0300 MEDICAL ASSISTANCE PROGRAM OVERVIEW

0300.05 MEDICAL ASSISTANCE PROGRAM PURPOSE

REV:06/1994

The Rhode Island Medical Assistance (MA) Program is the federal/state program to meet the medical needs of low income persons who are age 65 or over, blind, disabled, or members of families with dependent children, or qualified pregnant women and children.

The Statutory foundations of the Rhode Island MA Program are Title XIX of The Social Security Act and Rhode Island General Laws 40-8.

0300.10 PROGRAM ADMINISTRATION

REV:06/1994

The Rhode Island Department of Human Services (DHS) is the agency of state government which administers the Medical Assistance Program.

0300.15 CATEGORIES OF MEDICAL ASSISTANCE

REV:06/1994

DHS determines eligibility for and provides Medical Assistance to Rhode Island residents in two categories - Categorically Needy and Medically Needy.

0300.15.05 Categorically Needy

REV:06/1994

The Categorically Needy are those individuals or families eligible for or receiving cash assistance under the SSI or AFDC Programs, or who are deemed eligible, or are legislated under a special provision to be Categorically Needy.

SSI recipients, families eligible for and/or receiving AFDC and children for whom payments are made under Title IV-E are AUTOMATICALLY eligible for MA as Categorically Needy. A separate determination of eligibility for MA is not required for these individuals.

0300.15.10 Medically Needy

REV:06/1994

The Medically Needy are those individuals or families whose resources and/or income exceed the standards required for eligibility as Categorically Needy, but are within the Medically Needy standards. Applicants may achieve Medically Needy eligibility with a Flexible Test of Income which applies excess income to certain allowable medical

expenses, enabling individuals or families to spenddown to within Medically Needy income limits.

In addition to meeting the income and resources criteria, Medically Needy recipients must also meet all non-financial requirements for MA eligibility.

0300.20 SCOPE OF SERVICES

REV:06/1994

MA recipients eligible as Categorically Needy are entitled to the full scope of medical services provided by the MA Program.

Recipients eligible as Medical Needy are entitled to a limited scope of medical services.

0300.20.05 Medical Services Provided

REV:09/2006

The medical services provided to the Categorically Needy and the Medically Needy are:

MEDICAL SERVICES PROVIDED

SERVICE	CATEGORICALLY NEEDY	MEDICALLY NEEDY	TYPE OF
Inpatient Hospital Services	Yes 1,2	Yes 1,2 (see note below)	
Inpatient Psychiatric Hospital	Yes	Yes	Services for those age 65 and over or under age 21
Outpatient Hospital Services: (see note below)			
Clinic and Emergency Room	Yes 1,3	No	
Laboratory and X-rays	Yes	Yes	
Physician Services	Yes 1,2	Yes 1,2	
Pharmacy Services	Yes 8, 9, 10	Yes 8, 9, 10	
Dental Services	Yes	Yes	
Clinical Laboratory Services	Yes	Yes	
Durable Medical Equipment, Appliances, and Prosthetic Devices	Yes	Yes 4	Surgical
Certified Home Health Agency	Yes	Yes	Services
Podiatry Services	Yes	No	

Ambulance Services	Yes	Yes
Community Mental Health Center	Yes	Yes Services
Substance Abuse Services	Yes 5	Yes 5
Nursing Facility Services	Yes	Yes
Optometric Services	Yes 6	Yes 7
Intermediate Care Facility and Services for the Mentally Retarded	Yes	Yes Day Treatment

NOTE: Inpatient hospital services are subject to admission screening and hospital utilization review procedures. Outpatient hospital services are subject to hospital utilization review procedures.

1. The cost of abortion service is paid only when it is necessary to preserve the life of the woman or when the pregnancy is the result of an act of rape or incest.

2. Organ transplant operations as described in section 0300.20.05.25 are Medical Assistance services.

3. A $3.00 co-payment is charged to eligible individuals for non-emergency services provided in a hospital emergency room.

4. Hearing aids and molded shoes are excluded.

5. Limited to counseling and Methadone maintenance services provided by centers licensed and funded by the Division of Substance Abuse of the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (DBHDDH).

6. For recipients age 21 and older, the following optometry services are limited to once every two years:
   a. one refractive eye care exam;
   b. one pair of eyeglasses (frames, lenses, dispensing fees).

7. For recipients age 21 and older, payment will be made for one refractive eyecare exam in a two year period. Payment is not made for eyeglasses (frames, lenses, dispensing fees).

8. Individuals receiving Medicare Part A, Part B, and/or Part D will receive Pharmacy services through a Medicare Prescription Drug Plan.

9. Individuals receiving fee-for-service Medicaid are required to pay a co-payment for each prescription that they purchase. The following Individuals are exempt from the co-payment requirement:
   a. individuals residing in institutions such as nursing

facilities;
b. children under nineteen (19) years of age;
c. individuals eligible for the Breast and Cervical Cancer Program;
d. pregnant women; and
e. individuals enrolled in Home and Community Based Services Waiver.

10. Rhode Island Medicaid utilizes a preferred drug list. If an individual requires a drug that is not listed on the preferred drug list, it is necessary for the individual to obtain prior approval from DHS. Procedures for submitting a request for prior approval authorizations are delineated in the Medical Assistance Program Provider Reference Manual. Denials of a prior authorization are subject to the appeal process as stated in the General Provisions, Section 0110 of the DHS Rules.

0300.20.05.05 Emergency Room Co-Payment Required

REV:06/1994

With certain recipients exempted, a recipient co-payment of $3.00 will be imposed for a hospital emergency room visit WHEN THE SERVICES PROVIDED DURING THE VISIT DO NOT MEET THE DEFINITION OF EMERGENCY SERVICES. The co-payment is not imposed for children under 18, IV-E and non-IV-E foster care children, adoption assistance children, pregnant women, and institutionalized individuals.

