



Rhode Island Medicaid Program

PROVIDER *update*

Volume 320

September 2019

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Provider Update, you will also
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the services you provide.



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**Provider
Revalidation is
Around the Corner!**



For quick access to an article, click on the title.

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



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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 the 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.

Process to Request Nursing Home Level of Care (LOC)

LOC packets must be sent to DHS along with the Medical Assistance application to the LTSS UNIT, P.O. Box 8709, Cranston, RI 02920. The information will be scanned into the eligibility system, RI Bridges, and will generate a “task” to the Office of Medical Review (OMR) RN to conduct a LOC review. If additional information is needed, the OMR RN will request that information from the nursing facility. Only then should information be sent directly to the OMR (via fax - (401) 462-3496). Sending documents to the OMR (unless specifically requested), as opposed to the LTSS Unit PO Box, may cause delays in the application process and will be returned to the facility.

The Nursing Home Level of Care medical packet consists of the following:

- GW-OMR-PM I - Provider Medical Statement
- AP-70.I - RI DHS Social Worker’s Evaluation for Care in a Nursing or Intermediate Care Facility
- MA/PAS-I – RI DHS Level I Identification for MI and DD, ID Screen
- Any other information to support a level of care.

Please remember to sign and date forms and include any attachments referenced. Please note that ICD codes cannot be substituted for diagnosis on provider medicals.

PASRR - Level I Screen

It is mandatory for a nursing facility that receives federal dollars, regardless of a patient’s insurance, to conduct a Level I PASRR screening either before or on the day of admission. This document must be signed and dated. Please review the ID Screen to ensure that all information is accurate.

Please note that if a PASRR has not been submitted, the nursing facility will not be eligible for payment (due to PASRR Non-Compliance) and cannot bill the client or their family for those dates of service. In those instances, please contact BHDDH for a Resident Review. Payment will be allowed from the date the Resident Review is scheduled. If the ID screen indicates a 30-day exemption, and the client’s stay is over 30 days, a Resident Review will be required and should be requested directly from BHDDH.

ATTENTION DME PROVIDERS:

Effective 8/1/19, the following item-specific Certificates of Medical Necessity (CMNs) have been revised and are available on the [EOHHS website](#) under [Forms and Applications](#):

Diabetic Shoes
Disposable Gloves
Enteral and Parenteral Nutrition
Hearing Aids
Hospital Beds
External Infusion Pumps
Support Surfaces

The existing Coverage Guidelines for these items have not changed. The formatting of the CMNs has been updated to ensure uniformity. Please discard any old versions and use the revised CMNs going forward.

Info re: Naloxone Rx Policy

Effective **1/28/2019**, providers can dispense naloxone injection or inhaler from a physician's office without the need for the recipient to go to the pharmacy to pick up the drug. The prescribing/dispensing physician will submit the claim for the ingredient cost of the drug including the NDC.

In order to receive reimbursement, providers will bill using J2310 (Injection, naloxone HCl, per 1mg) along with the appropriate package NDC. For additional guidance on J Code/NDC billing please refer to [Medicaid's CMS 1500 instructions](#) on the EOHHS website.

*Note: Evisio™ is not covered.



RI Medicaid Annual Plan Change Opportunity

RI Medicaid is holding an Annual Plan Change Opportunity from September 3, 2019 through October 31, 2019 for currently enrolled members of Rlte Care, Rhody Health Partners and Medicaid Expansion. Letters will be mailed to beneficiaries announcing the option to change health plans starting in late August.

Letters will be mailed to members in 5 mailing waves beginning the last week of August and continuing through October. Members will have until October 31st to request a change in health plan. It is important for members to know:

- All health plans offer the same benefits and are all highly rated Medicaid plans.
- If they want to change plans, they should check to be sure that their family's doctors are in the plan and that the plan covers their medications. Members should call the health plan or go to the plan's website for more information.
- All Rlte Care members must choose the same health plan for all family members. Members in Rhody Health Partners and Medicaid Expansion may select their own health plan.

If a member is happy with their current plan, they do not have to do anything. No change will be made. If a member would like to change plans, they can contact HealthSource RI at 1-855-840-4774 to request the change, or complete the form enclosed with the letter and mail back to RI Medicaid.

Members who lose their form, or do not receive a letter, may download one from the EOHHS website at <http://www.eohhs.ri.gov/Home/PlanChange.aspx>

It may take up to 8 weeks for the change to be effective. Members will receive a welcome packet from the new health plan, as well as a new ID card.

