



Rhode Island Medical Assistance Program

PROVIDER *update*

Volume 252

January, 2014

Inside this issue:

ICD-10	1
New CMS-1500 Form	2
Electronic Updates	3
Integrated Care Initiative—Update	3
Medicare Crossover Claims—Rhody Health Options	5
Q and A	5
Maintaining your Interactive Web Services Account	6
EHR Incentive Update	7
Eligibility Rollback—Rlte Care	10
Medicaid Expansion	10
Change in Medicaid Funded Hospice	11

Assess How the ICD-10 Transition Will Affect Your Organization

To be ready for the ICD-10 transition deadline of October 1, 2014, your organization should already be in the planning stages. The switch to the new code set will affect every aspect of how your organization provides care, from registration and referrals, to software/hardware upgrades and clinical documentation.

A critical step in planning for the transition is to conduct an impact assessment of how the new code sets will affect your organization. Your impact assessment should include the topics below.



Are you ready?
October 1, 2014

DOCUMENTATION CHANGES

You will need to consider the increased specificity of ICD-10 codes compared to ICD-9 codes and ensure that patient encounters are documented with appropriately comprehensive clinical descriptions.

See below:

*Train staff to accommodate the substantial increase and specificity in code sets.

*Consider physician workflow and patient volume changes.

*Revise forms, documents, and encounter forms to reflect ICD-10 codes.

*Evaluate processes for ordering and reporting lab/diagnostic services to health plans.

REIMBURSEMENT STRUCTURES

You should coordinate with payers on contract negotiations and new policies that reflect the expanded code sets, since they can affect reimbursement.

BUSINESS PRACTICES

Once you have implemented ICD-10, you will need to determine how the new codes affect your processes for referrals, authorizations/pre-certifications, patient intake, physician orders and patient encounters.

SYSTEMS AND VENDOR CONTRACTS

Ensure your vendors can accommodate your ICD-10 needs. Find out how and when your vendor plans to update your existing systems. You will need to review existing and new vendor contracts and evaluate vendor capabilities against your organizations expectations. Work with your vendors to draft a schedule for needed tasks.

TESTING

Work with your vendors to determine the amount of time needed for testing and schedule accordingly.

ICD-10 will affect nearly all areas of your organization, but with a thorough impact assessment, you can keep your day-to-day activities running smoothly while you transition to ICD-10.

Keep Up to Date on ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare at: <http://www.cms.gov/medicare/coding/icd10>

New CMS-1500 Claim Form

Getting Ready for ICD-10

To comply with the CMS ICD-10 reporting mandate, Rhode Island Medicaid is implementing the following timeline for acceptance of the 1500 claim form:

**JANUARY 6
THROUGH
MARCH 31, 2014**

Dual use period during which Rhode Island Medicaid will accept and process paper claims submitted on both the old 1500 Claim Form (version 08/05) and the new 1500 Claim Form (version 02/12). *Note: RI Medicaid will only process up to four diagnosis codes during this period.*

APRIL 1, 2014

Rhode Island Medicaid will process paper claims submitted **only** on the revised 1500 Claim Form (version 02/12). Claims received on or after April 1, 2014 using Version 08/05 1500 Claim Form will not be processed and will be returned to the provider.

Changes to the 1500 Claim Form

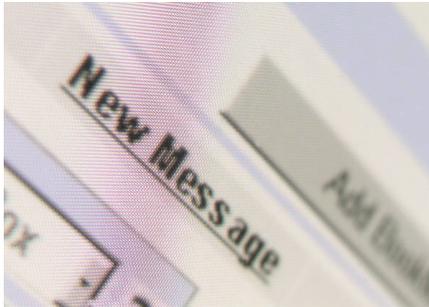
Please see the sample of the new form below. For a complete list of changes to the 1500 Claim Form, please go to the NUCC website at www.nucc.org.



