Rhode Island Medicaid Program

August 2023

Provider Update

See page 2 for Table of Contents.

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

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.

August 2023
Provider Update

RI Medicaid Customer Service Help Desk for Providers
Available Monday—Friday
8:00 AM-5:00 PM
(401) 784-8100
for local and long distance calls
(800) 964-6211
for in-state toll calls

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Medicaid Renewal Update

As of August 2023, five cohorts totaling about 70,000 Rhode Islanders have begun their renewal process. Interested in seeing the breakdown? Visit the Medicaid renewals dashboard on staycovered ri.gov.

CMS Updates

The Centers for Medicare and Medicaid Services (CMS) recently approved RI Medicaid Program's request for two temporary waivers. Our hope is that implementing these two changes will increase renewal rates and reduce gaps in coverage. Here is some information about both of those waivers, which go into effect immediately:

1. Temporarily waive the beneficiary asset test for renewals for non-MAGI eligibility groups. According to program records, no Medicaid members had their coverage terminated due to a benefit asset test since renewals restarted in April. This means that no corrective action is needed on any previous benefit determinations.

2. Temporarily permit Medicaid managed care organizations (MCOs) to assist their enrollees in completing the Medicaid renewal process, including completing certain parts of their renewal forms, in order to help reduce the number of procedural terminations during the state's unwinding period. The Medicaid Program has been in touch with MCOs to communicate this change.

Updated Communications Resources

- Recently updated Medicaid renewal FAQs are available in multiple languages to assist people with the Medicaid renewal process. To download the FAQs, and other helpful resources, visit our Medicaid renewal's materials page on staycovered.ri.gov.

- The Medicaid Renewal Date Look Up Portal is in development. This portal will allow Medicaid members, and people who may be helping them with their renewal, to easily and securely look up their anticipated renewal date without logging in to an account. We will share more details about this tool in the near future.

- Check out a series of short videos on YouTube that will help Medicaid members set up and use the HealthyRhode Mobile App. Videos are also being produced in Spanish and Portuguese.

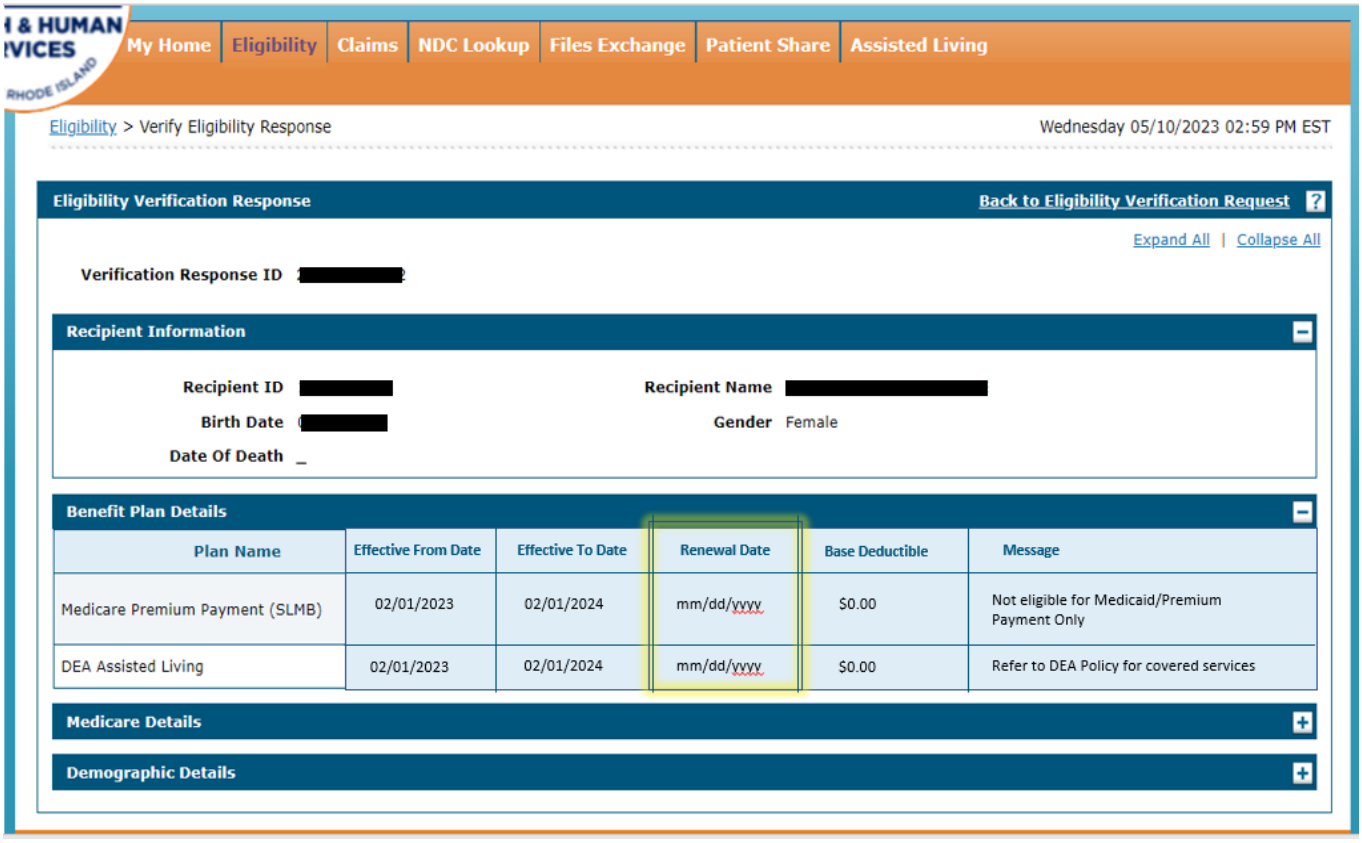
- Lastly, check out our recently updated webpage on Medicaid renewal information for healthcare providers.

