



Rhode Island Medicaid Program

PROVIDER *update*

Volume 324

January 2020

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Providers**

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for local and
long distance calls
(800) 964-6211
for in-state toll calls



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Attention Clearing Houses, Billing Agencies, and Providers

A Reminder on How to Manage your Covered Providers:

ERA Received by Clearinghouse/Vendors

Providers who have moved their business to a new clearinghouse/vendor will need to contact the original clearinghouse/vendor to be removed as a covered provider before the new enrollment can be completed. The provider must contact the existing clearinghouse/vendor and ask them to remove their association.

The original clearinghouse/vendor should log into the Healthcare Portal. Under the Covered Provider section of the Trading Partner Profile screen, access the details for a specific provider by either clicking Display Covered Providers, which will display all, or search for a specific provider using the Provider ID and ID Type.

Select the plus sign (+) next to the NPI of the specific provider. Uncheck the boxes for the 835 and 277 and select the save button.

Once this is completed, the new clearinghouse/vendor may complete the process to add the covered provider and select the 835/277 transactions. They will then complete the ERA enrollment form.

Note: To ensure continuous receipt of the 837/277U, the new billing entity must add the provider as a covered provider and complete the ERA enrollment form before the cut-off date of the financial cycle.

Medicaid Guidelines for ADA Code D9410

D9410* House call / Extended Care Facility Call

Includes nursing home visits, long-term care facilities, hospice sites, institutions, etc. Report in addition to reporting appropriate procedure codes for actual services performed.

**The D9410-House/Extended Care Facility Call procedure code must be billed with a reimbursable Medicaid service and cannot be billed alone.*

Mobile services provided by fee-for-service providers to nursing home residents may only be reimbursed for one visit per day, per facility, per provider. Providers may not bill the D9410-House/Extended Care Facility Call for each recipient seen during a single nursing home visit even when a reimbursable Medicaid Service is being rendered to multiple recipients.

For each nursing home visit, please add the D9410 to ONE claim being billed for a reimbursable service.

Mobile dental providers who bill fee-for-service cannot bill the D9410 for nursing home visits related to procedures whose payment is considered all-inclusive (i.e. impressions, try-in, adjustments, related to the fabrication of dentures.)



Happy new year

From RI Medicaid

Update Re: Incorrect RUG Scores

In the prior activity to reprocess MDS data and recalculate RI Medicaid recipients' RUG scores, MDS data files received by the MMIS after 9/21/2019 should have been used as opposed to files received after 9/30/2019. DXC has reprocessed all the MDS data received after 9/21/2019, and recipients' RUG scores have been updated in the MMIS to include these missing values.

All claims adjudicated in the 12/7/2019 financial cycle will be evaluated and all claims that contain a RUG score that is different from what is now reflected in the MMIS will be adjusted in the 12/21/2019 nursing home adjustment cycle. These adjustments will be viewable on the 12/27/2019 RA.

Please continue to contact Marlene Lamoureux at marlene.lamoureux@dxc.com or 401-784-3805 with any additional questions or concerns.

Important Updates Re: Electronic Data Interchange (EDI)

(Updated January 10, 2020)*



ATTENTION TRADING PARTNERS:

Our current Sybase Translator will be updated to the OXi SaaS translator on **Sunday, January 19, 2020**. We expect a seamless transition for providers, and you should not notice any differences in your claim acknowledgement reports; however, you are asked to refrain from submitting claims from 5:01 pm EST on Friday January 17, 2020 until 8:00 a.m. EST on **Tuesday January 21, 2020**, when the DXC staff returns from the MLK Day holiday and becomes available to offer technical support. You are also asked to check your claim acknowledgement reports after your submissions to ensure that claims are accepted. Along with the new translator, we will be upgrading the current 277U transaction from 3070 to 5010 version /005010X228. Please find the new transaction in the RI Companion guide [here](#). If you require any assistance or have any questions, please email riediservices@dxc.com.

