Topic	Q#	Question	Answer
Encounter Edits	1a	Ordering, Prescribing, and Referring (OPR) Provider: How do encounters/claim adjudicate for OPR providers?	**The edits only apply to Billing and Attending/Rendering provider fields on the encounter claim.** Billing and attending/rendering providers on the claim are checked if registered with EOHHS. If claim does not meet the 120-day rule for Billing or the 180-day rule for attending the claim will deny. **The 180-day rule also applies to rendering providers.**
Encounter Edits	1a	If an OPR provider is not screened, but rendering/billing provider is screened, what happens to the claim?	**The edits only apply to Billing and Attending/Rendering provider fields on the Encounter claim. If providers submitted in those fields are screened the claim will pay.**
Encounter Edits	1b	Neighborhood has not received clarification on provider screening encounter edits, if any, that may apply to NCPDP encounters yet pharmacies are required to be screened. Will encounter edits be implemented for prescribers and pharmacies? If so, what is the implementation date?	The Provider Encounter Screening Edits will apply to all Encounter claims coming through the MCO file upload, including drug-related claims. The billing provider will be checked on Pharmacy claims. If the billing provider is not screened with EOHHS and the 120-day rule does not apply then the claim will be denied.

Encounter Edits	1c	Non-par providers: Per email communication from Deputy Medicaid Director Kraics dated April 7, 2022, "Based on the CMS Medicaid Provider Enrollment Compendium, single-case agreements (SCA) and non-network providers are not required to enroll and EOHHS will be following this guidance." However, pursuant to guidance issued by EOHHS on 11/21/2022, there are two encounter edits for non-par providers that check compliance if such a provider submits one (1) or more claims within the last 180-days. Neighborhood is requesting clarification on how SCA and separately how non-par providers will be addressed.	Assuming non-par providers is the same as Out of Network (OON) providers, change requests 002 and 003 have the specific descriptions of how the edits will work for OON Providers.
			
			Edit 957 (billing provider) and 967 (attending provider) are the Out of Network provider edits and will only check the From DOS. The 180-day rule is explained:
			• If From DOS is before 7/1, edit will not be called.
			• If From DOS is on or after 7/1, a new table will be checked to see if this provider has provided care to more than one recipient in the past 180 days
			  ○ If Yes, this is the second or greater unique recipient the provider has given care to in the past 180 days, and the provider has NOT been screened/ approved, set the edit.
			  ○ If provider is screened/approved, do not set.
			  ○ If no, this is the only unique recipient the provider has given care to, even if they have given care to this one unique recipient multiple times, do not set the edit. However, a row for this unique recipient will be created on the new table and should the provider give care to another unique recipient within 180 days, then the edit will be called.
			
			Please refer to most recent MCO Encounter Provider Guide- v2.3 for clarification on non-par and OON distinctions.

Encounter Edits	1d	Neighborhood is particularly concerned about non-par emergency/urgent services, does the screening requirement apply in these situations? Are there any other situations where the screening requirement does not apply, or EOHHS will not screen for compliance with the Act? NHPRI has requested that not apply the screening edit to OON providers and single-case agreements	The edit logic does not consider specific procedure codes, but rather looking at whether the provider is screened. At this time; EOHHS will not be changing the logic on this.

Encounter Edits	1e	In a situation where a claim spans dates of service, e.g. inpatient stay, if the provider becomes (non)/compliant during the relevant period, how will the encounter be adjudicated? Will MCOs be required to resubmit the encounter if a provider's status changes during the date span?	The new Encounter Provider Screening Edits will check if the Provider appropriately screened and approved by RI Medicaid as of the From DOS. If From DOS predates the implementation date (July 1st), those claims will bypass the new edits.
Encounter Edits	1f	At Pharmacy POS, if the prescribing provider is screened but the pharmacy is not, what is the expected outcome for the member?	**The billing provider – in this case the pharmacy – must be screened for a pharmacy claim. Prescribing providers are not evaluated on the pharmacy encounter claim.**
Encounter Edits	1g	Are Interns, Residents and Foreign MDs in training allowed to prescribe in RI? EOHHS Question: What is the volume/scope of this?	Per RIDOH, "All physicians must have a full medical license to practice in Rhode Island. The only exemption are individuals in an accredited residency program and have been issued a training license." Interns would not qualify and cannot prescribe. Residents can practice under their training license and should be added as a new provider to an existing group (resident do not practice independently and would not have their own RI Medicaid provider ID). Foreign MDs would need to be licensed to practice in Rhode Island. Happy to connect you with RIDOH licensing more on this if needed.
Encounter Edits	1h	If allowed to prescribe on their own (vs under the supervision of a licensed practitioner) - do Interns, Residents and Foreign MDs need to obtain a RI Medicaid ID?	See above
Encounter Edits	1i	[THPP] Does the 180-day rule for OON providers require the provider has an "approved" screening status?	No
Encounter Edits	1j	[THPP] In some cases members may need to see an OON provider (I.e., continuity of care for new members receiving treatment). How are those claims being addressed?	Single Case agreements can be utilized; these should be used in rare cases only and not for ongoing care. All efforts should be made to maintain network adequacy and add providers to your networks in these cases.
Enrollment / Screening Process	3a	How far back can a provider ask their enrollment to be backdated?	With a manual sql update, Gainwell can backdate provider enrollments. Yes; so long as it is 120 days from the date of application Provider enrollment will be backdated from the date of approval to the date of application as long as it falls within the 120 days.

