Rhode Island Medicaid Program

February 2022 Provider Update

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State Offices will be closed in observance of the following Holidays in 2022

Memorial Day	Monday, May 30
Independence Day	Monday, July 4
Victory Day	Monday, August 8
Labor Day	Monday, September 5
Columbus Day	Monday, October 10
Election Day	Tuesday, November 8
Veterans' Day	Friday, November 11
Thanksgiving Day	Thursday, November 24
Christmas Day	Sunday, December 25 (State Employees celebrate on Monday, December 26)

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.

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riproviderserices@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.

February 2022
Provider Update

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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

Provider Enrollment Application Fee

As of January 1, 2022, the application fee to enroll as a Medicaid provider is $631.00

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

New Temporary CPT Codes

The following CPT codes have been added to the Medicaid program temporarily. These would be effective 9/1/2021 - 3/31/2022.

99401- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes. Reimbursement is $23.53

99402- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes. Reimbursement is $38.80.

99403- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes. Reimbursement is $53.46.

99404- Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes. Reimbursement is $67.91.

These CPT codes can be billed at only one visit for each beneficiary per day, but there are not quantity limits for the number of times this education can be provided to an individual beneficiary. Counseling may be provided in person, through live audio/video (telehealth) or telephonically. Additionally, this service can be billed by multiple providers and can be billed multiple times on different days.

Modifier 25-Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service, should be used if billing in addition to an office visit or an evaluation and management visit.

Attention Home Care and Adult Day Care Providers

The Office of Healthy Aging plans to increase services for its At Home Supports Program to include qualifying non Medicaid clients ages 19 and over with a diagnosis of Alzheimer's or related dementias and expand income up to 250% of the Federal Poverty Level (FPL). The names of the programs have been updated from DEA Copay to OHA At Home Cost Share Level 1, Level 2 and OHA Case Management (CNOM). Members are still enrolled in all three Co-Pay programs. The procedure code for home care services is S5125 U1. Please note that if you are billing for a member 19 or over that you will be using the taxonomy that you use today for the adult population. The procedure code for adult day care for the OHA program is S5102.

Previously recipients were 65 and over only. The new increased services for members, determined by the Office Of Healthy Aging, include:

- Recipients age 19 to 64 with an Alzheimer's or Dementia related diagnosis as noted by a licensed physician and an income up to 250 percent of the FPL
- Age 65 and older with no diagnosis requirement and an income up to 250 percent of the FPL

These changes are expected to go into effect in the coming months. More information to come soon on the official start date. Until such announcement is made, the program guidelines remain ages 65 and older and up to 200% FPL.

For eligibility questions please contact the Office of Healthy Aging or your regional case manager at Tri-County Community Action, East Bay CAP, West Bay CAP, or Child and Family Services.

If you have billing questions please contact the Gainwell Technologies Help Desk at 401-784-8100.

LTSS Services and the 3G Network Sunset

The EOHHS/LTSS Systems team is urging providers to educate and assist clients with an upcoming cell phone technology change. AT&T, Verizon and T-Mobile are transitioning from 3G to 5G network technology. As a result, customers who are using older phones will be unable to make or receive calls and text messages or use data services. This could also affect some medical-alert devices such as the Personal Emergency Response System (PERS).

Customers are being notified directly by their phone carriers and PERS providers. However, we are asking LTSS providers to educate and support clients with additional resources during this wireless technology transition.

The following sites and resources are available for customers when their carriers are unable to assist with the transition.
-Rhode Island Office of Healthy Aging DigiAGE program: https://oha.ri.gov/digiAGE or (401) 462-4644
-2-1-1
-Lifeline Support for Affordable Communications : (800) 234-9473 or LifelineSupport@usac.org
https://www.fcc.gov/lifeline-consumers

Attention Nursing Home Providers

Reminder regarding fee-for-service (FFS) claims submission

All FFS Medicaid claims must be received within 365 days of the first date of service in order to be accepted for processing and payment. Claims that are submitted electronically and are past the timely filing guidelines will be denied with EOB 38 "Claim Past the Timely Filing Limitations". A paper claim must be submitted to your Gainwell Provider Representative with proof of timely filing. Timely filing exceptions are listed below under Timely Filing Requirements. This would include as examples EOB 491 Gap in Billed Days, EOB 631 No Long Term Care on File, or EOB 916 RUG Cannot Be Determined.

During the Provider Escalation Project which ended in 2019, exceptions to timely filing rules were made. However, that project is now completed and the pre-existing rules governing claims submission will now be enforced.