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

17. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare) (Medicaid) (DH/DHQR) (Member ID#) (Not Working) (OW)</small>										16. INSURED'S ID NUMBER <small>(For Program in Item 1)</small>	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
5. PATIENT'S ADDRESS (No. Street)				6. PATIENT RELATIONSHIP TO INSURED		8. RESERVED FOR NUCC USE		9. RESERVED FOR NUCC USE		10. RESERVED FOR NUCC USE	
CITY STATE ZIP CODE TELEPHONE (Include Area Code)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER		12. RESERVED FOR NUCC USE		13. RESERVED FOR NUCC USE	
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				a. EMPLOYMENT? (Current or Previous)		11. INSURED'S DATE OF BIRTH		9. RESERVED FOR NUCC USE		12. RESERVED FOR NUCC USE	
9. RESERVED FOR NUCC USE				b. AUTO ACCIDENT?		12. OTHER CLAIM ID (Designated by NUCC)		10. INSURANCE PLAN NAME OR PROGRAM NAME		13. RESERVED FOR NUCC USE	
10. INSURANCE PLAN NAME OR PROGRAM NAME				c. OTHER ACCIDENT?		13. INSURANCE PLAN NAME OR PROGRAM NAME		14. RESERVED FOR NUCC USE		14. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
10. CLAIM CODES (Designated by NUCC)				YES <input type="checkbox"/> NO <input type="checkbox"/>		15. RESERVED FOR NUCC USE		15. RESERVED FOR NUCC USE		15. RESERVED FOR NUCC USE	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. Authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.											
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)				16. OTHER DATE				14. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE				17a. NPI				18. HOSPITAL DATES RELATED TO CURRENT SERVICES			
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)				17b. NPI				19. OUTSIDE LAB? \$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate Act. to service line below (2HE)				ICD-9-CM				22. RESUBMISSION CODE ORIGINAL REF. NO.			
A. _____ B. _____ C. _____ D. _____				E. _____ F. _____ G. _____ H. _____				23. PRIOR AUTHORIZATION NUMBER			
I. _____ J. _____ K. _____ L. _____				M. _____ N. _____ O. _____ P. _____				Q. _____ R. _____ S. _____ T. _____			
24. A. DATES OF SERVICE				B. PLACE OF SERVICE				C. PROCEDURES, SERVICES, OR SUPPLIES			
From MM DD YY To MM DD YY				SITES (SIC)				E. DIAGNOSIS			
25. FEDERAL TAX ID NUMBER				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT?			
28. TOTAL CHARGE				29. AMOUNT PAID				30. Reserved for NUCC Use			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH #			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH #			

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0928-1107 FCHM 1500 (02-12)



Monthly Provider Update Delivered to Your Inbox

Would you like to receive the monthly Provider Update delivered electronically to your Inbox?

To add your email to the electronic mailing list, please send an email to deborah.meiklejohn@hp.com. Please put "Subscribe" on the subject line of your email.

Also include your Provider Name and NPI, as well as the primary type of service you provide. In addition to the Provider Update, you will also receive any updates that directly relate to the services you provide.

Update on Rhode Island's Integrated Care Initiative

The Rhode Island Medicaid Program continues to enroll eligible individuals into the state's new *Integrated Care Initiative*. As of December 10, 2013, **7177 individuals have enrolled** in the *Integrated Care Initiative*: 6173 in *Rhody Health Options* through Neighborhood Health Plan of Rhode Island and 1004 in *Connect Care Choice Community Partners*, a partnership between RI Medicaid and CareLink.

The goal of the *Integrated Care Initiative* is to provide person-centered, comprehensive, quality health care and support services that enable members to maintain a quality of life so that they can live independently in the community if they are able to. It's designed to improve the coordination of care between primary care and acute care, behavioral health services, and long-term services and supports (LTSS). There are approximately 28,000 individuals eligible for this initiative. They include Rhode Islanders over age 65 and individuals with disabilities/chronic conditions who have either Medicaid coverage or Medicare and Medicaid coverage (dual eligibility).



*The **Integrated Care Initiative** is voluntary; people can choose to remain in Medicaid Fee-For-Service. Enrollment will occur over several months, with several thousand individuals enrolling each month. For more information, please see www.eohhs.ri.gov under "Integrated Care Initiative."*

Article continued on page 4

RI Integrated Care Initiative *-continued*

What Providers Need To Do:

- **Be sure to check a person's eligibility through Medicaid's Interactive Web Services:** <https://www.eohhs.ri.gov/secure/logon.do> . This *Recipient Eligibility Verification* will let you know which program a person is enrolled in – Rhody Health Options (through NHPRI) or CCC Community Partners. This is real time eligibility verification that verifies eligibility on the date it is accessed. For health plan enrollees, providers would have to bill NHPRI for products and services. Members enrolled in the CCC Community Partners Program remain in Medicaid fee-for-service and use HP as the fiscal agent. Providers would continue to bill Medicaid as they usually do for these enrollees.
- **Become a participating provider with Neighborhood Health Plan of RI** if you haven't already. Please contact NHPRI representatives listed below for more information:

Nursing Homes – Paula Lea, (401) 459-6037
Home Care Agency- Shirley Price, (401) 459-6683
Assisted Living & Adult Day Health Centers- Jacqui Pickering,
(401) 427-6746
DME & Minor assistive devices- DMENsion, 1-866-205-2122



What Providers Should Know:

- For members in *Rhody Health Options*—bill Neighborhood Health Plan of RI. For members in *Connect Care Choice Community Partners (CCCCP)* continue to bill Medicaid fee-for-service through HP.
- NHPRI will honor all Medicaid prior authorizations for the period of time authorized by Medicaid. NHPRI will also honor all existing pharmacy authorizations for sixty (60) days.
- NHPRI members can continue to see out-of-network providers for up to six (6) months after their enrollment start date.
- NHPRI will continue to help interested providers become part of NHPRI's network.
- Members, who are permanent residents of nursing homes or assisted living facilities at the time they are enrolled, may remain in that nursing home or assisted living facility, regardless of whether that nursing home or assisted living facility is in NHPRI's network.

For More Information:

Visit www.eohhs.ri.gov . The Integrated Care link is found on the home page. Then see section titled "Info for Stakeholders".

Medicare Crossover Claims for Rhody Health Options Members

Claims for individuals with both Medicare and Medicaid coverage (dual eligibles) automatically “crossover” to Medicaid Fee-For-Service (FFS) after Medicare has paid as the primary insurance. Effective November 1, 2013, providers who bill Medicare for services for *Rhody Health Options* members and whose claims then get sent to Medicaid, will have their claims denied payment by Medicaid FFS. Those claims will have to be submitted to Neighborhood Health Plan of Rhode Island.

This is a temporary situation involving “crossover” claims for dual eligibles enrolled in *Rhody Health Options*. A modification is underway and will be resolved by Winter/Spring 2014. In the meantime, denied claims from Medicaid FFS will say “Recipient is covered under Rhody Health Options, please bill Neighborhood Health Plan of Rhode Island.”

Q and A

This section will feature Frequently Asked Questions from providers.



Attention Nursing Home Providers:

Q: Do I complete a new MDS assessment when a patient is re-admitted after a discharge assessment?

A: A new MDS assessment needs to be submitted for residents re-admitted that are due for an OBRA MDS assessment or meets the qualifications for a significant change in status assessment upon return to the facility. (Refer to MDS 3.0 Chapter 2 for more information)

Entry tracking assessments (value of “01” in Field 0310F) should be submitted to track when patients are re-admitted to the Nursing Home at the same level of acuity when they were discharged. Clinical information is not included on the entry tracking assessment, and the RUG code that was in effect at the time of the discharge will be the RUG code in effect at the time of the re-entry admission.

For more information about RUG codes, visit:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RUG_FAQ.pdf

Maintaining Your Interactive Web Services Account

The beginning of the new year is a good time to make sure your Interactive Web Services (IWS) account is up to date. If you are the administrator of your account, take a few minutes to update or confirm your password and security questions, used to access the account.

To do this, log in to IWS and on the bottom left, select “Profile”. On this screen, select “Modify Security Information”. The next screen will allow you to update or confirm password and security questions.

Please note:

- Your password must be 6-8 characters, and may not contain any special characters, such as *, \$, #, etc.
- If you are only changing security questions, you will still need to confirm your existing password to proceed.
- For PES users—this password must match the one used as the Web Password in PES.

Once you complete the steps above, select “Update” and your information will be updated.

If your account has additional users, listed as “subordinates”, maintenance should be performed on this list as well by following these steps:

1. On the left side of the screen, select “User Account Maintenance”
2. On the row labeled “User Name”, check the check box, and enter your Trading Partner number as the User Name.
3. On the row labeled “Role”, check the check box, and from the drop down box, select “Subordinates for Master”. Then hit “Search”.

