Rhode Island Medicaid Program

July 2023

Provider Update

See page 2 for Table of Contents.

State Offices will be closed in observance of the following Holidays in 2023

Independence Day	Tuesday July 4th
Victory Day	Monday August 14th
Labor Day	Monday September 4th
Columbus Day	Monday October 9th
Veteran's Day	Monday November 13th
Thanksgiving	Thursday November 23rd
Christmas	Monday December 25th

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.

SUBSCRIBE

To Subscribe or update your email address Send an email to: riproviderservices@gainwelltechnologies.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.

July 2023
Provider Update

TABLE OF CONTENTS

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

What's Happening in Medicaid: Renewal Data Now Available

As of July 2023, four cohorts totaling about 54,000 Rhode Islanders have begun their renewal process. The first round of Rhode Island's Medicaid renewal data was recently published online. Interested in seeing the breakdown? **Visit the Medicaid Renewals Data Dashboard on staycovered.ri.gov.**

Answers to questions you may get about patients' Medicaid coverage ending.

What resources are available for Rhode Islanders who are determined to no longer be eligible for Medicaid?

If you're no longer eligible for Medicaid, the friendly team at **HealthSource RI** can help you find affordable healthcare coverage. Depending on your household size and income, you may qualify for:

- Auto-enrollment in a qualified health plan (QHP) and two months' premium assistance
- Two months' premium assistance and federal premium tax credits
- Federal premium tax credits to help make health coverage more affordable

I missed the deadline on my renewal packet. What should I do?

If you missed the deadline on your yellow renewal packet, sign the renewal form and submit your documents right away. Learn about the different ways you can submit your documents.

If the State gets your packet within 90 days of the date your benefits stopped (according to your Benefit Decision Notice), your documents will be accepted, and your eligibility will be reviewed.

- If the State gets your documents within 90 days and determines you are eligible for Medicaid, your coverage will be reinstated. You will get a white Anchor Card that you can use for medication and for doctor's visits if the provider accepts Medicaid fee-for-service. You will then be re-enrolled into your managed care plan (Neighborhood Health Plan of Rhode Island, Tufts Health (RITogether) Plan, or UnitedHealthcare Community Plan (UHCCP)).
- If the State gets your documents within 90 days and determines you are no longer eligible for Medicaid, you may be given information about how to get low-cost health insurance through HealthSource RI. Your Benefit Decision Notice will also give you information about how to appeal.

To learn more about your coverage options while your late documents are being reviewed, call HealthSource RI (HSRI) from 8 a.m. to 6 p.m. on weekdays at 1-855-840-4774.

What's Happening in Medicaid: Renewal Data Now Available (Continued)

I got a letter saying my Medicaid coverage is ending. I think this is wrong. What can I do?

If you don't agree with our decision about your Medicaid eligibility, you can:

1. **Call the Department of Human Services at 1-855-697-4347.** Someone can talk you through the Benefit Decision Notice. Be sure to have your Benefit Decision Notice and the case/identification number on-hand when you call.
2. **File an appeal.** An appeal is a formal request asking for the decision to be reviewed at a hearing.

How do I file an appeal?

There are a few ways to request an appeal related to your Medicaid coverage. You can file an appeal:

- **Online**. Log into your account at healthyrhode.ri.gov and click on "file an appeal".
- **By phone**. You can file an appeal by calling HealthSource RI at 1-855-840-4774.
- **In person**. Visit a local DHS office near you. An appeal form is included in every Benefit Decision Notice. Fill out this form and bring it with you.
- **By mail**. An appeal form is included in every Benefit Decision Notice. Fill out this form and mail it to ATTN: Appeals State of Rhode Island, P.O. Box 8709, Cranston, RI 02920-8787.

Instructions on how to file an appeal are also in your Benefit Decision Notice.

What is a fair hearing?

A fair hearing is a chance for you to tell an administrative hearing officer why you disagree with the decision about your Medicaid eligibility. An agency representative is also present at the hearing to explain the basis for their decision. By law, the administrative officer must review the facts of the case presented by both sides in a fair and objective manner.

You can either represent yourself at the hearing, or you can be represented by anyone you choose, like an attorney, advocate, friend, or relative. You can call RIPIN at 401-270-0101 or RI Legal Services at 401-274-2652 to find out whether free legal assistance is available.

What's the deadline for submitting an appeal?

You must file an appeal within 35 days after the date on the top of the Benefit Decision Notice

Your Medicaid coverage will automatically continue during the appeal process.

You do not need to pay the state for medical care you received if you lose the hearing.

COVER ALL KIDS IMPLEMENTATION

Cover All Kids extends full-benefit medical assistance to children who would otherwise be eligible for Medicaid, but for their immigration status.

Legislation passed effective July 1, 2022 – RIGL 42-12.3-15. Expansion of RIte track program.

While applications for coverage may be accepted through all available channels (online, mail, phone, in person), **we caution that we currently have system limitations which will delay eligibility determination**.

- Applications received **before September 1, 2022** may receive an initial denial notice, but will be manually reviewed by Department of Human Services (DHS) staff for Cover All Kids eligibility.
- **Beginning September 1, 2022**, applications will be accepted, and won't be initially denied, but also will not result in an automatic approval. These applications will be worked by DHS staff via a manual process. Approval notices will be sent when criteria is met. Denial notices will be sent when eligibility criteria is not met.
- All applications approved via this manual process will receive a retroactive eligibility start date of **July 1, 2022.** Once electronic processing has started, the effective date will be based on the application. Cover All Kids members will receive a Medicaid ID card – the white anchor card – about one week after their eligibility is processed.

Providers should be prepared to bill fee-for-service Medicaid for any approved member expenses for dates of service beginning July 1, 2022.

Though not immediately, the Cover All Kids population will be enrolled in Managed Care Organizations (MCOs). These enrollments are likely to begin on October 1, 2022 and based on a standard eligibility waiting period thereafter. Cover All Kids members will also receive RIteSmiles coverage, the Medicaid Children's dental program.

For emergency or high-need cases, providers and applicants are encouraged to submit applications as soon as possible and to request expedited assistance via Linda DeMoranville at linda.demoranville@dhs.ri.gov.

For all other cases, to avoid application backlog, we request applications be submitted on or after October 1, 2022. Thank you for your partnership and patience as we get our systems prepared to provide services to this new population of children.

Katie Beckett (KB) Medicaid Eligibility: Health Care Coverage for Children with Severe Disabilities

Please note that the clinical team overseeing the process for the Katie Beckett Medicaid Program has been moved to DHS-LTSS, kindly refer inquiries and mail application for the KB program to the DHS-LTSS contact below

Katie Beckett is an eligibility category in Medicaid that allows children under age 19 who have long-term disabilities or complex medical needs to become eligible for Medicaid coverage. To be qualified, child must meet the income and resource requirements for Medicaid for persons with a disability; qualify under the U.S. Social Security Administration's (SSA) definition of disability and require a level of care at home that is typically provided in a hospital, nursing facility or an Intermediate Care Facility for Persons with Intellectual Disability (ICF-MR). Katie Beckett Medicaid eligibility enables children to be cared for at home instead of an institution. With Katie Beckett, only the child's income and resources are used to determine eligibility.