In addition, some of the claims were put on suspense and were allowed to remain in suspense awaiting billing corrections. If the billing corrections are received, the claims will continue to process. However, there are still some claims in suspense that have older dates of service. Claims that have been on your remittance advice in suspense for over 60 days will now be allowed to process. In many of these cases, if billing corrections have not been made, the claims will be denied. You will see these denials reported on your future remittance advices.

Timely Filing Requirements

A claim for services provided to a Medicaid client, with no other health insurance, must 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 Explanation of Benefits (EOB) dated within 90 days
- If the client has other insurance and the claim is past the 365 day limit, then an exception will be allowed to process the claim if the other insurance EOB is within the past 90 days. The claim and supporting documentation to prove timely filing must be submitted on the appropriate paper claim form to your Provider Representative

(continued)

Attention Nursing Home Providers

Reminder regarding fee-for-service (FFS) claims submission (Continued)

Timely Filing Requirements (continued)

- 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. Any qualifying adjustments that need to be processed can be sent to your Gainwell Provider Representative on a paper adjustment form found on the www.eohhs.ri.gov website.
- Prior Authorization or TPL updates within 90 days

Additional information along with links to the FFS Provider Manual and other claims processing information can be found at the following websites:

https://eohhs.ri.gov/sites/g/files/xkgbur226/files/Portals/0/Uploads/Documents/MA-Providers/MA-Reference-Guides/General-Guidelines/General_Guidelines.pdf

https://eohhs.ri.gov/providers-partners/billing-and-claims/claims-processing

For any questions, please call the Gainwell Customer Service Help Desk at 401-784-8100 or your Gainwell Provider Representative at 401-784-3805.

Policy Change for NEMT Nursing Home Discharges

Nursing Home discharge to home transportation is now a covered service under the out of plan nonemergency medical transportation (NEMT) benefit, administered through MTM, for Rhode Island Medicaid members. MTM will not transport a Nursing Home discharge, in any mode, that is from Medicare skilled stay.

For dual eligible members (beneficiaries with Medicare-Medicaid), MTM will provide non-emergency transportation for nursing home discharge to home, except for non-emergency **ambulance** transport. Please note Medicare covers non-emergency **ambulance** transportation when determined as medically necessary by a medical provider.

All existing guidelines pertaining to advance booking and level of need will apply to this transportation service. This coverage does not apply to members that are in a Medicare skilled status.
Transportation can be arranged by utilizing MTM's facility portal located at:
https://mtm-prod.revealservices.net/www/link/#/login or by calling 855-330-9131.

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.

Provider training webinars were delivered on October 13th and October 15th. The slides used for the presentation are located on the EOHHS website under Nursing Home Stay 30 Days or Less (ri.gov)

REMINDER FOR NURSING HOME

Stimulus funds should be treated the same as a tax refund/rebate by nursing homes. The rebate is not treated as income, or as a resource for a 12-month period, in determining an individual's eligibility or assistance amount under any federally funded public program.

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 Popula-tion-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 Inten-sive Inpatient Services	H0011	1002	11x	324500000x	Provider must bill both HCPC and Rev code
Level 3.7-WM	Medically Monitored Inpa-tient Withdrawal Manage-ment	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.

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

Behavioral Health Rate Enhancement and Free Behavioral Health Training for Home Care Agencies

Effective January 1, 2022, a new behavioral healthcare rate enhancement of $0.39 per unit (fifteen 15 minutes) of Personal Care (S5125), Combined Personal Care/Homemaker (S5125-U1), and Homemaker (S5130) services shall be paid to "behavioral health-certified" (BH-certified) non-skilled home care providers. A BH-certified provider is a provider with at least thirty percent (30%) of its direct care workers (which includes C.N.A. and Homemakers) certified in behavioral healthcare training.

BH-Certified providers can submit their completed application for certification by emailing it to rixixqualityassuranceteam@gainwelltechnologies.com. All forms that are required for the BH Enhanced rates can be found on the Certification Standards | Executive Office of Health and Human Services (ri.gov) under Forms and Applications. If approved for the BH rate enhancement a letter provided by EOHHS will be sent to the agency by email.

