

# Nursing Home Billing October 2025

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# Billing Notes

Submit for dates of service within the same month only

Submit claim as 1 detail

Date of discharge is not payable

One financial per month for room and board

If either Medicaid or Long-Term care eligibility is not on file, contact DHS if the stay is 30 + days

Dates of service through 9/30/25 will pay based on RUG and dates of service as of 10/01/25 will pay based on PDPM.

# Timely Filing



365 days from  
date of service

If date of service is over 365 days old:

- a) Submit claim on paper
- b) Submit to provider representative attention
- c) Submit proof of timely filing

Acceptable proof of timely filing:

- a) EOB from primary within 90 days
- b) LTC eligibility updates within 90 days of submitting claim
- c) RUG updates in the system within 90 days of submitting claim

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Long Term Care Eligibility can be viewed in the Healthcare Portal at <https://www.riproviderportal.org> if within 1 year from today

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*Note: You can only see LTC eligibility for an approved recipient in your facility.*

- Enter the dates of service
- Verify correct spelling of recipient's name
- Verify that there is Medicaid Eligibility
- Verify there is a LTC segment on file for stays 30+ days
- If no LTC on file and needed or Medicaid eligibility missing, contact your LTC case worker

# Skill Level –Types of Bills

Verify LTC segment on the Healthcare Portal:

Bill Type	Explanation
210	Medicare free days. Although there is no Medicaid payment, these days must be billed to set up payment for Medicare Co-insurance days or nonskilled days if the LTC segment is for the entire month and there is no discharge to the hospital. Pays \$0
253	Medicare Co-Insurance days. Pays the coinsurance rate that applies to the dates of service for the year
263	Medicaid only days, claims process based on RUG through 9/30/25 and dates of service 10/01/25 forward will process with PDPM
Hospice	Members who have elected hospice services

# RUG Pricing Methodology

As of June 1, 2013, the Rhode Island Office of Health and Human Services (OHHS) adopted a Medicaid method of paying for Nursing Home room and board services. RUG pricing was replaced with PDPM for dates of service October 1, 2025, forward.

Minimum Data Set (MDS) 3.0 format with the CMS RUG IV V1.02 Grouper Version containing 48 RUG categories.

The MDS is a clinical tool used to identify all resident's strengths, weaknesses, preferences and needs in key areas of functioning.

For more information on RUG codes, review the Frequently Asked Questions document on the EOHHS website at:

[http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RUG\\_FAQ.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RUG_FAQ.pdf)

# RUG Codes

The RUG Grouper software reads MDS assessment in Sections B through P for clinical data and calculates the RUG code. Incomplete assessment will result in determining an incorrect and/or no RUG. The RUG code will appear on your Remittance Advice Report.

The default RUG code AAA will be selected for claim payment if any date during the period being billed has a RUG of AAA on file.

The entire claim will process with a RUG of AAA.



# RUG Code Differences

- The State's software calculates the RUG score based on the MDS record that the nursing facility submits
- 5% of the time the RUG may not be what the facility was expecting
- Fields on the MDS record (Z0200 or Z0250) RUG score not used
- State's software uses the score that their software determines
- The software used is: RUG-IV DLL Package (V1.04.0 FINAL)

# PDPM Pricing Methodology Dates of Service October 1, 2025

Effective October 1, 2025, the Rhode Island Office of Health and Human Services will be adopting the Centers for Medicare and Medicaid (CMS) Patient Driven Payment Model (PDPM).