The provider is responsible for collecting the co-payment. The collection of the co-payment is an issue between the recipient and the provider. A provider may not deny service to a recipient who is unable to pay the co-payment at the time the service is delivered. The co-payment will not be imposed on the recipient and deducted from the hospital's claim when a claim is for an emergency service as defined below.

Emergency services are defined as services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Following is a list of examples of presenting problems/diagnoses that will not incur a co-payment:

- Chest pain
- Shortness of breath or difficulty breathing
- The sudden onset of:
  - high fever in children under five years
  - loss of vision, hearing, memory, motion or speech
  - allergic reaction with swollen tongue or fullness of throat
  - paralysis
- Suspected poisoning

- Seizures, convulsions or unconsciousness
- Drug overdose
- Suicide attempt
- Psychotic behavior
- Complications of Pregnancy:
  - sudden vaginal bleeding
  - membrane rupture
  - premature labor
  - suspected miscarriage
- Severe and unexplained bleeding

At the point of service, the hospital will determine if the visit is subject to a co-payment, and if the recipient is subject to imposition of co-payment. If both conditions are met, the hospital will charge the recipient the $3.00 co-payment, and issue a form MA-300, which advises the recipient of the co-payment, and his/her rights to appeal (see Section 0110, Complaints and Hearings, of the DHS Policy Manual).

The hospital must bill the Medical Assistance Program with the appropriate ICD-9-CM diagnosis code(s), and a description of emergency services provided. Such services must be documented in the hospital medical record. The co-payment will be deducted from the Medical Assistance allowed payment during claims processing.

0300.20.05.10 EPSDT

REV:10/1994

Title XIX of the Social Security Act provides for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of eligible Medical Assistance recipients under age 21 to ascertain physical and mental defects, and requires treatment to correct or ameliorate defects and medical conditions found. The Omnibus Budget Reconciliation Act of 1990 (OBRA '90) further mandates that under EPSDT, services will be provided for such other necessary health care, diagnostic services treatment, and other measures described in section 1905(a) of the Social Security Act to correct or ameliorate defects, and physical and mental illnesses and conditions discovered by the screening services, WHETHER OR NOT SUCH SERVICES ARE NORMALLY COVERED UNDER THE MEDICAL ASSISTANCE SCOPE OF SERVICES. Eligible individuals under age 21 receive Medical Assistance services consistent with EPSDT requirements. All services formerly provided under the Severely Disabled Children (SDC) Waiver, which was discontinued October 15, 1994, are covered in the same way under the EPSDT program.

The Severely Disabled Children Waiver provided in-home nursing services for medically fragile children. The medically fragile child is one who requires a medical device to replace or to compensate for a vital body function. This includes but is not limited to mechanical ventilation, oxygen supplementation, feeding tubes, cardiorespiratory monitoring, tracheal care and suctioning, and/or I.V./T.P.N.

Children are referred for services from a variety of sources, including pediatricians, hospital discharge staff, VNA's and parents. In order for a child to be determined eligible for in-home services there needs

to be skilled nursing needs identified, that is, the child would have to be dependent on a medical device for maintenance of life.

When a child is identified as requiring in-home nursing care, the physician makes a request to DHS/EPSDT and includes a medical history and a description of the child's current status.

The request is then reviewed by the Office of Medical Review (OMR) and EPSDT staff. If the child is an in-patient, DHS staff participate in the discharge planning activities and assist in determining level of in-home services.

This process includes input from the parents, physicians, nursing staff, third party insurers and others as appropriate, e.g., DCYF. If the child is already in the community, OMR staff would meet with the parents, and determine the appropriateness of care in conjunction with the physician and others that may be involved with the child. The cost of in-home services must be less than care in a hospital or pediatric skilled nursing facility.

This process encourages a family centered approach which supports the parents in making decisions for and about the home care plan for their child. The parents are encouraged to communicate with other families who have experienced home care and to understand their options in making decisions regarding providers of care.

Nursing services are authorized by OMR staff on a monthly basis and are adjusted according to the medical/nursing needs of the child.

0300.20.05.15 Abortions, Rape, or Incest

REV:06/1994

The cost of abortion services is paid when the pregnancy is the result of an act of rape or incest or it is necessary to preserve the life of the woman.

The following policy and procedure is to be followed when the pregnancy is a result of an act of rape or incest which will qualify for reimbursement by the Rhode Island Medical Assistance Program:

- The patient must provide a signed written statement attesting to the fact that the pregnancy is the result of an act of rape or incest. This requirement shall be waived if the treating physician certifies that in his or her professional opinion, the patient was unable for physical or psychological reasons, to comply with this requirement.
- The treating physician must provide a signed statement that she/he performed the termination of the pregnancy and that the pregnancy resulted from an act of rape or incest.
- The statements must be kept in the medical record for a period of three years to maintain an audit trail.

- The procedure must be performed by a licensed treating physician in a hospital setting or licensed out-patient facility.

0300.20.05.20 Abortions, To Save the Life of the Mother

REV:05/1995

Payment for an abortion will be rendered when a physician has found, and certified in writing to the Department of Human Services at the time payment for services is requested, that an abortion was medically necessary to save the life of the mother.

To qualify for reimbursement by the Rhode Island Medical Assistance Program for an abortion, the following policy must be followed in order to document medical necessity to save the life of a mother. (See section 0300.20.05.15 relative to payment for an abortion when the pregnancy is the result of an act of rape or incest.)

To receive Medical Assistance payment for services, the physician must:

- be a doctor of medicine or osteopathy who is licensed to practice in the State of Rhode Island;
- determine and certify in writing that in his/her professional judgment, the abortion was medically necessary to save the life of the mother;
- retain a copy of the certification in the patient's medical record for a period of three years for purposes of audit;
- submit a copy of the certification, which must contain the name and address of the patient, attached to the request for payment for services.