Health Care Portal Medicaid Eligibility Renewal Dates

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

WHAT DOES THIS MEAN FOR YOU?????

Coming soon 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.



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.

Cedarr Rate Reform

2023 House Bill 5200 Substitute A as Amended authorizes EOHHS to implement a rate reform for CE-DARR Family Services.

Changes detailed below effective 7/1/2023

HCPCS	Description	Change
T2022	CASE MANAGEMENT, PER MONTH	End date as a billable service 6/30/2023.
T1023	SCREENING TO DETERMINE THE APPROPRI-ATENESS OF CONSIDERATION OF AN INDI-VIDUAL FOR PARTICIPATION IN A SPECI-FIED	New Rate effective 7/1/2023 - $330.00
H2000	COMPREHENSIVE MULTIDISCIPLINARY EVALU-ATION	Rate: $220 per unit Max: 4 units per year
H2021	COMMUNITY BASED WRAP AROUND SER-VICES, PER 15 MINUTES	Rate: $20 per unit. Unit interval: 15 minutes

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.

Attention Ambulance Providers:

EOHHS is implementing a rate increase for ambulance services as of date of service 7/1/23. 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 and forward.

Procedure Code	Description	Rate through 6/30/2023	7/1/2023 Rate-Forward
A0427 with all modifiers	AMBULANCE SERVICE, ADVANCED LIFE SUPPORT, EMERGENCY TRANSPORT, LEVEL 1 (ALS 1 EMERGENCY)	$69.95	$213.23
A0429 with all modifiers	AMBULANCE SERVICE, BASIC LIFE SUPPORT, EMERGENCY TRANSPORT (BLS EMERGENCY)	$69.95	$179.56

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

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***

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

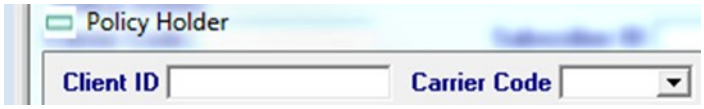
Continued on next page:

Electronic Billing for Medicare and Senior Replacement/Advantage Plans

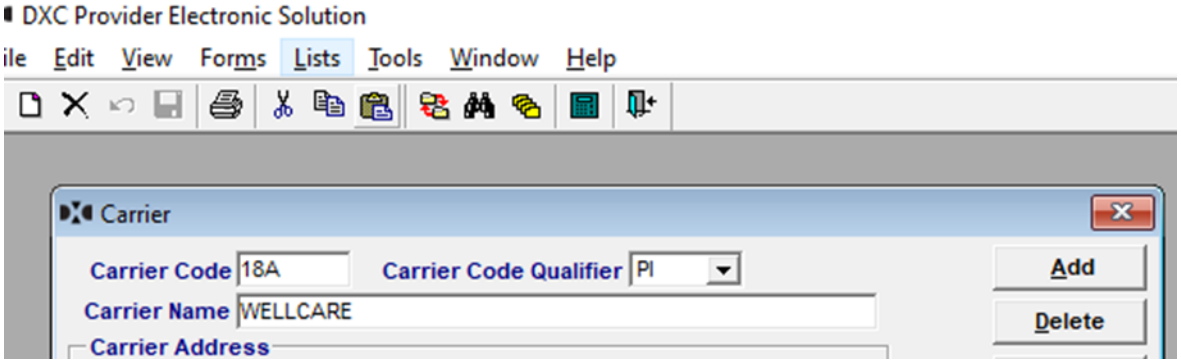
For PES Users, continued:

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.

Billing for Partial and Complete Dentures

Providers must use the date of delivery as the date of service when requesting payment for a partial or complete denture. Submission of a claim for payment indicates that all services on the claim have been completed or delivered. Therefore, claims for complete or partial dentures ***must not*** be filed until the date the appliances are delivered to the beneficiary. Medicaid payment may be recouped for claims filed using a date other than the delivery date.

Note: If the beneficiary's Medicaid eligibility expires ***between*** the final impression date and delivery date, the provider shall use the final impression date as the date of service. This exception is allowed ***only*** when the dentist has completed the final impression on a date for which the beneficiary is eligible ***and*** has actually delivered the denture(s). The delivery date ***must*** be recorded in the beneficiary's chart.

ADA Stretcher Compliance- NEMT Benefit

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

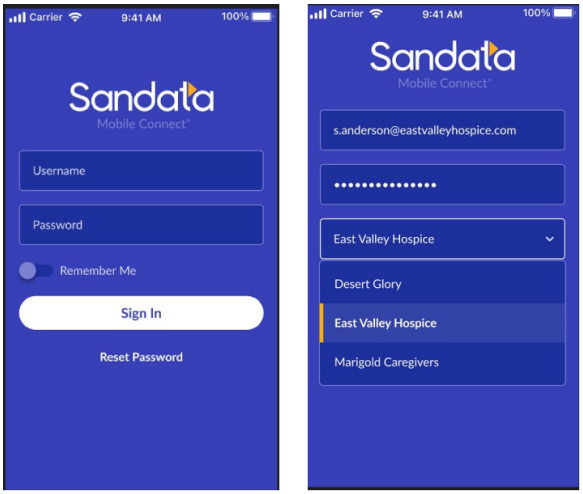
Under Title III of the Americans with Disabilities Act (ADA), healthcare providers must comply with the relevant physical access accommodations. Providers are required to make 'reasonable accommodations' to policies, practices, and procedures to avoid discriminating against an individual with a disability. 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.

New EVV Sandata Mobile Connect App Coming

Your EVV experience is about to get better! In July, a new Sandata Mobile Connect (SMC) app will launch in the App Store and Google Play.



This new app will help make EVV more efficient by focusing on the user experience and includes new features, like:

- Improved log in with a single username and password for all your agency accounts.
- Better offline performance when service is disrupted.
- Prompts to help you collect the information you need without mistakes.

Sandata Mobile Connect App
TRANSITION GUIDE

Where do I find the new app?
The new and improved app will be listed in the Apple Store and Google Play as Sandata Mobile Connect, mid-July. The original app will be renamed to Sandata Mobile. Look for the purple icon for Sandata Mobile Connect.

Sandata Mobile Connect App (opening July 2023)	Sandata Mobile App (live until July 2024)
	

How do I download the app?