For information about the Katie Beckett program, contact DHS LTSS at: 401-574-8474 or email: DHS.PedClinicals@dhs.ri.gov

To apply for the Katie Beckett Medicaid Program, Kindly complete the DHS-2 Application, check the KB-Katie Beckett: Health Care Coverage for Children with Severe Disabilities, and mail to:
Attention: DHS LTSS--Katie Beckett Program
P.O. Box 8709
Cranston, RI 02920

All Medicaid Members Eligible for Discounted Internet

The Federal Communications Commission recently **launched the Affordable Connectivity Program [r20.rs6.net]** to reduce the cost of internet service. Through this program, all Medicaid members are eligible for a $30 per month (or $75 per month on Tribal Lands) discount on any internet service plan from participating providers. Eligible households can also receive a one-time discount of up to $100 on a laptop, desktop, or tablet. **Households can enroll in the program here. [r20.rs6.net]**

Updates to the Healthy Rhode Mobile App for Customers

The Healthy Rhode Mobile App recently underwent important updates to enhance both customer experience and operations efficiency. In addition to providing a wider array of support services through the mobile app, it is expected these enhancements will also serve to improve the customer experience both in-person and via the call center by offering the types of services commonly sought through both of these venues, likely resulting in shorter wait times. These upgrades include:

- Displaying previously submitted documents, appointments, banner messages, and notices
- Allowing customers to enter reasonable explanations, along with the documents upload
- Allowing customers to reset passwords and recover their username via one-time password
- Allowing customers to login via Biometrics
- Notifying customers of key dates and information pertinent to their case
- Allowing customers to create accounts, reset passwords, and recover their usernames
- Allowing customers to opt into text messages and push notifications
- Allowing customers to view their Medicaid ID on the mobile app
- Allowing customers to get on-demand updates of the status of their applications or recertifications/ interims or periodic verifications
- Allowing customers the ability to submit simple changes to their case and household through the mobile app

These upgrades continue to further advance the customer service focus by addressing some of their most common needs. The ability to accomplish many of these necessary tasks through the mobile app is an exciting and extremely useful step that will help customers more quickly and efficiently accomplish tasks important to ensuring access to and continuity of benefits.

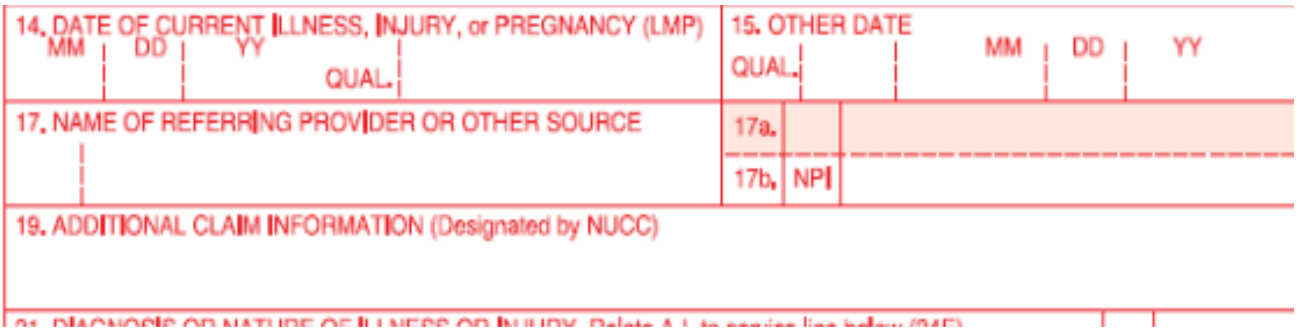
Attention Local Education Agencies (LEA) Providers:

Federal requirements specify that an individual must be identified as the ordering or referring professional on a claim in instances where an order or referral is required. For example under 42 CFR 440.110(a), in order to be eligible for Federal Financial Participation, Physical Therapy services must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of practice authority under state law. Similarly, under 42 CFR 410.110(b), Occupational Therapy services must be referred by a physician or other licensed practitioner of the healing arts within the scope of practice authority under state law. While the IEP may serve as the prescription or referral, an individual with the authority to prescribe or refer the specified services must be identified as the ordering/referring provider (ORP) using their Type 1 NPI on the claims submitted to Medicaid for those services consistent with §§ 455.410 and 455.440.

Effective July 1, 2023, **ALL** LEA claims will require a referring provider NPI. This requirement will be for any date of service past or present, when the claim is submitted on or after 7/1/2023. Claims submitted without the referring provider NPI will be denied with Explanation of Benefits (EOB) code 574 - REFERRING/ORDERING PROVIDER REQUIRED AND MISSING.
The referring provider must be either a fully participating RI Medicaid provider or a RI Medicaid enrolled non-billing provider. The referring provider may be the same as the rendering provider on the claim. More information can be found in the OPR Frequently Asked Questions.

Q: Where is the OPR information entered on the claim form?

A: 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.

For questions, contact your Provider Representative, Karen Murphy at (571) 348-5933 or

karen.murphy3@gainwelltechnologies.com .

Department of Health Program: Parents as Teachers

Starting May 1, 2023, the Parents as Teachers program will begin billing Medicaid for services. The Parents as Teachers (PAT) program is a statewide evidence-based family home visiting program. PAT enrolls pregnant people and children up to ages two or three and provides visits to a child until they turn four or five. Parent Educators listen and respond to family needs. They link families with supports such as medical homes to ensure children are receiving well-child visits and health screenings. Parent Educators also make linkages to community resources and social supports, and other families with young children. During visits, Parent Educators provide fun, healthy activities to do with children that support a child's growth and development and support families in achieving their goals.

To learn more about Parents as Teachers and other family visiting programs, please call 401-222-5960, or visit Department of Health.

Staying Connected

Are you a trading partner with RI Medicaid? Have you changed external or internal business processes? Have you had internal staff changes? If your contact information is out of date, you might miss vital information for your covered providers. Stay connected to RI Medicaid and send your email address to riproviderservices@gainwelltechnologies.com so that you can receive the monthly provider update with essential information for your covered providers.

Clearing Houses/Billing Agencies – Managing your Trading Partner Profile

Did you know you are responsible for managing the covered providers located in your trading partner profile? What does this mean? If you wish to conduct business on the providers behalf, you must add their NPI to your Covered Providers. If you would like to download the 835/277U transactions for the provider, you must also **check off** the 835/277U transaction boxes. Did you know when the provider no longer wants you to download their 835/277U, you **must** remove the NPI from your covered providers? Please select the link below for instructions on how to **add** and **remove** your covered providers.

Managing Covered Provider Guide

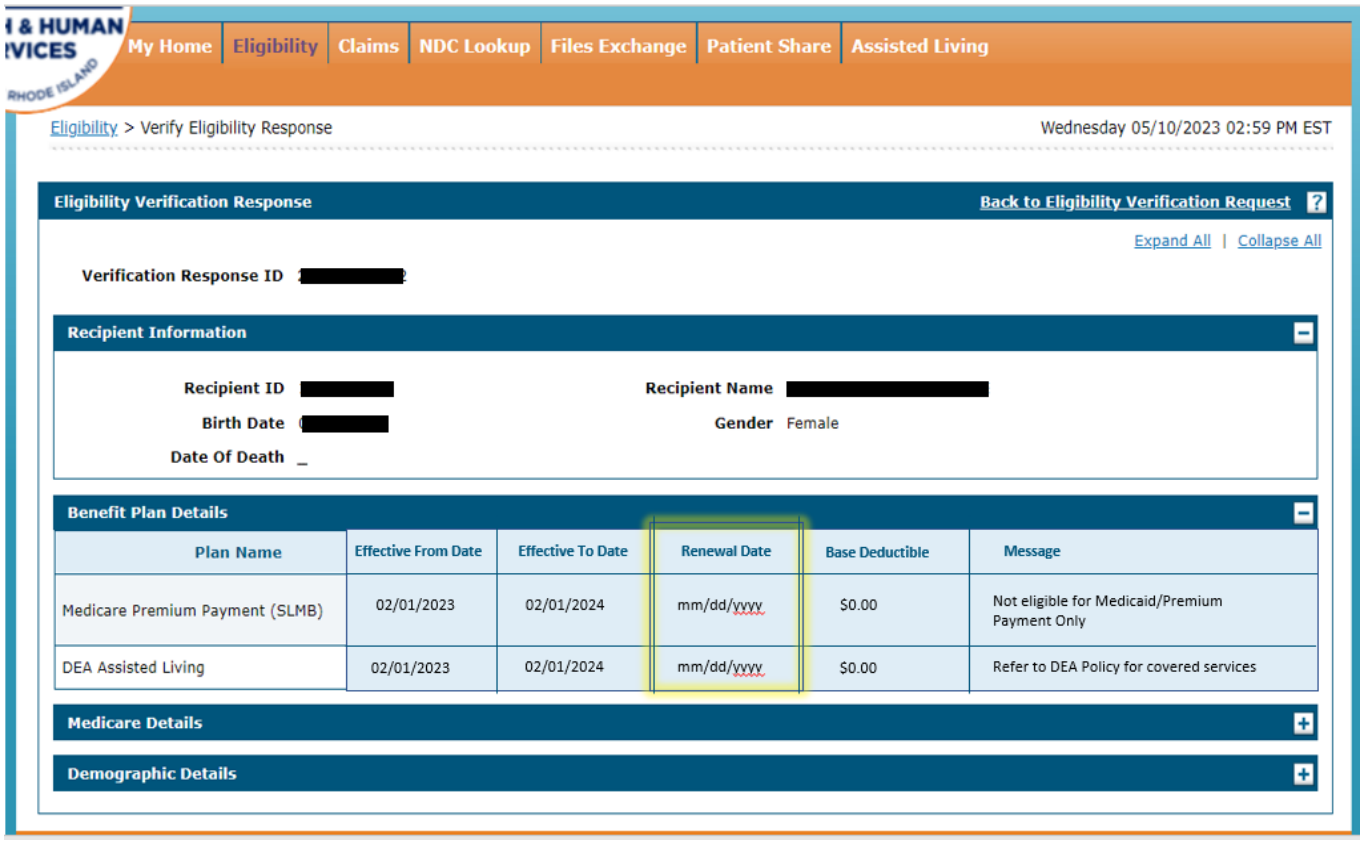
***** If you are no longer practicing business with a covered provider, please end date that NPI*****

