FEBRUARY, 2012 Volume 229

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

PROVIDER UPDATE

ALL PROVIDERS

IMPLEMENTATION OF X12 5010

RI has met the CMS requirements to be compliant for 5010 and NCPDP D.O HIPAA standards on 1/1/2012. RI will turn off the dual processing window on Tuesday, January 31st, 2012. Effective, Wednesday, February 1, 2012 only 5010 format will be accepted.

Currently the 835 transaction is available in both the 4010 and 5010 format. Please choose one format to download. Effective, February 1, 2012 the 835 will only be available in the 5010 format.

Frequently Asked Question's

Which HIPAA 5010 transactions has Rhode Island Medicaid implemented?

- Eligibility Inquiry/Response 270/271 005010X279A1
- Benefit Enrollment/Maintenance 834 005010X220A1
- Electronic Remittance Advice 835 005010X221A1
- Professional Claim 837 005010X222A1
- Institutional Claim 837 005010X223A2
- Dental Claim 837 005010X224A2
- Pharmacy Claim NCPDP D.0
- 999/TA1 File Acknowledgement 005010X231A1

We will continue to support the 277U 003070X70 version. (This is not a 5010 mandated transaction.)

Will submitters be assigned new submitter IDs for 5010 format testing and production?

No, submitters will retain the submitter IDs they currently use.

Will 835 files be sent in both 4010 and 5010 formats?

Currently the 835 is available in both 4010 and 5010 formats. Each file will be a complete set of all claims and financial transactions processed during the financial period. Submitters can choose

ALL PROVIDERS	1-5
PROFESSIONAL PROVIDERS	6
NON-EMERGENCY MEDICAL TRANSPORTATION PROVIDERS	7-10

ALL PROVIDERS –*continued*

to process either the 4010 or 5010 835 transactions.

Can I submit 5010 transaction with P.E.S. Software?

The current P.E.S. software version 2.05 can only be used for 4010 transactions. The new version of PES 2.06 is available to be downloaded from our website.

Will I be able to continue sending X12 4010 or NCPDP 5.1 transactions after January 1, 2012?

Our dual processing window will end on January 31st, 2012.

Will new transactions be added?

Yes, the 997 has been replaced with the 999 Acknowledgement for the 5010 transactions.

Will Rhode Island provide a file level acknowledgement for claim files?

A 997 will continue to be provided for 4010 file submissions, and the 999 has been sent for any 5010 transactions.

Will the same delivery method for 4010 and 5010 files be used?

Yes, the same method for uploading files to Rhode Island Medical Assistance will be used for 4010 and 5010. There will be no changes to the procedures for submitting claims to the MMIS, nor there any revisions to the existing Trading Partner Agreements.

Do 837 Institutional claims require a valid NPI (National Provider Identifier) in the Attending Provider field?

Yes, a valid NPI is required. There is a compliance check for this information during transmission. The entire file will be rejected if the compliance check fails.

ALL PROVIDERS –*continued*

****IMPORTANT CHANGES FOR 5010****

NPI Changes

When billing for the **Attending Provider** – you must choose to use a valid NPI format with the **XX** qualifier or a valid provider ID format with the **G2** qualifier.

Billing Zip Code Change

The **billing zip code** must contain 9 digits.

Dental Providers

Treatment Start and Stop dates must be used on all span billing such as; crowns, dentures and orthodontic procedures.

IMPORTANT CHANGES FOR **FIRST TIME VERSION 2.06 PES USERS**

Password

New default password for PES users is **hp-pes**

Copy Claim

If you should need to use the copy function of a claim - you will need to update the provider record of that claim to include the new zip code requirement. The **zip code must contain 9 digits**. You must copy the provider record containing the new 9 digit zip code for every claim that is copied.

NPI Change for Attending Provider

For providers who need to include the attending provider in your claim – you must send a valid format for the provider NPI with the XX qualifier. This NPI must be added to any claim that is copied and resubmitted. If you do not have a valid NPI format you can choose to select a provider from your **other provider list** and use the G2 qualifier with a valid provider number format. You cannot send the NPI and provider ID in the attending provider field.

ALL PROVIDERS –*continued*

Provider Enrollment Portal

EOHHS has been working with HP Enterprise Services in developing a new web based provider enrollment process. The first phase involves collecting all of the enrollment information for all current providers within the Medicaid Management Information System (MMIS) that are active and have submitted a claim since January 1, 2010.