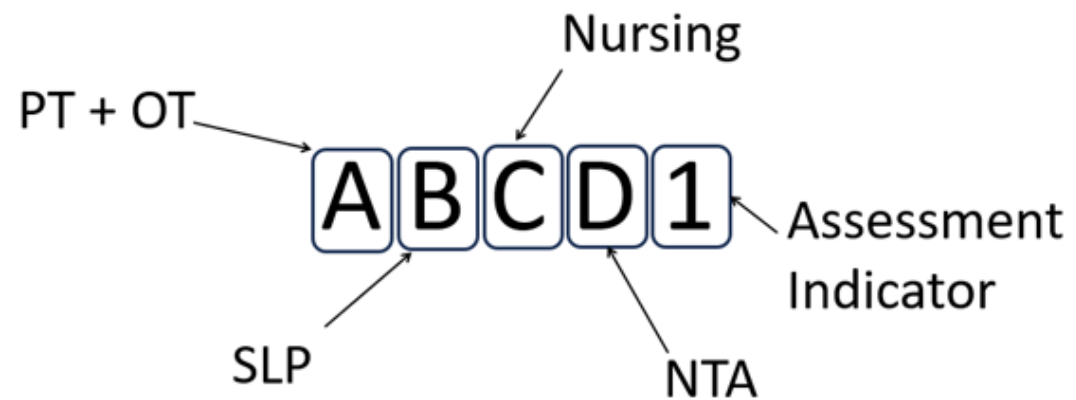
Payment for services will be based on Minimum Data Set (MDS) v3.10.1 or the most current version. As with the Resource Utilization Group (RUG) assessment, nursing home providers will be required to complete assessments and submit them to CMS.

The MDS assessment is a clinical tool used to identify all residents' strengths, weaknesses, preferences, and needs in key areas of functioning.

PDPM Consists of 5 major components: Physical Therapy, Occupational Therapy, Speech-Language Pathology, Non-therapy Ancillary assessment, and Nursing Care.

At this time, the 3<sup>rd</sup> character of the provider supplied 5-character HIPPS code will be used to price the claim. OHHS will be supplying rates to all facilities.

# HIPPS Code Breakdown



A0700: Medicaid Number

<b>A0700. Medicaid Number</b> - Enter "+" if pending, "N" if not a Medicaid recipient
<input type="text"/>

**A0600. Social Security and Medicare Numbers**

**A. Social Security Number:**

<input type="text"/>	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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**A0900. Birth Date**

<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	-	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Month		Day		Year					

# PDPM Code Missing

Verify that the SSN in field A0600 of the MDS record is the **same SSN** that is in the Medicaid system.

Verify that the 10 digit MID is in field A0700 of the MDS record. If it is N, Blank or a + sign and Medicaid does not have the RUG/PDP modify the record by adding it and resubmit MDS

Verify that the date of birth is the **same date of birth** in the Medicaid System. If not and the date of birth that you have is correct you will need to reach out to DHS to get the system corrected.

# RUG/PDPM Code Changes within the month

- If only one RUG/PDPM code is effective for all the dates of service on the claim, that code will be utilized.
- If multiple RUG/PDPM codes are effective in a month, and the dates of service span the 15<sup>th</sup>, the one effective on the 15<sup>th</sup> will be utilized.
- If the Date of Service on the claim does not span the 15<sup>th</sup>, the code on the “To” date of service will be utilized.

# Rhody Health Partners and Medicaid Expansion

Claims for beneficiaries admitted to nursing facilities who are enrolled in Rhody Health Partners or Medicaid Expansion plans must be submitted to the primary coverage through the month where the 30<sup>th</sup> day of the stay ends, regardless of the skill level.

When claims are received by RI Medicaid, they will suspend with 670 (Recipient has other insurance on date(s) of service) while they are researched to determine if the first 30 days were paid by the primary carrier.

The claims will then be processed to pay or deny, based on the findings.

Please allow two financial cycles for the process to be completed.

# Rhody Health Partners and Medicaid Expansion Examples

- **30-Day Stay at Nursing Facility**

Admitted 5/13, still there on 6/13:

- Member will be disenrolled from MCO effective 6/30
- Nursing home should bill MCO for 5/13–6/30 for services.

- **Stay Exceeds 30 Days**

Admitted 5/13, discharged 7/16:

- Member will be disenrolled from MCO effective 6/30
- Nursing home should bill MCO for 5/13–6/30 and bill FFS\* for 7/1–7/15.

- **Hospital Admission During Nursing Facility Stay**

Admitted 5/13, inpatient hospital 6/7–6/17 then discharged to a nursing facility:

- Nursing home should bill MCO for 5/13–6/6
- 30-day nursing home benefit count restarts on 6/17 upon hospital discharge
- Member will be disenrolled from MCO effective 7/31 (if they still reside at a nursing facility)
- Nursing home should bill MCO for 6/17–7/31 and bill FFS\* for 8/1 – forward.