Health Care Portal Renewal Dates

The **Eligibility** search will begin returning a response that includes the members renewal date.

WHAT DOES THIS MEAN FOR YOU?????

Sometime in late July 2023 we will be adding a new column to the Healthcare Portal that will allow you to view the members basic benefit plans renewal date. The screen will display as N/A if no renewal date is applicable. This will allow for you to inform the member that their Medicaid eligibility renewal date is coming up for review.



Attention Trading Partners:

Do you want to use these transactions, if you do then please share the information below with your technical support.

RI Medicaid is preparing to implement the **Real Time 270/271** Eligibility Verification Request and Response **and Real Time 276/277** Claim Status Request and Response Transactions

For **Real Time** transactions the sender remains connected while the receiver processes the transactions and returns a response to the sender and with an average response time within 20 seconds.

Gainwell will utilize a **Real Time** Safe Harbor interface referred to as HDE (Health Direct EDI). This will allow for trading partners to transmit the **Real Time** transactions directly to the translator (EDIaaS).

HDE connectivity and requirements per CAQH Core Rules

- Trading Partner Software web service to process transaction
- Trading Partner transaction can be in SoapUI or MIME format for submission

  Trading Partner will receive a URL, HDE username and password to access the HDE connection.

What does this mean? If you are a provider you will need to contact your software vendor, clearing house or billing agency. RI Medicaid does not offer software for these **Real Time** transactions.

To participate

Do you have a trading partner number?

Is your contact information on the Healthcare Portal current?

If you have answered yes to the above questions and are interested in these **Real Time** transactions, please answer the questions below.

Testing will begin late July-middle of August.

To participate in testing, you must provide the information below.

Name, TPID, contact name, email, and telephone number. Identify format (SOAPUI or MIME) for submitting the **Real Time** transactions.

Send your answers to riediservices@gainwelltechnologies.com. Please make sure to add a subject line of **Real Time** Transactions.

Electronic Billing for Medicare and Senior Replacement/Advantage Plans

To facilitate electronic billing and proper reimbursement for Medicare and Commercial Medicare (Advantage/Replacement) Plans the following fields are required:

- **Loop 2320** Other Subscriber Information **SBR09** - Must contain **MA** or **MB** as appropriate for the claim filing indictor
- **Loop 2320** Claim Level Adjustments **CAS** segment - Must contain Deductible **PR 1** or Coinsurance of **PR 2**
- **Loop 2320** Coordination of Benefits (COB) **Payer Paid Amount** – Must contain the **Amount Paid** (other insurance paid amount)
- **Loop 2330B Other Payer Name** (Carrier Code) **Segment NM109** Other Payer Primary Identifier – Must contain the appropriate **carrier code**, see below for list:

MDA/MDB Medicare	22A Aetna Medicare Advantage Plan
06A United Senior Care	24A Connecticare Medicare Advantage Plan
08A Healthfirst Medicare Advantage Plan	26A Humana Medicare Advantage Plan
09A HMO-Blue of Massachusetts Advantage Plan	26B Humana Medicare Advantage Dental Plan
12A Blue Chip—Medicare HMO	89A Tufts Health Plan (PPO) Medicare Advantage Plan
18A Wellcare Medicare Advantage Plan	C01 CarePlus Advantage Plan
19A MMM Healthcare of Puerto Rico Advantage Plan	C02 Commonwealth Care Alliance, Inc Medicare Advantage Plan

For Provider Electronic Solutions Software (PES) Users:

Claim Filing Indicator can be found on OI Screen

CAS Segments can be found on OI ADJ Screen

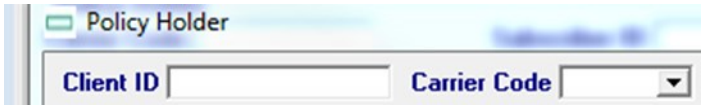
Continued on next page:

Electronic Billing for Medicare and Senior Replacement/Advantage Plans

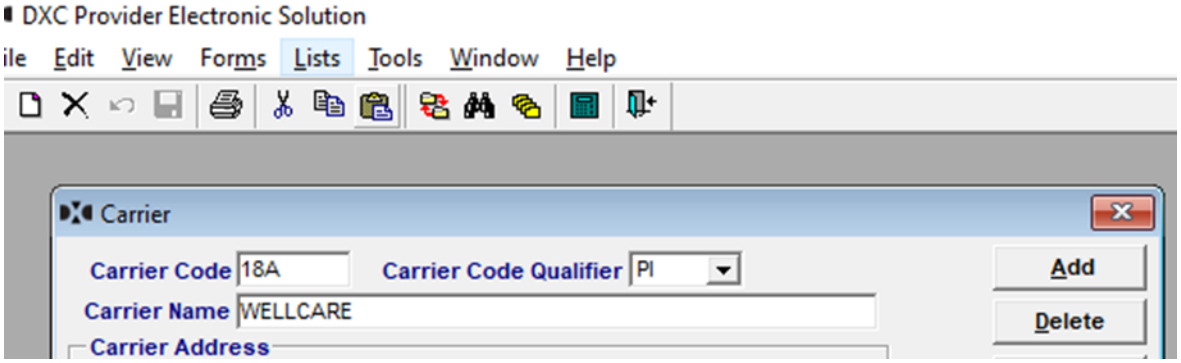
For PES Users, continued:

Payer Paid Amount can be found on OI Adj Screen

Payer Identifier Code (Carrier Code) can be found in the Policy Holder Screen



If you need to add a carrier code to your PES software, please select **LIST** along the top and then select **Carrier.** Once the carrier code has been added, you need to add it to your **Policy Holder Record.**



All Providers

Coverage Type Code Addition

Please be advised that a new coverage type code has been added to RI Medicaid. You may see this coverage type code in the Healthcare Portal when checking eligibility. The new coverage type is Medicare Part C Plan (Medicare Advantage). Previously, these policies had a commercial insurance coverage type code of HMO.