Letters were mailed to notify providers that they will need to revalidate their provider enrollment information on the new Enrollment Portal. In November our Provider Enrollment Team outreached to our first group of providers listed here:

Adult Day Care
Audiologist
Chiropractor
Eleanor Slater
Meals on Wheels
Shared Living
Ambulance
Case Managers
Dialysis
Free Standing Amb Surg Ctr
Nursing Homes
Assisted Living
CEDARR Center Services
Early Intervention
Independent Labs
RICLASS

In December, we mailed letters to our second group of providers:

Inpatient Hospitals
Conversion Waiver
Outpatient Psych Hospitals
Outpatient Hospitals
Group Homes – Private
Free Standing Psych Hospitals
Day Habilitation

Over the next several months we will continue to outreach to the additional providers. Listed below is the third group of providers:

Dental
DME
FQHC
Skilled Nursing
Lead Centers
Optician
Self Directed Community Services
Psychologists
Severely Disabled Homecare
Habilitation Group Home
Hospice
Licensed Therapists
Personal Care Aid/Assistant
Pharmacy
Vision
Other Therapies/Hippotherapy
Indian Health Services
Local Education Agency
Personal Choice/Hab Case Mgmt
Podiatry

ALL PROVIDERS –*continued*

Please watch your mail for more information about our new Provider Enrollment Portal and how to access your enrollment. The letter will contain a pre-determined Tracking ID. Providers will be asked to log into the Provider Enrollment Portal with this Tracking ID to verify their information that is currently in the MMIS. In addition, Providers will answer disclosure questions and attest online to their statements and the Provider Agreement.
Information updates about the new enrollment process will be available on the Provider News and Updates page of the DHS website: http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/ProviderNewsUpdates/tabid/907/Default.aspx

If you should have questions while completing your enrollment verification, please contact our Customer Service Help Desk at (401) 784-8100 for in state and long distance calls or (800) 964-6211 for in-state toll calls.

If you have received the letter requesting revalidation, please do so immediately. Delays in completion could result in interruption of enrollment.

New Fax Numbers

Effective February 1, 2012 the fax numbers for HP Enterprise Services will change to the following;

- **Provider Services / TPL / Prior Authorization – 401-784-3892**
- **Enrollment – 401-784-3889**

Should you have questions, please contact customer service at 401-784-8100 or for in-state toll calls at 800-964-6211.

PROFESSIONAL PROVIDERS

Billing Administration codes for Vaccinations

Rhode Island Medical Assistance does not reimburse state supplied vaccines. Rhode Island Medical Assistance will reimburse the administration for these vaccines;

- Procedure code 90460 (immunization administration through 18yrs via any route of administration, with counseling by physician) or 90461(immunization administration through 18yrs via any route of administration, each additional vaccine) allows one unit each.

- Vaccines with multiple components are considered as one unit.
  -For example: procedure code 90696 (DTap, Tetanus, Acelullar Pertussis, Polio) has four components; however this code allows one unit, and will be reimbursed as one unit utilizing procedure codes 90460 and 90461.

- If the vaccines are administered with a flu vaccine, RI Medical Assistance will reimburse multiple administrations.
  -For example: procedure codes 90748 (Hepatitis B), 90680 (Rotavirus vaccine), and 90670 (Pneumococcal Vaccine) are single components and can be reimbursed utilizing one unit of procedure code 90460 and two units of procedure code 90461.

In both examples the claims must be sent for review to the attention of Daphine Monroe at P.O. Box 2010 Warwick, RI 02887. If you have any questions please contact Daphine Monroe at 401-784-8003 or at darphine.monroe@hp.com.

TRANSPORTATION PROVIDERS

Medical Transportation Policy

Provider Participation Guidelines
To participate in the Medical Assistance Program, providers must have an office and performing services in Rhode Island or in a border community.
Ambulance providers must be licensed through the Department of Health (or other applicable agency for border community providers). Taxi and Public Motor Carriers must be licensed through the Public Utilities Commission. All license documentation (for companies, vehicles and drivers) must be submitted with the provider application.

Recertification
Ambulance providers are annually recertified by the Rhode Island Department of Health (DOH). Once license renewal is obtained, forward a copy of the renewal documentation to HP. HP should receive this information within thirty days of renewal to avoid interruption of provider eligibility. Taxi, Public Motor Vehicle Carriers, and Providers in border communities must send in copies of their license or recertification within thirty days of renewal to ensure continuation in the program.

Claims Billing Guidelines
Instructions for completing the CMS 1500 claim form are located on the Office of Health and Human Services (OHHS) website at; http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FormsApplications/tabid/164/Default.aspx

Origin/Destination Modifiers
Claims must include a two-letter origin-destination modifier indicating where the trip begins and ends if billing for mileage, (emergency or non-emergency) non-emergency stretcher and/or emergency (BLS/ALS) transportation services.

Covered and Non-Covered Services
The Medical Assistance Program Covers emergency and non-emergency medical transportation (NEMT) for Medicaid clients to a Medicaid covered service provided by a Medicaid provider. Only ground transportation is covered. The type of trip (emergency/non-emergency) must be consistent with the diagnosis of the patient transported (e.g., a trip billed as emergency transport would not be covered if the patient had a non-emergency diagnosis).
Emergency transportation claims for Medicaid clients enrolled in managed care plans should be referred to the appropriate Plan.

Non-Emergency Medical Transportation
Non-emergency medical transportation is covered when the recipient has no other means of transportation, no community resource exists and transportation by any other means would endanger the individual's health. Also, the non-emergency medical transportation must be for a Medicaid eligible person, receiving a Medicaid covered service from a Medicaid-participating provider.