- **Stay Overlapping Financial Cycle**

Admitted 7/27, still there on 8/27:

- Member will be disenrolled from MCO effective 9/30
- Nursing home should bill MCO for 7/27–9/30 and bill FFS\* for 10/1 – forward.

# Other Insurance Billing

Medicaid will pay the lesser of “allowed amount – OI payment” or the co-pay.

The following information must be included on the claim:

- Other Insurance paid date

- Other Insurance payment

- Co-pay amount

If the other insurer paid more than Medicaid allows, claim will be “paid” at zero.

If the other insurer paid less than Medicaid allows, it will process the “lesser of” calculation to determine payment.

Medicaid allowed amount will be calculated based on skill level.

- If recipient is skilled, allowed amount used is the Medicare co-insurance rate per diem.

# Common Edit

715  
Tad Control and  
Stacking

All nursing home claims hit this edit.  
This edit “holds” all nursing home claims in  
suspense so that they can be processed in  
chronological order if there are multiple claims  
for the same person in one month.

## Corrective Action

None, if the claim is only in 715, it should process on the  
next NH financial cycle

# Common Edit

252  
PDPM/RUG Code  
Missing or Invalid

This indicates that the PDPM/RUG code is not in the system for some or all dates of service on the claim

## Corrective Action

Check the Healthcare Portal the date of birth and SSN numbers must match what you have on the MDS records

# Common Denials

This indicates the MID you are billing does not exist in our system

008

Recipient Number  
Missing or Invalid

## Corrective Action

- Validate MID reporting on Remittance Advice is the correct MID for the recipient
- Validate the MID in the Healthcare Portal
- If MID does not come up in the portal, the MID is either incorrect or the recipient is not enrolled in RI Medicaid
- Once you have the correct MID and have validated it on the Healthcare portal, submit a new claim with the corrected information. You must use the ten 10 MID
- If you have the member's SSN you can use that to retrieve the 10 digit MID

# Common Denials

009

Recipient Name  
Missing or Invalid

This indicates the name you are billing does not match the name of file for that MID

## Corrective Action

- Validate name submitted on the Remittance Advice
- Validate name in the Healthcare Portal for the MID you are billing
- If name is not correct at all, contact your LTC office to have them validate and possibly update the recipient's name
- Once the appropriate corrections to the name have been made, re-bill with the corrected information

# Common Denials

230

Service not covered  
for this recipient

## Corrective Action

- Verify Medicaid eligibility for this recipient in the Healthcare Portal

# Common Denial

300

Claim Denied,  
Research Indicates  
Incorrect Billing

- EOB 300 Claim Denied, Research Indicates Incorrect Billing if the claim dates of service that are approved to pay do not match the dates of service on the claim

# Common Denial

408

Please Bill Other  
Insurance Carrier

- Claims will deny with EOB 408 if you are submitting for days that members with Medicaid Expansion or Rhody Health Partners plan are primary
- If the members has CMS Demo (Integrity)
- EOB 300 Claim Denied, Research Indicates Incorrect Billing if the claim dates of service that are approved to pay do not match the dates of service on the claim

# Common Denials

626/631

No Long-Term Care  
on file for date of  
service

## Corrective Action

- Validate LTC eligibility in the Healthcare Portal for stays 30+ days
- If no eligibility is found for LTC, contact your LTC worker
- If eligibility is found, validate that it is correct
  - Note: This denial may have occurred due to the claim being processed prior to the eligibility being updated
- Once any corrections are made, submit a new claim

# Common Denials

945

Attending Provider  
Missing/Not Enrolled  
or Same as Billing

## Corrective Action

- The attending provider's NPI is a required field on a nursing home claim
  - For electronic claims 837I, the attending is sent in loop 2310A
  - For UB04 paper claims, Field 76 should contain NPI, Last Name and First Name. The corresponding taxonomy should be in Field 81CC row A with a preceding qualifier of B3
- Validate that the attending is enrolled as a RI Medicaid Provider either as a billing provider or as an Ordering, Prescribing, Referring physician
- The attending's NPI on the claim must be the NPI of the individual and cannot be a group NPI
- Once corrections are made, submit a new claim

