Rhode Island Medicaid Program

September 2021

Provider Update

See page 2 for Table of Contents.

SUBSCRIBE

To Subscribe
or update your email address
Send an email to:
riproviderservices@dxc.com
or click the subscribe button above.
Please include your National Provider Identifier (NPI) and the primary type of services you provide.

Please put "Subscribe" in the subject line of your email.

In addition to the *Provider Update,* you will also receive any updates that relate to the services you provide.

State offices will be closed in observance of the following Holidays in 2021.

Holiday	Date
Labor Day	Monday, September 6
Columbus Day	Monday, October 11
Veterans' Day	Thursday, November 11
Thanksgiving Day	Thursday, November 25
Christmas Day	Saturday, December 25 (State Employees celebrate on Monday, December 27)

The RI Medicaid Customer Service Help Desk/Call Center will also be closed on the same days.

The RI Medicaid Health Care Portal (HCP) is available 24 hrs./7 days for Member Eligibility, Claim Status, View Remittance Advice and View Remittance Advice Payment Amount.

Click here for the HCP login page.

September 2021
Provider Update

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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RI Medicaid **Annual Plan Change** Opportunity

RI Medicaid is holding an Annual Plan Change Opportunity from September 7, 2021 through October 29, 2021 for currently enrolled members of RIte Care, Rhody Health Partners and Medicaid Expansion. Letters will be mailed to beneficiaries announcing the option to change health plans starting in early September.

Letters will be mailed to members in 5 mailing waves beginning the first week of September. Members will have until October 29th 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 RIte 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

tuftshealthplan.com/member/tufts-health-ritogether/home

1-800-587-5187

UHCCommunityPlan.com

Attention Nursing Home Providers

There will be a new billing process for members that have been released from a hospital setting and ***have not*** been determined eligible for Long Term Support Services. This new billing process will replace the existing one in place today of sending emails with an attached spreadsheet to Mary Ellen Jenkins at OHHS for nursing home stays that are 30 days or less.

Per EOHHS rule 210-RICR-50-00-1.7, Medicaid Long-Term Services and Supports Overview and Eligibility Pathways, Qualifying for Medicaid LTSS, states that, "With the enactment of the federal Affordable Care Act of 2010, federal law requires that Medicare, commercial health insurers, and group health plans provide as part of the primary care essential benefit package up to thirty (30) days of subacute and rehabilitative care for persons who have had an acute care incident requiring services in a health institution. Medicaid is also required to provide this benefit. Both existing beneficiaries and new applicants must have established a continuing need for LTSS -- that is, for an institutional level of care –to qualify for Medicaid LTSS once the thirty (30) days of essential benefit coverage is exhausted."

Members who require *Hospice services* must continue to go through the Long-Term Care Eligibility process and have LTC approval for claims to process.

There will be an additional communication sent out with information on how to sign up for a webinar on how to bill for this service. It is strongly recommended that you attend a webinar, as this is a different billing process then what you are accustomed to.

Some of what will be included in the webinar trainings are listed below:

1. Clients must have active Medicaid Eligibility
2. This billing process is for nursing home stays for 30 days or less with no long term care approval
3. Clients may have more than one consecutive 30-day period of Nursing Home services but there must be a gap between the "To" Date of service on the last bill and "From" Date of service on the new bill
4. New procedure code for S9976 "Lodging, Per Diem, Not Otherwise Classified"
5. This needs to be submitted as an 837 Professional Claim or Professional Cross Over claim
6. Clients may have a Patient Share on file, but it *will not* be automatically deducted for the 30-Day Nursing Home Services unless it is reported on the claim by the provider
7. A RUG Score must be on file for the recipient
8. If a member has primary insurance the claim must be submitted to the primary coverage and then submitted with the EOB to Medicaid
9. Claims submitted for CSM-Demo and PACE will be denied for Other Insurance.
10. This processing will not include 'Head on the Bed Logic' to ensure a client can receive 30 consecutive days of Nursing Home Services.

Please watch for an email with information on when the trainings are and how to sign up for the webinar.

