



Rhode Island Medical Assistance Program

PROVIDER *update*

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Volume 253

February, 2014

Getting Ready for ICD-10

Over the next few months, information and workshops will be offered to support providers during the transition to ICD-10. Although the October 1, 2014 is a few months away, there is much to be done to ensure a smooth transition.

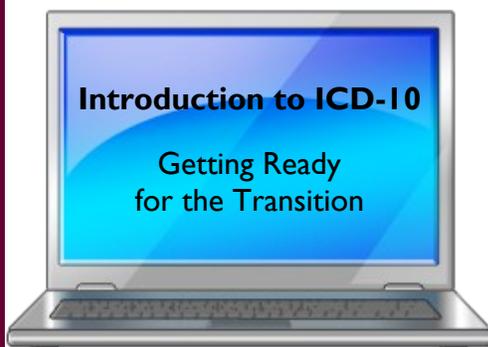
Recently, a ICD-10 readiness survey was sent to a random sampling of Medicaid providers to assess where they are in the process of transition. The information collected will inform the support delivered both in the monthly Provider Update as well as workshops and trainings. In this issue of the Provider Update the first few pages address training, frequently asked questions, as well as the important timeline for transition to the new CMS 1500 form. Be sure to review these important updates.



Will you be ready?
October 1, 2014

REGISTER NOW FOR AN INFORMATIONAL WEBINAR

(Participate conveniently from a computer in your location)



Choose one of four opportunities to participate:

Tuesday, February 25	10-11 AM
Thursday, February 27	10-11 AM
Tuesday, March 4	3-4 PM
Thursday, March 6	3-4 PM

To register: Please send an email to deborah.meiklejohn@hp.com. Include **ICD-10** in the subject line of your email. Spaces are limited. Please indicate both a first and second choice of dates for participation.

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.

Be sure to visit the ICD-10 Implementation link on the EOHHS website at <http://www.eohhs.ri.gov/ProvidersPartners/ICD-10Implementation.aspx> for updates.

ICD-10 Your Questions Answered

Answers to frequently asked questions

What is ICD-10?

The International Classification of Diseases (ICD) is a coding system to classify diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or disease. This information is used for morbidity and mortality statistics, reimbursement systems, and automated decision support systems in medicine.

ICD-10-CM is the diagnosis code set that will be replacing ICD-9-CM Volumes 1 and 2. ICD-10-CM will be used to report diagnoses in all clinical settings. ICD-10-PCS is the procedure code set that will be replacing ICD-9-CM Volume 3. ICD-10-PCS will be used to report hospital inpatient procedures only.

ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

What is the difference between ICD-9-CM (clinical modification) and ICD-10-CM (clinical modification) diagnosis codes?

The ICD-9-CM diagnosis codes are mostly numeric and are 3 to 5 characters. ICD-10-CM diagnosis codes are alphanumeric and contain 3 to 7 characters. ICD-10 diagnosis codes are more descriptive and in some situations a "one-to-many" match.

There are approximately 71,920 procedure codes in ICD-10-PCS, compared to almost 4,000 in ICD-9.

The ICD-10-CM code set allows 155,000 diagnosis codes, but currently has approximately 69,832 diagnosis codes, compared to nearly 15,000 in ICD-9.

The ICD code sets are updated annually on October 1, and the number of codes increases each year.

Does ICD-10 apply to all providers?

Under current policy, all claims except pharmacy and dental claims require ICD-9 diagnosis codes. All claims requiring an ICD-9 diagnosis code will transition to use of ICD-10 codes beginning on the ICD-10 compliance date.

Who else has to upgrade to ICD-10?

Health care clearinghouses and payers are also HIPAA covered entities, so they are required to convert to ICD-10 as well.

Who will be responsible for making sure providers use the correct codes?

Providers are responsible to use the correct code sets and adhere to the guidelines.

What should we be doing about our computer systems?

Review your file layouts and where your files are stored to be sure the fields and your system can accommodate the additional code length. Contact your software vendor to resolve any concerns.

You can further prepare by;

Familiarizing yourself with the ICD-10 code set and coding guidelines to help assess the impact on your system.

Note that the CMS-1500 form is in revision, and the diagnosis codes are expanding from four to 12 entries. Watch for information about the new release of this form.

Do not stop assessment and planning.

What is the compliance deadline for ICD-10?