0300.20.05.25 Organ Transplant Operations

REV:05/1995

ORGAN TRANSPLANT OPERATIONS

The following organ transplant operations are provided as Medical Assistance services when medically necessary and when prerequisites are met:

- KIDNEY TRANSPLANTS:
  Certification from an appropriate medical specialist as to the need for the transplant.
- LIVER TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.
- CORNEA TRANSPLANTS

Certification from an appropriate medical specialist as to the need for the transplant.

- PANCREAS TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant; evaluation at the transplant facility.

- BONE MARROW TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant.

- LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- HEART/LUNG TRANSPLANTS
  Certification from an appropriate medical specialist as to the need for the transplant and evaluation at the transplant facility.

- OTHER ORGAN TRANSPLANT OPERATIONS
  Such other organ transplant operations as may be designated by the Director of the Department of Human Services after consultation with medical advisory staff or medical consultants.

Medical Necessity

Medical necessity for an organ transplant operation is determined on a case-by-case basis using the following criteria: medical indications and contra-indications; progressive nature of the disease; existence of alternative therapies; life threatening nature of the disease; general state of health of the patient apart from the particular organ disease; any other relevant facts and circumstances related to the applicant and the particular transplant procedure.

Prior Written Approval

Prior written approval of the Director or his/her designee is required for all covered organ transplant operations. Procedures for submitting a request for prior approval authorizations are delineated in sections 200-30-1 through 200-30-5 of the Medical Assistance Program Provider Reference Manual.

0300.20.05.30 Transportation Services

REV:07/2008

The Department recognizes that Medical Assistance recipients need available and appropriate transportation in order to access medical care, and assures the provision of such transportation when required to obtain medically necessary services covered by the MA program as follows:

INFORMATION

An informational sheet about MA transportation services for elderly and individuals with disabilities is available at DHS offices or by calling the DHS Information line at 462-5300, for hearing impaired 462-3363.

EMERGENCY TRANSPORTATION

For purposes of this policy section, emergency transportation means transportation to medical treatment when required to obtain emergency health care services for unforeseen circumstances which demand immediate attention at a hospital to prevent serious impairment or loss of life. Medically necessary emergency transportation is provided by ambulance.

When medical services are obtained at a hospital participating in the MA program, appropriate transportation home, if needed, is arranged by the hospital social service or emergency department staff.

NON EMERGENCY TRANSPORTATION

Generally, non-emergency transportation means transportation needed to travel to or from necessary routine, planned medical treatment covered under the MA scope of services at a MA participating provider.

The use of friends, neighbors, and family members to provide non-emergency transportation is encouraged. In addition, free transportation, which may be available from health centers, community agencies or volunteer groups should be utilized whenever possible. Medically necessary transportation to or from medical treatment is also available as follows:

- RIDE PROGRAM

  RIDE provides door-to-door transportation to individuals over age sixty (60) and individuals with disabilities of all ages who meet certain criteria. Transportation is generally available weekdays for doctor's appointments, therapy, adult day care, medical tests and other medical treatment. Transportation may be requested by calling RIDE at 461-9760 or 1-800-479-6902 at least two (2) weeks prior to the medical appointment.

- Rhode Island Public Transit Authority (RIPTA)

  Individuals who receive MA based on age (65 or older) or disability may apply for the "no fare" program and ride free with a RIPTA Senior/Disabled ID card during all hours of operation on regularly scheduled routes.

The Senior/Disabled ID may also be used to obtain RIPTA Flex service, designed to reach areas where fixed bus routes do not go. Flex service is currently available by reservation or at designated regular bus stops from Monday through Friday, 6:00 AM to 6:30 PM in only a few areas of the State. Information about flex service may be obtained by calling RIPTA at 1-877-906-FLEX (3539).

Applications for the Senior/Disabled "no fare" program are available at the RIPTA Identification Office, 218 Weybosset Street, Providence, RI or through the RIPTA Road Trip Community Outreach Program. Applicants must provide a copy of their RI Pharmaceutical Assistance for the Elderly (RIPAE) Card, Medical Assistance ID card, or No Fare Certification Letter from the Department of Elderly Affairs to RIPTA. Information about the Senior/Disabled "No Fare" program may be obtained by calling 784-9500.

Non-emergency transportation is available to RIte Care and RIte Share program participants in accordance with provisions contained in Section 0348.45.05.05 of the DHS Rules.

RIPTA also offers modified curb to curb Paratransit Service that is comparable to existing RIPTA bus routes for individuals with disabilities who are unable to use regular bus service. Additional information and eligibility applications are available from the RIPTA Paratransit Division Coordinator at 784-9500, ext 153, or for hearing impaired 784-3524.

From time to time, transportation services offered by RIPTA may change as new or pilot programs are developed.

When none of the above options are available or appropriate, assistance with non-emergency transportation may be obtained by calling DHS at 784-3899 during normal business hours:

Monday through Friday, 8:30am to 4:00pm.

The recipient is not required to provide verification of the unavailability of alternative or free transportation. All vendors authorized to provide medical transportation must meet the standards established for MA providers by DHS. Prior authorization must be obtained before payment is made for non-emergency transportation to a provider of transportation services.

Transportation is authorized by the most economical means, unless there are compelling medical reasons for using more expensive means.

