



gainwell

RI Medicaid

Provider Reference Manual

General Guidelines

Version 1.5
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Revision History

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1.1	November, 2015	All sections	HPE changes
1.2	January 14, 2016	Provider enrollment, Record Retention, Prior Authorization, Covered Services, Medical Necessity, Investigative/Experimental procedures, Ordering, Prescribing, Referring Provider	Updated information
1.3	June, 2017	All	DXC conversion
1.4	August, 2017	Enrollment	Clarification of enrollment effective date
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INTRODUCTION

The Rhode Island Executive Office of Health and Human Services (EOHHS), in conjunction with Gainwell Technologies, developed provider reference manuals for all Medicaid Providers. The purpose of this guide is to assist Medicaid providers with general Medicaid policy, coverage information and claim reimbursement applicable for all providers. Information pertaining to individual provider types is found in the more specific provider manuals. The Gainwell Technologies Customer Service Help Desk is also available to answer questions not covered in these manuals.

Gainwell Technologies can be reached by calling:

- 1-401-784-8100 for local and long distance calls
- 1-800-964-6211 for in-state toll calls or border community calls

ENROLLMENT

For participation and recertification guidelines for specific provider programs and service types, please refer to the provider manual for that program or service type. The following enrollment guidelines are general in nature, and apply to all providers.

Provider Enrollment

Gainwell Technologies is the fiscal agent for EOHHS and the Medicaid Program, and as the fiscal agent is responsible for enrollment, claims processing and reconciliation.

Providers must complete the enrollment process before claims are accepted. Information on enrollment is found on the [EOHHS](#) website. From the *Providers and Partners* dropdown, select [Provider Enrollment](#).

Providers enroll electronically through the [Healthcare Portal](#). Instructions for completing the online application can be found on the Healthcare Portal homepage, on the *Enrollment User Guide* tab.

Enrollment Effective Date

Retroactive enrollment date is limited to the first day of the month in which the enrollment application is approved.

Trading Partner Agreement

A Trading Partner Agreement is required to access the secured portion of the EOHHS website. Providers must complete an Electronic Data Interchange (EDI) Trading Partner Agreement (TPA). Trading Partner enrollment allows access to the following:

- Electronic submission of claims
- Eligibility verification
- Claims status

- Access to Remittance Advice documents
- Third Party Liability and Prior Authorization information

Enrollment as a Trading Partner

New providers, and providers needing to re-enroll as a Trading Partner, must enroll as a Trading Partner in the [RI Medicaid Healthcare Portal](#). Select the Trading Partner enrollment link from the homepage to complete the online Trading Partner enrollment application. After successful completion, a Trading Partner number is assigned. This number is then used to register in the [Healthcare Portal](#). Instructions for enrollment and registration are found on the [Healthcare Portal resource page](#).

Registration in the Healthcare Portal

Once a Trading Partner number is obtained, that number must be used to register in the Healthcare Portal. Registration is required before any electronic services can be accessed.

From the homepage of the [RI Medicaid Healthcare Portal](#), select the *Register Now* link and follow the online instructions. For additional help, a user guide and a quick reference troubleshooting guide are available on the [Healthcare Portal resource page](#).

Eligibility Verification and Claim Search Functions

Once registered in the Healthcare Portal, Trading Partners must login to the [RI Medicaid Healthcare Portal](#) with their identification number and password. Once logged into the portal, the Trading Partner must select *My Profile*, and scroll down to the *Roles* section of the page and select the *Add Role* button. After entering the requested information, access to the eligibility verification and search claims functions will be enabled. Step by step instructions are available in the first section of the [Quick Reference Guide](#).

Record Retention

Providers agree to maintain, for a minimum of ten (10) calendar years after the year of service, information and records necessary to determine the nature and extent of services rendered under the RI Medicaid Program and furnish them in the State of Rhode Island upon request by the Secretary of the Executive Office of Health and Human Services (EOHHS), the RI Medicaid Program, and to the Department of Attorney General Medicaid Fraud Control Unit.

ELIGIBILITY

Benefit Category

For payment to be made by the RI Medicaid Program, a beneficiary must be eligible on the date of service. It is the provider's responsibility to confirm the beneficiary's eligibility on the date the order is received and on the date of service. Beneficiary eligibility can be verified on the RI Medicaid Healthcare Portal.

Trading Partners may verify the eligibility of beneficiaries, by selecting the *eligibility tab* on the orange tool bar in the [RI Medicaid Healthcare Portal](#). The beneficiary's Medicaid ID number is required to perform an eligibility search.

The RI Medicaid Program provides coverage for necessary medical services to beneficiaries who are Categorically Needy or Medically Needy. Both provide the same level of coverage, but the method of qualification is different.

