

Provider Update, March 2009, Vol. 196

PERM Review

In January of 2008, the State of Rhode Island was part of a Payment Error Rate Measurement (PERM) review by the Centers for Medicare and Medicaid Services (CMS). This is mandated by the Improper Payments Act of 2002 (IPA), Public law 107-30, enacted on November 26, 2002. Medicaid and the State Children's Health Insurance Program (SCHIP) were identified as programs at risk.

PERM Reviews are conducted in three areas: fee for services (FFS), managed care and eligibility for both Medicaid and SCHIP. Each state will be reviewed once every three years. The past review was looking at claims with a DOS for Federal Fiscal Year (FFY) 10/01/2006- 09/30/2007. The next PERM review for Rhode Island will be in 2010.

CMS reviewed the same sample of claims for data processing/payment errors and medical documentation. In order to support the medical documentation, review letters were sent out by CMS in the first six months of 2008 asking for specific documentation for an Internal Control Number. If the submitted documentation was insufficient or not received, second and third request letters were sent. Due to the very strict timelines associated with these requests, missing or late documentation was considered an error. In order to reduce the number of errors, some providers were called and asked to respond to CMS promptly.

CMS has compiled all of the errors and calculated the error rates for RI. RIMA is required to return the federal monies paid for these claims to CMS. Providers were notified in a letter prior to the recoupment taking place. All of the recoups have been completed.

The last part of the PERM review is to create a Corrective Action Plan (CAP). One of our CAP items is to educate providers about the audit and to encourage a more timely response to future audits. We will also give providers plenty of advanced notice prior to the PERM audit in 2010.

Refraction Testing Reimbursement

The Medical Assistance Program will reimburse for Refraction testing, procedure 92015, when Medicare reimburses for one of the following procedures (routine eye exam) performed on the same date of service as the Refraction testing: 92002, 92004, 92012 and 92014. Medicare commercial products are not eligible.

To process these claims a completed CMS 1500 claim form must be forwarded with procedure 92015 as the line item. The Medicare EOMB reflecting payment for the routine eye exam must accompany the claim. The fee for procedure 92015 is \$20.00.

EDS
Attn: Sandra Bates
P.O. Box 2009
Warwick, RI 02887

If you have any questions, please contact your EDS provider representative, Sandra Bates, at 401-784-3832 or via [email](#).

Other Insurance Processing - Nursing Homes

Effective with Date of Service February 1, 2009, Nursing Home claims pricing will be changed to go through a “lesser of” processing logic when Other Insurance and/or a Co-pay is billed. Claims processing will determine the appropriate payment based on which is less, the co-pay (aka “adjustment”) submitted or the Medical Assistance allowed amount. The Medical Assistance allowed amount for this claim type will be determined by reducing the allowed amount by patient liability, if applicable.

If there is a patient liability present on the claim and the “lesser of” amount is the ‘adjustment’ amount, the patient liability will be subtracted from that amount to determine the final Medical Assistance Program reimbursement amount. If the Medical Assistance allowed amount is the “lesser of” the two, then final payment will be the Medical Assistance allowed amount.

If you have any questions about this change or need help with processing these claims, please contact [Kelly Leighton](#) at 401-784-3823.

Other Insurance Processing Change for Institutional Claims Billing

Effective with Date of Service February 1, 2009, Other Insurance claims will be processed using “lesser of” logic. This will compare Medicaid’s Allowed Amount minus any Other Insurance Payment to the total of any submitted co-pay, co-insurance and/or deductible (aka: “adjustments”) multiplied by RCC to determine which payment is truly the “lesser” and the claim will reimburse accordingly.

The following fields should be reported:

- Carrier Code
- Other Insurance Payments
- Co-Pay, Co-Insurance and/or deductible
- Other Insurance Paid Date

If there is an other insurance payment posted, and no adjustments, the claim will pay zero

RIt Share Processing for Institutional Claims

The following is how RIt Share claims will be processed if submitted electronically. The RCC% will be applied to the co-pay, co-insurance and/or deductible submitted. RIt Share claims should be billed with the same process that “other insurance” claims are processed with the following fields reported:

- Carrier Code
- Other Insurance Payment
- Co-pay, Co-Insurance and/or Deductible

- Other Insurance Paid Date

When submitting RIte Share claims on paper, please continue to use the type of bill 994 and only submit the charge for the co-pay, co-insurance and/or deductible. The paper process has not changed.

If you have any questions on this processing change, please contact the Customer Service Help Desk at 401-784-8100 or 1-800-964-6211 for In-State toll calls.

Change in Digital Hearing Aid Coverage

RI Medical Assistance recognizes that analog hearing aids are being phased out in favor of digital hearing aids which are more precise and are of a better quality.

Therefore, as of January 1, 2009, both digital and analog hearing aids will be covered under the same Prior Authorization policy. Further documentation and a cost validation form for digital hearing aids will no longer be needed. Below are the new allowable amounts for digital hearing aid codes:

Code	Allowable	Code	Allowable
V5254	\$575	V5253	\$1,050
V5255	\$575	V5258	\$1,050
V5256	\$575	V5259	\$1,050
V5257	\$575	V5260	\$1,050
V5252	\$1,050	V5261	\$1,050

Please contact your DME Provider Representative, [Jeanne Giroux](#), at (401) 784-8826 with any questions.

