screenings

Health System Navigation and Resource Coordination Services that prevent disease, disability, and other health conditions or their progression; prolong life; and/or promote physical and mental health and efficiency.

The following are examples of health system navigation and resource coordination services:

- Helping to engage, re-engage, or ensure patient-led follow-up in primary care; routine preventive care; adherence to treatment plans; and/or self-management of chronic conditions
- Helping a beneficiary find Medicaid providers to receive a covered service
- Helping a beneficiary make and keep an appointment for a Medicaid covered service
- Arranging transportation to an appointment for a Medicaid covered service
- Helping a beneficiary find and access other relevant community resources
- Helping a beneficiary with a telehealth appointment and/or educating a member on the use of telehealth technology.

Care Planning with a beneficiary's interdisciplinary care team. As part of a team-based, person-centered approach, the prevention of disease, disability, and other health conditions are considered. By meeting a beneficiary's situational health needs and health-related social needs, prolonging life, and/or promoting physical and mental health and efficiency are taken into account. These include time limited episodes of instability and ongoing secondary and tertiary prevention for members with chronic condition management needs.

Recommendation Requirement

As a preventive health service, CHW services must be recommended for a patient by a licensed practitioner of the healing arts. Licensed practitioners of the healing arts include any licensed care professional. This definition is not limited to physicians.

The recommendation may be recorded in a recommending practitioner's electronic health record. Alternatively, the recommending practitioner may provide the patient with a written statement that the practitioner recommends the patient receives CHW services and the patient may then provide this written statement to the CHW provider. CHW providers should retain the records of the recommendation, either electronically or in hard copy.

A licensed practitioner of the healing arts may establish a standing order or protocol as their mechanism to implement the recommendation. In this case, the CHW must document in clinical notes how the patient meets the requirements of the standing order or protocol. For example, if the protocol states that a person who has a positive result on a social determinants of health screening is recommended to receive CHW services, and a patient has screened positive on such a screening, the clinical notes should state this fact and state that this aligns with the protocol's recommendation requirements.

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The recommendation must be in place *before* billable CHW services are rendered. This means that if a CHW conducts a screening before a recommendation is in place, that screening is not billable.

“Intake” Activities/Calls

EOHHS understands that CHW Providers may spend time conducting initial conversations with potential/new patients. In order to bill for such calls, two conditions must be met:

1. A licensed practitioner must have recommended that the patient receive CHW services. In some cases, part of an intake might be a CHW Provider identifying whether and how the patient meets criteria from a clinical protocol and documenting that the person does meet the criteria in clinical notes. In that case, subsequent time spent may be billable if the other condition is met.
2. The beneficiary must be receiving an actual CHW service as listed above. Activities such as learning information about the patient and explaining information about the provider’s services are not CHW services. In some “intake” conversations, the CHW may deliver Health Promotion & Coaching or Health System Navigation services, in which case the time spent on those activities may be billable.

Settings for Services

Services, including initial visits, may be delivered in a medical clinic setting or in a community setting, including but not limited to beneficiaries’ homes.

For example, CHW’s may provide Health Promotion and Coaching services while accompanying (including transporting) a beneficiary to a medical appointment. A CHW may coach the beneficiary before and during the appointment and support the beneficiary in taking further steps after the appointment based on what happens in that appointment. In this case, it is the Health Promotion and Coaching activity that the CHW is providing and that is therefore reimbursed.

Note that travel time, whether time a CHW spends traveling to see patients or transporting/accompanying patients to appointments, is not billable. This is a federal rule. As described above, a CHW can deliver services such as Health Promotion and Coaching *while traveling* with a beneficiary. However, the travel *itself* is not billable – the Health Promotion and Coaching is the billable activity. Similarly, accompanying a patient for an appointment – merely being present for the appointment – is not billable, again pursuant to federal rules. However, if the CHW is actively helping the patient during the appointment, such as by supporting their communication with the provider, that is considered Health Promotion and Coaching and is billable.

