

Provider Update, October 2008, Vol. 192

SFY 2009 State Budget - Medical Assistance Eligibility Changes

[Article 10 of the Rhode Island State Budget for State Fiscal Year 2009](#) made several changes in the law affecting Medical Assistance eligibility. The following changes will take place on **October 1, 2008**. Clients impacted by these changes have received both an informational letter and an adverse action notice explaining how these changes impact their families.

- Adults between 175-185% FPL will no longer be eligible for Medical Assistance coverage. The closure notice will contain language about the RI community health centers.
- Families between 150-250% FPL will experience an increase in monthly premium.
- Families between 133-150% FPL will be subject to a premium for the first time.

The premiums will be as follows:

Family Income Level:	If they were paying:	They will be paying:
133-150% FPL	\$0	\$45.00
150-175% FPL	\$61.00	\$86.00
175-200% FPL	\$77.00	\$106.00
200-250% FPL	\$92.00	\$114.00

- Clients eligible for Extended Family Planning benefits will now be required to re-certify for eligibility on an annual basis. These members will receive re-certification packets at 12 months of enrollment, as do all other RIte Care/RIte Share members.
- Enrollment in managed care health delivery systems will become mandatory for children in substitute care, children receiving Medical Assistance through an adoption subsidy, and children eligible for Medical Assistance based on their disability (SSI and Katie Beckett children) provided they have no other third-party medical insurance.

SFY 2009 State Budget - Requirement Pertaining to Medicaid Providers Who Employ Medical Assistance Recipients

[Article 17 of the Rhode Island State Budget for State Fiscal Year 2009](#) contains a section that impacts Medical Assistance providers. Any Medical Assistance provider who receives a request from the Department of Human Services to provide information about their employer-sponsored health insurance must provide the requested documentation to DHS in a timely manner (within 14 days from the time of the request). This information will be used to determine if Medical Assistance-eligible employees can be enrolled in RIte Share,

Rhode Island's Premium Assistance Program.

EDS will send out more detailed communications regarding these changes, including a request that all Medicaid providers sign an updated Provider Agreement that acknowledges this requirement. Providers will be expected to establish a process that will ensure compliance with this law which took effect upon passage (7/1/08). Below is the language regarding this requirement.

40-8-27. Cooperation by providers. – Medicaid providers who employ individuals applying for benefits under any chapter of title 40 shall comply in a timely manner with requests made by the department for any documents describing employer sponsored health insurance coverage or benefits the provider offers that are necessary to determine eligibility for the state's premium assistance program pursuant to section 40-8.4-12. Such documents requested by the department may include, but are not limited to, certificates of coverage or a summary of benefits and employee obligations. Upon receiving notification that the department has determined that the employee is eligible for premium assistance under section 40-8.4-12, the provider shall accept the enrollment of the employee and his or her family in the employer based health insurance plan without regard to any seasonal enrollment restrictions, including open enrollment restrictions, and/or the impact on the employee's wages. Additionally, the Medicaid provider employing such persons shall not offer "pay in lieu of benefits." Providers who do not comply with the provisions set forth in this section shall be subject to suspension as a participating Medicaid provider.

Billing Fluoroscopic Guidance In Conjunctions with Facet Joint Injections

Since fluoroscopic guidance is required to perform paravertebral facet joint and paravertebral facet joint nerve with destruction by neurolytic agent or sacroiliac joint injections, code 77003 *should* be additionally reported in conjunction with codes 64470-64476, 64479-64484 and 64622-64627; and in certain circumstance, with code 27096.

Subsequent CPT Assistant articles in the January and February 2000 issues repeated the critical language "**code 77003 should be additionally reported**" when **fluoroscopic guidance and localization is performed in conjunction with the epidural, subarachnoid, transforaminal, facet joint and paravertebral facet joint injections.**

The Director of CPT Information and Education Services confirmed that "**...from a CPT coding perspective code 77003 should be separately reported in addition to codes 62270-62273, 62280-62282, 62310-62319, and 64470-64484.**"

Failure to report the fluoroscopic guidance code may result in the recoupment of claims for facet injections.

Billing for Hearing Aid Repairs

There are three scenarios for billing hearing aid repairs on paper. Hearing aid repairs are billed with one of two set standard rates or with an option for a repair cost plus a set mark up. Use procedure code V5014 in box 24D for all repairs.

To bill for a repair plus mark up when a repair will cost more than one of the set amounts, but still be less than a replacement hearing aid, note X7010 in box 19 and send an invoice with the claim.

To bill the set standard rates of \$50 or \$85:

- For extensive repairs, bill \$85 and note X7000 in box 19.
- For office repairs, bill \$50. No invoice or note in box 19 is needed

In no instance will a hearing aid repair be paid that occurred within the one year guarantee period other than the reduced cost replacement.