OCTOBER, 2010 Volume 213

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

PROVIDER UPDATE

ALL PROVIDERS

NATIONAL CORRECT CODING INITIATIVE EDITS

The federal Patient Protection and Affordable Care Act, passed into law earlier this year, mandates that claims filed on or after October 1, 2010, State Medicaid Agencies must incorporate and apply editing methodologies of the National Correct Coding Initiative (NCCI). The Centers for Medicare and Medicaid Services (CMS) has been charged by Congress with the responsibility for defining the adjudication rules, provider types and claim types that will be subject to the NCCI edits. On September 1, 2010, CMS will issue these directions to State Medicaid agencies.

Rhode Island Medical Assistance, like all other State Medicaid agencies, will be required to enforce these edits within the claims processing environment. Two types of edits are mandated in the law: procedure-to-procedure and unit of service. The types of claims subject to these types of edits and the scope of these edits will not be known until further information is received from CMS. The potential exists that these edits could impact your claims filed on or after October 1, 2010.

Rhode Island Medical Assistance will provide additional guidance and clarification about NCCI editing as information becomes available.

SMOKING CESSATION PRODUCTS

Beginning 10-1-10 Smoking Cessation Products will now be covered for Medical Assistance FFS clients. All products will be covered through prior authorization. Please refer to the website for coverage policy and prior authorization form.

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TIMELY FILING

The Rhode Island Department of Human Services Program has a claim submission restriction of twelve (12) months from the date of service provided to Medical Assistance clients. HP must receive a claim for services for Medicaid clients with no other health insurance and no previous denial from HP within 12 months of the date of service in order to process claims for adjudication.

- Claims with a date of service over one year with an involved third party payer (insurance) must be submitted within ninety (90) days from the process date of the other payer (insurance).

- Claims with a date of service over one year that had denied previously by HP must be submitted within ninety (90) days from the date on the remittance advice.

- Any claim with a service date over one year and a process date from another payer or a remittance advice date from HP over ninety (90) days will be denied for timely filing.

Once the date of service is over 1 year old, the claim and supporting documentation to prove timely filing must be submitted on paper to your provider representative for approval. If you are not aware of who your provider representative is, please go to: http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/ProviderRepresentatives/ListofProviderReps/tabid/786/Default.aspx

- The only exception to this is on Medicare Crossover claims. If the date of service is over 1 year old and Medicare has made a payment within the past 90 days of your submission date, you can submit that claim electronically or if billing on paper, directly to the claims department.

PROFESSIONAL, DENTAL, WAIVER & INSTITUTIONAL PROVIDERS

ADJUST OR RECOUP YOUR CLAIMS ELECTRONICALLY

Rhode Island Medical Assistance accepts electronic replacements and voids. With replacements you can make changes to a paid claim, as in an adjustment. With voids you may remit the entire payment on a claim, as in a recoup. Both voids and replacements process overnight.

Please follow the process specific to your claim type as listed below:

Professional, Dental and Waiver Claims:
Identify a replacement or void by the claim frequency code.
7 = Replacement
8 = Void

Institutional Claims:
Identify a replacement or void by the third position of the bill type.
7 = Replacement
8 = Void

Required information: The Internal Control Number (ICN) from the claim that you would like to replace or void. The ICN is a 15 digit number that can be found on your remittance advice.

Denied claims cannot be adjusted. Your claim will need to be corrected and resubmitted.

If you use Provider Electronic Solutions for electronic billing, please click here for a complete set of instructions for submitting electronic replacements or voids.

If you utilize another software for electronic billing, verify with your vendor that you can bill electronic replacements or voids using that software.

Please call the Customer Service Help Desk for further assistance at 800-964-6211 for bordering communities and in-state toll calling or 401-784-8100 for long distance calls.

PHYSICIANS AND OTHER MEDICAL PROFESSIONAL PROVIDERS

RIte SHARE MEMBER BILLING

PAPER BILLING ONLY:

*Use State Local Procedure Code **X0700** when billing **co-payments**:*

Do not submit Explanation of Benefits (EOB)/Remittance Advice (RA) from the primary RIte Share commercial insurance carrier.

CMS 1500 Field/Box Requirements:
- 9D – No carrier code is required
- 11D – Indicate **NO** to other insurance
- 24F, 28 & 30 – Enter amount of the co-payment only*
- 29 – Leave blank

**please note the maximum reimbursement amount for co-payments is $40.00*

*Use State Local Procedure Code **X0701** when billing **co-insurance or deductible**:*

Submit the EOB/RA from the primary RIte Share commercial insurance carrier.