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Collateral Services

Service time billed must be for either direct contact with a beneficiary (in-person or through telehealth) or for collateral services on an individual basis. Collateral services are those delivered on behalf of an individual beneficiary but that are not delivered in that beneficiary's presence/directly to the beneficiary.

The collateral service must actively involve the beneficiary in the sense of being tailored to the beneficiary's individual needs. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service. Many health system navigation and resource coordination activities, for example, can be appropriately delivered for a patient without the patient being present, and care planning with a beneficiary's interdisciplinary care team may also occur outside the patient's presence.

Examples of services that can be delivered without the patient's (physical or virtual) presence include:

- Time spent researching the most appropriate medical or social services provider to meet a particular patient's needs.
- Time spent arranging appointments for a patient to receive services and/or arranging the patient's travel to an appointment.
- Time spent discussing the patient's needs and situation with other members of the patient's care team.

By contrast, time spent preparing for a visit – such as reviewing patient notes or preparing a presentation for a training – is not considered a billable collateral service. Time spent documenting a visit is also not considered a billable collateral service.

The same recommendation and billing requirements apply for collateral services as for services delivered in direct contact with the beneficiary.

Information on Billing Procedure

Requirement to Verify Eligibility

To ensure that a patient is enrolled in Medicaid and therefore that CHW services provided to the patient may be reimbursed by Medicaid, the CHW must first **verify** the beneficiary's Rhode Island Medicaid eligibility. Eligibility information is located on the Health Care Portal and is available 24 hours per day, seven days per week. The member's eligibility must be verified, by the CHW, on **each date of service**.

Timely Filing Guidelines

The Rhode Island Executive Office of Health and Human Services has a claim submission restriction of **twelve (12)** months from the date the service was provided to Medicaid recipients.

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Gainwell Technologies must receive a claim for services for Medicaid clients within 12 months of the date of service in order to process claims for adjudication.

Any claim with a service date over one year and a remittance advice date from GWT over ninety (90) days will be denied for timely filing. Denials must be for reasons other than timely filing to be considered.

Claims Submission Formats

Providers have a choice of using Electronic Claim submission or Paper Claim Submission.

Electronic claims are the preferred method for claim submission. CHW services are submitted using HIPPA compliant software and electronic claim type 837 professional.

To submit claims electronically, providers have access to the free Provider Electronic Solutions (PES) software. The software along with written instructions for download and setup can be found on the EOHHS website.

Paper claims are to be submitted using the 02/2012 version of the CMS 1500 professional claim form, which providers will need to purchase. Claim forms can be purchased at medical supply stores.

Information Needed for Claim Submission

Diagnosis Code

It is important that the proper diagnosis code(s) be indicated on the claim form when billing for CHW services.

Diagnosis codes from the ICD-10 diagnosis set are required when submitting a claim. It is the provider's responsibility to determine the correct diagnosis code. One sources of ICD-10 diagnosis codes is ICD10Data.com. Printed versions of ICD-10 diagnosis code listings are also available.

Almost any diagnosis code for a chronic disease, including Behavioral Health (BH) conditions, may be used. For example, this would include diagnosis codes reflecting that a beneficiary has a condition such as diabetes, hypertension, cardiovascular disease, COPD, cancer, renal disease, depression, anxiety, etc. Because diagnoses of medical conditions will always be made by the appropriate licensed clinician (e.g., a physician), these diagnosis codes are expected to be identified by licensed clinicians, not by CHWs. That is, while CHW providers will document these diagnoses codes in their claims where applicable, EOHHS expects that CHW will collaborate with licensed clinicians to determine the appropriate codes when a medical diagnosis is the basis for the clinician's recommendation that the beneficiary receive CHW services.