1. Visit the App Store or Google Play store, depending on your mobile device.
2. Type "Sandata Mobile Connect" in the store's search bar.
3. Select the listing with the purple Sandata Mobile Connect app.
4. You will be taken to the app's page. Click the "install" or "get" button. You may need to enter your device password to complete the download.
5. Look for the app on your home screen.
6. Tap the icon to open the app and start using it.

What do I need to log in to the app?
To log in to the new Sandata Mobile Connect app, you will need to enter a username and password of your choice.

Username: Please use an email address you already use with your agency. If you have accounts with multiple agencies, you only need to select one of those emails. With our new simplified sign-on process, you'll select your agency after sign-on.

Password: When signing-on for the first time, you will be asked to create your own password.

With the new app, you will use the same username and password for all your agency visits. You will not need to log-on separately for visits with different agencies. You will only need to remember one username and password.

Sandata Mobile Connect App

TRANSITION GUIDE continued

What are the benefits of the new app?
The new Sandata Mobile Connect app focuses on the customer experience. Caregivers will have better functionality and guidance within the app to complete record keeping in real time, allowing them to spend less time in the app and more time with their clients.

Can I continue to use the original Sandata Mobile app?
You will still be able to log in to the original app, Sandata Mobile. If you log in to the new Sandata Mobile Connect app, your username and password will be updated for the existing Sandata Mobile app as well.

Can I use both apps at the same time?
Yes. You can use both apps at the same time. However, if you begin a visit in one app and end it in another, you will need to reenter any tasks completed during that visit.

Will any existing features go away with the launch of the Sandata Mobile Connect app?
No. At this time there are no features that will go away. There may be slight differences in how things look or how they might be referred to, but the core functions will remain the same.

Is there any training available for the new app?
Yes. Training will be available on Sandata On-Demand for all new features pre-launch. Additional training documentation for existing features will be updated with the new look of the app as soon as possible.

What happens if I forget my password to the new app?
Password reset has been made easier with the new app! Now, instead of reaching out to an administrator, you'll be able to request a password reset prompt to be sent to your email and can reset your password yourself.

Attention Nonskilled Home Care Providers

EOHHS has implemented 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. In addition, Sandata was able to get the updated rates in their system (EVV) before 7/1/23. Therefore, no mass adjustments need to be done.

The below reflects the base rates for procedure codes S5125, S5125 U1 and S5130 for agencies without enhanced rates. For those 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. You should already be billing at the higher rates

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

**** There are no enhanced rates for these procedure codes.***

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	G0299	$16.58

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 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 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 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 Community Health Workers

If you're using a third-party vendor or clearing house to submit your claims, you will need to let them know that **CHW providers are atypical meaning they do not have an NPI or taxonomy**. It is important that you identify yourself as an atypical provider to your clearinghouse or third-party vendor.

Per mandates by CMS there are different billing requirements for atypical verses NPI providers. This impacts paper claims and 837 electronic submissions. CHWs will use their 7-character provider ID as the billing provider in the REF02 segment with the G2 qualifier, which is noted in the RI companion guide and captured below.

LOOP ID	2010BB PAYER NAME	
Segment	NM1 Payer Name	
Reference	Name	Rhode Island Requirements
NM103	Name Last Organization Name	Populate with 'RI Medicaid'.
NM108	Identification Code Qualifier	Populate with 'PI'.
NM109	Identification Code	Populate with the RI Medicaid EIN '056000522'.
Segment	REF Billing Provider Secondary Identification	
Reference	Name	Rhode Island Requirements
REF01	Reference Identification Qualifier	Populate with 'G2' for atypical providers. This field is required when submitting for an Atypical Billing provider. This field should only be populated if the Billing provider NPI was not submitted.
REF02	Payer Additional Identifier	Populate with 7-digit RI Medicaid Provider ID. This field is required when submitting for an atypical provider. If more than 7 characters are sent the claim will be rejected

Attention Federally Qualified Health Centers Dental Providers

Providers are able to bill encounters to Medicaid for removable prosthetics during the fabrication phase based on standard of care. While post-insertion inspection and adjustments are anticipated, these are not covered per Medicaid policy in the first 6 months after delivery and similarly are not covered in the FQHC setting as additional encounters. The expected and allowed number of visits based on standard of care are listed below. Providers may be able to accomplish with fewer visits and should then bill fewer encounters. If additional visits are required during fabrication, it is allowed with documentation and subject to post-payment review.