For a direct care worker to become BH-certified, s/he must successfully complete a behavioral health certificate training program offered by Rhode Island College, or an equivalent training program that has been prospectively approved by EOHHS (Attachment C). For an Agency to become a BH-certified provider, it must submit to EOHHS a form (Attachment A) and supporting documentation identifying those C.N.A.s and Homemakers who are BH-certified. This list may be submitted at any time, and, upon review and approval by EOHHS, an Agency shall remain BH-certified for one year from the date of approval. Agencies must provide an updated list annually to renew their

BH-certification by emailing rixixqualityassuranceteam@gainwelltechnologies.com.

Employers shall submit to EOHHS a Report and Attestation (Attachment B) on January 15, 2023 and annually thereafter affirming that all BH-certified employees received one-hundred percent (100%) of the Behavioral Health Rate Enhancement ($1.56/hour) paid to the employer for all hours worked by the BH-certified employee during the preceding January 1 – December 31, in addition to the hourly rate, and any shift differential or other compensation that they were receiving immediately prior to becoming eligible to receive the BH rate enhancement. All applications and supporting documents can be emailed to rixixqualityassuranceteam@gainwelltechnologies.com

COVID-19 Vaccine Administration Codes for Children

The COVID-19 vaccine has been approved for children ages 5-11 years old. The administration codes can be billed to Medicaid effective 11/2/21. The codes are In Plan for those recipients in a managed care plan. The codes and reimbursement are:

0071A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 ages 5-11 first dose, reimbursed at $41.63.

0072A Immunization administration by intramuscular injection of sever acute respiratory syndrome coronavirus 2 ages 5-11 second dose, reimbursed at $41.63.

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 were extended through September 30, 2021. Effective October 1, 2021, prior authorization requirements were 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.

Prior Authorization for Durable Medical Equipment (DME)

Physicians writing scripts/prescriptions for durable medical equipment (i.e. diapers, nutrition, etc.) should give the script directly to the recipient and indicate to the recipient to contact a DME Supplier provider. **The DME Supplier provider will initiate the prior authorization request with RI Medicaid.**

When prior authorization is required for a service, the DME Supplier provider is to submit a completed Prior Authorization Request form which can be obtained on the EOHHS website. This form must be signed and dated by the **DME Supplier provider** as to the accuracy of the service requested. Attached to this form will be the Proof of Medical Necessity signed by the prescribing provider. When necessary, further documentation should be attached to the Prior Authorization Request form to justify the request. Forms can be faxed to (401) 784-3892.

Please note prior authorization requests for DME supplies received from a physician will be returned.

Prior authorization does not guarantee payment. Payment is subject to all general conditions of RI Medicaid, including beneficiary eligibility, other insurance, and program restrictions.

An approved prior authorization cannot be transferred from one vendor to another. If the beneficiary wishes to change vendors once the prior authorization has been approved, the new vendor will submit another Prior Authorization Request form with a letter from the beneficiary requesting the previous prior authorization be canceled.

For those beneficiary's dually enrolled in the RI Medicaid Program and Medicare, prior authorization is not required for Medicare covered DME services. Providers are required to accept Medicare assignment for all covered DME services. RI Medicaid will reimburse the copay and/or deductible as determined by Medicare up to the RI maximum allowable amount using the lesser of logic.

Attention LTSS Providers

As of 12/01/21, the DHS contact information for the Long Term Services and Support (LTSS) program has been changed. Please update your contact information for LTSS updates and inquiries to reflect the followings:

LTSS coverage line number 401-574-8474
DHS Call center line 1-855-697-4347
Email: dhs.ltss@dhs.ri.gov
Fax#: 401-574-9915

LTSS: MOVING THE OFFICE OF MEDICAL REVIEW (CLINICAL TEAM) FROM EOHHS TO DHS

The Executive Office of Health and Human Services (EOHHS) and DHS have together cared for our consumers on the State's Medicaid program. Specifically, EOHHS has been responsible for the clinical eligibility determinations for Medicaid Long Term Services and Supports (LTSS) through its Office of Medical Review (OMR) while DHS determines the financial eligibility for those applicants.

To create a more efficient process, we have moved all LTSS eligibility, both financial and clinical, to DHS. The Office of Medical Review, now called the DHS Clinical Team, will continue to be responsible for determination of LTSS clinical levels of care, Katie Beckett clinical eligibility, disability determinations by the Medical Assistance Review Team, and Pediatric Private Duty Nursing (PDN) assessments, authorizations and oversight. Regarding the latter, parents of children receiving PDN, as well as the agencies providing pediatric PDN, have been directly notified about this change. Relatedly, the two departments finalized a PDN Policy Guidance Document that puts into writing the current processes for the administration of PDN. This document will be available on the DHS website soon.