Payment is not authorized for any of the following reasons:

1. For transportation which is ordinarily made available to other persons in the community without charge;

2. For care or services that are not covered under the MA program;

3. To non-participating service providers; or,

4. When the MA recipient is not actually transported in the vehicle.

0300.20.05.35 Pharmacy Services

REV:09/2006

Under the Medicare Part D Program, in accordance with the Medicare Modernization Act of 2003, Medicaid beneficiaries who also receive Medicare Part A and or Part B, qualify for Part D and must receive their pharmacy services through a Prescription Drug Plan. Therefore, Medicaid beneficiaries who also receive Medicare benefits do not receive pharmacy benefits under the State Medicaid Program. There are, however, six (6) classes of drugs that are exempted from these drug plans and for which Medicaid will provide coverage under Medicaid Pharmacy Services to those receiving Medicare. The six (6) classes of drugs are: barbiturates, benzodiazepines, vitamins, over the counter medications, and cough and cold medications and covered weight loss medications. When purchasing these six (6) classes of drugs, Medicaid beneficiaries are required to pay a co-payment of one dollar ($1.00) for generic drug and three dollars ($3.00) for brand name drug prescription.

0300.20.05.35.05 Pharmacy Services Cost Sharing Requirements

REV:09/2006

Individuals who receive both Medicaid and Medicare benefits may be subject to cost sharing requirements under Medicare Part D in the form of premiums and/or co-payments.

PREMIUMS:

Individuals who receive both Medicaid and Medicare benefits may be subject to cost sharing requirements under Medicare Part D in the form of premiums.

Individuals who select a Part D plan with enhanced benefits will be responsible for that plan's premiums.

Co-Payments:

Individuals will be required to pay a co-payment for each prescription that they purchase.

Income Level	Amount of Co-Payment
Income below 100% FPL	$1.00 Per Generic Prescription $3.00 Per Brand Name Prescription
Income above 100% FPL	$2.00 Per Generic Prescription

$5.00 Per Brand Name Prescription

Individuals who are participants in both waiver and assisted living programs and who receive both Medicaid and Medicare benefits will be required to pay a co-payment for their prescriptions.

EXCEPTION TO CO-PAYMENT REQUIREMENT:

Institutionalized individuals residing in nursing facilities will not be required to pay a co-payment for their prescriptions.

0300.20.20 Waiver Programs

REV:06/1994

Section 1915(c) of the Social Security Act permits states to offer, under a waiver of statutory requirements, an array of home and community-based services that an individual needs to avoid institutionalization. Waiver services are in addition to the services otherwise provided under the Medical Assistance Program.

Waiver services may include case management, personal care, adult day care, homemaker services, respite care and similar home-based services.

The Rhode Island Department of Human Services operates several programs under Home and Community-Based Services Waivers. To be eligible, a recipient must require the level of care provided in an institutional setting, be in one of the target groups of an established waiver program and meet the requirements of the particular waiver program. Waiver recipients must be eligible as Categorically Needy or Medically Needy, as required by the specific waiver program.

0300.20.25 MA Payment Policy

REV:03/2002

Medical Assistance is the payor of last resort. Community, public and private resources such as Federal Medicare, Blue Cross/Blue Shield, VA benefits, accident settlements or other health insurance plans must be fully utilized before payment from the Medical Assistance Program can be authorized.

Payments to physicians and other providers of medical services and supplies are made on a fee for service basis in accordance with applicable federal and state rules and regulations, and established rates of reimbursement governing the Rhode Island Medical Assistance Program. Payments to physicians and other providers of medical services and supplies represent full and total payment. No supplementary payments are allowed. Direct reimbursement to recipients is prohibited except in the specific circumstances set forth in Section 0302.30.10 to correct an erroneous denial which is reversed on appeal.

Payments for enrollment in a Rite Care Health Plan or a Rite Share approved employer based group health plan are made in accordance with policy contained in Section 0348.75.15 and 0349.30 respectively.

0300.20.30 Provider Deficiencies/Plan of Correction

REV:06/1994

The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities/Mental Retardation (ICF/MR) for compliance with the federal participation requirements of the Federal Medicare and State Medical Assistance Programs. As a result of these surveys, reports are issued for certification purposes which cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported.

Statements of provider deficiencies must be made available to the public through the Social Security Offices and Public Assistance Agencies.

The Health Standards and Quality Bureau of the Regional Office transmits these reports in the following manner:

- Nursing Facilities (NF) - Reports are sent to the Social Security Administration (SSA) district office that covers the area in which the facility is located, and the Central Office of the Department of Human Services (DHS).

- Intermediate Care Facilities/Mental Retardation (ICF/MR) - Reports are sent to the Central Office of DHS.

The agency is required to send the reports for both Nursing and Intermediate Care Facilities/Mental Retardation to the appropriate Long Term Care (LTC) Unit covering the district in which the facility is located. The agency must also send the ICF/MR reports to the SSA office covering the catchment area in which the facility is located.

These files are available to the public upon request. If an individual has questions about the reports, or requests additional data, the Supervisor will be informed and will contact the Chief Medical Care Specialist in the Long Term Care (LTC) Unit at Central Office. Material from each survey will be held in the District Office for three (3) years and then destroyed.

0300.20.35 Medicare Buy-in

REV:05/1995

Medicare Buy-in is a provision of the Medical Assistance program which allows Medical Assistance to pay for the Medicare Part A and/or Part B premiums of certain categories of MA eligibles.

0300.20.40 Pharmacy Lock-In Program

REV:09/2010

The Code of Federal Regulations (CFR) at 42 CFR sec. 440.230(d) allows the Department of Human Services (DHS), or its contracted Managed Care Organization(s), to place appropriate limits on a medical service based

on such criteria as medical necessity or on utilization control procedures. The Medical Assistance Pharmacy Lock-In Program has been established by DHS to restrict recipients whose utilization of Medical Services is documented as being excessive. Recipients are "Locked-In" to specific providers in order to monitor services received and reduce unnecessary or inappropriate utilization. This program is intended to prevent Medical Assistance recipients from obtaining excessive quantities of prescribed drugs through multiple visits to physicians and pharmacies.