ATTENTION PROVIDER ELECTRONIC SOLUTION (PES) USERS:

Beginning **Sunday, January 19, 2020**, PES version 2.10 will be obsolete and all claims must be submitted using the newest version of the software, PES 2.11. Please do not submit claims from 5:01 pm EST on Friday January 17, 2020 until 8:00 a.m. EST on **Tuesday January 21, 2020**, when the DXC staff returns from the MLK Day holiday and becomes available to offer technical support. Note that your submissions will fail if you do not comply. See upgrade instructions [here](#). If you require any assistance or have any questions, please email riediservices@dxc.com.

ATTENTION CLEARINGHOUSES:

You were previously instructed to contact riediservices@dxc.com and identify yourselves as automated script users. If you have not yet identified yourself as an automated script user or if you have not yet tested the new code, please contact riediservices@dxc.com to do so. Automated script users must update the URLs in their scripts as is specified in the *Standard Companion Guide for the Web Interface* [here](#). Please note that automated script users who fail to identify themselves or test the new code will be unable to submit any X12 transactions. DXC staff returns from the MLK Day holiday on **Tuesday January 21, 2020**, and will be available to offer technical support at this time.

A previous version of this article included Sunday January 12, 2020 as the date of implementation. That has been changed to **Sunday, January 19, 2020.*

Upcoming: Covered Physical Therapy Services

RI Medicaid will begin covering
physical therapy services.

Stay tuned for more information coming soon!



FYI:

The application fee
to enroll as a Medicaid provider is \$586.00
as of January 1, 2019.

*See more information regarding providers
who may be subject to application fees [here](#).*

Updated Claims Processing and Payment Schedule

See information regarding when claims are due and when EFT payments will be made from July 2019 to July 2020.

[Click here to view 2020 Financial Calendar!](#)



Information Re: PASRR for Nursing Home and Hospice Providers

In order for nursing home claims and hospice room and board claims to pay, a Pre-Admission Screening and Resident Review (PASRR) must be completed.

This is an evaluation process that is mandated by the Nursing Home Reform Act under the Omnibus Budget Reconciliation Act of 1987. A Level I PASRR is required for all applicants to Medicaid certified nursing facilities, regardless of the payor. A Level II Evaluation and Determination must be completed prior to admission if a serious mental illness and/or intellectual disability or related condition is identified through the Level I screening. This requirement excludes Eleanor Slater Hospital, The Tavares Pediatric Center and RICLASS facilities.

In late June 2019, RI Bridges began sending an indicator of "Y" (for yes) to indicate that this screening has been completed or "N" (for no) to indicate the screening has not been completed. This indicator is viewable on the eligibility page on the Health Care Portal. If the PASRR is set to "N" for the dates of service being submitted on the claim, the claim will go into suspense and be denied if the PASRR is not updated to a Y for the dates of service on the claim.

DXC is working with EOHHS to add the PASSR indicator of Y to all previously approved recipients. Claims processing began to utilize this indicator for all claims submitted after June 24, 2019.

*The PASRR indicator is available for viewing
in the Health Care Portal as of June 27, 2019.*

Pharmacy Spotlight

Meeting Schedule:

Pharmacy and Therapeutics Committee

Drug Utilization Review Board



The next meeting of the
Pharmacy & Therapeutics Committee (P&T)
is scheduled for:

Date: April 7, 2020

Registration: 7:30 AM

Meeting: 8:00 AM

Location: DXC Technology

301 Metro Center Blvd.,
Suite 203

Warwick, RI 02886

[Click here for agenda](#)

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

Date: April 7, 2020

Meeting: 10:30 AM

Location: DXC Technology

301 Metro Center Blvd.,
Suite 203

Warwick, RI 02886

[Click here for agenda](#)

2020 Meeting Dates:

April 7, 2020

June 9, 2020

September 15, 2020

December 15, 2020

Medicare ID Project

As part of changes related to the CMS New Medicare ID card project, some changes will be observed to the following MMIS reports.

Three TPL billing reports (the Inpatient, Outpatient, and Part B Professional Billing) are being changed to relabel the field 'Medicare HIC' to now be 'Medicare ID'. The new Medicare Beneficiary ID (MBI) will be listed when it is known to the MMIS, otherwise the Health Insurance Claim Number (HICN) will be displayed as is the case today. After the January 1, 2020 dual processing (MBI or HICN as the primary Medicare identifier) cut-off, these reports will only display the MBI information. This change is observed in the August 2019 report generation.