This will list the subordinates associated with your account. Manage your team by removing any inactive members. Maintenance of the team list is the administrator’s responsibility.

Rhode Island Medicaid EHR Incentive Update

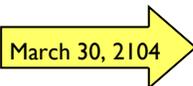
Avoid MEDICARE Payment Adjustments

For providers who are eligible to participate in the Medicare or Medicaid EHR Incentive Program, you may be subject to a **MEDICARE** negative payment adjustment starting in 2015. In order to avoid MEDICARE negative payment adjustments, eligible providers (EPs) need to attest to meaningful use in program year 2013 or by October 1, 2014.

In essence, if you accept MEDICARE payments and have not attested for meaningful use with your certified electronic health record technology, you will receive a negative payment adjustment to your MEDICARE Reimbursements. Also note that eligible providers who are participating in the Medicaid EHR Incentive program must attest to Meaningful Use in order to avoid a MEDICARE negative payment adjustment. EPs who have only submitted a Medicaid EHR application for the Adopt, Implement, Upgrade (AIU) year will **not** qualify as a meaningful use attestation.

For more information on EP payment adjustments, view CMS' [Payment Adjustments and Hardship Exceptions](#) [Tipsheet](#) for EPs.

2013 RI Medicaid EHR Incentive Application Deadlines



2013 is coming to an end and **EPs** have until March 30, 2014 to submit their 2013 RI Medicaid EHR Incentive attestation.

Hospitals have until December 30, 2013 to submit their 2013 applications.



On January 1, 2014, we will start accepting 2014 Medicaid EHR Incentive applications.

2014 Meaningful Use Attestations Timeframe

CMS has modified the EHR Incentive program policy in that all 2014 Meaningful Use applications will attest for a **90-day** reporting period. It does not matter if you are attesting to Stage 1 or 2, applicants for program year 2014 will attest for 90-days even though you may have previously attested meaningful use for 90-days in a previous program year.



Other 2013 EHR Incentive Program Facts and Changes

- **CHIP reduction no longer required** – Starting in 2013 Eligible Providers are not required to apply a Medicaid CHIP reduction to their Medicaid patient volume calculation even though it was required in 2011 and 2012.
- Medicaid as a secondary pay source can be counted as a Medicaid encounter even though Medicaid has not paid any part of the premium or service. For example, when a patient who has other medical insurance as a primary pay source and Medicaid as secondary, their encounter can be counted in the patient volume numerator as a Medicaid encounter, even if Medicaid does not pay for any part of the service provided. This change applies to applications submitted for 2013 and beyond.
- Patient volume reporting period can be any consecutive prior period within the prior calendar year (Federal Fiscal Year for Hospitals) or preceding 12-month period from the date of attestation.

Preparing for EHR Incentive Audits

Please note that we ask that you maintain all EHR Incentive program attestation documentation for at least 10 years. Any supporting documentation that validates the patient volume attestation and provides evidence for each provider's meaningful use attestation will be invaluable, should you or your practice be selected for an EHR Incentive audit. Any questions feel free to email ehraudit@ohhs.ri.gov.

Learn More about Health Information Exchange for Stage 2

If you are an eligible professional preparing for Stage 2 of the EHR Incentive Programs, check out the new CMS [tip sheet](#) on Stage 2 health information exchange requirements.

Three Data Sharing Measures in Stage 2

The tip sheet outlines the required data elements and provides additional guidance for the following three Stage 2 objectives that call for data sharing:

- [Summary of Care](#)
- [Clinical Summary](#)
- [Patient Electronic Access](#)

Click links to access documents

While some of the data elements are common between the three measures, other data elements are individual to each measure.

The RI Regional Extension Center (RIREC) is available to assist you in meeting meaningful use requirements. You can visit their website at www.docehrtalk.org, or call them at 888-924-4156, or email them at info@RIREC.org.

When does Stage 2 Begin for Eligible Professionals?

If you are an eligible professional who has completed at least two years of Stage 1 of meaningful use, you will begin [Stage 2 in 2014](#). CMS has additional resources available to help you participate in the next stage, including:

- ⇒ [Stage 2 Beginner's Guide](#)
- ⇒ [Stage 2 PowerPoint and webinar recording](#), including an overview of audits and payment adjustments
- ⇒ [Specification sheets for Stage 2 criteria](#)
- ⇒ [My Participation Timeline widget](#) to help you determine the year you start each stage of meaningful use
- ⇒ [Stage 2 Exchange Requirements for Eligible Professionals Presentation](#)

"If you are just beginning meaningful use, or have only completed one year, you must complete two full years of Stage 1 before moving to Stage 2."