2/27/2023 Memo	4a	The memo states that providers must be screened/enrolled before 6/1/23 even if provider is already fee for service. Please elaborate on the foregoing requirement. Does a provider need to update their application?	If the provider is a FFS provider, they do not need to complete a separate MCO Only screening for the MCO screening requirement. The weekly file has all screened providers, including FFS, MCO, FFS-only and MCO-only. If a FFS-only provider wants to become an MCO provider, they have that option on the application.
2/27/2023 Memo	4b	If a provider is in-progress on 7/1, is it EOHHS' expectation that MCOs terminate these providers and reinstate upon confirmation of compliance?	In-Progress could mean multiple statuses: Are we referring to: • Incomplete - Pending Provider; not submitted • Pending - Application was submitted. Either pending Gainwell review or working with provider to obtain more information. • Sent to State - Pending EOHHS approval. **As of 11/1:** **There will be a sixty (60) day time period in which they are pended; however all claims should be held until a final decision is reached.**
2/27/2023 Memo	4c	Multiple Provider types: The memo mentions that if a provider has multiple provider types, the provider needs to complete the screening process for each provider type. Neighborhood is assuming screening aligns only with NPI and that this requirement refers to organizations that may have more than one NPI to screen and does not apply to individual providers that may have multiple specialties but only one NPI. If screening is tied to the unique National Provider Identifier (NPI), Neighborhood assumes that each individual NPI requires one screening application that covers any provider service/specialty for that NPI. Please confirm.	If an NPI has been screened, they do not need to also be screened for another provider type.
INTEGRITY	5	With respect to the INTEGRITY product and pharmacy claims if we apply the point of service edit to block Medicaid covered claims at non-compliant pharmacies, the system will also block the adjudication of Part D drugs. We have a wrap benefit for INTEGRITY and there is no way to exclusively block the adjudication of Medicaid covered drugs (under the secondary carrier) without impacting Part D drugs. What is the expectation for these services? Neighborhood is extremely concerned that this will provide an access issue for services that should not fall under this requirement.	**The billing provider must be screened for a pharmacy claim.**

Enrollment / Screening Process	6	The MCOs will need to notify providers in advance of an upcoming possible termination date (e.g., 30 day notice). If the provider is in an "in progress" status at the time of the mailing, should the MCO exclude the provider from the notification?	The respective MCO has discretion here. EOHHS advises and encourages relevant MCOs to streamline communication amongst shared networks to reduce provider abrasion. **In progress** does not mean approved.
Enrollment / Screening Process	6a	If so, and the provider does not complete the application before June 30th, will the MCO be able to extend a 30-day grace period to allow for the advance notice?	N/A due to the 120- day extension
Enrollment / Screening Process	7	If a provider application is in an **"in progress – State or in progress - Provider"** status, can the MCO pend the claims until the status is resolved (either approved or removed)?	Yes
Enrollment / Screening Process	7a	Will the provider's screening status be retroactive to the date the application was submitted or effective the date the "approved" status is determined?	**Effective date, which is part of the application, will be used for retroactive date once approved by EOHHS as long as it is within 120 days** **.**

Edit Logic	8a	**In-Network Provider/Pharmacy/OPR –**
		• **CLAIMS PAY**
		  • When DOS is >= 7/1/23 attending and billing NPIs must be screened with active dates within the Effective and End Date of weekly enrollment file prvr950.YYYYMMDD#######
		  Or
		  • Spanned date ranges only review "From DOS" - attending and billing NPIs
		  ○ Provider not screened - If "From DOS" is BEFORE 7/1 and "TO DOS" is after 7/1
		  ○ When DOS is >= 7/1/23 if the provider is enrolled during "From DOS" and becomes disenrolled by the "To DOS" claims will still be paid	