Additionally, the electronic Remittance Advice report will display either the MBI or the HICN in the TPL section of the report (in the field labeled 'Medicare ID'). After the January 1, 2020 cutoff, the RA will only display the MBI in the Medicare ID field. This change is observable in the August 24 financial cycle.

Pharmacy Update—Pain Management

The Department of Health continues to receive questions about the requirement of ICD-10 codes for controlled substance prescriptions. Below are questions and answers regarding ICD-10 codes on controlled substance prescriptions. Also below, is a link to more FAQs about Pain Management on the Department of Health website.

Documenting International Classification of Diseases (ICD) 10 Diagnosis Code(s) on Controlled Substance Prescriptions

1. Why is the documentation of ICD-10 diagnosis codes on all controlled substances prescriptions required?

The requirement for prescribers to provide a diagnosis code on a patient's prescription allows pharmacists to understand why the controlled substance is being dispensed. Pharmacists are able to use this information to have follow-up conversations with prescribers and patients to ensure that patients are being treated with the appropriate medication. This is a requirement for all clinicians with a Controlled Substance Registrations (CSR), including dentists, physicians, physician assistants (PAs), Advanced Practice Registered Nurses (APRNs), optometrists, midwives, podiatrists, and veterinarians. The ICD-10 code(s) must be entered in a visible location on the prescription.

2. Where can dentists and other clinicians who typically do not work with ICD-10 codes find the appropriate diagnosis code?

The most common dental ICD-10 codes are:

- K01: impacted teeth
- K04: pulpal and periapical diseases
- K05: periodontal diseases
- K08: loss of teeth (This code could be used for implant placement or another pre-prosthetic surgery.)

For dentists, it is sufficient to document the three-character code—the category code—when documenting a diagnosis on a prescription. For example, the three-character code of **K01** supplies sufficient information to indicate a diagnosis of **Embedded and Impacted Teeth**. To find a more specific diagnosis code, prescribers can visit the World Health Organization's (WHO) [comprehensive list of ICD-10 codes](#).

3. If the prescriber cannot find an appropriate ICD-10 code or if the prescriber's profession does not typically use ICD-10 codes, how should the patient's diagnosis be indicated on the prescription?

In these specific cases, the patient's diagnosis should be written legibly in a visible location on the face of the prescription.

4. Does the ICD-10 code have to be documented in the medical record, too?

RIDOH does not require a prescriber to record an ICD-10 code in the patient's medical record.

5. If a prescriber omits the ICD-10 code, can pharmacists take verbal orders from the prescriber for the code, or does a new prescription need to be issued?

A verbal order from the prescriber can be obtained to fulfill the requirement for the ICD-10 code. Dentists and veterinarians do not use ICD 10 codes and may write the diagnosis on the prescription in place of the ICD 10 code.

<http://health.ri.gov/publications/frequentlyaskedquestions/PainMgmtRegs.pdf>



**See link to the Preferred
Drug List (PDL) here:**

[http://www.eohhs.ri.gov/ProvidersPartners/
GeneralInformation/ProviderDirectories/Pharmacy.aspx](http://www.eohhs.ri.gov/ProvidersPartners/GeneralInformation/ProviderDirectories/Pharmacy.aspx)

Provider Revalidation: Wave 1 Concludes!

The first wave of provider revalidation concluded at the end of October. Noncompliant providers have been informed that they will be suspended on 12/20/2019 and terminated from the RI Medicaid Program on 12/31/2019.

Providers requiring revalidation:

Inpatient facilities	Hospice services
Outpatient facilities	Assisted living facilities
Independent pharmacies	Case management services
Independent labs	Adult day cares
Ambulances	Shared living agencies
DME/prosthetic/orthotic suppliers	Day habilitations
Nursing homes	Waiver case management
Federally Qualified Health Centers	Personal choice/habilitation case management services
RICLASS	Self-directed community services
Home meal delivery services	
Outpatient psychological facilities	

RI Medicaid provider enrollment revalidation is mandated by the Centers for Medicare and Medicaid (CMS) provider screening and program integrity rules. As such, providers are required to submit supplemental application materials.