The Department of Health and Human Services (HHS) has set October 1, 2014 as the compliance deadline.

Will there be a phased implementation of ICD-10 or is there a hard cutover date?

The ICD-10 implementation date is now set to October 1, 2014, with no exceptions. This is a hard cutover date.

Will RI Medicaid test ICD-10 with trading partners, vendors and providers? If yes, when will testing guidelines be available?

Yes. RI Medicaid will test some trading partners, vendors, and providers. The specific parties have not yet been identified.

Will Rhode Island Medicaid support both ICD-9 and ICD-10 code sets?

Yes, RI Medicaid will support both code sets based on the claim date of service.

Date(s) of service will determine which code set is used to submit the claim.

How can I learn more about ICD-10?

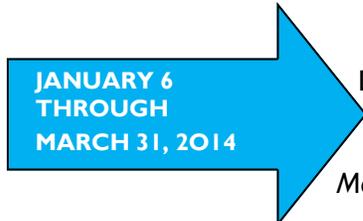
For more information on ICD-10, please refer to the CMS web-site; <http://www.cms.gov/Medicare/Coding/ICD10/index.html>



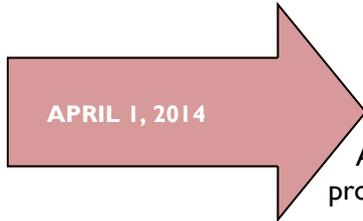
New CMS-1500 Claim Form

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:



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.*



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

1. MEDICARE MEDICAID TRICARE CHAMPVA OTHER FECA (LAND) OTHER FECA (SEA)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) 4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street) 6. PATIENT RELATIONSHIP TO INSURED (Self, Spouse, Child, Other) 7. INSURED'S ADDRESS (No. Street)

8. CITY 9. STATE 10. IS PATIENT'S CONDITION RELATED TO: (a. EMPLOYMENT? (Current or Previous) YES NO (b. AUTO ACCIDENT? YES NO (c. OTHER ACCIDENT? YES NO) PLACE (State) 11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Indicates the release of any medical information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.) 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the assigned physician or supplier for services described below.

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (IMP) (MM DD YY) 15. OTHER DATE (MM DD YY) 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE (17a. NAME (17b. NPI) 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE (FROM MM DD YY TO MM DD YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 20. OUTSIDE LAB? (YES NO) \$ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service (see below) (24E) ICD (incl.) 22. DISPOSITION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE (from MM DD YY to MM DD YY) B. PLACE OF SERVICE (EMG OPT/ACPCS) C. PROCEDURES, SERVICES, OR SUPPLIES (EUBEN (Usual Charge) MODIFIER) D. DIAGNOSIS POINTER F. \$ CHARGES G. DATE OF SERVICE H. PLAN NO. I. L. QUANTITY J. RENDERING PROVIDER(S) #

25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (YES NO) 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. PAID FOR NUCC USE \$

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (I certify that the statements on this invoice apply to this bill and are made a part thereof.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PI #

SIGNED DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0928-1197 FORM 1500 (02-12)

Attention Early Intervention Providers Code Changes for 2014

In order to comply with CPT code changes for 2014, we will eliminate code 92506-Speech Evaluation as an Early Intervention code and replace it with the following two codes:

92522
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).
The rate is \$149.80

92523
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language).
The rate is \$299.60

92523
With Modifier 52
Will be used when only evaluation of language comprehension and expression are provided.
The rate is \$149.80



Code Changes for LEA's and Hippotherapy/ Outpatient Therapy

The elimination of code 92506-Speech Evaluation also impacts both Local Education Agencies (LEAs) and Hippotherapy/Outpatient coding. For these two provider types, the following codes are to be used in place of 92506:



92521
Evaluation of speech fluency.
The rate is \$85.00

92522
Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria).
The rate is \$85.00

92523
With Modifier 52
Will be used when only evaluation of language comprehension and expression are provided.
The rate is \$42.50

92523
Evaluation of speech sound production with evaluation of language comprehension and expression.
The rate is \$85.00

92524
Behavioral and qualitative analysis of voice and resonance.
The rate is \$85.00

Attention DME Providers

New Clinical Guidelines for Enteral Nutrition

New guidelines have been established to identify the clinical information that the RI Medicaid program requires to determine medical necessity for Enteral Nutrition products. These guidelines are based on generally accepted standards of medical practice, review of medical literature, federal and state policies, and laws applicable to Medicaid programs.