Edit Logic	8b	**Out-of-Network Provider/Pharmacy/OPR Logic**
		• **CLAIMS PAY –**
		  • When the DOS is >7/1/23 attending and billing provider claims will be subject to the 180 day rule
		  Or
		  • When DOS is >= 7/1/23 attending and billing NPIs must be screened with the claims from date of service within the Effective and End Date of weekly enrollment file prvr950.YYYYMMDD#######
			At this time, EOHHS will not be implementing any changes to logic

		• **CLAIMS DENY -** When DOS is >= 7/1/23 attending and billing NPIs claims includes >1 unique Medicaid IDs from 180 days "From DOS" claim • This includes denying claims for the first unique member that was receiving services	
Edit Logic	8c	[THPP] re: PRVR950 File If the provider is no longer in an "approved" status on the weekly file (I.e., dropped from the list), what effective date should the MCO use to update the provider record? Will this date be passed on the file?	Gainwell modified the document to verify the term date and will keep them on the file for 30 days, at which time they will be removed.
Edit Logic	8d	[THPP] re: PRVR950 File If the provider is no longer in an "in process" status on the weekly file (I.e., dropped from the list), is it correct to assume the provider did not complete the screening process? If claims were pended for this provider, should the MCO deny those claims?	

EDITS & LOGIC:

Questions from UHC (8.7.2023)

- Please confirm what providers are in scope for 11/1 enforcement: **The edits only apply to Billing and Attending Rendering provider fields on the Encounter claim.**
  - Any NPI that is submitted in the billing or attending/rendering fields in the 837 will be screened.
  - Medical/Behavioral
  - Pharmacy
  - Ordering/prescribing/referring
- Please confirm if there are any exceptions - **The only exceptions are the 120 or 180 rule**
- Process will identify claims that should be excluded from Provider Validation **The only exceptions are the 120 and 180 day rules**
  - Emergency service - Urgent/Emergent Rule -
    - The process will look for an Urgent or Emergent claims where box 32 [Box 33 if 32 is empty] (Professional) and Box 1 for (Institutional) does not equal state RI and has a POS 20/23, 41/42 (Professional) or REV code 450-459, 540-549. (Institutional claims).
  - Bypass NPI – used for one off exceptions
    - Prescriber – Emergency situations
    - Single Case Agreements

Edit 950 (billing provider) and 960 (attending provider) are the In Network provider edits and will only check the From DOS

- If From DOS is before 7/1, edit will not be called.
- If From DOS is on or after 7/1, will check if the provider was screened/ approved on that date.

120 Day rule:

If an in-network provider (billing or attending) submits a claim with a From DOS on 7/1 or after and is NOT screened/ approved, the Encounter Provider Database is checked to see when the provider was first added and Accepted into the Encounter Provider Database.

- If the provider has been added to the Encounter Provider database within the last 120 days of the From DOS, do not call the edit.
- If the provider has been added to the Encounter Provider database more than 120 days of the From DOS, call the edit.

Questions from UHC (8.7.2023)

- In the logic what does “Accepted” refer to (Added and Accepted)? – **First date provider was accepted in Encounter database through the MCO provider load.**
- Please confirm that the 120 day timeframe starts from date of application – From DOS on the claim to when new provider was first accepted in the Encounter database. This is separate from Provider Applications.
- After the 120 days does the provider come off the weekly enrollment report? Providers that are terminated will be removed after 30 days from the weekly enrollment report (PRV950).
  - If not what date will the MCOs use to track the 120 days – The MCO Provider Response File from Gainwell indicates when new providers are first accepted.

Edit 957 (billing provider) and 967 (attending provider) are the Out of Network provider edits and will only check the From DOS.

The 180 Day rule is explained here also:

- If From DOS is before 7/1, edit will not be called.
- If From DOS is on or after 7/1, the new table will be checked to see if this provider has provided care to more than one recipient in the past 180 days **from the DOS**
    - If Yes, this is the second or greater unique recipient the provider has given care to in the past 180 days, and the provider has NOT been screened/ approved, set the edit. If provider is screened/approved, do not set.
    - If no, this is the only unique recipient the provider has given care to, even if they have given care to this one unique recipient multiple times, do not set the edit.
        - However, a row for this unique recipient will be created on the new table and should the provider give care to another unique recipient within 180 days, then the edit will be called.

Spanned Date Range: From DOS

- If a claim comes in and the From DOS is BEFORE 7/1, the edits will NOT be called, even if the TO DOS is after 7/1.
- If a claim comes in and the FROM DOS is on or after 7/1, the edits will be called accordingly.
- With this current understanding, if a claim comes in with a DOS of 7/1 or greater, and the Provider(s) is compliant on that From DOS, the edits will not set. Even if the provider becomes uncompliant during the span of care, the edits will not be called because we are only checking the From DOS.