Visit <http://www.eohhs.ri.gov/ProvidersPartners/ProviderEnrollment.aspx> to see more info about provider revalidation.

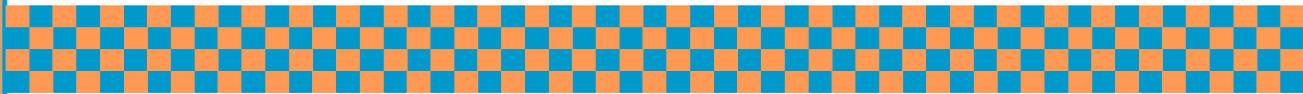
If you have questions, please contact the Customer Service Help Desk at 401-784-8100 or 800-964-6211 for instate toll calls.



Please Note!

Providers can access the Healthcare Portal directly, without going through the [EOHHS website](#), by going directly to this address:

<https://www.riproviderportal.org/HCP/Default.aspx?alias=www.riproviderportal.org/hcp/provider>



Info Re: Prescribing Nutritional Supplements

Please note that physicians prescribing nutritional supplements must:

- Direct recipients to DME suppliers and **not pharmacies**
- Provide DME suppliers with recipients' CMNs
- Submit* Prior Authorization (PA) requests using [this form](#) for the following procedure codes:

B4102
B4103
B4149
B4150
B4152
B4153
B4154
B4155
B4157

*PA requests can be faxed to (401) 784-3892

Questions regarding prescribing nutritional substances can be directed to the RI Medicaid Customer Service Helpdesk at (401) 784-8100.

ENTERAL NUTRITION INSTRUCTIONS for PHYSICIANS

Physicians who are prescribing Enteral Nutrition for RI Medicaid members should fill out section B of the Certificate of Medical Necessity (CMN) for Enteral Nutrition and fax it to the DME provider that will be providing the nutrition to the member. The CMN form can be found on the EOHHS website at:

http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/MA%20Reference%20Guides/DME/CMN_enteral_and_parentral_nutrition.pdf

The DME provider is responsible for filling out Section A of the CMN that they receive from the physician's office. The DME provider will fax the CMN with a Prior Authorization request form to:

DXC Technology
Fax: 401-784-3892

If you have any questions, please call the DXC Customer Service Helpdesk at 401-784-8100

Revised Form for Requesting Hearing Aids

Effective January 1, 2020, a revised PDF version of the Director of Nurses Statement for Hearing Aids (GW-DON) form will be available on the EOHHS website. This form should be completed by the Director of Nurses or Administrator of a Long Term Care facility when a Fee for Service Medicaid resident is requesting a hearing aid. The completed form should be forwarded to the Medicaid vendor that is requesting prior authorization for the hearing aid. The vendor will then submit the form along with the prior authorization request to Medicaid for review.



The [revised PDF form](#) can be found on the EOHHS website under Prior Authorization Forms ([here](#)) and in the Coverage Guidelines for Hearing Aids ([here](#)).

DME Proof of Medical Necessity

Proof of Medical Necessity is required for all services covered under this program. All prescriptions for DME, regardless of format used (e.g., CMN, Prescription pad, or letter) shall, at a minimum containing the following elements:

- (1) Member name, and DOB
- (2) Diagnosis code for which the DME is required
- (3) Description of the DME, including quantities and any special options or add-ons:
- (4) Length of need for the DME use:
- (5) Name, address and NPI of the prescribing provider; and
- (6) Prescribing provider's signature and date of signature.
(Prescribing providers are enrolled physicians, clinical nurse specialists, certified nurse practitioner or physician assistants, within the scope of their practice as defined by state law).

All requests for purchase of DME to replace an item shall be fully explained, documenting the continuing medical necessity and including reasons for the replacement and the reason that repairs are not feasible or are more costly than replacement.

Proof of medical necessity should be kept on file by the supplier, and made available upon request.

See DME Provider Reference Manual [here](#).