Determination of medical necessity for enteral products shall be based upon a combination of clinical data and the presence of indicators that would affect the relative risks and benefits of the product.

The new guidelines for coverage and non coverage can be found at <http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/>

[ScreeningListForDurableMedicalEquipment.aspx](http://www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/DME/ScreeningListForDurableMedicalEquipment.aspx).

Prior authorization will be required and determinations made on a case by case basis. Approval of prior authorization is still subject to all general conditions of RI Medicaid including member eligibility, other insurance and program restrictions.

Requests for prior authorization **must include:** (click links for forms)

- [RI MA Prior Authorization form](#),
- [RI MA Certificate of Medical Necessity for Enteral Nutrition form](#),
- Invoice attached for all manually priced Enteral Nutrition codes.

Prior Authorization is valid for 12 months from date of issuance.

For more information, contact:

Marlene Lamoureux, DME Provider Representative at 784-3805

Smoking Cessation Products

Please be advised that effective January 9, 2014, smoking cessation products do not require prior authorization.



Attention Physician Providers:**New Guidelines for Bariatric Surgery**

New guidelines have been established to identify the clinical information that the RI Medicaid program requires to determine medical necessity for Bariatric Surgery effective January 1, 2014. The update can be found on the EOHHS website at: www.eohhs.ri.gov/ProvidersPartners/ProviderManualsGuidelines/MedicaidProviderManual/Physician/PriorApprovalCriteriaforSurgicalProcedures.

Prior authorization will be required and determinations made on a case by case basis. Approval of prior authorization is still subject to all general conditions of RI Medicaid including member eligibility, other insurance and program restrictions.

For more information, contact Daphine Monroe at darphine.monroe@hp.com or 401-784-8003.

Q and A



This section will feature Frequently Asked Questions from providers.

Attention CEDARR Center Providers:

Q: Why did my claim deny for the following EOB's: 067 – procedure code missing or invalid, 091 – service denied; not covered by RI Medical Assistance Program, or 704 – procedure code not consistent with provider type?

A: In order for a CEDARR claim to process and pay appropriately the recipient must be Medicaid eligible and must be enrolled with the CEDARR Center. If the recipient is not enrolled in the CEDARR Center in the Medicaid system for dates of service on the claim then the claim is unable to process as a CEDARR claim so the procedure codes are no longer valid codes.

If you receive this type of denial, check your system to ensure enrollment in CEDARR for those dates of service, then contact the HP Enterprise Services Help Desk and have the Customer Service Representative check the recipient's CEDARR enrollment. If the CEDARR enrollment dates in the Medicaid system do not match your system dates then follow the process to forward the enrollment to HP Enterprise Services to be updated. Once updated you can resubmit your claims.

Health IT Certification: Free through RI REC

Now available to college students enrolled in a Healthcare or Health IT-related program at any Rhode Island based college.

FREE online training offered by HealthITCertification.com.

[Click here for more information about this program.](#)



Visit CurrentCare's New YouTube Channel



Check out our new YouTube channel to get the latest on CurrentCare!

- Hear from providers who are taking advantage of their patients' information in CurrentCare. (click links to left)
- Learn more about the power and simplicity of Hospital Alerts and Viewer with short instructional clips.
- Visit often – we'll be adding more all the time!

Medically Needy Services

The Medically Needy are those individuals whose resources and/or income exceed the standards required for eligibility as Categorically Needy, but are within the Medically Needy standards. Medically Needy individuals are entitled to a lesser scope of services.



If a medically needy individual resides in a Nursing Home he/she may be allowed glasses and hearing aids.
The claim should NOT be sent to HP Enterprise Services.
The claim should be send directly to:

Nancy Tasca, Executive Office of Health and Human Services,
74 West Road, Hazard Bldg, Cranston, RI 02920.

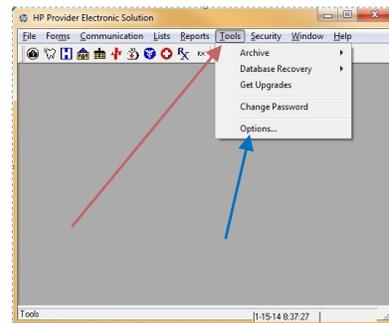
For additional assistance, please call Nancy at 401-462-1796.

