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RHODE ISLAND MEDICAL ASSISTANCE PROGRAM

PROVIDER UPDATE

ALL PROVIDERS

Assess How the ICD-10 Transition will Affect your Organization

Although the final rule on the proposed ICD-10 deadline change has been delayed for one year from October 1, 2013 to October 1, 2014, it is important to continue planning for the transition to ICD-10. The switch to the new code set will affect every aspect of how your organization provides care, from registration and referrals, to software/hardware upgrades and clinical documentation.

A critical step in planning for the transition is to conduct an impact assessment of how the new code sets will affect your organization. Your impact assessment should include:

- Documentation Changes: You will need to consider the increased specificity of ICD-10 codes compared to ICD-9 codes, and ensure that patient encounters are documented with appropriately comprehensive clinical descriptions. You should:
  - ◊ Train staff to accommodate the substantial increase and specificity in code sets
  - ◊ Consider physician workflow and patient volume changes
  - ◊ Revise forms, documents, and encounter forms to reflect ICD-10 codes
  - ◊ Evaluate processes for ordering and reporting lab/diagnostic services to health plans
- Reimbursement Structures: You should coordinate with payers on contract negotiations and new policies that reflect the expanded code sets, since they can affect reimbursement schedules.
- Systems and Vendor Contracts: Ensure your vendors can accommodate your ICD-10 needs. Find out how and when your vendor plans to update your existing systems. You will need to review existing and new vendor contracts and to evaluate vendor offerings and capabilities against your organization's expectations. Work with your vendors to draft a schedule for needed tasks.
- Business Practices: Once you have implemented ICD-10, you will need to determine how the new codes affect your processes for referrals, authorizations/pre-certifications, patient intake, physician orders, and patient encounters.
- Testing: Work with your vendors to determine the amount of time needed for testing and schedule accordingly.

ICD-10 will affect nearly all areas of your organization, but with a thorough impact assessment, you can keep your day-to-day activities running smoothly while you transition to ICD-10.

Keep Up to Date on ICD-10. Please visit the ICD-10 website for the latest news and resources to help you prepare at; **http://www/cms.gov/medicare/coding/icd10**

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ALL PROVIDERS *continued*

PERM (Payment Error Rate Measurement) Review

In January of 2013 the State of Rhode Island will take part in the 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. This law requires the heads of Federal agencies to review annually programs they oversee that are susceptible to significant erroneous payments, to estimate the amount of improper payments, to report those estimates to Congress, and to submit a report on actions the agency is taking to reduce erroneous expenditures. Medicaid and the State Children's Health Insurance Program (SCHIP) were identified as programs at risk.

PERM Reviews will be 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 three year time frame is relative to date of service on the claims being reviewed. The next PERM review for Rhode Island will be starting in January 2013 and will include claims with a date of service between 10/01/2012 and 09/30/2013.

The data processing reviews are based on how well the MMIS processes the claims. This includes payments, data entry, edits and audits. This part of the review does not require any provider cooperation. The eligibility reviews are based on the InRhodes system processing clients correctly for Medical Assistance and other state programs.

Additionally, CMS will review the same sample of claims for data processing/payment errors and medical documentation. In order to support the medical documentation, review letters will be sent out by CMS in the first six months of 2013 asking for specific documentation for a specific ICN. If the correct documentation is insufficient or not received, a second and third request letter will be sent to providers. Additionally, a phone call will be made by the CMS contractor who will fax the letter once phone contact is made with the provider. There are very strict timelines associated with these requests so if the documentation is not received or received late this will be considered an error. The State of Rhode Island will then recoup the money associated with any claims deemed as an error by CMS and their contractor after the audit is complete. In order to support this process and reduce the number of errors for no documentation providers will be called directly requesting providers to respond to the CMS request and to send in the documentation as soon as possible.

CMS will complete this process in Rhode Island by compiling all of the errors and calculating the error rates for the state. The follow up to this process is the requirement to return the federal monies paid for these claims to CMS. Providers were notified in a letter prior to the recoupment taking place.

