



## RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

# PROVIDER UPDATE

### ALL PROVIDERS

*We're going Green....eliminating paper Provider Updates will save more than 8 trees per year!!!*

### IMPORTANT NOTICE

This is the last paper version of the Provider Update you will be receiving.

Future Updates will be found at <http://www.dhs.ri.gov/dhs/heacre/prosvcs/mprvlib.htm> beginning with the May Update which will be available May 1, 2009.

Subsequent Provider Updates will be available on the first of every month or on the business day following the first day of the month.

### MEDICAID GLOBAL WAIVER

Rhode Island's Global Consumer Choice Compact Waiver was approved by the Center for Medicare and Medicaid Services (CMS) on January 16, 2009. The waiver will be in effect for five years, from January 2009 through December 2013.

The primary goals of the Global Waiver are to:

- Rebalance the Long Term Care system
- Require Medicaid beneficiaries to participate in a managed care program
- Transition the Medicaid Program from a payer of services to a purchaser of services

With the Global Waiver, the state receives an agreed upon aggregate allotment of federal funds and also some flexibility on federal Medicaid rules. For more information on the Rhode Island's Global Waiver, please check the DHS website at [www.dhs.ri.gov](http://www.dhs.ri.gov).

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## **DOCUMENTATION TIPS TO AVOID RECOUPMENT**

Appropriate documentation will help to avoid delay of payment and/or recoupment.

Important **charting** points to remember:

- Recipient's name must be on each side of every chart sheet utilized
- Dates of service for every entry
- Clear, legible notations of service and findings
- Signature of professional
- Credentials of professional
- Length of time of service – starting and ending time for codes billed in time increments
- Corrections should be done appropriately – no obliteration of error – simply put one line through the error and initial it
- When records are requested, please send legible copies, not originals
- Remember medical records are legal documents - no anecdotal remarks should be included

**Coding** of services rendered:

- Use current CPT and HCPCS code manuals bill with the most appropriate code to adequately describe the service provided and pay you the appropriate fee.
- Do not “Up-code” - ex. using a code that is not equivalent to the service, but which pays more
- Do not “Un-bundle” – ex. billing for individual components of a “panel” which will result in overpayment and recoupment
- Do not use a “99” code to be reimbursed at a higher rate when there is already an appropriate code for the service you have provided

Please refer to the Provider Manuals which are located on the DHS web site at [www.dhs.ri.gov](http://www.dhs.ri.gov).

### **REMINDER**

DHS and EDS are requiring that all active Medicaid providers sign an updated Provider Agreement. The addition of item 18 in the Agreement acknowledges the new requirement that providers who receive requests from the Department of Human Services for information about their employer-sponsored health insurance provide the requested documentation to DHS in a timely manner. Please find the Provider Agreement at: [http://www.dhs.ri.gov/dhs/heacre/prosvcs/prvforms/prov\\_agreement.pdf](http://www.dhs.ri.gov/dhs/heacre/prosvcs/prvforms/prov_agreement.pdf).

### **Provider agreements must be completed with signature, date and provider number.**

Mail completed provider agreements to: EDS an HP company  
ATTN: Barbara Lynch  
PO Box 2010  
Warwick, RI 02887-2010

If you are unable to access the Agreement, please contact your Provider Representative for assistance. Find your Provider Representative at: [www.dhs.ri.gov/dhs/heacre/prosvcs/mprvrep.htm](http://www.dhs.ri.gov/dhs/heacre/prosvcs/mprvrep.htm).

**SINGLE AND MULTIPLE ADJUSTMENT REQUEST FORMS AND  
RELATED BUSINESS FORMS**

The Single Adjustment Request Form and Multiple Adjustment Request Form are used to request adjustments of only paid or partially paid claims.

**Q & A**

**Q.** When should it be suggested that a providers' request be sent to us as an adjustment?

**A.** Adjustment should be used when the provider needs to make one of the following changes on a PAID claim.:

- Change in procedure code
- Change in billed amount
- Change in units
- Changes dates of service
- Changes in other insurance payment amount (include other insurance documentation)
- Change in Medicare payment
- Change in revenue code
- Change in liability
- Change in modifiers
- Change in NDCs
- Change in UCR amounts
- Change in diagnosis
- Change in patient status

**Q.** When should it be suggested that a providers' request be sent to us as a recoup?

**A.** Recoups should be used when a claim needs to be taken back for the following reasons:

- Duplicate payments
- Billed with the wrong provider number
- Billed for the wrong client
- Client has RIte Care
- Services not received by client

These forms cannot be used to resubmit a denied claim. Denied claims need to be corrected and re-submitted on a valid claim form or sent electronically.

There is no formal appeals process and no related business form. For further assistance regarding claim status, please contact a Customer Service Representative at 401-784-8100 for local and in-state toll calls or 1-800-964-6211 for long distance calling.

If claims are past the timely filing limit, you may direct your request to your provider representative with the necessary supporting documentation.

## PROVIDERS USING PAPER HCFA 1500 FORMS

### TAXONOMY REMINDER

When entering your taxonomy on a HCFA 1500 in box 33b, please enter the “ZZ” qualifier followed immediately by the taxonomy. DO NOT leave a space between the qualifier and the taxonomy.

## LABORATORY PROVIDERS

### LABORATORY CODE PANELS

Are you tired of those annoying claims that get re-bundled into a panel by our RI Medical Assistance system? Would you like to get paid in a more timely manner?

This could be achieved simply by utilizing your CPT Standard Edition. You can access all the information needed. The “Organ or Disease-Oriented Panels“ are listed on pages 341 and 342 of the current CPT guide.

Using this guide, you can research the codes that are included in each panel. If you bill the panel instead of each individual component, the claim will not set Claim Check. This will decrease claim processing time and eliminate the manual work required to adjudicate your claim.

For example, if you performed the following tests:

**82374** Carbon Dioxide  
**82435** Chloride  
**84132** Potassium  
**84295** Sodium

The appropriate code to bill would be the panel code of **80051**. This code is inclusive of all the procedures performed and is the code that will be reimbursed.

## DIALYSIS PROVIDERS

### CHANGE IN REIMBURSEMENT CALCULATION FOR DIALYSIS OUTPATIENT CROSSOVER CLAIMS

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:

**Co-insurance + Deductible x Rate (75%) = RIMA Allowed Reimbursement Amount**

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

**\$100.00 + \$225.00 = \$325.00 X .75 = \$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.*

## VISION PROVIDERS

### Determination of Refractive State 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 the 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.

All paper claims must be sent to:  
EDS

P.O. Box 2009  
Warwick, RI 02887

If you have any questions, please call your EDS provider representative, Sandra Bates, at 401-784-3832 or via email at [sandra.bates@eds.com](mailto:sandra.bates@eds.com).