0300.20.40.05 Enrollment in Pharmacy Lock-In Program

REV:09/2010

Whenever Medical Assistance records indicate that recipient utilization is excessive or inappropriate with reference to medical need, the Department of Human Services (DHS) or its contracted Managed Care Organization(s) may require an individual to designate a physician and pharmacy of choice for exclusive service in order to:

- Protect the individual's health and safety;
- Provide continuity of medical care;
- Avoid duplication of service by providers;
- Avoid inappropriate or unnecessary utilization of Medical Assistance as defined by community practices and standards; and,
- Avoid excessive utilization of prescription medications.

Excessive utilization of prescription medications will be determined from published current medical and pharmacological references.

The Department or its contracted Managed Care Organization(s) selects for enrollment in the Medical Assistance Pharmacy Lock-In Program recipients who have a documented history of obtaining excessive or inappropriate prescribed drugs under the Medical Assistance Program.

Recipients will be given a written notice (MA/DUR-1 or similar notice from the specific health plan) of his/her excessive or inappropriate utilization thirty (30) days prior to the implementation of the restriction and will be asked to choose a primary pharmacy/physician as a single source of medical care.

The notification will also advise the individual that failure to cooperate in this program will necessitate the Department's designating a physician/pharmacy for the individual based on the recipient's previous use and geographical location.

The notification will include the individual's right to request a fair hearing within thirty (30) days if he/she disagrees with the findings and the Department action.

0300.20.40.10 REVS Identification of Lock-In Recipients

REV:05/1995

Recipients who are in the Medical Assistance Pharmacy Lock-In Program are identified through the Recipient Eligibility Verification System (REVS).

0300.20.40.15 Primary Pharmacy of Choice

REV:09/2010

The Primary Pharmacy of Choice must monitor the drug utilization of each restricted recipient and must exercise sound professional judgment when dispensing drugs in order to prevent inappropriate drug utilization by the recipient. When the pharmacist reasonably believes that the recipient is attempting to obtain excessive drugs through duplicate prescriptions or other inappropriate means, the pharmacist must contact the providing physician to verify the authenticity and accuracy of the prescription presented. Primary pharmacies that are found on review to be dispensing drugs in a manner that is inconsistent with professional standards may be subject to administrative action by DHS or its contracted Managed Care Organization(s), including the recovery of payments.

0300.20.40.20 Primary Care Physician

REV:05/1995

The Primary Care Physician is delegated the responsibility of overseeing the health care needs of the restricted recipient and providing all medically necessary care for which the recipient is eligible. The provider should be knowledgeable about the recipient's health care problems and aware of the care and services the recipient is receiving.

0300.20.40.25 Change in Primary Pharmacy/Physician

REV:09/2010

A recipient may change his/her primary pharmacy/physician for reasonable cause by notifying the Medical Assistance Pharmacy Lock-In Program or its contracted Managed Care Organization(s) and choosing a new primary pharmacy/physician.

0300.20.40.30 Change in Recipient Status

REV:05/1995

If, after review of the recipient's drug-usage profile, it is determined by the Medical Assistance Pharmacy Lock-In Program that restriction is no longer appropriate, the restriction will be removed. Such review will not take place prior to 15 months from the date of enrollment.

0300.25 OVERVIEW OF MA ELIGIBILITY REQUIREMENTS

REV:06/1994

The eligibility requirements of the MA Program are categorized as technical requirements, characteristic requirements, cooperation requirements, cost effectiveness and financial requirements.

0300.25.05 Technical Eligibility Requirements

REV:07/2006

Technical eligibility requirements for the Rhode Island Medical Assistance Program are citizenship, residence and possession of, or application for, a social security number.

Effective July 1, 2006, in conformance with the federal Deficit Reduction Act of 2005, both applicants and recipients for Medical Assistance must submit verification of both citizenship and identity.

All applicants must submit verification of citizenship and identity at the time of application for benefits. Recipients who have not previously provided verification of citizenship and identity to the Medical Assistance Program must submit this verification at the time of redetermination.

Applicants who do not comply with the requirement to verify both citizenship and identity will be denied medical assistance benefits.

Recipients who do not comply with the requirement to verify both citizenship and identity will have their medical assistance benefits terminated.

0300.25.10 Characteristic Eligibility Requirements

REV:01/2002

Characteristics are non-financial eligibility factors. The required characteristics for an individual applying for MA are those of the SSI program - age (65 or older), blindness or disability. The required characteristics for families are generally those of the state TANF program - age, relationship and deprivation factor (absence, death, unemployment, or incapacity of a parent or caretaker relative).

Pregnant women, certain children and parent(s) (or caretaker relative) of eligible children may be eligible for MA without having one or more of the usual characteristics of the AFDC program prior to 5/97. For example, pregnant women, poverty level children and Section 1931 parents or caretaker relatives are not required to meet a deprivation factor. All children are required to meet an age requirement.

0300.25.15 Cooperation Requirements

REV:06/1994

As a condition of eligibility, the MA applicant/recipient must meet certain cooperation requirements, such as providing the information needed for an eligibility determination, taking reasonable action to make income or resources available for support, assigning of rights to medical support or other third party payments for medical care, or pursuing eligibility for other benefits. Failure to cooperate may result in a denial of eligibility or case closure.

0300.25.20 Financial Eligibility Requirements

REV:06/1994

Financial eligibility is based on the applicant/recipient's income and resources. Certain income and resources are COUNTABLE and thus included in the calculation of the individual's total income and resources to determine if financial eligibility exists. Other income and resources may be EXCLUDED from the calculation and not count toward the individual's allowable limit.

0300.25.20.05 Income Flex-Test and Spenddown

REV:06/1994

Medical Assistance policy provides that an otherwise eligible applicant with income in excess of the allowable income limits may be eligible for MA if the excess income is insufficient to meet the cost of certain medical expenses. An individual's unpaid medical bills and current receipts for incurred medical expenses may be subject to an Income Flex-Test. The applicant may qualify for an income spenddown in which allowable medical expenses absorb his excess income, enabling him to qualify for MA as Medically Needy.