Shared Living Rate Increase

Effective 7/1/2021, the shared Living procedure codes shown below have been increased by 10%. A mass adjustment of all previously submitted claims will be on the September 10, 2021 remittance advice. If you have any questions please contact Karen Murphy at karen.murphy3@gainwelltechnologies.com or (401) 784-8004.

Code	Description	Current Rate	New Rate – Eff.
S5136	Stipend, per diem, high LOC, client attended adult day	$32.30	$35.53
S5136TG	Stipend, per diem, highest LOC, attended adult day	$40.89	$44.98
S5136TGU1	Stipend, per diem, highest LOC, no adult day	$48.11	$52.92
S5136U1	Stipend, per diem, high LOC, no adult	$38.00	$41.80
S5136U1UN	Second participant stipend, per diem, high LOC, no	$28.50	$31.35
S5136UN	Second participant stipend, per diem, high LOC, client attended adult day	$24.23	$26.65
S5136TGUN	Second participant stipend, per diem, highest LOC,	$30.67	$33.74
S5136T-GU1UN	Second participant stipend, per diem, highest LOC, no adult day	$36.09	$39.70

Attention DME Providers:

Effective 9/1/21, Rhode Island Medicaid Fee-for-Service will be activating coverage for HCPCS code A9274 - EXTERNAL AMBULATORY INSULIN DELIVERY SYSTEM, DISPOSABLE, EACH, INCLUDES ALL SUPPLIES AND ACCESSORIES. This code will require prior authorization and the maximum units per month is 20. Coverage Guidelines can be found here: Coverage Guidelines For Durable Medical Equipment | Executive Office of Health and Human Services (ri.gov)

Attention Home Health Agencies

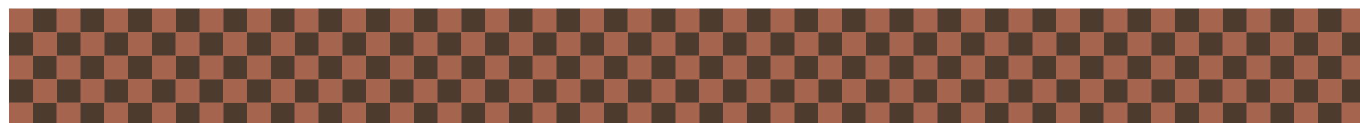
We are writing to inform you of two changes related to the authorization and payment of pediatric private duty nursing and certified nursing assistant services that will take effect on 07/01/2021.

Medicaid now has the ability to enter authorizations for CNA services (S5125) for children under twenty-one (21) and PDN services (T1000) for children under and over twenty-one (21) directly into the MMIS. The process will be as follows: We ask that you submit your prior authorization requests via secure email (for up to a 6 month timeframe, along with Home Health Certification and Plan of Care – Form 485), with a copy to the parents, to Mary-Ellen Jenkins (MaryEllen.Jenkins@ohhs.ri.gov) and Robin Etchingham (robin.etchingham@ohhs.ri.gov). Clinical Assessments will be conducted, when appropriate, and approved hours will be entered directly into the MMIS (Medicaid payment system) and available for you to view on the provider portal as you do today by selecting "Check Prior Authorization." The member will also need to show active eligibility for "Severely Disabled Home Care Services." We will also respond to your email indicating the hours that were approved for the specific time period so that both you and the child's parents are aware of the decision. Additionally, effective 07/01/2021, your agencies will be able to bill for PDN services for children over 21 directly through the system. These claims will no longer require the manual, off-line payment processing that exists today.