Telehealth Service Codes Update for Medicaid

Due to recent changes made by Medicare, effective as of April 4, 2022 the Rhode Island Executive Office of Health & Human Services (EOHHS) is adding Place of Service Code 10 (Telehealth Provided in Patient's Home) as a telehealth place of service for Fee-for-Service and Managed Care. Please submit telehealth claims with Place of Service Code 02 (Telehealth Provided Other than in Patient's Home) or Place of Service Code 10 (Telehealth Provided in Patient's Home) as applicable.

EOHHS requests that all MCOs complete the implementation of this change in claims submission by April 30, 2022. Fee-for-Service Providers should submit telehealth claims with the applicable Place of Service Code 10 for dates of service of April 4, 2022 forward.

Pharmacy Spotlight

The following drugs changed status on the RI Medicaid Fee-for-Service Preferred Drug List (PDL) effective January 2022.

Analgesics, Narcotics Short-Acting **Changed status to Non-preferred** tramadol 100 mg **Changed status to Preferred** morphine solution (AG) oral	**Anticonvulsants, Other** **Changed status to Preferred** Valtoco
Antimigraine Agents, Other **Changed status to Preferred** Ubrelvy **Changed status to Non-Preferred** Nurtec ODT	**Antimigraine Agents, Triptans** **Changed status to Preferred** Imitrex nasal **Changed status to Non-Preferred** sumatriptan nasal
Atypical Antipsychotics **Changed status to Preferred** Perseris	**Neuropathic Pain, Topical** **Changed status to Preferred** Lidoderm
NSAIDS **Changed status to Preferred** ibuprofen suspension (OTC)	**Ophthalmics, Allergic Conjunctivitis** **Changed status to Preferred** olopatadine HCL
Ophthalmics, Anti-Inflammatories **Changed status to Preferred** Pred Forte **Changed status to Non-Preferred** Ilevro Nevanac	**Ophthalmics, Anti-Inflammatory/ Immunomodulators** **Changed status to Preferred** Xiidra
Stimulants and Related Agents **Changed status to Non-preferred** Aptensio XR	
To view the entire Preferred Drug List please check the Rhode Island EOHHS Website at: http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Pharmacy.aspx	

Pharmacy Spotlight

Treatment of Hepatitis C
Prior Authorization Guidelines
Effective: January 1, 2022

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, non-panogenic medications require genotyping.

v History of prior Hepatitis C treatment if request is for non-preferred medication

vi 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 January 1, 2022:

i Preferred agents: Mavyret® and Vosevi®.

ii Non preferred agents:

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

Treatment of Hepatitis C
Prior Authorization Guidelines
Effective: January 1, 2022 (continued)

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: January 1, 2022.

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

Approved:

Jerry Fingerut, MD.

Date:

December 13, 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: April 12, 2022
Registration Deadline:
April 7, 2022 by 5pm EST
Meeting: 8:00 AM
Location: Executive Office of Health and Human Services, Virk's Bldg., 3 West Road, Cranston, RI
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: April 12, 2022
Registration Deadline:
April 7, 2022 by 5pm EST
Meeting: 10:30 AM
Location: Executive Office of Health and Human Services, Virk's Bldg., 3 West Road, Cranston, RI
Registration by email to:
Karen.mariano@gainwelltechnologies.com

Click here for agenda

2022 Meeting Dates:
April 12, 2022
June 7, 2022
September 20, 2022
December 13, 2022

Prior Authorization Requests

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

Physician Medical (PMI) Form: Update to Signatory Requirements

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]

Attention Assisted Living Facilities (ALF) Providers

Effective January 1, 2022, the monthly Room and Board Rate for all Medicaid LTSS Assisted Living Facility (ALF) customers with income under 300% Federal Benefit Rate (FBR) or $2523, will change to $1053 to reflect the Year 2022 Federal Benefit Rate (FBR). Room and Board Rate for customers with income over the 300% FBR will be $2523 adjusted for a single versus double room accordingly. Cost of Care (COC) for all ALF customers may also change to reflect the 2022 COLA for customers who are receiving SSA benefits. Personal Need Allowance for all ALF customers regardless of ALF program (CAT D, RMFHC, PACE) will remain at $120.