Providers are reminded to ask members to show their health plan identification cards prior to delivering services. This will prevent billing the wrong health plan and delays in payment. Members will be able to select from three health plans for their Medicaid coverage:



1-401-459-6020 or 1-800-459-6019
nhpri.org



1-866-738-4116
www.ritogether.com



1-800-587-5187
UHCCommunityPlan.com

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: September 10, 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: September 10, 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

Calculating Total Daily Dose of Opioids for Safer Dosage Developed by the CDC:

[https://www.cdc.gov/drugoverdose/pdf/
calculating_total_daily_dose-a.pdf](https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf)



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 is Around the Corner!

What's Changed?

Have you moved, engaged a new billing service or had another change in the information on file with RI Medicaid? We want to know!

To report a change of pay to, mail to or service location address please complete the Provider Change of Information Form found [here](#) on the EOHHS website and submit per the instructions at the bottom of the form.

This same form may also be used to report a change in ownership, changes to certifications, notification of adverse action to license and notice of bankruptcy filing.

With the first wave of provider revalidation happening this fall, it's crucial that RI Medicaid have the most current information on file for providers.

If you have questions, please contact the Customer Service Help Desk at 401-784-8100 or 800-964-6211 for instate toll calls.



NEW VIDEO

ADD A DESIGNEE TO YOUR CURRENTCARE FOR ME ACCOUNT

Now that you've seen our [How to Enroll in CurrentCare](#) video, you can now add a designee to your CurrentCare for Me account. A designee is someone you assign access to your account – a friend, family member, or caregiver – in case of emergency. Check out [this quick video](#) to learn how to add a designee.

Watch Now



Skilled Home Care Rate Increases

EOHHS is implementing a rate increase for skilled home care services with an effective date of service as 7/1/2019. Please begin billing with these rates in order to be reimbursed at the higher rates.

Description	Procedure Code	7/1/19
Home Health Aide	G0156	\$7.12
RN, PT, OT and ST per visit	X0043	\$108.15

There will be a mass adjustment retro to 7/1/2019. Details of the adjustments are still being worked out. A follow-up communication will be sent out once we have a Remittance Advice date on which you can expect to see these adjustments.

Pediatric and Adult Home Care Rate Increases

EOHHS has implemented rate increases for non-skilled home care services. Please be on the lookout for an email notification containing the specific rate increases after the changes go into effect. There will be a mass adjustment for these claims retro to 7/1/2019. More details will be available in the near-future.

Hospice Rate Increases

EOHHS is implementing a rate increase for hospice services. Please see the below hospice rate increases that are effective for dates of service 7/1/19 ongoing.

Please begin billing with these rates in order to be reimbursed at the higher rates.

There will be a mass adjustment retro to 7/1/2019. Details of the mass adjustment are forthcoming. Please be on the lookout for an email notification regarding the date on which you can expect to see this information reflected in Remittance Advice.

Description	Procedure Code	Effective Date
		7/1/19
Home care by clinical social worker in home health or hospice setting - Continuous Care	G0155	\$12.61
Direct Skilled Nursing services of a registered nurse in the home health or hospice setting - continuous care	G0299	\$13.42
Routine Home Care: 1 - 60 days	T2042	\$239.05
Routine Home Care: >60 days	T2042	\$187.75
Continuous Home Care Per Hour	T2043	\$50.40
Inpatient Respite Per Day	T2044	\$225.22
General Inpatient Care	T2045	\$920.81

New 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.

Attention RI Medicaid Home Care Providers:

There will be an automated process to extend home care prior authorizations (PAs) for those members with existing PAs and have current eligibility in one of the following waivers:

- Core Community Services
- Preventative Services
- Habilitation Community Services
- DEA Waiver

Prior Authorizations for both DEA and DHS cases that are scheduled to end in thirty (30) days will be automatically extended for twelve (12) months from the end date of the member's most current PA.

Prior Authorizations will not be automatically extended if a member has experienced a change in eligibility from one waiver to another after the PA was initially added. For example, if the member had an active Preventive Services waiver at the time the initial PA was added, and then the member's waiver eligibility was changed to Core Community Services between the time the PA was entered and the time it is due to expire. Because this is a different waiver than what it was when the PA was initially added, this PA will not be auto-extended.

Prior Authorizations for members who have been enrolled into Nursing Homes, Shared Living Facilities, Assisted Living and Managed Care (Rite Care/Integrity/Pace) will not be auto-extended. Recipients who are now deceased will have their existing PAs end-dated to the member's date of death minus 1 day.