There are a few caveats to note:

- Severely Disabled Home Care Services members who turn 21 will have their CNA services authorized under the waiver program into which the child transitions, i.e., LTSS Core or the DD waiver.
- Severely Disabled Home Care Services prior authorizations for CNA services will end three months following the month of the enrolled member's twenty-first birthday.
- In the event CNA services are authorized under both Severely Disabled Home Care Services and the BHDDH waiver claims will be paid through the BHDDH waiver for the units authorized under the Debit Authorization only.
- If a member has dual enrollment in Severely Disabled Home Care Services and one of the following LTSS waivers: Core Community Services, DEA Waiver, Habilitation Community Services, and, if there are overlapping dates of service with prior authorizations under both enrollments, claims may process under both.
- Medicaid coverage of Adult PDN is limited to children enrolled in the Severely Disabled Home Care Services program as they transition to adulthood.
- PDN services will continue to be authorized by Medicaid, regardless of the program into which the child
- transitions.
- Ex., Severely Disabled Home Care program enrollees who age into the BHDDH/DD waiver will continue to get their PDN services authorized by Medicaid.
- We will enter all current authorizations for both PDN and CNA services into the MMIS prior to July 1st so that you can begin billing for these services for dates of service 7/1/2021 forward.
- Claims for dates of service prior to 7/1/2021 for clients over 21 years old for PDN services (T1000) will still require claims to be submitted on paper and paid as a "System Payout."

For general questions about the process, please contact lissa.dimauro@ohhs.ri.gov. For any billing questions unrelated to approval of eligibility and hours please contact Marlene.Lamoureux@Gainwelltechnologies.com. Thank you for your attention to this matter.



COVID-19 Vaccine Administration-3rd Dose

COVID-19 3rd dose administration codes have been approved effective August 1, 2021. Per CMS, the reimbursement will be the same as the existing Covid-19 vaccine administration codes which is $41.63.

0003A -ADM SARSCOV2 30MCG/0.3ML 3rd
(Pfizer-Biontech Covid-19 Vaccine Administration – Third Dose)

0013A-ADM SARSCOV2 100MCG/0.5ML 3rd
(Moderna Covid-19 Vaccine Administration – Third Dose)

Prior Authorization Requirements To Be Reinstated October 1, 2021

Prior Authorizations for all services except behavioral healthcare previously extended to June 30, 2021 will be extended through September 30, 2021. Effective October 1, 2021, prior authorization requirements will be reinstated for all services except for behavioral healthcare services. Effective January 1, 2022, prior authorizations will be reinstated for behavioral healthcare services. For those services that require a prior authorization, providers will need to proactively ensure that members' services are authorized prior to providing them. To review the list of services that require prior authorization, please see https://eohhs.ri.gov/providers-partners/billing-and-claims/prior-authorization .

Should you have questions please contact the Customer Service Help Desk at (401) 784-8100 for local and long-distance calls (800) 964-6211 for in-state toll calls.

Provider Enrollment Revalidation Requirements

Effective September 1, 2021, provider enrollment revalidation requirements will no longer be waived. Providers will now be expected to respond to enrollment revalidation information requests from Gainwell in a timely manner. As required per usual protocols that were in place prior to March 2020, providers will be required to return information to Gainwell within 35 days of a request. If you would like more information about this process, please visit https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/provider_revalidation.pdf .

HHS Announces Provider Relief Fund Reporting Update

The U.S. Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), is issuing new reporting requirements and announcing that it will be amending the reporting timeline for the Provider Relief Fund Program (PRF) due to the recent passage of the Coronavirus Response and Relief Supplemental Appropriations Act.

These reporting requirements will apply to providers who received the Medicaid PRF funds. The reporting requirements released today do not apply to funds from: Nursing Home Infection Control, Rural Health Clinics Testing, and COVID-19 Claims Reimbursement to Health Care Providers and Facilities for Testing, Treatment and Vaccine Administration for the Uninsured recipients.

Additionally, starting today, PRF recipients may begin registering for gateway access to the Reporting Portal where they will ultimately submit their information in compliance with the new reporting requirements HHS is issuing.

Read the full **press release** here [hhs.gov] [clicktime.symantec.com].

Learn more about the **reporting requirements** and new portal here [hhs.gov] ktime.symantec.com].

Pharmacy Spotlight

Treatment of Hepatitis C Prior Authorization Guidelines

Effective: August 1, 2021

Introduction:

Hepatitis C has been identified as a significant etiology of chronic liver disease, associated comorbidities, liver cancer, need for transplantation and death. These guidelines document eligible beneficiaries and the information that must be submitted in order to determine a coverage determination. Modifications to the Preferred Drug List require approval by the Rhode Island Medicaid Pharmacy and Therapeutics Committee.