TRANSPORTATION PROVIDERS-continued

SNF or ICF Resident
An individual residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) whose condition precludes transportation by the facility automobile to and from physician's office, medical laboratory, hospitals, etc., may be transported subject to the following restrictions.
Non-emergency medical transportation services should only be utilized when the patient cannot be transported by any other means through the facility and when the required medical service cannot be provided within the facility. It is the responsibility of the facility to ensure that the patient is transported by alternative means whenever possible.
Non-emergency transportation services should not be utilized to transport patients to receive services that can be provided within the facility; e.g., portable x-ray services can be provided in a facility setting.
Emergency medical transportation services should only be provided when a patient is severely ill or injured and transportation by any other means would endanger the individual's health.

Out of State
Non-emergency medical transportation for out-of-state trips will only be considered for payment on the basis of medical necessity. The patient's provider must provide written medical documentation in advance to the State for review. Please allow at least ten business days for the review to be completed. In general, such services will only be authorized if the Medicaid covered service is not available in Rhode Island or there are other extenuating medical circumstances. Refer to Section 200-30 of the Provider Manual for authorization guidelines and procedures.

Round Trips
Emergency transportation will not be paid for transport back to the point of origin. Emergency round trips are paid only if the patient is transported out of state and back. Non-emergency round trips can be paid if authorization was obtained. Hospital initiated (Emergency Room, Inpatient, Outpatient) non-emergency transports must be billed to the requesting facility.

Repeat Trips/Extra Attendants
Up to four (4) one-way non-emergency medical trips may be provided to a patient in one day. All trips must be authorized. Payment for an extra attendant to accompany a patient may be permitted if medically necessary and must be authorized.

Authorization
All non-emergency procedure codes (excludes non-emergency stretcher transports) require authorization. In addition, extra attendants also require authorization. When requesting authorization, medical justification must be documented. Authorization should be requested from the transportation scheduler, by calling 401-784-3899.

Physician's Statement
Non-emergency medical transportation may require a written statement by the recommending physician. This statement must include the recipient's medical condition that prevents them from taking public transportation and why non-emergency medical transportation is required. If the non-

TRANSPORTATION PROVIDERS-continued

emergency transportation is on-going (such as for kidney dialysis), one statement can be used for a period of up to one year.

Reimbursable Ambulance Procedure Codes
Reimbursable emergency and non-emergency medical transportation procedure codes and the corresponding reimbursement rates can be found on the OHHS website at; http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FormsApplications/tabid/164/Default.aspx
In addition, Medical Assistance may also provide bus passes and para-transit services through the Rhode Island Public Transportation Authority.

ALS andBLS
ALS (Advanced Life Support) includes oxygen and heart monitoring devices and is indicated if a condition is life-threatening. BLS (Basic Life Support) does not include oxygen. The level of support is determined by the services that are provided en-route. Additional life support services are not separately payable.

Mileage
Mileage is reimbursable for wheelchair, BLS, ALS and out-of-state ambulatory transportation services. There is no mileage reimbursement for in-state ambulatory trips. The maximum mileage allowed for each trip will be predetermined by the State or its designee during the authorization process.

Waiting Time
Waiting time is reimbursed for out-of-state trips up to a maximum of two hours. In-state waiting time is included in the base rate.

Oxygen
The need for oxygen must bear a reasonable relationship to the medical diagnosis and requirements of the patient. Oxygen will not be allowed on a routine basis.

Multiple Passengers
More than one recipient may be transported by the same vehicle on the same trip, provided there are adequate seating and safety restraints for all passengers. Passengers must not have their trip lengthened by more than 30 minutes due to multi-loading of passengers.

Reimbursement Guidelines
The reimbursement rates for transportation providers are listed on the OHHS website at; http://www.dhs.ri.gov/ForProvidersVendors/MedicalAssistanceProviders/FeeSchedules/tabid/170/Default.aspx
Providers must bill the Medical Assistance Program for their usual and customary rate (UCR) as charged to the general public and not for the published fee schedule amount. Rates discounted to specific groups (such as Senior Citizens) must be billed at the same discounted rate to the Medical Assistance Program. Payments to providers will not exceed the maximum reimbursement rate of the Medical Assistance Program.

TRANSPORTATION PROVIDERS-continued

Quick Response to obtain Recipient Eligibility & Other Valuable WEB Tea

Medicare/Medicaid Crossover
The Medical Assistance Program payment for crossover claims is always capped by the established Medical Assistance allowed amount, regardless of coinsurance or deductible amounts. The standard calculation for crossover payments is as follows:

Medical Assistance will pay the lesser of:
o The difference between the Medical Assistance allowed amount and the Medicare Payment (Medical Assistance allowed minus Medicare paid); or
The Medicare coinsurance and deductible up to the Medical Assistance allowed amount, calculated as follows: (Medicare coinsurance/deductible + Medicare paid) - (Medical Assistance allowed).

Patient Liability
The Medical Assistance Program payment is considered payment in full. The provider is not permitted to seek further payment from the recipient in excess of the Medical Assistance Program rate.

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