Updating Your EOHHS (IWS) Password for PES Users

Your password to access Provider Electronic Solutions (PES), and the EOHHS password which is used to check eligibility, claims status, remittance advice, etc., expire every 90 days. When the password to access IWS on the EOHHS website is changed, it must **also be updated** within the PES software. Failure to do this will prevent you from successfully uploading a file.

The following steps should be followed when updating expired passwords:

- For updating the EOHHS (IWS) password: This must be done when you receive the pop-up message that the password has expired. The only person who should update the password is the person who actually utilizes the Trading Partner number to log in. Subordinate users, whose user ID begins with an "S", should contact the master user of the account to update the password.
- Once you have updated the password on the EOHHS website (IWS), you should then go into your PES software.
- Click **TOOLS** on the task bar. (**DO NOT CLICK "CHANGE PASSWORD"**) CHANGE PASSWORD is actually used to update the password to access the software and **IS NOT** where you update the web password.
- Click **OPTIONS** on the TOOLS drop down and the screen will automatically open to **BATCH**.



- In the box labeled **WEB PASSWORD** –YOU WILL NEED TO enter the new password to be in sync with the EOHHS (IWS) password. Once completed select **OK**. This should ensure a successful upload of claims.

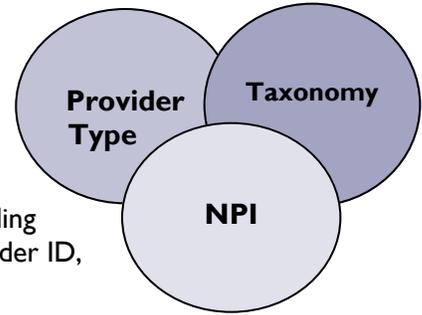


Customer Service Help Desk for Providers

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

NPI Enhancement Project

Interactive Web Services (IWS) allows providers to access information including claim status inquiries, prior authorizations and other business functions. IWS is accessed from the EOHHS website by those providers registered as Trading Partners. To access IWS, providers enter their Trading Partner ID and password. Once in the system, the user verifies their Provider ID, or Legacy number to access their information.



As part of the NPI (National Provider Identifier) Enhancement Project, that will soon be changing. Providers will still access the IWS with a Trading Partner ID, but to utilize the business functions, they will have to select three unique identifiers: NPI, Taxonomy, and Provider Type. Legacy numbers or Provider ID numbers will no longer be allowed.

Exceptions to this change include the following: Pharmacy providers who do not have taxonomy numbers will be excluded from entering that number. Atypical providers who do not qualify for an NPI or taxonomy will continue to use their Legacy ID.

It will be critical for providers to select a valid NPI, taxonomy, and provider type combination to utilize the business functions. This change is the first step leading to the roll out of the new Healthcare Portal. More information will follow as the implementation date approaches.

Provider E-Learning

The EOHHS website has another enhanced feature to support providers. The Provider E-Learning Center has been enhanced and the library of trainings for providers will continue to grow.

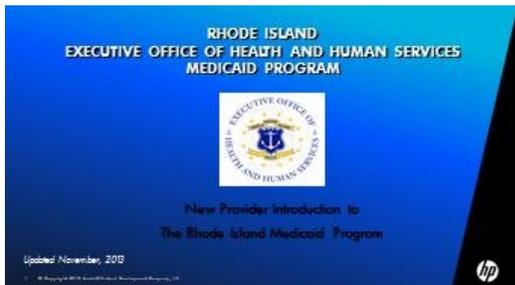
These self-paced PowerPoint presentations can be viewed at your convenience. To access the E-Learning Center, click the Providers and Partners drop down and select General Information. You can access from the link on the center of the page, or from the index on the right.



www.eohhs.ri.gov

Current training presentations include *Welcome to Medicaid*—an overview for new providers, and *Navigating the EOHHS Website*, which can help providers locate claim related forms, resources such as the Provider Manuals, and contact information. Trainings will be added, so providers should check back often to view topics.

For best viewing, after opening file, click “Slide Show” tab on the tool bar and click “From Beginning”. Advance slides by clicking your mouse.



New Forms and Applications On the EOHHS Website

Many of the forms providers utilize to submit information for themselves or their clients have recently been updated. If you are using forms that you have printed from the website, be sure to visit the [Forms and Applications](#) page to download and print the new format for documents frequently used. Many of these forms can now be completed online and then printed, instead of handwriting the information.