For assistance, questions, or concerns, please contact:
LTSS Coverage: 401-574-8474 or DHS Coverage: 1-855-697-4347 or the LTSS Email: dhs.ltss@dhs.ri.gov .
For Cost of Care (COC) and Room and Board updates and discrepancies, please contact:
OHHS Contacts: OHHS.LTSSEscalation@ohhs.ri.gov or Sally.mcgrath@ohhs.ri.gov

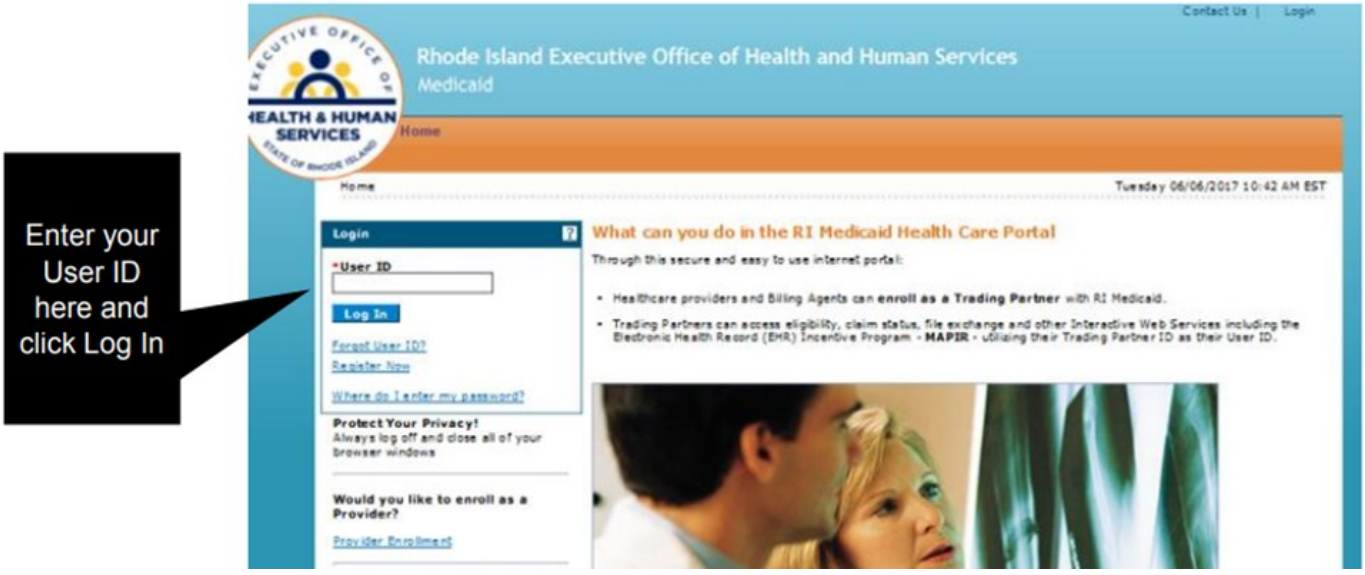
Emailing for Technical Support

When sending an email to EDI (riediservices@gainwelltechnologies.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).

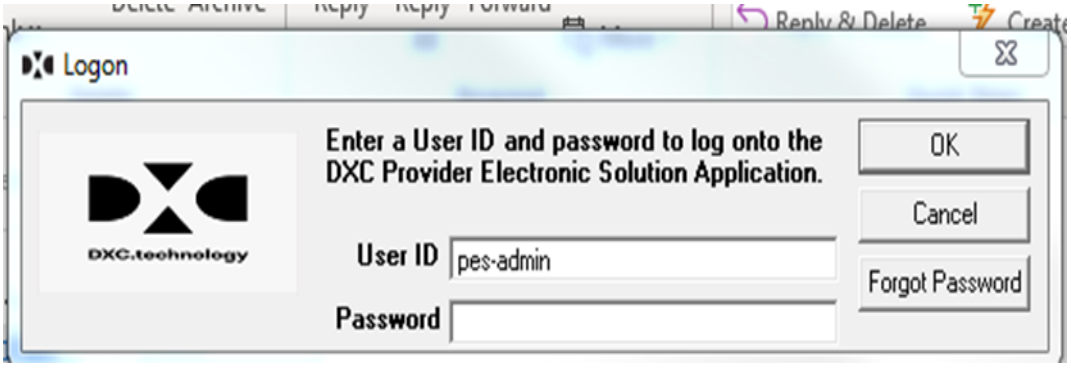
If you are emailing about login issues, please include the platform you are trying to access (Healthcare Portal, PES, etc).

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:



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 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.

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 February 11, 2022.

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 February

February 2 - Ground Hog Day

February 3 - National Physicians Day

February 21 - Presidents' Day