Single complete denture, single complete denture with partial denture, or both upper and lower complete dentures:

Five encounters may be billed to Medicaid, based on anticipated appointments as follows:

1. Preliminary impressions
2. Final impressions
3. Jaw relation records
4. Wax try-in
5. Delivery

The appropriate appliance D codes should be included on the dental claim form only once for the appliances on the date they are delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

Single partial denture:

Three encounters may be billed to Medicaid, based on anticipated appointments as follows:

1. Impression and bite registration
2. Wax try-in
3. Delivery

The appropriate appliance D code should be included in the dental claim form only once for the appliance on the date it is delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

Upper and lower partial denture:

Four encounters may be billed to Medicaid, based on anticipated appointments as follows:

1. Impressions
2. Bite registration
3. Wax try-in
4. Delivery

The appropriate appliance D codes should be included on the dental claim form only once for the appliances on the dates they are delivered to the patient. The additional encounters for fabrication steps should include a D0999 (unspecified diagnostic procedure, by report) on the claim form with a note that indicates the encounter is for a denture-related visit due to the fabrication of a new appliance.

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.

When submitting your claims, if enrolled as a 340B provider and purchase the LARC drugs at a discounted price you will need to use the modifier **UD.**

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

Outpatient Providers

The Outpatient Prospective Payment System (OPPS) is a pricing methodology used by Medicare to price Outpatient Hospital claims. This methodology groups Healthcare Common Procedure Coding System (HCPCS), or procedure codes, to an Ambulatory Payment Classification (APC) status indicator/action code based on clinical and cost similarities. The assignment of HCPCS to APC status indicator is determined by CMS. Recently, CMS has added six new APC status indicators to the list that will need to be incorporated into the current APC pricing logic.

This new payment methodology requires a new "conditionally packaged" logic that checks the APC status indicator of the other HCPCS on the claim to see if any of the conditions are met. The below table will describe the CMS guidelines of this conditional packaging.

APC Status Code	APC STAUS DESCRIPTION	PRICING (Logic)
D	Discontinued Codes	Reimbursed at zero
E1	Codes/services not covered under outpatient, statutorily excluded or not reasonable/	Reimbursed at zero
E2	Codes/services for which pricing info and claims data is	Reimbursed at zero
J1	Hospital Part B services paid through a comprehensive APC	Reimbursed at APC fee schedule for costliest J1 on the claim. Other HCPCS on the claim with APC action codes N, Q1, Q2, P, S, V, and lower cost J1, K and R
J2	Hospital Part B services that may be paid through a comprehensive APC	Reimbursed at APC fee schedule except when included on a claim with a paid J1 APC Status Indicator, in which case reimbursed at
Q4	Conditionally Packaged Laboratory Tests	Reimbursed at zero if claim also has a procedure code with an APC status indicator of J1, J2, S, V, Q1, Q2, or Q3. Otherwise reimbursed using lab or therapy fee schedules, as applicable.

An updated APC Status Code list can be found on the EOHHS website Fee Schedule page.

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.

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.

Attention: Outpatient Hospitals

The Outpatient Prospective Payment System (OPPS) is a pricing methodology used by Medicare to price Outpatient Hospital claims. This methodology groups Healthcare Common Procedure Coding System (HCPCS), or procedure codes, to an Ambulatory Payment Classification (APC) status indicator/action code based on clinical and cost similarities. The assignment of HCPCS to APC status indicator is determined by CMS. Recently, CMS has added six new APC status indicators to the list that will need to be incorporated into the current APC pricing logic.

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An updated APC Status Code list can be found on the EOHHS website Fee Schedule page.