0300.30 METHODOLOGY FOR DETERMINING COVERAGE GROUP

REV:11/1998

A Coverage Group is a classification of individuals eligible to receive Medical Assistance benefits. There are numerous coverage groups distinguishable by income and resource standards and other non-financial criteria. An individual must satisfy all the requirements of at least one coverage group to be eligible for Medical Assistance.

Medical Assistance coverage groups are categorized as SSI-related, family-related or special treatment coverage groups.

The term "SSI-related" refers to the methodologies used for evaluating the individual's income and resources, and the non-financial criteria to be met for MA eligibility. Thus, an individual may be eligible for one of the SSI-related coverage groups if he/she is blind, disabled or age 65 or over, and has income and resources within the limits required for MA eligibility. Some coverage groups in this category are referred

to as "special treatment" coverage groups (e.g., QMBs, SLMBs, QIs, etc.).

Similarly, the term "family-related" refers to the methodologies for evaluating income, resources, and the non-financial criteria to be met for determining eligibility under family MA coverage groups. Thus, if family members meet the required characteristics of MA for families, then the countable income and resources are evaluated using the family-related methodologies.

Pregnant women, certain children and parent(s) of eligible children may qualify for MA without possessing an SSI characteristic or a family characteristic of deprivation through the absence, death, incapacity or unemployment of a parent or caretaker relative. For example, a pregnant woman may be eligible for MA without a deprivation characteristic or a resource test. For families, only Medically Needy eligibility, including Medically Needy eligibility based on spending down excess income, requires a deprivation characteristic.

Early in the application process an initial determination is made regarding the potential coverage group to which the MA applicant may belong, usually based on the non-financial criteria of the coverage groups. MA eligibility is then determined based on the applicable income/resource standards of the individual's particular coverage group.

If an applicant is a potential candidate for more than one coverage group, then the determination of MA eligibility is made considering all possible coverage groups. The agency must allow an individual who would be eligible under more than one category to have his/her eligibility determined for the category he/she selects.

0300.35 ORGANIZATION OF THE MANUAL

REV:01/2002

The Medical Assistance Policy Manual is comprised of four major topics of which COMMON PROVISIONS is the first. The three remaining topics are as follows:

- Sections 0326 through 0350 set forth the policies and procedures which govern Medical Assistance eligibility for families with dependent children, poverty level children, pregnant women, and children in foster care.

- Sections 0351 through 0374 set forth policies and procedures to determine Medical Assistance eligibility for Aged, Blind, or Disabled individuals or couples living in community settings (SSI-Related cases).

- Sections 0376 through 0399 set forth policies and procedures to determine Medical Assistance eligibility and Medical Assistance payment for services to institutionalized individuals. Institutionalized persons in this context refers to individuals who reside in institutional settings, or who receive home and community based services under a Waiver.

0300.40 Procedure for Imposing Admin Sanctions

REV:09/2010

0300.40.05 Statutory Authority

REV:08/2007

In accordance with Title 42 Chapter 35 of the General Laws of Rhode Island (The Administrative Procedures Act), Title 40 Chapter 8.2, the Rhode Island Department of Human Services hereby establishes administrative procedures to impose sanctions on providers of medical services and supplies for any violation of the rules, regulations, standards or laws governing the Rhode Island Medical Assistance Program. The Federal Government mandates the development of these administrative procedures for the Title XIX Medical Assistance Program in order to insure compliance with Sections 1128 and 1128A of the Social Security Act, which provides for federal penalties to be imposed for activities prescribed therein.

0300.40.10 Definitions

REV:09/2010

As used hereafter, the following terms and phrases shall, unless the context clearly required otherwise, have the following meanings:

Rhode Island Medical Assistance Program - established on July 1, 1966, under the provisions of Title XIX of the Social Security Act, as amended (P. L. 89-97). The enabling State Legislation is to be found at Title 40, Chapter 8 of the Rhode Island General Laws, as amended.

Department - the Rhode Island Department of Human Services which is designated under the Medicaid State Plan as the Single State Agency responsible for the administration of the Title XIX Medical Assistance Program.

Director - the Director of the Rhode Island Department of Human Services.

Provider - any individual, firm, corporation, association, institution or group qualified or purporting to be qualified to perform and provide the medical services and supplies, which are within the scope of the services covered by the Rhode Island Medical Assistance Program.

Statutory Prerequisites - any license, certificate or other requirement of Rhode Island law or regulation which a provider must have in full force and effect in order to qualify under the laws of the State of Rhode Island to perform or provide medical services or to furnish supplies. The prerequisites include but are not limited to, licensure by the Rhode Island Department of Health, the Rhode Island Department of Behavioral Healthcare, Developmental

Disabilities and Hospitals (DBHDDH), certification for participation in the Federal Medicare Title XVIII Program and any other legal requirement pertinent to the delivery of the specific medical services and supplies. The term statutory prerequisite includes any requirement imposed by this Department through duly promulgated administrative regulations.

State Health Care Program – includes but not limited to those programs defined in section 1128 (h) of the Act such as those totally state-funded and administered by the Department.

0300.40.15 Sanctionable Violations

REV:08/2007

All providers of medical services and supplies are subject to the general laws of the State of Rhode Island and the rules and regulations governing the Rhode Island Medical Assistance Program. Sanctions may be imposed by the Department against a provider for any one (1) or more of the following violations of applicable law, rule or regulation:

(i) Presenting or causing to be presented for payment any false or fraudulent claim for medical services or supplies.

(ii) Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than to which the provider is legally entitled.