Categorically Needy are those adults, families, pregnant women, and children who qualify based on income level, as well as those receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program, and the SSI program for the Aged, Blind or Disabled.

Medically Needy are those beneficiaries whose income or resources disqualify them for coverage, but qualify when a flexible test of income applies excess income to certain allowable medical expenses. This enables the individual to “spend down” to within a medically needy income limit (MNIL) established by the Medicaid agency.

Procedures billed retrospectively for beneficiaries who have retroactive eligibility are valid if all conditions for billing are met.

Prior Authorization

Prior Authorization (PA) is required for specific procedures, services, and equipment as identified by the RI Medicaid Program. The request for Prior Authorization is initiated by the provider. Upon completion of the review, Prior Authorization status is available in the Healthcare Portal. Written notification of denials and incomplete requests are returned to the provider. See specific provider manual for more information. Prior Authorization is not a guarantee of payment. Payment is subject to all general conditions of RI Medicaid, including beneficiary eligibility, other insurance and program restrictions.

Retroactive authorization is required in the following instances:

- Retroactive eligibility
- Primary payer benefits exhausted
- Primary payer recoupment

Third Party Liability (TPL)

RI Medicaid is the payer of last resort. All third party programs must be utilized before any payment can be made by RI Medicaid. If payment from other third parties is equal to or exceeds the RI Medicaid allowable amount, no payment will be made on the claim by RI Medicaid. RI Medicaid is considered payment in full. The provider is not allowed to bill the recipient for any additional charges not paid for by RI Medicaid

To determine primary coverage, providers should obtain information from the beneficiary at the time service is requested. A provider could also verify third party coverage through the Healthcare Portal, using the eligibility verification function. After exhausting all third party resources, the following information is required to appear on all claims billed to the Medicaid Program:

- Other insurance carrier name
- Policy number
- EOB (with explanation page if separate) from primary carrier if billed on paper
- Applicable TPL carrier code ([found on EOHHS website](#))
- Payment amount from the other insurance, as well as copay, co-insurance, and deductible.

The Medicaid Program is not liable for payment of services that would have been reimbursable by the private payer if applicable rules of that private plan had been followed. The beneficiary must seek care from network providers and authorizations or referrals must be obtained as required. If the provider does not participate with the commercial carrier, the provider is expected to refer the beneficiary to a participating provider.

CLAIMS PROCESSING

For claims processing details for specific provider programs and service types, please refer to the provider manual for that program or service type. Claims may only be submitted for services after the delivery of the service.

Covered and Non-covered Services

Covered services are listed in the Provider Manuals. Some services are subject to frequency limitations.

Providers are required to consult the appropriate provider manual for covered services and frequency limitations.

Electronic Claims Processing

Electronic submission of claims is the preferred method to expedite claims processing. Electronic claims offer:

- Cost savings
- Faster turnaround time
- Free Provider Electronic Solutions (PES) software for billing
- No original signature required
- Quicker corrections
- Quicker reimbursements

All Medicaid providers must utilize HIPAA compliant software to submit claims electronically. Providers in Rhode Island may use Gainwell Technologies free software, Provider Electronic Solutions (PES), or software that has completed HIPAA compliance testing with Gainwell Technologies.

Provider Electronic Solutions Software (PES)

Free software is available for providers to submit claims electronically. [Provider Electronic Solutions software \(PES\)](#) is available to support your HIPAA compliant electronic billing needs and may be downloaded from the website. Electronic submission of claims ensures faster turnaround time, which increases payment to your office based on the validity of your submission.

Point of Service

Pharmacy claims are submitted POS, using NCPDP D.0 standards only. Pharmacy claims cannot be submitted using PES or paper.

Testing Claim Submission

Trading Partners who wish to test electronic claim submission with RI Medicaid should send a testing request to: riediservices@dxc.com.

Paper Claim Submission

There may be instances when it is necessary to submit a claim on a paper claim form. For sample claim forms and instructions for completion, please visit the [Forms and Applications](#) page of the EOHHS website.

Remittance Advice Document

Remittance Advice (RA) documents are available to review the status of claims submitted to RI Medicaid. Remittance Advice documents are accessed electronically through the [Healthcare Portal](#). Trading Partners can access the last four remittance advice documents. Once a new one is produced, the oldest one is no longer available. Trading Partners are encouraged to download or print these documents as soon as they become available to ensure access to this important information. The Payment and Processing Schedule for claims can be found on the [Billing and Claims](#) page of the [EOHHS website](#)

The first page of the RA contains important messages and updates for Trading Partners. For assistance in reading the document, visit [Billing 101: Understanding Remittance Advice](#).