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 DME Providers

Effective 3/1/23, Rhode Island Medicaid Fee-for-Service will be activating coverage for HCPCS code K1005 - DISPOSABLE COLLECTION AND STORAGE BAG FOR BREAST MILK, ANY SIZE, ANY TYPE. Reimbursement is $0.24 per unit with a maximum of 120 units per month.

No prior authorization is required. Vendor must verify continued medical necessity for lactating members on a monthly basis prior to delivering refills for this item per DME regulations detailed on page 11 of the DME Provider Manual under Refill Requirements. This item must be billed monthly. Three-month and/or automatic shipments are not permitted.

Attention Assisted Living Facilities (ALF) Providers

Effective January 1, 2023, the monthly Room and Board Rate for all Medicaid LTSS Assisted Living customers will change to $1246 to reflect the Year 2023 Federal Benefit Rate (FBR). Cost of Care (COC) may also change to reflect the 2023 COLA for customers who are receiving SSA benefits. For customers with income below $1246, their R&B may be less.

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

ADA Stretcher Compliance- NEMT Benefit

Healthcare Providers to Comply with ADA Stretcher and Wheelchair Requirements for NEMT Benefit

Under Title III of the Americans with Disabilities Act (ADA), healthcare providers must comply with the relevant physical access accommodations. Providers are required to make 'reasonable accommodations' to policies, practices, and procedures to avoid discriminating against an individual with a disability. EOHHS is in receipt of several complaints from contracted transportation providers (TP) regarding stretcher transportation issues at healthcare provider facilities.

EOHHS reminds healthcare providers that under its non-emergency medical transportation (NEMT) benefit, **transportation providers cannot leave an unattended stretcher at a provider/facility unless it is the member's personal mobility device or leave the transportation provider's stretcher at the facility.**

We thank you for your cooperation and attention to this important matter and kindly remind contracted network providers to comply with all ADA requirements, including wheelchair and stretcher transport for member's utilizing the NEMT benefit.

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 July 14th, 2023

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.

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.

Attention Medicaid HIV Targeted Case Managers

Effective for dates of service beginning June 1, 2023, there will be a change to the billing. The change will differentiate claims for HIV Positive recipients and High-Risk Negative recipients. To accomplish this a modifier will be required when billing for High-Risk Negative Medicaid recipients. The modifier is U4 and the payment will continue to be $15.00 per unit, see chart below.

Proc Code	Modifier	Rate	HIV Status
X0377	None	$15.00	HIV Positive
X0377	U4	$15.00	High Risk Negative

For questions about billing please contact your Provider Representative, Karen Murphy at karen.murphy3@gainwelltechnololgies.com or 571-348-5933.

Nursing Home Transition Program and Money Follows the Person

The Nursing Home Transition Program and Money Follows the Person program (NHTP) can offer support to your facility, helping residents who are eligible for Medicaid return to the community, when appropriate.

Referrals to the program can come from nursing home staff, residents, family, or others. On receiving a referral, the NHTP Transition Team provides information and support to develop a plan and facilitate the transition, including coordinating community services and supports, helping find housing, obtaining necessary household goods and furniture, and assisting with the move.

Transition services are available to individuals who are directly served through the RI Medicaid office and those who are served by a managed care organization.

Following a move, the Team maintains weekly contact with an individual for the first thirty days and establishes a care management plan for subsequent follow up.

To refer someone interested in discussing options for returning to the community, complete a referral form and fax it to (401) 462-4266. The form can be found on the Rhode Island Executive Office of Health and Human Services website via a link on the Nursing Home Transition Program webpage: https://eohhs.ri.gov/Consumer/NursingHomeTransitionProgram.aspx.

We welcome your questions and feedback and are happy to meet with your staff. Please contact us by email at ohhs.ocp@ohhs.ri.gov, by telephone at (401) 462-6393 or individually using the information below.

Contact Information

Karen Statser
Money Follows the Person Program Director
Karen.statser@ohhs.ri.gov
(401) 462-2107

Robert Ethier
Money Follows the Person Deputy Director
robert.ethier.ctr@ohhs.ri.gov
(401) 462-4312

Rhode Island will require the use of the Optional State Assessment (OSA) for Nursing Facilities Reimbursement effective October 1, 2023

Background: The Centers for Medicare & Medicaid Services (CMS) is ending support for Resource Utilization Groups (RUG)-III and RUG-IV on federally required assessments for patients residing in Nursing Facilities and Skilled Nursing Facilities as of October 1, 2023. The ending of this support was previously communicated in a 2018 Medicaid Informational Bulletin which had signaled that this support would end on October 1, 2020, however, because of the COVID-19 Public Health Emergency, the end date was delayed, providing stakeholders additional time to make necessary systems changes.
CMS released a State Medicaid Director's Letter (SMD# 22-005) on September 21, 2022. This letter, coupled with the release of draft Minimum Data Set (MDS) changes on September 1, 2022, has several implications for state Medicaid programs and their nursing facility (NF) reimbursement systems. Beginning October 1, 2023, MDS items necessary for resident classification under a RUG-based acuity system (RUG-IV) will no longer be available on the standard MDS item sets. States wishing to maintain a RUG-based acuity system after October 1, 2023, need to implement and require submission of an OSA as of that date. CMS will support the use of an OSA by state Medicaid agencies wishing to maintain a RUG-based acuity system through September 30, 2025, at which time states must have any necessary regulatory changes in place to change from a RUG-based acuity system.
Rhode Island will require the submission of OSA beginning on October 1, 2023. All nursing facilities submitting MDS assessments in Rhode Island will be required to submit the OSA assessment with all MDS assessments.

What To Do to Ensure Your Facility Is Ready for October 1st

Beginning this October, nursing facilities will have to complete and submit Optional State Assessments (OSA). RI Medicaid will utilize the Optional State Assessments (OSA) as of 10/1/2023 to allow for continued utilization of CMS RUG-IV grouper and facility reimbursement determination. RI plans to transition to PDPM payment System effective 10/1/2025	Nursing facility payment information is available here: https://eohhs.ri.gov/providers-partners/provider-directories/nursing-homes. The website has links to current rates and the Rhode Island Medicaid State Plan, which details the current payment methodology. Please contact the Medicaid Finance team (OHHS.MedicaidFianance@ohhs.ri.gov) for questions related to nursing facility payment.
Facilities should begin now reviewing MDS 3.0 Changes coming 10/1/2023. Facility should continue to complete and ensure appropriate documentation items are in place to support all contributing factors of the CMS RUG-IV grouper.	Federal based MDS Updated Guidance: CMS MDS 3.0 Facilities should begin updating documentation methods in support of new RAI guidelines & MDS 10.1.23 Federal-based required changes. However, ensuring to retain evaluation, care plans, and other documentation items that support coding RUG-IV items. **Example:** Section G- Late Loss ADLs, PHQ-9
The OSA is a standalone assessment that cannot be combined with any other assessment type, this will be an added assessment to the required federal assessment completion schedule.	Monitor & Review your E H R Provider Updates to ensure you have elected to enable the COPY OVER configuration feature to eliminate additional unnecessary workloads.
	The OSA Item Set is 20 pages in length and includes an abbreviated Sections G, I and O (Special Treatments): The direct link to the 3 items in a .zip file is **here**. This file includes: OSA Item Set Change History version 1.0 OSA Item Set version 1.0 OSA Manual version 1.0
RI Medicaid Case Mix FAQ under development to include OSA guidance.	

ATTENTION NURSING HOME PROVIDERS

As you know, CMS is ending support for RUG-III and RUG-IV on federally required assessments for patients residing in Nursing Facilities and Skilled Nursing Facilities as of October 1, 2023, but will allow for the use of Optional State Assessments (OSAs) through 9/30/2025. Beginning 10/1/2025, CMS will no longer support the RUG-III and RUG-IV groupers via the OSAs. RI Medicaid has been working with CMS to understand our options regarding NF payments. From 10/1/2023 through 9/30/2025, RI Medicaid will require that nursing facilities use OSAs to continue RUG-IV based payment while RI Medicaid moves toward the adoption of the PDPM model in October 2025.
The OSAs will gather the needed assessment data to calculate a RUG payment amount for provided services. Between 10/1/2023 – 9/30/2025, the only method for states to obtain a RUG calculation via the CMS submission system (iQIES) will be the OSA.