(iii) Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

(iv) Failure to disclose or make available to the Single State Agency or its authorized agent records of services provided to Medical Assistance recipients and records of payments made for such services.

(v) Failure to provide and maintain quality services to Medical Assistance recipients within accepted medical community standards as determined by an official body of peers.

(vi) Engaging in a course of conduct or performing an act deemed improper or abusive of the Medical Assistance Program or continuing such conduct following notification that said conduct should cease.

(vii) Breach of the terms of a Medical Assistance provider agreement or failure to comply with the terms of the provider certification of the Medical Assistance claim form.

(viii) Over-utilizing the Medical Assistance Program by inducing, furnishing or otherwise causing a recipient to receive services or supplies not otherwise required

or requested by the recipient.

(ix) Rebating or accepting a fee or portion of a fee or charge for a Medical Assistance recipient referral.

(x) Violating any provisions of applicable Federal and State laws, regulations, plans or any rule or regulation promulgated pursuant thereto.

(xi) Submission of false or fraudulent information in order to obtain provider status.

(xii) Violations of any laws, regulations or Code of Ethics governing the conduct of occupations or professions or regulated industries.

(xiii) Conviction of a criminal offense for any intentional, reckless, or negligent practice resulting in death or injury to patients.

(xiv) Failure to meet standards required by State or Federal laws for participation such as licensure and certification.

(xv) Exclusion from the Federal Medicare Program or any state health care program administered by the Department because of fraudulent or abusive practices.

(xvi) A practice of charging recipients or anyone in their behalf for services over and above the payment made by the Medical Assistance Program, which represents full and total payment.

(xvii) Refusal to execute provider agreement when requested to do so.

(xviii) Failure to correct deficiencies in provider operations after receiving written notice of these deficiencies from the Single State Agency.

(xix) Formal reprimands or censure by an association of the provider's peers for unethical practices.

(xx) Suspension or termination from participation in another governmental medical program such as Workers' Compensation, Children With Special Health Care Needs Program, Rehabilitation Services, the Federal Medicare Program, or any state health care program administered by the Department.

(xxi) Indictment for fraudulent billing practices or negligent practice resulting in death or injury to the provider's patients.

(xxii) Failure to repay or make arrangement for the repayment of identified overpayments or otherwise erroneous payments.

0300.40.20 Provider Sanctions

REV:08/2007

Any one (1) or more of the following sanctions may be imposed against providers who have committed any one (1) or more of the violations contained in Section 0300.40.15, above:

(i) Termination from participation in the Medical Assistance Program or any state health care program administered by the Department.

(ii) Suspension of participation in the Medical Assistance Program or any state health care program administered by the Department.

(iii) Suspension or withholding of payments.

(iv) Transfer to a closed-end provider agreement not to exceed twelve (12) months or the shortening of an already existing closed-end provider agreement.

(v) Prior authorization required before providing any covered medical service and/or covered medical supplies.

(vi) Monetary penalties.

(vii) Prepayment audits will be established to review all claims prior to payment.

(viii) Initiate recovery procedures to recoup any identified overpayment.

(ix) Except where termination has been imposed a provider who has been sanctioned may be required to attend a provider education program as a condition of continued participation in any health care program administered by the Department. A provider education program will include instruction in: (a) claim form completion; (b) the use and format of provider manuals; (c) the use of procedure codes; (d) key provisions of the Medical Assistance Program; (e) reimbursement rates; and (f) how to inquire about procedure codes or billing problems.

0300.40.25 Notice of Violations and Sanctions

REV:08/2007

When the Department is in receipt of information indicating that a provider has committed a violation, and that provider is formally suspended or terminated, it shall forward by registered mail a notice of such violation to the provider. The notice shall include the following:

(i) A short and plain statement of the facts or conduct, which are alleged to warrant the intended departmental action. If the Department is unable to state the matters in detail

at the time the notice is served, the initial notice may be limited to a statement of the issues involved and detailed statement shall be furnished.

(ii) A statement of the provider's right to a hearing and that such a hearing must be claimed within fifteen (15) days of the receipt of the notice.

0300.40.30 Informal Hearing

REV:08/2007

Within fifteen (15) days after the receipt of a notice of an alleged violation and a sanction, the provider may request an informal hearing with the Department of Human Services (DHS).

This informal hearing will provide an opportunity for the provider to discuss the issues and attempt to come to a mutually agreeable resolution, thereby obviating the need for a formal administrative hearing. Informal dispositions may also be made of any contested case by stipulation, consent order, or default.

0300.40.35 Administrative Hearing

REV:08/2007

The right to an administrative appeal is conditioned upon the appellant's compliance with the procedures contained in these regulations and the hearing will be held in compliance with the provisions of the State's Administrative Procedures Act, as found at RIGL 42-35, as amended, and in conformance with DHS Policy Section 0110 et al.

0300.40.40 Appeal for Judicial Review

REV:08/2007

Any provider who disagrees with the decision entered by the Hearing Officer as a result of the Administrative Hearing has a right to appeal for judicial review of the Hearing decision by filing a complaint with the Superior Court within thirty (30) days of the date of the decision in accordance with RIGL 42-35- 15.

0300.40.45 Administrative Actions

REV:08/2007

Once a sanction is duly imposed on a provider, the Department shall notify the Rhode Island Department of Health (the licensing agent)and the Federal Medicare Title XVIII program if appropriate, state health care programs as defined in Section 1128(h) of the Social Security Act (as amended), state-funded health care programs administered by the Department, or any other public or private agencies involved in the issuance of a license, certificate, permit or statutory prerequisite for the delivery of the medical services or supplies. Furthermore, the Department shall notify all affected Medicaid recipients.

0300.40.50 Stay of Order

REV:08/2007

Orders may be stayed in accordance with RIGL 42-35-15 and 40-8.2-17.