RIte Care Open Enrollment

RIte Care members will have a chance to change their health plan if they choose during RIte Care’s Open Enrollment period. This year, Open Enrollment is from March 9, 2009 to April 10, 2009. In early March, RIte Care head of household members will receive a letter in the mail notifying them of Open Enrollment. If members would like to stay in their current health plan, they don’t have to do anything. If they would like to switch health plans, they would need to select a new health plan, sign a simple form, and send to DHS by the end of the open enrollment period.

Revised EPSDT Schedule for Children Under 21

The Department of Human Services convened a review panel in 2008 to revise Rhode Island Medicaid’s EPSDT (Early Periodic, Screening, Diagnosis, and Treatment) Schedule for Children. This schedule is being distributed to family physicians and pediatricians throughout Rhode Island. The goal of the EPSDT Schedule is to identify and treat health conditions early to promote normal growth and development. The

EPSDT Schedule provides guidance on the number and frequency of recommended preventive visits, screenings and procedures for children enrolled in Medicaid, although it can be used for all Rhode Island children.

For a copy of the schedule, please check the [DHS website](#)

Dialysis Outpatient X-Over Claim Reimbursement

Effective February 1, 2009, the Rhode Island Department of Human Services modified the way in which the Rhode Island Medical Assistance Program reimburses Dialysis Outpatient Crossover claims. Dialysis Outpatient Crossover Claims are now being reimbursed based on the following logic:

$$\text{Co-insurance} + \text{Deductible} \times \text{Rate (75\%)} = \text{RIMA Allowed Reimbursement Amount}$$

Example: Co-insurance = \$100.00, Deductible = \$225

$$\text{\$100.00} + \text{\$225.00} = \text{\$325.00} \times .75 = \text{\$243.75 allowable reimbursement}$$

Although the modifications took effect February 1, 2009, the new pricing methodology for Dialysis Outpatient Crossover claims will be retroactive to January 1, 2008. Dialysis Outpatient Crossover claims processed and paid with a 'Date of Service' July 1, 2008 thru December 31, 2008 forward were effected and will be mass adjusted to reflect the new rate of reimbursement. Necessary recoupments will be deducted from future payments. Any claim with a date-of-service January 1, 2008 thru June 30, 2008 that has not previously been submitted to the Rhode Island Medical Assistance Program for reimbursement will also be considered for payment using the new rate logic.

In addition, any claim with a system calculated reimbursement of greater than \$1,000.00 will require manual (paper) submission to Rhode Island Medical Assistance. Claims that meet this criterion will be automatically denied if submitted electronically. These claims can be identified by the Explanation of Benefit (EOB). The EOB will indicate that the dialysis electronic crossover claim exceeds the limit, and to submit manually. When manually submitted, these claims must be accompanied by documentation substantiating the amount. There are no additional changes to the current billing procedure.

Should you have any questions please do not hesitate to contact your Dialysis Provider Representative, [Sandra Bates](#), at 401-784-3832.

Early Intervention Reimbursement Schedule Change

There are some changes to the Early Intervention reimbursement schedule that became effective for dates of service beginning on 2/1/2009:

Integrated Group Service (H2015 HQ) will be eliminated as a reimbursable service from the Early Intervention Program.

Case Management (T1016) and Transition Planning (T1016 TG) will only be reimbursed up to (but not including) the child's third (3rd) birthday.

Billing for Dentures

Claims are to be submitted for dentures only after the dentures are actually delivered to the recipient, not for the date of service of the alginate impressions or the dates of any of the try-ins. This will avoid dental providers having to reimburse the RI Medicaid Program for services not rendered should the recipient not comply with appointments and not return to have the dentures inserted and fitted..

It has become evident through Surveillance and Utilization Review of dental services that some dental providers are, in fact, billing Medicaid for dentures when only the decision to fabricate them has been made, or when the first impression has been taken.

Billing in advance of delivery is contrary to Dental Policy and should not be done. This practice may result in recoupment of funds paid.

As a reminder, adjustments may not be billed within the first six months (183 days) after delivery of the dentures as this service is included in the global fee for the dentures. Adjustments will be allowed once per year thereafter.

A reline is allowed once per year as deemed medically necessary after the initial 6-month period (183 days) from delivery has passed.

A rebase will be covered 2 years (730 days) from the date of delivery of the dentures and then once every two years as deemed medically necessary.

Billing for Orthodontic Services

Requests for payment can only be submitted after placement of permanent bands / wires and completion of six-month time intervals.

Submitting claims for orthodontic services that have not yet been performed is in direct violation of the Rhode Island Medical Assistance Dental Policy and payment for these claims may be subject to recoupment. Repeat offenses may be subject to disciplinary action by the Department of Human Services.

As always, for any questions, please refer to the online [RIMA Dental Policy Manual](#) at or contact the Dental Provider Representative, [Sandra Bates](#), at 401-784-3832