# Common Denials

633  
Gap in Billed Days

All approved days are not accounted for in the  
billing

## Corrective Action

- Validate LTC segment for the month you are billing on the Healthcare portal
- If eligibility is for the whole month and you are only billing a portion, did the member discharge to the hospital for 30 days or less:
  - If so, use revenue code 0160 for the first claim back to the same facility using the appropriate type of bill
- If the segment is for the entire month and the member did not discharge:
  - Are you submitting a claim for the entire month
  - Use a 210 type of bill if you are not expecting payment for a portion of the stay
- Submit new claims including all dates of service for the month

# Common Denials

682

PASRR Flag “N” Non-compliant

## Corrective Action

- PASRR (Pre-Admission Screening and Resident Review) requirements is mandatory for all admissions to a Medicaid Certified nursing facility
- If a PASRR flag is “N” (no) this indicates the assessment was missed, incomplete, or done incorrectly complete screening immediately
- Contact DHS to update the long-term care segment with PASRR flag of “Y” (yes) if completed

# Example of 633- Gap in Billed Days

DOS billed 01/15/23-01/31/23 – type of bill is a 253

LTC eligibility on the Healthcare Portal shows recipient has a LTC segment for 01/01/23-01/31/23 (full month)

If LTC eligibility is correct, and you are only looking for coins days or Medicaid days for 01/15/23-01/31/23, then you must submit a claim for:

01/01/23-01/14/23 as a 210 type of bill (no pay)

A second claim for 01/15/23-01/31/23 as a 253

If LTC eligibility is not correct and the recipient should not be eligible until 01/15/23

Contact your LTC worker so they can update the eligibility

Once that is completed, you can submit a new claim

## Discharges to hospital 30 days or less with LTC

- ▶ Members have long term care approval in place
- ▶ Hospital admission is for 30 days or less
- ▶ Readmission is back to the same facility that they were discharged from
- ▶ Do not submit a discharge and admit slip in CSM
- ▶ Submit bill type 263, 210, 253 based on the members skill level with a **revenue code of 0160** when submitting the first claim back to the same facility
- ▶ Important: If a member discharges to the hospital for more than 30 days, then it is required that you submit both discharge and admission slips

Example:  
Discharges  
to hospital  
30 days or  
less

Member discharges to the hospital on 2/10/23 and returns to the same facility after a 10-day inpatient stay

- Submit a claim (263,253,210) based on their skill level for 2/1/23-2/10/23 with a patient status 02 (discharged to Hospital).
- Member then returns to the same facility on 2/19/23
  - Submit a nursing home bill type based on their skill level for 2/19/23-2/28/23 with revenue code 0160.
- Do not submit a discharge and admit slip in CSM

Important: If a member discharges to the hospital for more than 30 days, then it is required that you submit discharge and admission slips and then bill using revenue code 0100

# Adjustments and Recoups

If date of service is within 365 days (1 year), submit electronically

If date of service is over 365 days (1 year), they **MUST** be submitted on a paper adjustment form and not on a claim form

Adjustments and recoups submitted on paper can take up to two NH adjustment cycles to process. Once submitted, please allow sufficient time for processing

Adjustments and recoups submitted on paper should be sent to the address on the form, not to your provider representative's attention

If submitted electronically, processing is much quicker

# Adjustments and Recoups - *continued*

## Recipient Liability

- Recipient liability adjustments will be done automatically if the claim submitted was for an entire month (example: 01/01/23-01/31/23)
- Liability adjustments will happen on the NH adjustment financial (usually the 2<sup>nd</sup> financial of the month), the month following when the update was made
- If claim was for entire month, you do NOT have to send in a request to have the claim reprocessed
- If a claim was not billed for entire month as one claim type (01/01/23-01/10/23 & 01/11/23-01/31/23), you must submit an adjustment request
  - If claim is within 1 year old, you can do electronically.
  - If over 1 year old, must be completed on paper adjustment form

# Adjustments and Recoups - *continued*

## Split Billing of Claims

Some situations require one claim to be divided into 2 claims  
Example: Recipient is skilled 10/01/25-10/31/25  
Claim was billed and paid 10/01/25-10/31/25 as 253 (co-insurance)

