JULY, 2012 Volume 234

RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

PROVIDER UPDATE

All PROVIDERS

Open Enrollment Period For Medicaid MCOS And Connect Care Choice Ends May 31, 2012

On an annual basis, Medicaid's RIte Care, Rhody Health Partners (RHP), and Connect Care Choice (CCC) programs conduct open enrollment which allows RIte Care members to switch health plans, and RHP and CCC members to switch programs or health plans. In April, letters were mailed to RIte Care, Rhody Health Partners, and Connect Care Choice members. Members excluded from this mailing were those enrolled in Extended Family Planning, Foster/Substitute Care, Adoption Subsidy or Chafee/Post Foster Care, Medicare, those with verified comprehensive commercial coverage including RIte Share, those living in a long-term setting or a Skilled Nursing Facility, and those who are Medically Needy or QMB. The Open Enrollment period ended May 31, 2012 . Enrollment in the new health plan or program will be effective July 1, 2012.

HOSPITAL PROVIDERS

Present on Admission/Health Care Acquired Conditions

The CMS mandated requirements in section 2702 of the Affordable Care Act - CFR Parts 434,438 and 447 dated May 25, 2011 - state: "This final rule will implement section 2702 of the Patient Protection and Affordable Care Act which directs the Secretary of Health and Human Services to issue Medicaid regulations effective as of July 1, 2011 prohibiting Federal payments to States under section 1903 of the Social Security Act for any amounts expended for providing medical assistance for health care acquired conditions specified in the regulation. The act also authorizes States to identify other provider-preventable conditions for which Medicaid payment will be prohibited."

Hospital Acquired Conditions (HAC's) are a baseline for withholding or reducing Medicaid payment. For admissions occurring on or after July 1, 2012, hospitals will not receive the higher payment for cases when one of the selected conditions is identified as acquired during hospitalization (i.e., was not present on admission). The case is paid as though the secondary diagnosis is not present.

A **Present on Admission (POA)** indicator reports whether or not a recipient's condition existed as of admission. Present on Admission is defined as present at the time the order for inpatient admission occurs. Conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

HOSPITAL PROVIDERS *continued*

Effective with admissions on or after July 1, 2012, RI Medical Assistance will require all inpatient claims to be submitted with a POA indicator for diagnoses in the primary and secondary field.

The POA Indicator Reporting Options and Definitions are as follows:

Code	*Reason for Code*
Y	Diagnosis was present at time of inpatient admission. *RI Medicaid will pay the complicating condition/major complicating condition (CC/ MCC) DRG for those selected Hospital Acquired Conditions (HACs) that are coded as "Y" for the POA Indicator.*
N	Diagnosis was not present at time of inpatient admission. *RI Medicaid will **not** pay the CC/MCC DRG for those selected HACs that are coded as "N" for the POA Indicator.*
U	Documentation insufficient to determine if the condition was present at the time of inpatient admission. *RI Medicaid will **not** pay the CC/MCC DRG for those selected HACs that are coded as "U" for the POA Indicator.*
W	Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission. *RI Medicaid will pay the CC/MCC DRG for those selected HACs that are coded as "W" for the POA Indicator.*

As of July 1, 2012 RI Medical Assistance will implement a new edit and explanation of benefit (EOB) to support identification of POA for institutional claims processing

Children's Hospitals, Cancer Hospitals and Inpatient Psychiatric facilities are exempt from the reporting POA and should not report a POA with their submissions. If you are uncertain if you meet these criteria please contact Kelly Leighton at the contact information listed below.

Edit # 286 Missing/Invalid POA Indicators

This edit will identify inpatient claims that should be denied when the POA indicator is missing or invalid on the institutional claim.

EOB # 286 Missing/Invalid POA Indicators

Inpatient Crossover claims will be exempt from this editing.

There are also several diagnosis codes which are exempt from this editing. However, if you submit a POA indicator on these exempt codes, your claim will be subject to the POA processing rules. The exempt diagnosis list will be forwarded to you prior to implementation.

Failure to submit a POA indicator on institutional claims with an admission on or after July 1, 2012, will deny unless it is a diagnosis that does not require a POA.