Detailed prescribing and drug warning information may be obtained at:

http://www.fda.gov/Drugs/DrugSafety/ucm522932.htm

Prior Authorization is required for medications not on the Preferred Drug List.

General Approval Criteria:

A. Prescribers must be enrolled as a billing provider or an ordering, prescribing or referring (OPR) provider with Rhode Island Medicaid.

B. Beneficiaries:

i. All patients with documented Hepatitis C Stages 0 through 4 are eligible for treatment.

C. Required Documentation:

i. Prior Authorization is not required when prescribing Mavyret®.

ii. Prior Authorization is not required for prescribing Vosevi® when used as a salvage medication after prior treatment failure. See package insert for FDA approved indication, and prescribing information.

iii. Neither Mavyret® nor Vosevi® require genotyping.

iv. Treatment request for non-preferred medications require genotyping.

v. History of prior Hepatitis C treatment if relevant.

vi. Treatment plan which includes:

(continued)

Pharmacy Spotlight

Treatment of Hepatitis C Prior Authorization Guidelines

Effective: August 1, 2021 (continued)

Treatment plan which includes:

i. Medication name, dose and duration.

ii. Agreement to submit post treatment viral load data if requested.

D. Treatment recommendations as of August 1, 2021:

i. Preferred agents: Mavyret® and Vosevi®.

ii. Non preferred agents: all other agents with exception of ribavirin;

i. Will be approved if patient is completing a cycle of therapy initiated prior to current policy implementation date, or

ii. Will be reviewed on a case by case basis. The Prior Authorization request must include clinical documentation of need for an alternative, non-preferred agent.

E. Continuity of Treatment;

i. When transitioning between publicly funded delivery systems (i.e. between Fee for Service Medicaid and managed Care Medicaid, between managed Care Medicaid and Fee for Service Medicaid or between the Department of Corrections and the Medicaid Program) any medication approval by the prior delivery system will be honored for the portion of the treatment that remains after the transition.

F. Policy Effective Date: August 1, 2021.

i. Above policy replaces all prior Hepatitis C policies including revision with implementation date of March 1, 2021.

Approved:

Jerry Fingerut, MD.

Date:

June 7, 2021

Pharmacy Spotlight cont.

Meeting Schedule:

Pharmacy and Therapeutics Committee and Drug Utilization Review Board

The next meeting of the Pharmacy & Therapeutics Committee (P&T) is scheduled for:

Date: September 21, 2021
Registration Deadline: September 14, 2021 by 5pm EST
Meeting: 8:00 AM
Location: Gainwell Technologies – Virtual
Registration by email to:
karen.mariano@gainwelltechnologies.com

Click here for agenda

The next meeting of the Drug Utilization Review (DUR) Board is scheduled for:

Date: September 21, 2021
Registration Deadline: September 14, 2021 by 5pm EST
Meeting: 10:30 AM
Location: Gainwell Technologies - Virtual
Registration by email to:
Karen.mariano@gainwelltechnologies.com

Click here for agenda

2021 Meeting Dates:
September 21, 2021
December 14, 2021

FYI:

The application fee
to enroll as a Medicaid provider is $599.00
as of January 1, 2021.

Please note that effective September 1, 2021, the RI Medicaid Application Fee will no longer be waived. Effective September 1, 2021, providers that submit provider applications will be required to pay the RI Medicaid Application Fee.

See more information regarding providers who may be subject to application fees here.

Please **do not** fax prior authorization requests that contain more than 15 pages. If your request is over 15 pages please mail your requests to:

Gainwell Technologies
Prior Authorization Department
PO Box 2010
Warwick, RI 02887-2010

To improve access to Medicaid Long-Term Services and Supports (LTSS), EOHHS will now accept Physician Medical (PM1) Forms that are signed by the applicant's physician, PA, NP, as well as a registered nurse or discharge planner (who holds, at a minimum, a bachelor's degree in nursing or social work). PM1 Forms are used for determining if an individual who is disabled or over 65 years old meets a Nursing Home needs-based level of care (LOC), and is therefore clinically eligible for Medicaid LTSS. To review the full policy, please visit our website https://www.eohhs.ri.gov/sites/g/files/xkgbur226/files/2021-03/Medicaid-Policy_PM1-Signatory-Change_032221.pdf [clicktime.symantec.com]

Ordering, Prescribing, and Referring Providers

Frequently Asked Questions

Q: What provider types does this apply to?