The Federal MDS assessments (quarterly, comprehensive, PPS, IPA, discharge) will not contain all needed items for RUGs and thus a score will not be calculated. Several items—A0300, D0200, D0300, G0110, K0510, O0100, O0450, O0600, O0700, and X0570 have been removed from federally required item sets but remain on the OSA for the purpose of calculating RUG-IV scores.

Instructions for completing these items are included in CMS posted OSA Item Set and Manual on its website [cms.gov].
Instructions for completing other items on the OSA can be found in the respective sections of Chapter 3 of the Minimum Data Set (MDS) Resident Assessment Instrument (RAI) 3.0 User's Manual, available on the CMS website [cms.gov].

CMS noted that if the provider's billing software is up to date with CMS' current MDS specification then the OSAs will be completed using existing billing software.

Attention Nonskilled Home Care Providers

EOHHS is implementing a rate increase for nonskilled home care services as of the date of service 7/1/23. Gainwell has updated the rates in the Medicaid system. Sandata is making every effort to get the rates updated as well. If Sandata is not able to accomplish this before billing for these dates of service, a mass adjustment may be needed. This is because the Medicaid system will pay based on the lessor of logic, the allowed amount or the billed amount whichever is less. If a mass adjustment becomes necessary, a communication will be sent out to let providers know which RA that you can expect to see the adjusted claims on.
The below reflects the base rates for procedure codes S5125, S5125 U1 and S5130. Please begin billing at these rates for those agencies without enhanced rates. For agencies that have been approved for enhanced rates, the rates for the procedure codes S5125, S5125 U1 and S5130 were sent out by email on 6/29/23.

If you have any questions please contact marlene.lamoureux@gainwelltechnologies.com

Procedure Code	Description	Allowed Amount per unit
S5125	Attendant Care Services; per 15 minutes	$6.79
S5125 L9*	BHDDH Only	$14.68
S5125 U1	Combined Attendant Care/Homemaker; per 15 minutes	$6.56
S5130	Homemaker Services; per 15 minutes	$6.35
S5130 L9*	BHDDH Only	$14.68
S5130 TE*	BHDDH Only	$14.68
T1000 with and w/o shift modifiers*	Private Duty Nursing; per 15 minutes	$14.68
T1000 TE with and w/o shift modifiers*	Private Duty Nursing; per 15 minutes LPN	$11.88
T1001*	Nursing Assessment/Evaluation for the following programs: LTSS-HCBS Services , Medicaid Preventive, Habilitation Community and OHA Community Services and Severely Disabled Home Care Services	$106.21

No enhanced rates

Attention Skilled Home Care Providers

EOHHS has implemented a rate increase for skilled home care services as of 7/1/2023. The below procedure codes reflect this most recent update. Please begin billing at these rates in order to be reimbursed at these higher rates for dates of service 07/01/2023 forward.

Description	Procedure Code	Rate Effective 07/01/2023
RN, PT, OT and SP Per Visit	X0043	$117.16
Home Health Aide per unit	G0156	$7.71

Attention Hospice Providers

EOHHS has implemented a rate increase for hospice services as of 7/1/2023. The below rates reflect this most recent updates to the allowed amounts for these procedure codes. Please begin billing at the new rates to be reimbursed at these higher rates for dates of service 07/01/2023 forward.

Description	**Procedure Code**	**Effective 7/1/2023 forward**
Hospice Routine Home Care	T2042 Days 1-60	$258.97
Hospice Routine Home Care	T2042 Days 61+	$203.40
Hospice Continuous Home Care Per Hour	T2043	$66.31
Hospice Inpatient Respite Per Diem	T2044	$539.24
Hospice General Inpatient Care Per Diem	T2045	$1157.14
Services of clinical social worker in hospice setting	G0155	$16.58
Direct skilled nursing services of a registered nurse in a hospice setting	G0299	$16.58

Attention Community Supports Management (CSM) Users

The Community Supports Management Website was designed to help users enter forms electronically. Users can enter the following forms on the CSM without a need to fax them over to the local DHS office.

Nursing Home Admission Slips

Nursing Home Discharge Slips

In order to gain access to the CSM Website, **all new users must fill out and submit a** CSM User ID form which can be found on the www.eohhs.ri.gov website. Please email the completed form to Nelson.Aguiar@gainwelltechnologies.com.

Once the form is received, please allow 7-10 business days to process your request. The user will receive an email with their CSM User ID, a temporary password, and a link to the CSM with some basic instructions on logging in.

Please remember that passwords must be between six and eight alphanumeric characters in length, contain no special characters or spaces, cannot be all nines and expire every 90 days.

For passwords that require Gainwell to reset them for you, please email rixix-ticket-system@gainwelltechnologies.com or call 1-844-718-0775.

***Important Reminder**

Please remember as a user of the Rhode Island Community Supports Management System (CSM), it is your agency's responsibility, upon someone leaving your workforce, to notify the State of Rhode Island Executive Office of Health and Human Services or Gainwell to revoke access to the CSM. Requests for termination of access must be sent on the CSM User Form, with the selection of "Delete" at the top of the form. Please send the form to Nelson.Aguiar@gainwelltechnologies.com to have the worker's access to CSM removed. It is our shared responsibility to prevent unauthorized access to the CSM and to protect and safeguard the Personal Health Information of our Health & Human Services program enrollees.

Attention Dental Providers

As noted in the Dental Provider Manual, in-office topical fluoride is covered for recipients 21 years of age or older who have medical or dental conditions that significantly interrupt the flow of saliva. These conditions may include, but are not limited to, radiation therapy, tumors, and certain drug treatments, such as some psychotropic medications and certain diseases and injuries.

When used as a preventive measure only for members at low risk for caries, topical fluoride treatment for recipients 21 years or older is not a covered benefit of Medicaid. To support use of topical fluoride, providers should document level of caries risk. It is required that once a year for topical fluoride varnish (prophylaxis not included) D1206 and topical application of fluoride-excluding varnish D1208 that caries risk assessment is listed on claims.

Those codes are:

D0601 -Caries risk assessment and documentation, finding of low risk

D0602 -Caries risk assessment and documentation, finding of medium risk

D0603 -Caries risk assessment and documentation, finding of high risk

These codes should be billed at zero dollars ($0). Codes D0602 and D0603 both support the use of topical fluoride in adult however D0601 does not. The assessment must have been performed within the twelve months directly preceding the date of service for D1206 or D1208. Providers should perform a caries risk assessment for patients using a Caries Risk Assessment form of their choice. In typical use, a copy is provided to the patient, and a copy is kept in the record. Failure to comply could lead to claims being recouped.

Resource: Caries Risk Assessment and Management, American Dental Association

- Caries Risk Form (over age 6)
- Topical fluoride for caries prevention

If you have questions, please contact customer service at 401-784-8100 and for in-state toll calls, 800-964-6211.

You may also contact Andrea Rohrer, Provider Representative at (469) 897-4389 or andrea.rohrer@gainwelltechnologies.com

Attention: Inpatient and Outpatient Hospitals

The inpatient hospital DRG base rate has been increased to $14,431.00, effective 7/1/2023. The DRG Calculator located on the EOHHS website has been updated to reflect the change. Claims submitted and previously paid with a date of service on or after 7/1/2022 will be adjusted by RI Medicaid.

Outpatient hospital rates are being increased by 4.1% above their current level, effective 7/1/2023. The rates will be available on the EOHHS website.