PROVIDER CHANGE OF INFORMATION FORM

Provider Name: _____
 Provider Number (if affected by the change): _____
 Old Service Address: _____
 Old Pay - To Address: _____
 Old Mail - To Address: _____
 New or Additional Service Address: _____
 New Pay - To Address: _____
 Phone: _____

TPL INFORMATION CARD

Client Name: _____
 Medical Assistance Number: _____
 Agency: _____
 Section B: Cognitive Patterns
 1. Memory _____
 2. Cognitive Skills for Daily Decision Making _____

...entering service to a Medicaid recipient and you are made aware of Medicare rate Insurance information that does not appear on their Medicaid ID card or appears on their card in error, please complete as much of the following information as possible:

1) Patient's Name _____ 2) MID Number _____ 3) Insurance Name/Medicare _____
 4) Policy # or Group # _____ 5) Effective Date _____ 6) End Date _____ 7) Policy Holder Name _____

RHODE ISLAND MEDICAID PRIOR AUTHORIZATION FORM

Requesting Medicaid Provider ID# _____
 Requesting Provider Name _____
 City _____ ST _____ ZIP _____ Phone _____ Fax _____
 Performing Billing Provider Name _____
 HOSPITALS ONLY SERVICE TYPE INPATIENT OUTPATIENT

EOHHS ONLY	BILLING-PROV NPI	TAXONOMY	START DATE	END DATE	NDC/PROCEDURE OR REVENUE CODE/MOD	ADD MOD	UTI SRE	DIAG CODE	UNITS OCCUR	DOLLAR AMOUNT

Reason service is required, diagnosis/prognosis and treatment described: _____

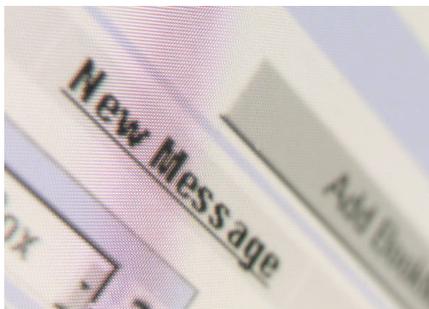
PERFORMING PROVIDER SIGNATURE AND TITLE: _____

EOHHS AUTHORIZED _____ EOHHS DENIED _____ DATE _____

NOTES _____

Also new on the website are interactive instructions for completion of the Prior Authorization form and the CMS 1500 form. New instructions for the revised CMS 1500 (02/12) will be posted soon.

To use these instructions, hover over the field and the instructions for that field will appear in a pop-up box.



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.

Resource Utilization Grouper (RUG) *Frequently Asked Questions*

Effective June 1, 2013, the Rhode Island Office of Health and Human Services (OHHS) adopted a new Medicaid method of paying for Nursing Home and Hospice room and board services based on the Minimum Data Set (MDS) 3.0 format with the **CMS RUG IV VI.02** Grouper version containing 48 RUG categories. The MDS assessment is a clinical tool used to identify all residents' strengths, weaknesses, preferences, and needs in key areas of functioning.

To assist providers, Frequently Asked Questions are available on the EOHHS website at http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RUG_FAQ.pdf.

In this issue of the Provider Update, two questions are highlighted below for clarification.

Question 7. Should a Nursing Home put a RUG Case Mix Group and RUG Version Code information in Field Z0200 or Z0250 of the MDS assessment form?

No, it is not a required field for RI Medicaid. Information in these fields **will not be used** or will be ignored during the determination process of a RUG code by the RUG Grouper.

Question 25. Which RUG classification should I use for the RUG Grouper software: Index Maximizing or Hierarchical?

Index Maximizing. For detailed definition refer to CMS RUG-IV Version 1.02.0 Grouper Documentation .

In clarification of the way claims have been processed using RUG methodology, there are two classifications within the Index Maximizer. RI will use the Index-Maximized Normal classification.

- An Index-Maximized normal classification which includes a Rehabilitation and Extensive Services group or a Rehabilitation group
- An Index-Maximized Non-Therapy classification which excludes the Rehabilitation and Extensive Services groups and the Rehabilitation groups.

RI will use the Index Maximizer normal classification as this group also includes the Rehabilitation groups within the 48 Model Group. The RUG Grouper software calculates/generates the RUG code based on the MDS data and populates a Rug code in the field name sRugHier. This RUG code from the sRugHier field will be used for claims processing.