Reprocessing of Claims

At times, claims may need to be reprocessed. Adjustments may be requested on paid or partially paid claims. Recoupments are necessary when the full amount paid needs to be recouped. Recoupments are deducted from the next Medicaid payment to the provider. Refunds are made by sending checks payable to the State of Rhode Island. For detailed information, visit [Billing 101: Adjustments, Recoupments and Refunds](#).

Medical Necessity

The RI Medicaid Program provides payment for covered services only when the services are determined to be medically necessary. The term “medical necessity” or “medically necessary service” means medical, surgical, or other services required for the prevention, diagnosis, cure or treatment of a health related condition including such services necessary to prevent a decremental change in either medical or mental health status.

Medically necessary services must be provided in the most cost effective and appropriate setting and shall not be provided solely for the convenience of the beneficiary, caretaker, or service provider.

Determinations of Medical Necessity

Determinations that a service or procedure is medically necessary are made by the staff, consultants and designees of the RI Medicaid Program, and also by individuals and organizations under contract to EOHHS.

Certificate of Medical Necessity

A Certificate of Medical Necessity is required for all services covered under this program. This form must be completed and signed by the prescribing prescriber. An actual signature must be present on this form. Rubber stamps or facsimiles are not allowed.

A Certificate of Medical Necessity is valid for 12 months from the date of issue.

Approval of Medical Necessity

The RI Medicaid program and its designees determine which services are medically necessary on a case-by-case basis, both in pre-payment and post-payment reviews, and via prior authorizations. Such determinations are the judgment of the RI Medicaid program. The prescription or recommendation of a physician or other service provider of medical services is required for a determination of medical necessity to be made, but such prescription or recommendation does not mean that the RI Medicaid program will determine the provider’s recommendation to be medically necessary. The RI Medicaid program is the final arbiter of determination of medical necessity.

Denial of Medical Necessity

When the RI Medicaid Program is requested to pay directly (fee-for-service) for a particular service for a beneficiary who has other third party coverage (such as Medicare or Blue Cross), for that particular service, if the third party denies payment for services based on medical necessity, this determination is adopted by the RI Medicaid Program. An independent determination of medical necessity is not made in such circumstances. For example, if federal Medicare determines that a home health service or DME item is not medically necessary, then that determination is binding on the RI Medicaid Program and payment for the service cannot be made.

Appeal of Denial of Medical Necessity

Determinations made by the RI Medicaid Program are subject to appeal by the beneficiary only. Providers may not appeal denials of medical necessity. Procedures are available for individuals who are aggrieved because of an agency decision or delay in making a decision of medical necessity. Please refer to the Medicaid Code of Administrative Rules, Section 0110: Complaints and Hearings.

Investigative/Experimental Medical Procedures

RI Medicaid does not cover experimental or investigational medical and surgical procedures, equipment, medications, or cosmetic procedures.

RI Medicaid does not cover FDA Category A or B devices or equipment.

Medical devices not approved by the FDA are considered investigational and are not covered by RI Medicaid.

The RI Medicaid Program determines whether a treatment, procedure, facility, equipment, drug or supply is experimental or investigational.

Charging Medicaid Beneficiaries

Unless otherwise stipulated, the Medicaid Program reimbursement is considered payment in full. The provider is not permitted to seek further payment from the beneficiary in excess of the Medicaid Program rate. This includes the billing of a beneficiary resulting from a denied claim for any reason other than eligibility. In general, beneficiaries of RI Medicaid cannot be billed for any covered service or missed appointment.

Medicare/Medicaid Crossover

The Medicaid Program reimbursement for crossover claims is always capped by the established Medicaid Program allowed amount, regardless of coinsurance or deductible amounts. This includes Medicare replacement policies.

Professional Crossovers

The Medicaid Program will pay the lesser of:

- The difference between the Medicaid Program allowed amount and the Medicare Payment (Medicaid Program allowed minus Medicare paid); or
- The Medicare coinsurance and deductible up to the Medicaid Program allowed amount

Institutional Claims

The Medicaid Program will pay:

- The provider's Ratio of Cost to Charges (RCC) percentage times the Medicare coinsurance and deductible.

Pharmacy Claims

The only claims that are covered are the Part D excluded drugs. Medicaid does not wrap co-payments or co-insurance for Medicare.