RI's Regional Extension Center (RIREC) can assist your organization or practice with meeting meaningful use. Feel free to contact them by phone at 888-924-4156 or email them at info@RIREC.org. For more information feel visit their website at www.docehrtalk.org.

Stage 2 Guide for the EHR Incentive Programs Now Available

CMS has released a new resource, [An Eligible Professional's Guide to Stage 2 of the EHR Incentive Programs](#), which provides a comprehensive overview of Stage 2 of the EHR Incentive Programs to eligible professionals. The guide outlines criteria for Stage 2 meaningful use, 2014 clinical quality measure reporting, and 2014 EHR certification.

The guide's table of contents makes it easy for you to navigate through Stage 2 topics. Interactive tabs included at the bottom of each page allow you to transition between different chapters.

Chapters include:

What is Stage 2 of the EHR Incentive Programs?

What are the requirements under Stage 2 of Meaningful Use?

How will clinical quality measures (CQMs) change?

Resources

The guide can be found on the [Educational Resources](#) page of the [EHR website](#).

Want more information about the EHR Incentive Programs?

Visit the [EHR Incentive Programs](#) website for the latest news and updates on the EHR Incentive Programs.

Eligibility Rollback for Some Parents in RItE Care



Eligibility for parents on RItE Care (and RItE Share) is being rolled back from 175 percent of the federal poverty level to 133 percent effective January 1, 2014.

There are approximately 6500 parents who are currently enrolled in RItE Care or RItE Share who will be affected by this change. The state has notified parents of this change and will be facilitating enrollment into Neighborhood Health Plan of Rhode Island for the month of January.

The state will pay for the premium cost for January and will provide parents with information on how to enroll at HealthSource RI, the state's health insurance marketplace, for health coverage beginning February 1. Eligibility for children in RItE Care has not changed.

Medicaid Expansion

Rhode Island was one of 25 states and the District of Columbia to expand Medicaid to adults, age 19-64, without dependent children. Individuals can enroll online at www.healthsourceri.com or can call HealthSource RI at 1-855-840-4774.

Coverage begins January 1, 2014 for people that applied before mid-December. Eligible individuals have a choice to enroll in either UnitedHealthcare or Neighborhood Health Plan of RI. There is no open enrollment period for Medicaid; eligible individuals can enroll at any time of the year.



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

Change in Medicaid Funded Hospice Benefit

The Rhode Island Medicaid Program under the authority of the Centers for Medicare and Medicaid will eliminate the 210 day benefit limit effective January 1, 2014. The Medicaid Hospice Benefit will have the same amount, duration and scope as the Medicare benefit, which is offered in two 90-day periods and an unlimited number of 60-day periods.

The Medicaid Hospice Benefit will follow the Medicare certification process to provide the initial and ongoing Hospice Benefit.

Medicaid Hospice General Inpatient care must meet Federal and State requirements for appropriate care level and document that the beneficiaries' need for pain and symptom management is beyond the routine care level. Beneficiaries should be evaluated on a case-by-case basis- but in general may be admitted for short-term General Inpatient Care when the physician and Hospice Interdisciplinary Team believes the beneficiary needs pain control or symptom management that cannot feasible be provided in other settings. Also the beneficiary must require an intensity of skilled nursing care by a Registered Nurse and frequent skilled nursing intervention on all three shifts directed toward pain control and symptom management.

All Medicaid funded Hospice General Inpatient Admissions will require a prior authorization, using the current Prior Authorization process in place through HP, our fiscal agent.

“The Medicaid Hospice Benefit will have the same amount, duration and scope as the Medicare benefit, which is offered in two 90-day periods and an unlimited number of 60-day periods.”

Annual Provider Survey



The 18th Annual Provider Survey was distributed to a random sampling of all Medicaid providers.

Thank you to all the providers who took the time to complete the survey and give feedback.

Your feedback is very important and helps to drive improvement in service. We will be reviewing your comments and looking for ways to improve the quality of services we provide.

THANK YOU