A:

Inpatient
Outpatient (except clinic visits-rev codes 510-519,
ER visits-rev codes 450-459 and observation-rev codes 760-769),
Pharmacy
Skilled Home Health
Independent Radiology,
Durable Medical Equipment (DME)
Chiropractor
Dialysis
Ambulatory Surgical Centers
and Hospice.

Q: Who is eligible to order/refer?

A: Only Medicaid-enrolled individuals of the following types can order/refer:

Certified Nurse Midwives
Clinical Nurse Specialists
Clinical Psychologists
Clinical Social Workers
Interns, Residents, and Fellows*
Nurse practitioners
Optometrists (may order and refer only laboratory and X-ray services)
Physician's Assistants
Physicians (Doctors of Medicine or Osteopathy, Doctors of Dental Medicine, Doctors of Dental Surgery, Doctors of Podiatric Medicine, Doctors of Optometry)
*Interns and non-licensed residents must use the NPI of the teaching, admitting, or supervising physician.

Q: How will I know if an OPR provider is enrolled with RI Medicaid?

A: It is ultimately the responsibility of the RI Medicaid provider rendering the service to obtain the OPR provider's NPI and taxonomy code, and to confirm participation with RI Medicaid.
RI Medicaid maintains a provider search function on the website, although all providers may not be listed.

Q: How will I know the NPI of the physician or healthcare professional who wrote the prescription or order?

A: A prescribing physician or licensed health care provider should be including their NPI on the prescription or order.

Ordering, Prescribing, and Referring Providers
Frequently Asked Questions Continued

Q: **Where can I obtain the OPR taxonomy code if I only have the NPI?**
A: This information can be found on the NPPES website, by completing a provider search by NPI.

Q: I am a member of a group. As an OPR provider, do I list my group NPI or my individual NPI?
A: Only individual NPIs are accepted as an OPR provider on a claim.

Q: What will happen to a "qualifying" claim submitted without an OPR listed?
A: The claim will be denied by RI Medicaid with EOB Message 574—Referring/Ordering Provider required and missing or invalid.

Q: Where is the OPR information entered on the claim form?
A: UB-04 – Box 79 – Other– Referring Provider NPI,
Box 81CC (Row d) Referring Provider Taxonomy Code

CMS 1500 Claim Form Box 17a—Referring Provider Taxonomy code with qualifier "ZZ"
Box 17b—NPI of referring provider

Q: Where is the OPR information entered for electronic claims?
A: For clearing houses/vendors and professional claims the OPR information should be entered in Loop 2310A, and for institutional claims the information should be entered on Loop 2310F

Ordering, Prescribing, and Referring Providers
Frequently Asked Questions Continued

Q: If the attending provider is the same as the ordering/referring/prescribing provider(s) do you have to list the OPR in addition to the attending?
A: Yes. In situations where the attending provider is the same as the OPR, the NPIs are still required. If the OPR is not listed, even if the NPI is the same as the attending, the claim will deny.

Q: If RI Medicaid is secondary, is the OPR provider still required?
A: Yes. The enrollment requirement applies even if Medicaid is the secondary payer.

Q: Do Medicare crossover claims require the OPR provider to be enrolled?
A: Yes, Medicare crossover claims are subject to the enrollment requirement.

Q: What if the OPR provider is enrolled with another state's Medicaid program?
A: Enrollment in another state's Medicaid program does not exempt a provider from enrolling with the RI Medicaid program.