If you have questions please contact the Customer Service Help Desk at 401-784-8100 or for in-state toll calls 800-964-6211 or your Provider Representative.

Attention Community Health Workers

EOHHS has implemented a rate increase for community health worker services. The below procedure code and modifiers reflect this most recent update. Please begin billing at these rates in order to be reimbursed at these higher rates for dates of service now and moving forward. Effective date for SFY 23 is 07/01/2022-06/30/2023 and Effective date for SFY 24 is 07/01/2023– current.

Procedure Code	**Modifier**	**Rates Effective SFY 23 *7/01/2022***	**Rate Effective SFY 24 *07/01/2023***
T1016	No Modifier (Established Patient)	$12.41	$12.69
T1016	U3 (New Patient)	$16.14	$16.51
T1016	HQ (Group Setting)	$4.55	$4.65

If you have any questions, please reach out to your provider representative Andrea Rohrer at andrea.rohrer@gainwelltechnologies.com.

Attention Federally Qualified Health Centers

Effective 07/01/2022 FQHCs can receive reimbursement for LARC (Long-acting reversible contraception) separately from and in addition to your reimbursement for encounters. You will need to use the appropriate NDC with the J codes listed below.

The LARC procedure codes are:

Intrauterine contraceptive devices, including:

J7296 (Kyleena)

J7297 (Liletta)

J7298 (Mirena)

J7300 (ParaGard)

J7301 (Skyla)

Implants, including:

J7307 (Nexplanon)

Billing instructions

In addition to billing your encounter claims, you may bill the applicable procedure code from the list above on a separate claim and receive full reimbursement for those codes. If you're enrolled as a 340B provider and purchase those drugs at a discounted price, you will need to send us your 340B report. You can send over that report to our enrollment department at rienrollment@gainwelltechnologies.com.

Please contact Andrea Rohrer, Provider Representative at andrea.rohrer@gainwelltechnologies.com if you have questions.

Partner Advisory from the Rhode Island Executive Office of Health & Human Services Regarding Access to Mifepristone- 4/17/2023

Under the leadership and direction of Governor Daniel McKee, the Rhode Island Executive Office of Health & Human Services (EOHHS) is committed to ensuring patients' access to Mifepristone as various national legal proceedings continue. Access to this medication remains legally protected in Rhode Island.

Mifepristone is a medication prescribed to people for the medical termination of pregnancy. This medication is safe and effective and has been authorized for use by the U.S. Food and Drug Administration (FDA) for more than 20 years.

EOHHS has taken the following actions to ensure Rhode Islanders have access to Mifepristone:

Communicated and required our three contracted Medicaid Managed Care Organizations, Neighborhood Health Plan of Rhode Island, UnitedHealthcare of New England and Tufts Health Public Plans, which currently serve one out of every three Rhode Islanders, continued access to Mifepristone under current rules and regulations allowed under the Medicaid Program;
Coordinated with the Rhode Island Department of Health (RIDOH), the Office of the Health Insurance Commissioner (OHIC) and HealthSource RI to provide information to other commercial and qualified health plans, doctors and other prescribers, and pharmacies; and
Shared important updates with community partners and advocates to ease concerns or confusion in light of various federal rulings about Mifepristone access. As of today, this access remains legal and allowable in Rhode Island.

"At EOHHS, we work every day to ensure that all Rhode Islanders have a voice, a choice and equity in the health and human services they and their families receive," said EOHHS Acting Secretary Ana Novais. "I am proud to stand with the organizations and advocates who fight every day for reproductive rights—whether it be for this medication or for our Equity in Abortion Coverage proposal, as all people deserve a comprehensive array of reproductive services from our health system. **As of today, all Rhode Islanders have access to the same coverage, treatments, and care that they had before federal court rulings. Access to mifepristone is not impacted in Rhode Island.** We will continue to work with the Governor and our state's health and human services agencies to share information, ensure that access to Mifepristone and other essential treatment continues to be protected, and inform the public about any changes on this matter."

Pharmacy Spotlight

Attention Pharmacies

Due to the restart of Medicaid Renewals, there may be instances where Medicaid members are losing coverage or experiencing gaps in coverage. Gaps in coverage could impact managed care enrollment. When presented with a managed care claim denial, please request the white anchor ID card from the member. The white anchor card contains the members fee-for-service ID which may be active during a managed care coverage gap.

RI AIDS Drug Assistance (ADAP) – Payor of Last Resort

What does this mean? Simply, that all other prescription benefits must be billed before billing ADAP.

When a RI AIDS Drug Assistance (ADAP) patient presents a prescription for a pharmacist to fill, the pharmacist should ask the patient to provide all cards for private prescription programs, Medicare Part D or Medicaid.

All non-ADAP prescription drug programs will be the primary payor. If the drug is covered under the scope of primary payer's program, then RI ADAP will pay the co-pay. If the drug is not covered by the primary payer's program, **and** ADAP covers the drug, then ADAP will pay the claim.

If the primary payor denies the claim because the drug requires prior authorization, then a PA must be sought from the primary payor.

At-Home COVID-19 Test Kits Update

RI EOHHS Fee-for-Service (FFS) Medicaid program allows enrolled pharmacy providers to process At-Home COVID Test Kits at point of service (i.e., at the pharmacy). As with any over-the-counter (OTC) product, coverage of the claim requires a prescription. **As of February 24, 2023, the RI Department of Health (RIDOH) standing order for At-Home COVID-19 Test Kits is expired**. Therefore, in order to obtain an At-Home COVID-19 Test Kit, the beneficiary must request a prescription from their FFS Medicaid enrolled prescriber. The process to prescribe an At-Home COVID-19 Test Kit is the same as the process for other OTC product. Coverage for At-Home COVID-19 Test Kits is unchanged; this update is solely regarding the need for a prescription from beneficiaries' prescribers now that the RIDOH standing order is expired.

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 12th, 2023

In Person Registration on site: 7:30 AM

Meeting: 8:00 AM

Location: Executive Office of Health and Human Services, Virk's Bldg., 3 West Road, Cranston, RI

Click here for agenda

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

Date: September 12th, 2023

In Person Registration on site: 10:15 AM

Meeting: 10:30 AM

Location: Executive Office of Health and Human Services, Virk's Bldg., 3 West Road, Cranston, RI
om

Click here for agenda

2023 Meeting Dates:

September 12th,2023
December 12th, 2023

Pharmacy Spotlight cont.

The following drugs changed status on the RI Medicaid Fee-for-Service Preferred Drug List (PDL) effective July 2023.

Antibiotics, GI **Changed status to Non-preferred** Firvanq	**Antibiotics, Vaginal** **Changed status to Non-Preferred** Clindesse Nuvessa
Hepatitis C Agents **Changed status to Non- Preferred** Vosevi	**Macrolides/Ketolides** **Changed status to Non-Preferred** E.E.S. 200 suspension **Changed status to Preferred** erythromycin ethylsuccinate 200 Suspension erythromycin ethylsuccinate 200 Suspension (AG)
Tetracyclines **Changed status to Preferred** doxycycline monohydrate tablet	**Acne Agents, Topical** **Changed status to Non-Preferred** Retin-A cream **Changed status to Preferred** tretinoin cream
Rosacea Agents, Topical **Changed status to Preferred** metronidazole cream metronidazole gel metronidazole gel (AG)	**Cytokine and CAM Antagonists** **Changed status to Preferred** Otezla
Bronchodilators, Beta Agonist **Changed status to Preferred** Xopenex HFA	**Intranasal Rhinitis Agents** **Changed status to Preferred** Dymista
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	

Rite Share Billing

Program Description

RIte Share is Rhode Island's Premium Assistance Program that provides help paying for an employer's health insurance plan. The State will pay all or part of the cost for employee health insurance coverage.