Claim should have been billed  
as 210 from 10/01/25-10/10/25 (Medicare free days)  
And then as a 253 10/11/25-10/31/25  
You can submit  
An adjustment to change the paid 253 claim to dates of service  
10/11/25-10/31/25,  
Then you must submit a new claim for 10/01/25-10/10/25  
as a bill type 210

Adjustments can only be processed on PAID claims  
The adjustment form should not be used for “appeals”

# Refunds

Preferred method to refund money is to process appropriate adjustment to the paid claim

If that is not possible and you must submit a refund,  
please use the “refund log” found at:

[http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/refund\\_log.pdf](http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/refund_log.pdf)

You must submit the following information:

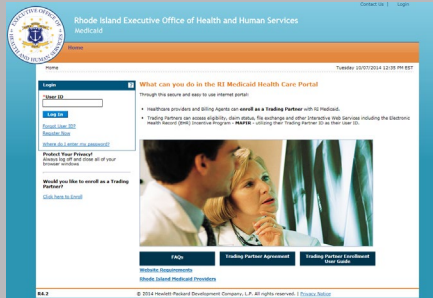
Name	Refund Amount
MID	Any comments
ICN	Check for payment
DOS	
RA Date	

# Provider Responsibilities

- Check recipient eligibility on the first of every month including other insurance
- Important: Check SSN and Date of Birth to make sure this information matches what you have on file
- Stay current with RI Medicaid and CMS initiatives
- Renew license yearly with DOH
- Provide the new license number to RI Medicaid Provider Enrollment if the license number changes
- Claim submission by deadline every month
  - (Generally, on a Thursday at noon)
- Use the website [www.eohhs.ri.gov](http://www.eohhs.ri.gov) to stay up to date on:
  - Provider Revalidation, Provider Electronic Solutions (PES) Upgrades, monthly *Provider Updates*, etc..
- Download Remittance Advices EVERY financial
  - (Only 4 most current are available for download)

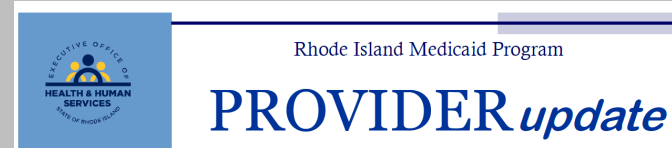
## Healthcare Portal

<https://riproviderportal.org>



## PAYMENT AND PROCESSING SCHEDULE

[Billing And Claims | Executive Office of Health and Human Services \(ri.gov\)](#)



PROVIDER UPDATES – posted monthly on the 1<sup>st</sup> of every month

<http://www.eohhs.ri.gov/News/ProviderNewsUpdates.aspx>

*To receive the Provider Update electronically, send an email to [riproviderservices@gainwelltechnologies.com](mailto:riproviderservices@gainwelltechnologies.com). Put **subscribe** in the subject line of your email and include your NPI.*

# Contact Information

Customer Service Help Desk	First line of contact for eligibility or claims inquiry that you could not determine after consulting the website.	401-784-8100 (For local and long-distance calls) 800-964-6211 (in-state toll calls)
Marlene Lamoureux	Provider Representative	571-895-4938 <a href="mailto:Marlene.Lamoureux@gainwelltechnologies.com">Marlene.Lamoureux@gainwelltechnologies.com</a>
Kelly Leighton	Provider Services Manager	571-348-5975 <a href="mailto:kelly.leighton@gainwelltechnologies.com">kelly.leighton@gainwelltechnologies.com</a>
EDI Questions	EDI department	<a href="mailto:riediservices@gainwelltechnologies.com">riediservices@gainwelltechnologies.com</a>
CSM	Password Resets	<a href="mailto:Rixix-ticket-systems@gainwelltechnologies.com">Rixix-ticket-systems@gainwelltechnologies.com</a>
DHS	LTC Eligibility Issues	Help Line 401-574-8474 <a href="mailto:Dhs.NusingHomeInquiries@dhs.ri.gov">Dhs.NusingHomeInquiries@dhs.ri.gov</a>
OHHS LTSS Escalation Team	Eligibility Issues greater than 1 Year old	<a href="mailto:OHHS.LTSSEcalation@ohhs.ri.gov">OHHS.LTSSEcalation@ohhs.ri.gov</a>



Questions