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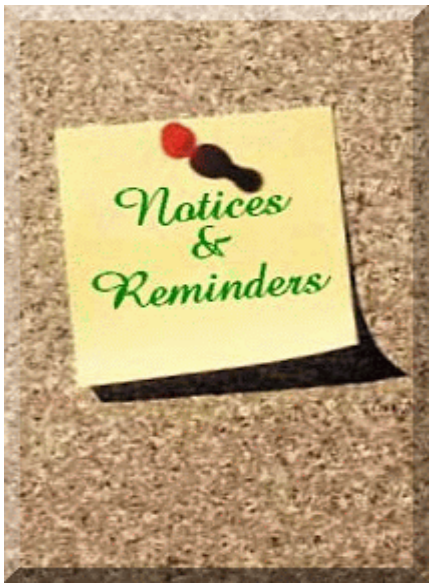
E2	Codes/services for which pricing info and claims data is not available	Reimbursed at zero
J1	Hospital Part B services paid through a comprehensive APC	Reimbursed at APC fee schedule for costliest J1 on the claim. Other HCPCS on the claim with APC action codes N, Q1, Q2, P, S, V, and lower cost J1, K and R are reimbursed at zero.
J2	Hospital Part B services that may be paid through a comprehensive APC	Reimbursed at APC fee schedule except when included on a claim with a paid J1 APC Status Indicator, in which case reimbursed at zero
Q4	Conditionally Packaged Laboratory Tests	Reimbursed at zero if claim also has a procedure code with an APC status indicator of J1, J2, S, V, Q1, Q2, or Q3. Otherwise reimbursed using lab or therapy fee schedules, as applicable.



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

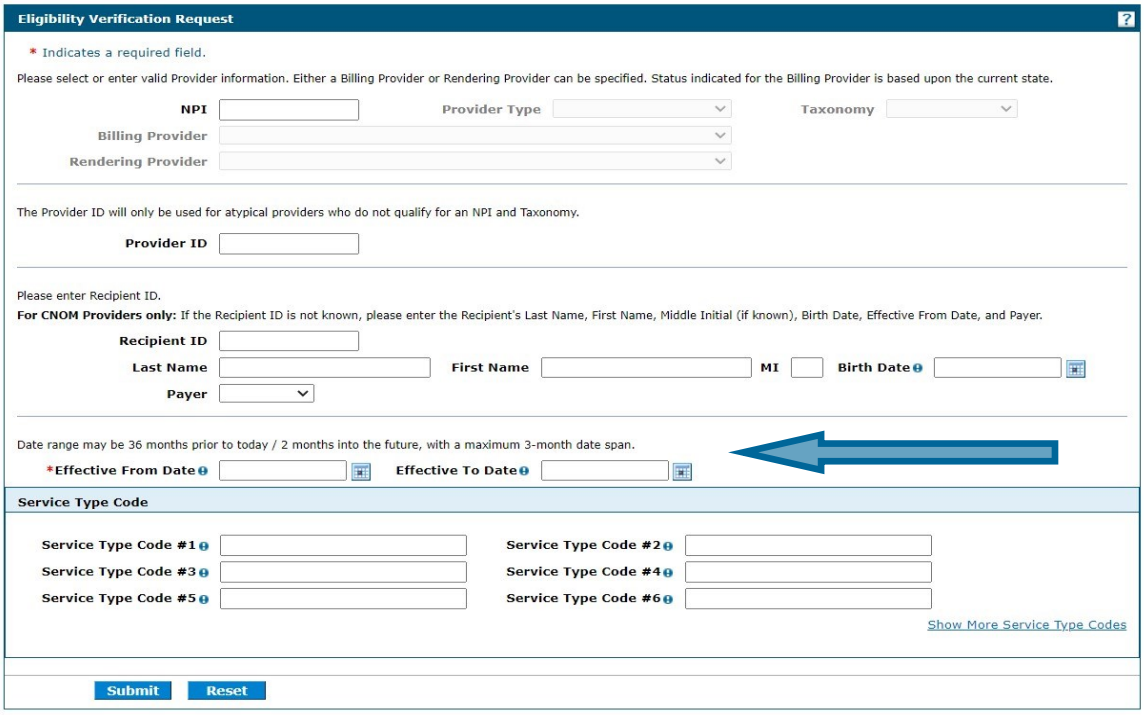
Provider Enrollment Application Fee

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.

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 August

August 3rd – National Watermelon Day

August 15th — National Relaxation Day

August 30th—National Beach Day