Professional Billing

Rite Share Paper Submission

RI Medicaid will usually pay the patient responsibility (coinsurance and/or deductible) portion indicated on the EOB of the primary payer of recipients enrolled in the Rite Share program. Payments are capped at $500.
When billing RI Medicaid for the patient responsibility portion of the services billed to the primary payer;

- There should be only one line of charges on the claim
- The charge on that detail should be the total amount of the coinsurance and/or deductible
- Total charges should equal those on detail one.
- No "other insurance" information should be reported on the claim
- No "prior payments" should be reported on the claim
- Primary payer EOB should be included with the claim
- HCPC code is X0701

RIte Share-Electronic Submission

Patient Responsibility (coinsurance and/or deductible) should be submitted using the actual procedure code for the services performed. Indicate yes to other insurance and enter Adjustment Codes, Group/Reason Codes as reported on the primary payers EOB. The PR codes will indicate the amount of the coinsurance and/or deductible.

Institutional Billing

RIte Share-Paper Submission

RI Medicaid will usually pay the patient responsibility (copay, coinsurance and/or deductible) portion indicated on the EOB of the primary payer of recipients enrolled in the Rite Share program. Payments are capped at $1000 and are paid at the Ratio of Cost to Charges (RCC) x total charges rate.

When billing RI Medicaid for the patient responsibility portion of the services billed to the primary payer;

- There should be only one line of charges on the claim
- The charge on that detail should be the total amount of the copay, coinsurance and/or deductible
- Total charges should equal those on detail one.
- No "other insurance" information should be reported on the claim
- No "prior payments" should be reported on the claim
- No primary payer EOB should be included with the claim
- All amounts are paid at the RCC x total charges
- TOB should be 994
- For Hospitals the Provider ID will be the Legacy ID not the NPI/Taxonomy

RI Medicaid may also consider for payment services that are non-covered by the primary carrier if these services are generally covered by Medicaid. ***Note: Any denials by primary indicating non-compliance with policy are considered invalid and Medicaid will not consider these services for payment.***

RIte Share-Electronic Submission

Patient Responsibility (copay, coinsurance and/or deductible) should be submitted using the actual procedure code for the services performed. Indicate yes to other insurance and enter Adjustment Codes, Group/Reason Codes as reported on the primary payers EOB. The PR codes will indicate the amount of the coinsurance and/or deductible.

New - Fingerprinting Requirements for "High Risk" Providers and Owners

With the passage of the SFY23 budget and in accordance with Section 6401 of the Affordable Care Act, Medicaid enrollment. Requires a fingerprint-based criminal background check (FCBC) as part of new screening and enrollment requirements for all "high risk" providers and all persons with a 5% or greater direct or indirect ownership interest in such providers. The final rule for Section 6401 assigned risk levels for provider types that are recognized by Medicare. Rhode Island Medicaid adopted those risk levels and assigned risk levels for Medicaid-only provider types. Provider screening and enrollment requirements are based on the risk level for a particular provider type or provider.

Rhode Island Medicaid may rely on fingerprinting and background checks performed by Medicare (or another State Medicaid Agency) for an individual when it can be verified, and the provider is still in an approved status.

The following is a list of the provider types that have been classified as high risk.

High Risk Providers

- New enrollees in the following provider types:
  - Durable Medical Equipment Providers (newly enrolling on or after July 1, 2018 only)
  - Home Health Agencies (newly enrolling on or after July 1, 2018 only)
- Federal regulations also require that any provider that meets one of the following criteria be classified as high risk:
- Has had a payment suspension based on a credible allegation of fraud, waste, or abuse since July 1, 2018;
- Excluded by OIG or another state Medicaid program within the past 10 years; or
  Has a qualified overpayment and is enrolled or revalidated on or after July 1, 2018

Notification and Process

Impacted providers will receive written notification from Rhode Island Medicaid that they and/or their owners are required to comply. Applicant Registration form will need to be uploaded to the Provider Portal within 30 days. That information will be entered into the Rhode Island Office of the Attorney General's fingerprinting system by Rhode Island Medicaid.

A letter will then be generated and sent to the individuals to be fingerprinted that includes a unique ID number and instructs them to visit the Rhode Island Office of the Attorney General's offices in Cranston, Rhode Island within 30 days. Providers must ensure that each of their qualifying owners do so within this timeframe.

Failure to have the fingerprints of each individual on the notification letter scanned within these time frames may result in denial of an enrollment application or termination of enrollment with Rhode Island Medicaid.

Continued: New - Fingerprinting Requirements for "High Risk" Providers and Owners

In addition, if providers or their owners are found to have been convicted of any the legislative disqualifying felonies under the National Criminal Background Check Program (NBCP) and/or convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs, Rhode Island Medicaid may deny their enrollment application or terminate their enrollment. To avoid a denial or termination, providers may be required to remove any owners who fail to have their fingerprints scanned within 30 days, or are found to have been convicted of any of the previously mention offences.

Background Check Results

The results of your National Background Check (NBC) will be provided directly to Rhode Island Medicaid, where you will receive a qualified or unqualified decision. An unqualified decision is reached when one of the nineteen felonies are found during the background check, if you receive an unqualified decision, you are entitled to reach out to the Attorney General's office for detailed information and appeal the decision.

Providers/Owners that receive an unqualified decision will not be allowed to participate in Rhode Island Medicaid.

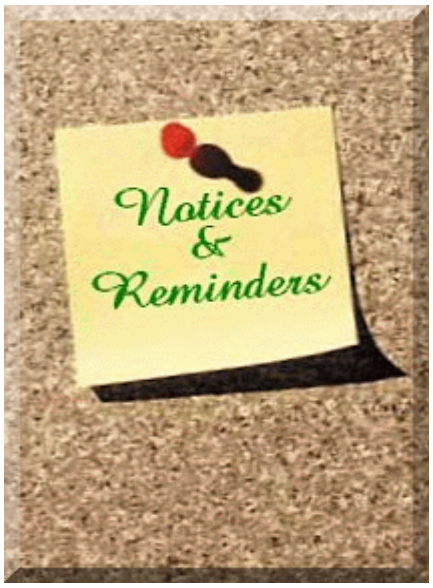
Signature Requirements

Several RI Medicaid documents still require live provider signatures (no stamps, typed or initials) to be accepted. If the document is received without the live signature, it will be returned for signature, delaying the processing of your request.

This applies to the following documents:

- Paper Claim Forms
  - ◊ ADA Dental
  - ◊ CMS 1500
  - ◊ UB-04
  - ◊ Waiver/Rehab
- All Prior Authorization Forms
- MDS Forms
- Certifications of Medical Necessity
- Paper Provider Enrollment Applications for adding new providers to a group
- W-9 Form
- Paper Adjustment and Recoupment forms
- Electronic Funds Transfer (EFT) Paper Form
- Provider Change of Information Forms

There has been an increase in documents being returned to providers and we want to ensure to process documents in a timely manner for all providers. Thank you for your understanding



Keep up to date with all provider news and updates on the EOHHS website:

Provider News

Provider Updates

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

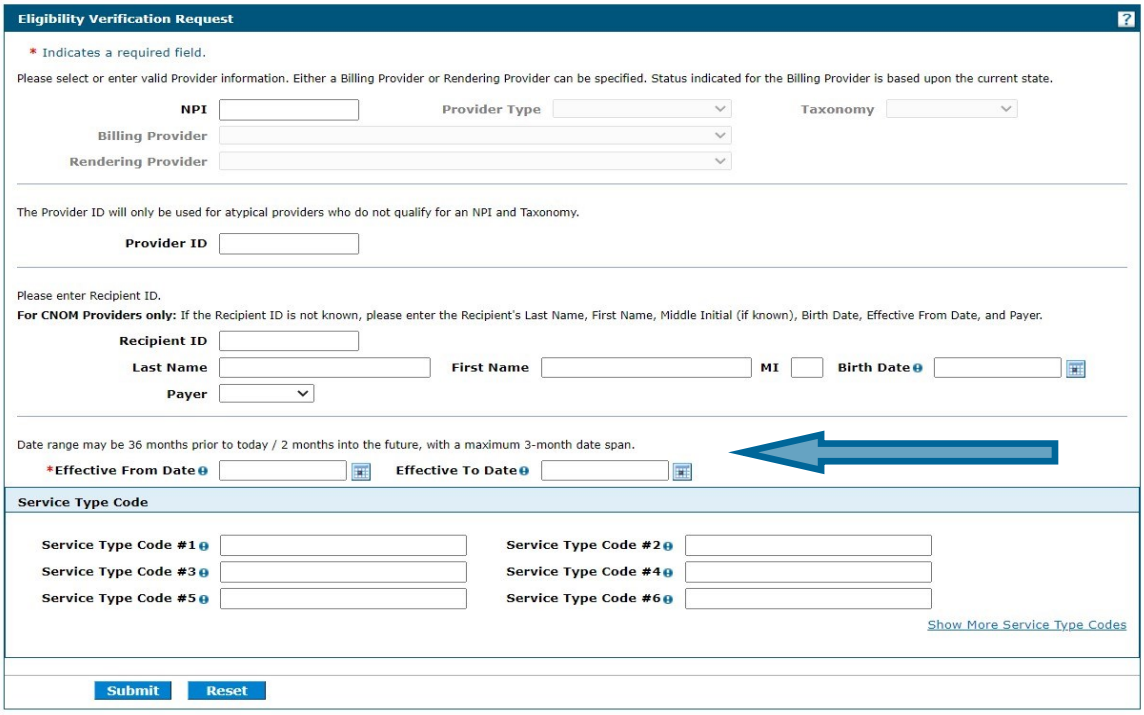
Provider Enrollment Application Fee

As of January 1, 2023 the application fee to enroll as a Medicaid provider is $688.00

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

Healthcare Portal Recipient Eligibility Verification

The Healthcare Poral functionality for verifying eligibility allows providers to check the previous thirty-six (36) months and two (2) months into the future from the present date. The maximum span of three (3) months per inquiry is allowed. The timely filing rule of one (1) year from date of service applies to claims processing.



Information Regarding Remittance Advice

Just a reminder…..

As a reminder, remittance advice (RA) documents are accessed through the Healthcare Portal. The most recent four RA documents are available for download.

Providers must download and save or print these documents in a timely manner to ensure access to the information needed. When a new RA becomes available, the oldest document is removed, and providers are unable to access it. The Payment and Processing calendar lists the dates of the RA for your convenience.

RI Medicaid does not provide printed copies of RA documents. Please see the financial schedule here.

Meet the Teams that Support our Providers

RI Medicaid would like to introduce you to our Provider Representatives.

Provider Representative

Keri Thompson is a recent addition to the RI Medicaid Provider Representative Team as an Electronic Data Interchange (EDI) coordinator, joining in April 2023.

Keri brings with her over 15 years of customer service experience in the healthcare industry.

Previous to her role with Gainwell Technology, she worked at XRA Medical Imaging for 9 years as a Billing support specialist/Trainer and became proficient in handle different types insurance. In her new role, she enjoys working with the provider community, familiarizing herself with the Medicaid program and EDI.

In her time outside of work, Keri like to entertain and spend time with her family and friends, attending all her son's sporting events, and reading.

PAYMENT ERROR RATE MEASUREMENT PROGRAM (PERM)
INITIAL MEDICAL RECORDS REQUESTS

CMS PERM Review Contractor, NCI Information Systems, Inc. continues to review randomly selected samples of claims to request medical records for. Additional (First, Second, Third/Final Notice of Non-Response) medical records requests are mailed to providers.

If you receive one of these requests, please follow the instructions for submission. This request, as pictured below, is a legitimate request from a CMS contractor. Failure to submit medical records could lead to claim recoupment.

Date: [||RequestDate||]
Reference ID: [||PERM ID||]
OMB Control Number: [||OMB#||]
NPI: [||NPI#||]

Request Type & Purpose: Additional Documentation Request (First Additional Documentation Request)
Subject: Additional Documentation – This is not a duplicate request

To request a copy of this letter in Spanish, please contact the PERM Customer Service Department at 800-393-3068. Once a Spanish-language letter is requested, all future correspondence for this specific PERM ID will continue in Spanish.

Para solicitar una copia de esta carta en Español, por favor de contactar al Departamento de Servicio al Cliente de PERM al 800-393-3068. Una vez que la carta en Español sea solicitada, toda correspondencia futura especifica a este identificación PERM será continuada en Español.

Dear Medicaid and/or CHIP Provider:

The Centers for Medicare & Medicaid Services (CMS), in partnership with the states, is measuring improper payments in Medicaid/CHIP under the Payment Error Rate Measurement (PERM)[1] program.

Reason for Selection: A claim submitted by or on behalf of you/your organization has been randomly selected for review under this program. The review will be completed by CMS' review contractor, NCI Information Systems, Inc.

Action: Send Additional Documentation: A request for the medical/supporting record was sent to you on xx/xx/xxxx for the beneficiary listed on the enclosed Claim Summary. Thank you for your response to the request. It has been determined by the reviewer, however, that additional documentation is needed to complete the review of this claim. **Your cooperation in submitting the additional documentation to us within fourteen (14) days is essential to ensure that the claim is accurately reviewed to determine proper payment.** Federal regulations require that you provide the documentation to support claims for Medicaid/CHIP services upon request[2]. **Providing medical records for Medicaid/CHIP patients does not violate the Health Insurance Portability and Accountability Act (HIPAA). Patient authorization *IS NOT REQUIRED* to provide medical records in response to this request.** CMS and its contractors will remain in compliance with the Privacy Act and regulations.

When: [||MedrecDueDate||]
Please provide the requested documentation by [||**MedrecDueDate**||]. **A response is still required by [||MedrecDueDate||] even if you are unable to locate the requested information.**

Consequences: If you fail to deliver the requested additional documentation or contact us by [||**MedrecDueDate**||], the claim will be cited as an erroneous payment and your state agency may pursue recovery of payment for this claim from you.

State FY 2024
Claims Payment and Processing Schedule

MONTH	LTC CLAIMS Due at Noon	EMC CLAIMS Due by 5:00PM	EFT PAYMENT
July	7/06/2023	7/07/2023	7/14/2023
		7/21/2023	7/28/2023
August		8/4/2023	8/11/2023
	8/10/2023	8/11/2023	8/18/2023
		8/25/2023	9/01/2023
September			
	9/07/2023	9/08/2023	9/15/2023
		9/22/2023	9/29/2023
October	10/05/2023	10/06/2023	10/13/2023
		10/20/2023	10/27/2023
November		11/03/2023	11/10/2023
	11/092023	11/10/2023	11/17/2023
		11/24/2023	12/01/2023
December	12/07/2023	12/08/2023	12/15/2023
		12/22/2023	12/29/2023
January		1/05/2024	1/12/2024
	1/11/2024	1/12/2024	1/19/2024
		1/26/2024	2/02/2024
February	2/08/2024	2/09/2024	2/16/2024
		2/23/2024	3/01/2024
March	3/07/2024	3/08/2024	3/15/2024
		3/22/2024	3/29/2024
April	4/04/2024	4/05/2024	4/12/2024
		04/19/2024	04/26/2024
May		5/03/2024	5/10/2024
	5/09/2024	5/10/2024	5/17/2024
		5/24/2024	5/31/2024
June	6/06/2024	6/07/2024	6/14/2024
		6/21/2024	6/28/2024
July		7/05/2024	7/12/2024
	7/11/2024	7/12/2024	7/19/2024
		7/26/2024	8/02/2024

View the SFY 2024 Payment and Processing Schedule on the EOHHS website

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

Notable Dates in July

July 4th-Independece Day

July 11th -World Population Day

July 15th -World Youth Skills Day

July 30th -International Friendship Day