Q: I wish to enroll as a RI OPR provider. Where do I go to enroll in the Medicaid program?
A: RI Medicaid has an OPR registration process in the Healthcare Portal. OPR providers are not able to submit claims for reimbursement. The OPR registration process can be accessed by visiting the Healthcare Portal and clicking **Enroll as an OPR Provider**. The OPR Provider User Guide is found on the home page of the Healthcare Portal.

Q: Will claims submitted with an NPI for a non-Medicaid OPR be denied?
A: Yes, claims for a non-Medicaid OPR will be denied.

Q: What information is required on a Prior Authorization request?
A: The OPR provider's information must be listed in the OPR fields. The Performing/Billing provider information should be listed on the Performing/Billing Provider line. If the OPR information is missing, or the OPR is not enrolled with RI Medicaid, the PA form will be returned.

Emailing for Technical Support

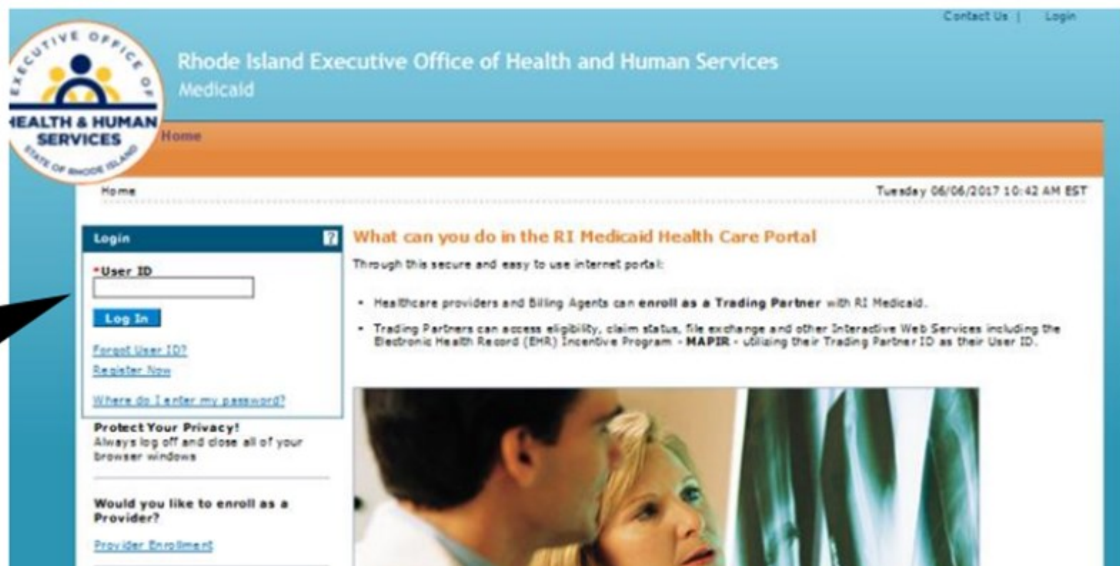
When sending an email to EDI (riediservices@dxc.com) or your provider rep for assistance, it is important to include vital information so that we may best assist you. In your email please include your: name, phone number, user id, NPI and Trading Partner ID (if applicable).

If you are emailing about login issues, please include the platform you are trying to access (Healthcare Portal, PES, etc).

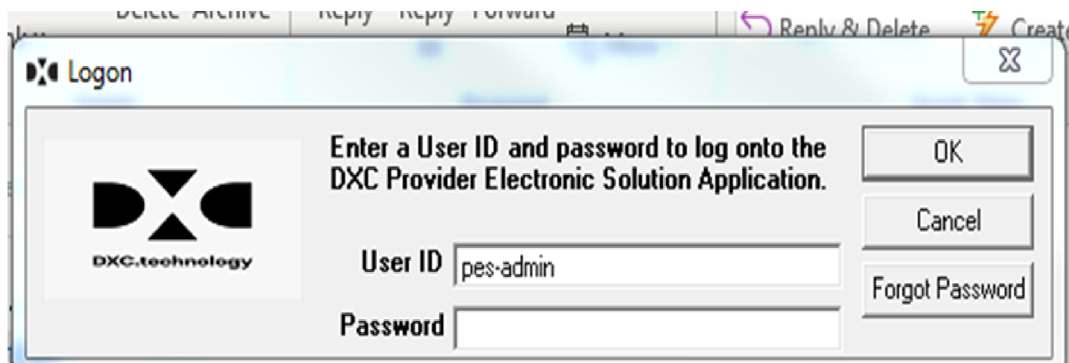
If you are getting an error message, please include a screenshot of the error, or let us know *exactly* what the error message says. Depending on the platform you are using, there are multiple reasons an error could kick back, so providing this specific information in your email will help us to best assess the root of the issue and how to solve it.
Below are screenshots of the most commonly used platforms that you may be logging into.