In many cases, the basis for a recommendation for CHW services is that a beneficiary is experiencing a health-related social need, such as needing help with food or housing. In this case,

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CHW Providers may use a “Z code” in the range Z55-75 to identify a social determinant of health as a diagnosis code. Z codes are part of the ICD-10 diagnosis set.

Please note the fact that a Z code might exist that describes a patient’s situation does not automatically mean that the patient meets the medical necessity criteria to receive CHW services. CHWs must ensure that a patient meets the medical necessity criteria listed above and that a licensed practitioner has recommended that the patient receive CHW services. Once these elements are established, the CHW provider may review Z codes to identify any/all that apply to the patient.

Anchor Card/Medicaid ID

It is necessary to include the patient’s Anchor card/Medicaid ID on claims submitted to Medicaid. If the patient is a member of a Medicaid managed care organization and does not have their Anchor card with them and does not know their Medicaid ID number, CHW Provider can obtain the number in one of two ways:

1. Use the Health Care Portal. By entering the social security number, the CHW Provider can look up the beneficiary’s Medicaid ID number.
2. Call the Gainwell Customer Service Help Desk at **401-784-8100** or **Toll Free 1-800-964-6211**. The provider will be **required** to have the beneficiary’s name, date of birth **and** social security number. The Customer Service Help Desk will not release the Medicaid ID if the provider does not have all three (3) pieces of information.

Beneficiaries can also call the Department of Human Services themselves to request their Medicaid ID number, at **1-855-697-4347**.

Procedure Code and Modifiers

CHW services will be billed using the Healthcare Common Procedure Coding System (HCPCS) **Procedure Code: T1016** – Case Management – Each Fifteen (15) Minutes. There are three versions of this code that should be used in three distinct circumstances:

- T1016 – without a modifier will be used when billing for services rendered to an *established patient*
- T1016 – with the U3 Modifier will be used when billing for services rendered to a *new patient*
- T1016 – with HQ Modifier will be used when rendering services in a *group setting* (*The rate is paid for each eligible Medicaid member*)

New Patient Definition

It is appropriate to bill with the New Patient modifier in the following circumstances:

1. The CHW Provider has never provided CHW services to the beneficiary before.
2. The CHW Provider has not provided CHW services to the beneficiary in the previous three (3) years.

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CHW Providers should include the New Patient modifier on the first claim they submit for services rendered to a beneficiary who falls into one of the two categories above.

For organizations providing CHW services, the new patient code can only be applied once, even if different individual CHWs work with the patient over time. That is, having a different individual CHW provide a service does not make the patient “new” to the organization.

Similarly, if an established patient has a new problem requiring attention, they remain an established patient and the new patient code should not be used.

If a patient has been seen first in the context of a group Health Education and Training class, and is subsequently seen individually, it is permitted to bill the new patient code for that first individual session.

Billing for Services in a Group Setting

Any time a CHW seeks reimbursement for the same unit of time spent with multiple beneficiaries, the group setting code must be used. For example, if a CHW works with three people for 15 minutes, they are not permitted to bill the individual “established” or “new” patient codes for these patients, and instead must bill the group setting code for those three people for that 15-minute period. The only way to be reimbursed multiple times for the same 15-minutes of work is to properly use the group setting code.

The group setting code, T1016-HQ, should be used for Health Education and Training services delivered to groups of patients where at least two (2) participants are Medicaid beneficiaries. If a patient is seen for the first time in a group setting, the group setting code should be used, not the new patient code. The group setting code should not be used in the context of Care Planning, because that activity is highly individualized.

Health Promotion and Coaching; and Health System Navigation are generally expected to be delivered to individuals rather than groups, because these activities are so specific to the needs and circumstances of the individual. However, in the case of families/households, the needs and circumstances of multiple beneficiaries may overlap considerably. For example, multiple family members may benefit from coaching related to nutrition in the context of family meals, and multiple family members may benefit from support to access social services. In that case, the CHW may be providing Health Promotion and Coaching or Health System Navigation services to multiple household members at the same time, and therefore should bill the group setting code for each family member who is enrolled in Medicaid and who received a recommendation for CHW services.