CMS 1500 Field/Box Requirements:
- 9D – No carrier code is required
- 11D - Indicate **NO** to other insurance
- 24F, 28 & 30 – Enter amount of the co-insurance and/or deductible only*
- 29 - Leave blank

These claims will be manually priced according to the co-insurance and/or deductible amount posted on the EOB from the RIte Share primary commercial insurance carrier.

**please note the maximum reimbursement amount for co-insurance and/or deductible is $500.00*

If there is a dollar amount under **one** column on the primary carrier's EOB or RA which indicates co-payment and co-insurance or deductible, look for the reason code for that line item. It should specifically designate whether the amount is a co-pay, co-insurance or deductible and that will indicate the correct procedure code to bill. If there is not a reason code the Claims Department will accept whichever "X" code the provider bills and will either pay the amount billed or up to the allowable amount whichever is the lesser amount.

If the EOB or RA has both a co-payment amount and a co-insurance or deductible amount on the same date of service, bill each X code on separate HCFA claim form. **Procedure codes X0700 and X0701 can not be billed on the same HCFA claim form.**

If the EOB or RA has multiple lines for co-insurance or deductible on the same date of service, bill one line on a HCFA claim form with procedure code X0701 and total the amount of the co-insurance or deductible. Add the total amount to fields/boxes 24F, 28 and 30.

Always include the EOB "glossary" page when billing procedure code X0701 which explains the reason code located next to the co-insurance and/or deductible.

ELECTRONIC BILLING ONLY:

RIte Share claims should be billed electronically whenever possible. When billing electronic claims, use the applicable procedure codes originally billed to the primary insurance.

The "X" codes (X0700 / X0701) should not be billed electronically.

Remember to indicate the primary insurance information in "CAS" (Claim Adjustment Segment) using PR1 (Deductible), PR2 (Co-insurance), PR3 (Co-Payment) and the billed amount.

WHAT THIS MEANS TO YOUR SOFTWARE VENDOR:

The total claim charge amount belongs in **the CLM02 of LOOP 2300**

The CAS is where the reason adjustment codes(claim level adjustments) belong as follows:

Loop 2320 CAS01: should have the PR (claim adjustment group code)

CAS02: should have 1, 2 or 3 (claim adjustment reason code)

CAS03: should have monetary amount (of the deductible, co-ins or co-pay)

MANAGED CARE PROVIDERS

TRANSITION OF BCBSRI RIte CARE MEMBERS

Blue Cross & Blue Shield of Rhode Island (BCBSRI), a RIte Care participating health plan for the past 16 years, did not submit a proposal to continue participating in the RIte Care Program. BCBSRI RIte Care members' medical benefits will continue without interruption provided that the member continues to be otherwise eligible for Medical Assistance. The State is working closely with the two participating health plans, UnitedHealthcare of New England and Neighborhood Health Plan of Rhode Island, to assure a smooth transition of approximately 15,000 RIte Care members (6,600 families).

The transition of BCBSRI members will occur as outlined below. BCBSRI members will receive a letter from DHS about their new health plan and important phone numbers to call if they have questions. Careful consideration will be made for members who are receiving ongoing care or treatment.

Mailing to members	Enrollment effective date	Town/city of residence
Sept 15, 2010	Oct 18, 2010	Providence, Pawtucket
Oct 4, 2010	Nov 1, 2010	Northern RI
Oct 18, 2010	Nov 15, 2010	East Bay, Aquidneck Island, Block Island, South County
Nov 1, 2010	Dec 1, 2010	West Bay

Until a member receives a letter from DHS regarding their new health plan, they should continue to seek services using their BCBSRI card.

MANAGED CARE PROVIDERS

GENERIC DRUGS FIRST PHARMACY BENEFIT

Beginning October 1, 2010**,** all RIte Care and Rhody Health Partners members will have a *Generic Drugs First* Pharmacy Benefit. Exceptions to this policy have been made for some therapeutic classes of drugs and a limited number of brand name drugs within certain therapeutic classes. On a case-by-case basis, additional brand name drugs may be available based on medical necessity and demonstrated lack of efficacy of the generic drug. Medical necessity reviews will be available according to the health plans' individual protocols and PDL (Preferred Drug List) formularies.

The health plans will be sending letters and fact sheets to all prescribing providers who are licensed in Rhode Island including physicians, nurse practitioners, dentists, and pharmacists. In addition, each health plan will send letters to their members who will need to switch to a different drug and will need a new prescription.

For More Information please call the Health Plans' Customer Service Department or check their websites.

Neighborhood Health Plan of RI	(800) 459-6019	www.nhpri.org
UnitedHealthcare of New England	(800) 587-5187	www.uhcmedicaid.com

Information on the Generic Drugs First Pharmacy Benefit policy is available on the DHS website at www.dhs.ri.gov. Member letter & FAQs and the provider letter & fact sheet are also available.