If you have any questions, please contact Kelly Leighton at 401-784-8013 or Kelly.leighton@hp.com

DME PROVIDERS

Manually Priced Durable Medical Equipment

DME Providers are asked to remember to send a manufacturer's invoice with prior authorization requests and paper claims submitted for items which are priced manually, for example T2028, T2029 and S5165 (or any other code where there is no set amount on the fee schedule). The item(s) being billed on the request/claim should be easily differentiated from any other items on the invoice by such means as an asterisk or by blacking out items not being billed. The invoice must also show if the cost on the invoice is retail or wholesale. If the item is shipped in a case, package or box, we will need clear indication of cost per unit. If you have any questions, please contact Jeanne Giroux, DME Provider Representative, at 401.784.8020 or at jeanne.giroux@hp.com.

New DME Certificate of Medical Necessity for Adults

A revised Certificate of Medical Necessity (CMN) for Durable Medical Equipment/Supplies for Adults form and instructions are now available on the DHS web-site at www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/DME.CMN. Effective August 1, 2012, please submit this form with all Prior Authorization Requests excluding oxygen, Minor Assistive Devices, Special Medical Equipment and Home Modifications. Prior Authorization Requests submitted on or after August 1, 2012 without the revised CMN forms will be returned. This will result in delayed processing and approval of requests. If you have any questions concerning this change, please contact Jeanne Giroux at 401.784.8020 or jeanne.giroux@hp.com.

HOME CARE AND MEALS ON WHEELS PROVIDERS

Global Waiver Service Plan

As of July 1 2012 the Global Waiver Service Plan (GW-SP) will replace the pro -panel and the as the authorization for home care services and Meals on Wheels provided to those individual eligible for Global Waiver Services. The Division of Elderly Affairs will also use the GW-SP for authorization of home care services and Meals on Wheels. The GW-SP will include: The Service plan,The hours authorized and The client share.

INDEPENDENT LABORATORY PROVIDERS

Reference Laboratory

The Medical Assistance Program will reimburse for testing performed within the laboratory billing for the service or when provided by a referring laboratory where there exists a wholly owned relationship between the referring or primary laboratory. Services are considered performed by the provider when either an employee or the individual provider personally performs the service. Referred services are provided by the laboratory who performed the lab services for the primary laboratory. The part of a test performed by another lab will be reimbursed through the Medical Assistance Program to the primary laboratory and will be the responsibility of the primary laboratory provider. The primary laboratory provider is responsible to reimburse the referencing laboratory for the services performed.

OUTPATIENT, DIALYSIS, ASC, PRACTITIONER & DME PROVIDERS

National Correct Coding Initiative (NCCI)

The Patient Protection and Affordable Care Act (PPACA) mandates that all Outpatient, Practitioner and DME claims be filed in accordance with the National Correct Coding Initiative (NCCI) guidelines. The Center for Medicare & Medicaid Services (CMS) developed NCCI to promote correct coding of health care services by providers. Currently, Rhode Island Medicaid is using ClaimCheck Version 6 to edit on procedure code pairing discrepancies. A new version of the McKesson ClaimCheck software, Version 10, now supports the PPACA federal regulations, along with other CMS federal regulations. Once integrated in the RI MMIS, ClaimCheck Version 10 will bring the MMIS into compliance with the PPACA.

To ensure full compliance, with the NCCI mandates, the Office of Health and Human Services (OHHS) has opted for an approach involving two separate components. There will be a component to store and edit on Medically Unlikely Editing (MUEs) within the MMIS, and a component to upgrade the McKesson ClaimCheck software to edit on procedure code pairing and modifiers.

The NCCI mandate went into effect on April 1, 2011. The following types of providers are affected by this change:

- Outpatient Hospitals
- Dialysis Centers
- Ambulatory Surgical Centers
- Practitioner
- Durable Medical Equipment

All changes will be retro-active to April 1, 2011. Both components of NCCI will be implemented the week of June 25, 2012.

ClaimCheck:
Effective the week of June 25, 2012 claims began processing using ClaimCheck Version 10; this change is effective for dates of service beginning April 1, 2011.

Medically Unlikely Editing (MUE)
An MUE is a unit of service (UOS) edit for a HCPCS/CPT (Healthcare Common Procedure Coding System/Current Procedural Terminology) code that applies to services performed by a provider/supplier for a beneficiary on a single date of service.

Effective the week of June 25, 2012 a new Edit and EOB was implemented.

New Edit and EOB 781 - Units Exceed Medically Unlikely Editing

- This edit will set when the units billed exceeds the CMS-defined maximum Units of Service (UOS) allowed.
- This edit will supersede any existing max UOS edits within other fee schedules.

In July 2012, RI Medicaid will process an adjustment for claims with dates-of-service April 1, 2011 through the present using the new Version 10 of ClaimCheck and MUE editing.