Healthcare Portal:

Enter your User ID here and click Log In



PES (aka Provider Electronic Services):



(Cont.)

HEALTHCARE PORTAL

LOGIN TROUBLESHOOTING

ISSUE	POSSIBLE THINGS TO CHECK/DO
Login Issues	
You are getting an error message that your security question answer is incorrect	• We are not able to reset security questions. Only the owner of the account can change their questions and answers. • If you are getting an error that your security question answer is incorrect it is typically indicative that your username is wrong. Please go back to the home page and make sure you are typing in your username correctly. ***Please type slowly to ensure there are no mistakes*** • Additionally, please make note of your security questions and answers to ensure that you are entering the correct answer each time.
You are getting an error message that your password is incorrect	• Passwords are CASE-SENSITIVE. So please take care to ensure you are entering your password correctly and that caps-lock is not on.
You are getting questions you do not recognize -OR- you do not remember your username.	• Have you already enrolled as a trading partner or delegate? • You need to have already enrolled as a trading partner -OR- have had your admin user create a delegate account before being able to sign in. • *Please* make sure you have **REGISTERED** and **VERIFIED** your account. If you have not registered and verified your account, you will be prompted with questions you do not recognize.
You are getting an error when resetting your password on the Portal	• The Portal is VERY specific on what a password can be. • Your password must be **EXACTLY 8 characters** (no more, no less), with at least one capital letter, one lowercase letter, and NO special characters. • For example, something like “Portal21” would work, but something like “Pa55w@rd2021!” would not.

Providers can access the Healthcare Portal directly, without going through the EOHHS website, by going to this address:

https://www.riproviderportal.org/HCP/Default.aspx?alias=www.riproviderportal.org/hcp/provider

Click here to view the **UPDATED** RI Medicaid memo regarding telehealth and COVID-19

Attention: Physicians and Non-physician Practitioners

CPT Consultation Codes

Effective January 1, 2010, the Centers for Medicare and Medicaid eliminated the use of all consultation codes (inpatient and office/outpatient codes) for Medicare beneficiaries. Please refer to the MLN Matters number MM6740 Revised for complete information. However, existing policies and rules governing Medicare advantage or non-Medicare insurers were not revised.

RIMA has not revised their policy on the use of consultation codes. RIMA still requires the use of CPT Consultation codes (ranges 99241-99245 and 99251-99255). Some providers may have already or will receive notifications regarding recoupment when the consultation codes are not utilized.

Substance Abuse Residential Treatment Code Update

Rhode Island Executive Office of Health & Human Services (EOHHS) requires that Managed Care Organizations (MCOs) and Rhode Island Medicaid providers adhere to the specifications outlined in the following table:

ASAM Level	ASAM Description	HCPC Code	Rev Code	Bill Type	Taxonomy Code	Notes
Level 3.1	Clinically Managed Low-intensity Residential Ser-	H0018	1003	86X	324500000x	Provider must bill both HCPC and Rev code
Level 3.3	Clinically Managed Population-specific High-intensity	H0010	1002	86X	324500000x	Provider must bill both HCPC and Rev code
Level 3.5	Clinically Managed High-Intensity Residential Ser-	H0010	1002	86X	324500000x	Provider must bill both HCPC and Rev code
Level 3.7	Medically Monitored Intensive Inpatient Services	H0011	1002	11x	324500000x	Provider must bill both HCPC and Rev code
Level 3.7-WM	Medically Monitored Inpatient Withdrawal Management	H0011	116, 126, 136, 146, 156	11x	324500000x	Provider must bill both HCPC and Rev code

MCOs and providers must begin engaging in the appropriate implementation processes, such that the aforementioned specifications will be effectuated for all claims with a *Date of Service* start date of **October 1, 2021**. Please ensure adequate provider education regarding claims billing is completed prior to the October 1st launch date.