The last part of the PERM review is to create a Corrective Action Plan (CAP) so when the PERM audit is done in 2013 the state of Rhode Island will have less errors and better cooperation from Providers for submitting sufficient medical documentation timely. One of our CAP items is to educate providers about the audit and to encourage better cooperation in future audits.

ALL PROVIDERS *continued*

Billing Medical Assistance Recipients

As a reminder RI Medical Assistance providers cannot bill Medicaid recipients for covered services or missed appointments. The recipients are not responsible for these charges.

Prior Authorization Letters

The Executive Office of Health and Human Services (EOHHS) ceased the mailing of prior authorization approvals as of September 1, 2012. You can obtain the status of a prior authorization request by utilizing the interactive web services available on the EOHHS web site at www.dhs.ri.gov. Through the web site you can verify whether the prior authorization request is suspended for review, approved or denied as well as view if any units on the authorization have been used.

If you already have a trading partner number and password:

- When you completed your Trading Partner agreement if you selected prior authorization status all you will need to do is access https://www.dhs.ri.gov/secure/logon.do and select check prior authorization.
- If you do not have access to view prior authorizations you can request access by filling out the Trading Partner Agreement Change/Add form located here: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/tpa_chgfrm.pdf

If you do not have a trading partner number and password please request one by filling out the Trading Partner Agreement Form located here: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/tpa.pdf

Further information relating to program participation, claim billing and the Electronic Health Records Incentive Program is also available via the EOHHS web site:

Recipient Eligibility Verification
- Verify recipient eligibility information
- Batch eligibility transactions - do multiple transactions and receive verification on the next business day
- Print information for your files

Service limits for vision & dental benefits
- Verify available benefits or exhausted services

Claims Processing
- Check the status of a submitted claim and adjustments

Prior Authorization
- Check the status of a prior authorization request

National Drug Code (NDC) Search
- Pharmacies can search for a NDC that is reimbursable by the RI Medical Assistance Program

Remittance Advice
- Confirm your Medical Assistance payment history for the last 12 months
- View and print your Remittance Advice (RA) electronically in the paper RA format

DME PROVIDERS

ELIGIBILITY FOR MINOR ASSISTIVE DEVICES (T2028)

In order to receive services for Specialized Supplies (Minor Assistive Devices) - Code T2028, web eligibility for a recipient must include one of the following programs:

Core Community Services
Department of Elderly Affairs
DEA assisted living
Habilitation Community Services
Preventive Community Services
Self-Direction Community Services
Shared Living
RI Housing Assisted Living
Intellectual Disability Services

Here is the Approved Items List for T2028 - Specialized Supplies (Minor Assistive Devices):

abduction wedge
adaptive kitchen utensils
bath/shower chair
gait belt
wander device
hip kit
offset hinges
raised toilet seat
shampoo tray
threshold ramps
transfer bench
transfer handle
repairs or modifications to the items on this list
adaptive eating utensils
aids for personal care
dressing aids
grab bars
hip abduction pillow cover
pivot disc to transfer
reacher
safety transfer belt
standing pole
tract glove
versa frame (toilet safety frame)
hand held shower unit/diverter valve

All Minor Assistive Devices require a prior authorization. The Prior Authorization form can be accessed via the following link: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/pa_form.pdf

Form GW-SF is also required which can be accessed via the following link: http://www.dhs.ri.gov/Portals/0/Uploads/Documents/Public/GW_SF.PDF

If you have questions, please contact Jeanne Giroux at (401)784-8020 or jeanne.giroux@hp.com.

HOSPICE PROVIDERS

Hospice Rates

Effective October 1, 2012

Code	Description	Rate
T2042	Routine Hospice Care	$153.65/day
T2043	Continuous Home Care	$37.33/hour
T2044	Inpatient Respite Care	$167.07/day
T2045	General Inpatient Care	$682.59/day