Other Insurance - Co-insurance, Deductible, and Co-payments

Medicaid Program beneficiaries who have other insurance may have a co-insurance, deductible, and/or co-payment liability amount that must be met. The other insurance carrier must be billed first, then the provider must submit the appropriate claim adjustment reason codes from the other carrier's EOB for electronic claims. Claims submitted on paper must include the other carrier's EOB. If the other insurance has paid for the service, the Medicaid Program will pay any co-insurance, deductible, and in some instances co-payment as long as the total amount paid by the other insurance does not exceed the Medicaid Program allowed amount(s) for the service(s). If the other insurer paid more than the Medicaid allowed amount, the claim will be paid at zero and is considered payment in full

Rlte Share

Rlte Share Premium Assistance Program subsidizes the costs of enrolling Medicaid eligible individuals and families in employer sponsored health insurance (ESI) plans that have been approved as meeting certain cost and coverage requirements.

RI Medicaid pays the ESI premium the policy holder must pay to the employer for his or her own individual coverage and for family/dependent coverage. Medicaid members enrolled in ESI are not obligated to pay any cost-sharing that is not otherwise applicable to Medicaid. The Medicaid agency pays for any ESI co-insurance and deductibles in such instances. Co-pays are not covered by the Medicaid agency, but Rlte Share enrollees are not required to pay co-payments to Medicaid certified providers.

The healthcare provider may not bill the Rlte Share member for any cost-sharing required by the ESI, including co-payments. Services and benefits that are covered by Medicaid, but are not offered through the ESI plan, are made available through the Medicaid program. Wrap-around services/coverage ensures that Rlte Share enrollees receive health coverage comparable in scope, amount and duration to Medicaid members enrolled in Rlte Care or Rhody Health Partners. Medicaid covers these services for Medicaid members participating in Rlte Share enrollees when using Medicaid providers. The rules of the primary payer must be followed before Medicaid

will process/reimburse claims for RIte Share members including using in-network providers.

Ordering, Prescribing and Referring Providers

The Affordable Care Act requires physicians or other eligible practitioners to be enrolled in the Medicaid program to order, prescribe, and refer items or services for Medicaid beneficiaries, even if they do not submit claims to Medicaid.

Providers who must include the referring provider's information include inpatient, outpatient (excluding clinic and ER visits, and observation), pharmacy, psychiatric hospital, skilled home health, radiology, laboratory, DME, chiropractor, dialysis, ambulatory surgical centers, and hospice.

It is the responsibility of the RI Medicaid provider rendering the service to obtain the NPI of the Ordering, Prescribing, Referring provider (OPR) and to confirm that the OPR provider is enrolled in the RI Medicaid program.

Claims submitted without the OPR information will deny due to missing information. Claims with complete information that are processed and paid, will be subject to a post claim review. If it is determined that the OPR provider is not enrolled as a RI Medicaid provider, the claim may be recouped.

The OPR requirement also applies to the submission of prior authorization requests. Prior Authorization request forms must contain the Ordering, Prescribing, or Referring provider's information. If a prior authorization request is submitted without the OPR information or if the OPR provider is not enrolled in the RI Medicaid Program, the prior authorization form will be returned to the billing provider.

Timely Filing Requirements

A claim for services provided to a Medicaid client, with no other health insurance, has to be received by the States' fiscal agent, Gainwell Technologies within 365 days of the date of service. If the claim is over a year old then a list of the criteria to bypass timely filing is as follows:

- Retroactive client eligibility (within the previous 90 days)
- Retroactive provider enrollment (within the previous 90 days)
- Previous denial from Medicaid (other than a timely filing denial) within the previous 90 days
- Gainwell Technologies processing error within the previous 90 days
- Recoupment of a claim within the previous 90 days. Please note that a recoupment of claims greater than 365 days are not allowed when a new claim will be submitted for increased reimbursement, unless there is a primary payer EOB dated within 90 days.

- Adjustments to a paid claim, over a year old, will be accepted up to 90 days from the remittance advice date that the original claim payment was posted. Adjustments for claims over one year old, cannot be adjusted to pay at a higher amount than originally paid.
- Prior Authorization or TPL updates within 90 days.

Claims with a date of service over one year that meet any of the above criteria must be submitted within ninety (90) days from the remittance advice date and/or PA or TPL update. Any claim appeal that does not meet these criteria will be denied for timely filing.

Claims with a date of service over one year with an involved third party payer (insurance) must be submitted within ninety (90) days of the payer's valid Explanation of Benefits (EOB) date. Denials for timely filing or failure to comply with the primary payer rules are not included in this exception.

Any claim with a service date over one year and an EOB date from another payer over 90 days will be denied for timely filing. Claims over 1 year old that meet the timely filing criteria must be sent to the Provider Representative for handling.

Services and Utilization Reviews

Medicaid, in the process of utilization review and/or in determining its responsibility for payment of services, may request the treating provider to submit appropriate diagnostic imaging and/or other clinical information, which justifies the treatment to the Medicaid Program. Payment may be denied if the requested diagnostic imaging and/or other clinical information are not submitted.