To bill for a service delivered to multiple family members at the same time, each person participating in the visit/service must have received a recommendation from a licensed clinician. If only one family member has been recommended for CHW services, the CHW Provider may only bill for that one person, even if other family members are present and may benefit from the service. If there are multiple family members recommended for CHW services and the CHW works individually with each family member, these can be billed as individual sessions – the fact

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that other family members may receive services at a different time does not transform the individual service into a group visit.

If multiple household members have been recommended to receive CHW services, and the CHW is delivering services to multiple household members at the same time, it is permitted to bill the group setting code for each such member.

Payment for Services

Payment for services is made by EFT (electronic funds transfer) only. You will set this up during enrollment.

Payment frequency is determined by the State Fiscal Year (SFY) Claims Payment and Processing Schedule. The schedule can be found [here](#) on the EOHHS website.

The reimbursement rates for Community Health Workers are listed in the Fee Schedule. Community Health Workers cannot, by law, be paid more than the amount allowed in the published fee schedule.

Clinical Documentation

CHW Providers are required to maintain notes reflecting the dates and time/duration of services provided to beneficiaries. The notes should also reflect information on the nature of the service provided and support the length of time spent with the patient that day. The notes may also need to document how a patient meets criteria in a standing order or protocol to be recommended for CHW services (see Recommendation Requirement above).

For example, a note might state, “Discussed the patient’s challenges accessing healthy food and options to improve the situation for 15 minutes. Assisted with SNAP application for 30 minutes. Referred patient to XYZ food pantry.”

General Policy and Claims Guidelines

A provider enrolled both as a provider type other than CHW and as a CHW provider can submit claims for the provider’s other services and for CHW services on the same day.

Ex. A dental provider enrolls as a CHW provider. A member goes in for a cleaning by a hygienist. The dentist can bill for the cleaning using their dental provider number and also for a CHW that performed oral health coaching on the same date/visit, using their CHW provider number.

Each unit billed represents 15 minutes of time. For the first 15 minutes, services must be provided for the full 15 minutes; all subsequent units after the first 15 minutes can be rounded up. Total amount of time spent with a member should be totaled and billed on one detail of the claim.

*Ex. One hour with a member should be billed on one line as 4 total units.
Ex. If the CHW provides eight (8) minutes of service, that time is not billable.*

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Ex. If the CHW provides twenty-three (23) minutes of service, this can be billed as two (2) units.

There is no limit to the number of visits/hours allowed per member

Appendix

Access to the RI Medicaid Healthcare Portal (HCP) <https://www.riproviderportal.org>.

The Healthcare Portal Resource Page can be accessed using the following link:
<http://www.eohhs.ri.gov/ProvidersPartners/HealthcarePortal.aspx>.

State Fiscal Year (SFY) Claims Payment and Processing Schedule
[SFY2022 payment schedule.pdf \(ri.gov\)](#)

ICD-10 diagnosis codes: ICD10Data.com

Executive Office of Health and Human Services: <https://eohhs.ri.gov/>

Contact Information

Provider Services: riproviderservices@gainwelltechnologies.com

Provider Enrollment: rienrollment@gainwelltechnologies.com

Customer Service Help Desk: 401-784-8100 (Local); 1-800-964-6211 (Toll Free)
Available Monday through Friday 8:00 A.M -5:00 P.M. (EST)

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Additional Resources

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The image shows a sample of a CMS 1500 Claim Form, which is a standard form used for medical billing. The form is filled with red text and lines, indicating it is a sample. A large, semi-transparent watermark with the word "SAMPLE" is printed diagonally across the center of the form. The form includes various sections for patient information, insurance details, and a table for procedure codes and charges. The top left corner features a QR code and the text "QUALITY INSURANCE CLAIM FORM".

CMS 1500 Claim Form Example