Please contact your Medicaid MCO provider representative if you have further questions about this change.

NURSING HOMES, ASSISTED LIVING, AND HOSPICE PROVIDERS

Payment Delivery for Interim Payments

Due to the ongoing COVID-19 State of Emergency, Interim payments will continue to be automatically deposited into the bank account associated with your Gainwell Technologies MMIS account.

This will alleviate the need for in-person visits to the Gainwell Technologies office.

The next system payment will be deposited into the bank account directly, in line with the financial calendar on September 17, 2021.

Gainwell Technologies will securely mail the member information to providers detailing which client and date of service the payment is for.

We will continue to communicate with providers on any changes.

Long Term Supports and Services Cost of Care

Since the start of the COVID-19 public emergency, Medicaid has not permitted any increase in a client's cost of care (also known as "patient share"). The federal waiver prohibiting cost of care increases has ended in November, 2020.

All LTSS recipients are being reviewed for potential cost of care increases, effective January 1, 2021. Cost of care increases will **NOT** be retroactive.

Clients may have accrued assets over the $4,000 limit due to the implementation of this policy change. DHS will review assets upon recertification. Recertifications will begin in the month following the end of the Federal Public Health Emergency (PHE). The PHE is extended through 2021, or with a 60-day notice of cancelation.

DME Providers—Enteral Nutrition Guidelines

The Enteral Nutrition Guidelines have been updated. Guidelines can be found here in the Enteral Nutrition and Total Parental Nutrition section of the provider manual.

http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/CoverageGuidelinesforDurableMedicalEquipment.aspx

State FY 2022
Claims Payment and Processing Schedule

SFY 2022 Financial Calendar

MONTH	LTC CLAIMS Due at Noon	EMC CLAIMS Due by 5:00PM	EFT PAYMENT
		7/02/2021	7/09/2021
July	7/08/2021	7/09/2021	7/16/2021
		7/23/2021	7/30/2021
August	8/05/2021`	8/06/2021	8/13/2021
		8/20/2021	8/27/2021
September		9/03/2021	9/10/2021
	9/09/2021	9/10/2021	9/17/2021
		9/24/2021	9/30/2021
October	10/07/2021	10/08/2021	10/15/2021
		10/22/2021	10/29/2021
November	11/04/2021	11/05/2021	11/12/2021
		11/19/2021	11/26/2021
December		12/03/2021	12/10/2021
	12/09/2021	12/10/2021	12/17/2021
		12/24/2021	12/31/2021
January	1/06/2022	1/07/2022	1/14/2022
		1/21/2022	1/28/2022
February	2/03/2022	2/04/2022	2/11/2022
		2/18/2022	2/25/2022
March	3/03/2022	3/04/2022	3/11/2022
		3/18/2022	3/25/2022
April		4/01/2022	4/08/2022
	4/07/2022	4/08/2022	4/15/2022
		4/22/2022	4/29/2022
May	5/05/2022	5/06/2022	5/13/2022
		5/20/2022	5/27/2022
June		6/03/2022	6/10/2022
	6/09/2022	6/10/2022	6/17/2022
		6/24/2022	6/30/2022
July	7/07/2022	7/08/2022	7/15/2022
		7/22/2022	7/29/2022

View the SFY 2022 Payment and Processing Schedule on the EOHHS website

http://www.eohhs.ri.gov/ProvidersPartners/Billingamp;Claims/PaymentandProcessingSchedule.aspx

Notable Dates in September

- September 1-National Nutrition Week
- September 6-National Labor Day
- September 8-International Literacy Day
- September 11-Patriot Day (9/11 A National Day of Service & Remembrance)