0300.40.55 Reinstatement

REV:08/2007

(i) Pursuant to 42 CFR 1002.214 Subpart C, a state may afford a reinstatement opportunity to a state-initiated termination or suspension of any individual or entity. Such individuals or entities may be reinstated to the Medical Assistance Program only by the Department. The sanctioned individual or entity may submit a request for reinstatement to the Department at any time after the date specified in the notice of termination or suspension.

(ii) The Department may grant reinstatement only if it is reasonably certain that the types of actions that formed the basis for the original exclusion have not recurred and will not recur. Factors the Department will consider in making such a determination are contained in 42 CFR 1002.215(a)(l)(2)(3) Subpart C.

(iii) If the Department approves the request for reinstatement, it will provide the proper notification to the excluded party and all others in accordance with 42 CFR 1002.212 Subpart C. If the Department does not approve the request for reinstatement, it will notify the excluded party of its decision. Any appeal of a denial of reinstatement will be in accordance with state procedures and not subject to administrative or judicial review.

0300.45 EXPEDITED SERVICES

REV:02/2008

0300.45.05 EXPEDITED SERVICES PROVISION for H.C.B.S.

REV:10/2008

Section 40-8.9-4 of the Rhode Island General Laws was amended in June 2007 to require the Department of Human Services (DHS) to establish criteria for the purpose of accessing home and community care effective January 1, 2008. The funding for this mandate is from the added dollars realized from the cost savings from reductions in the number of nursing facility bed days from those projected to be used annually (including bed days used for persons utilizing the hospice benefit).

The DHS has instituted an Expedited Services provision in order to enable the temporary provision of specified Home and Community Based Services (HCBS) to those entrants to the publicly financed Long Term Care system who meet certain criteria and requirements, and who are

deemed likely to be successful in their application for Long Term Care (LTC) Medical Assistance.

Persons who are already in receipt of HCBS are not eligible for this Expedited Services provision.

Receipt of LTC Medicaid, Title XX home-care services, D.E.A.

home-care services, P.A.C.E., Medicare home-care services, Visiting Nurse services, etc. are disqualifiers for the authorization of Expedited Services.

If there is a recognized Third Party Liability (TPL) opportunity, then the applicant is not eligible for Expedited Services.

Trained and certified home and community-based service providers will be reimbursed for the provision of these Expedited Services to individuals who are pending a determination of LTC Medicaid eligibility, ONLY IF that provider, and the individual they refer, successfully meet the requirements set forth in the following sections.

The HCBS services which are covered under this provision are authorized for up to twenty-one (21) days, and up to ten (10) hours weekly. Some subsequent extension may be possible after a review of the case.

The Adult Day Care services which are covered under this provision are authorized for up to twenty-one (21) days, and up to three (3) days weekly. Some subsequent extension may be possible after a review of a case.

Payment for the HCBS so provided will cease upon the determination of the applicant's eligibility for Long Term Care Medical Assistance, or upon the twenty-first (21st)day of Expedited Services, whichever comes first. It is possible that in cases of pending applications, Expedited Services may be extended beyond the initial twenty-one (21) days.

Successful LTC Medicaid applicants will be transitioned onto the HCBS waiver program. Applicants who are denied LTC Medicaid will immediately cease to be eligible for DHS payment for their Expedited Services.

Whenever the applicant is determined to be eligible for LTC Medicaid, the expense incurred by the state for their HCBS under this provision will be submitted for standard Medicaid re-imbursement, back to the date of LTC Medicaid eligibility.

It is important to note that this is NOT a determination of LTC Medicaid eligibility. What is being determined is only whether the requirements for Expedited Services are met.

Applicants may be found eligible for Expedited Services, but subsequently be determined ineligible for LTC Medicaid. (The reverse is also possible).

Note: Individuals may submit applications for Medicaid at any time during the month of application.

0300.45.10 HOME & COMMUNITY BASED SERVICES COVERED

REV:10/2008

Persons who are already covered by LTC Medicaid are NOT eligible for these Expedited Services.

ONLY individuals who need to file a new application to obtain LTC Medicaid can qualify for the provision of Expedited Services.

The services that are guaranteed temporary payment under this provision are:

1. Assistance to the applicant in obtaining, completing, and submitting a COMPLETE LTC Medicaid application and supporting financial and medical documentation as specified by the R.I. DHS.

Additionally, all the Expedited Service forms must be complete and submitted at the same time.

Payment for this assistance is at a capped rate, established by the R.I. DHS

NOTE: THE SERVICE OF ASSISTING WITH a new LTC/Medicaid APPLICATION IS A PREREQUISITE FOR THE AUTHORIZATION OF ANY EXPEDITED SERVICE.

2. Homemaking services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate

3. Personal Care services provided by a home health agency licensed to practice in Rhode Island at the established Medicaid rate

4. Adult Day Care services provided by a licensed Adult Day Care Provider at the established Medicaid rate

0300.45.15 PROVISION FOR RECEIVING EXPEDITED SERVICES

REV:01/2013

Trained and certified providers will be reimbursed for these Expedited Services while a decision on the LTC Medicaid application is pending under the following circumstances:

I. The provider has assisted the individual in completing, signing, and submitting a COMPLETE LTC Medicaid application with all required financial and medical documentation to the R.I. DHS.

   The application and documentation submitted must include or indicate the following:

   1. No transfers of assets within the past five (5) years

2. The applicant's income is:
   a. at or below one hundred percent (100%) of the Federal Poverty Level, or
   b. at or under three (3) times the Federal Benefit rate (in Sec. 0362.05) and the individual signs a DISCLAIMER AND AGREEMENT form, in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over one hundred percent (100%) of the Federal Poverty Level must be contributed on a monthly basis towards the cost of these Expedited Services. or
   c. ONLY for individuals who are 65 years of more of age, a third option is available: (if the applicant's income is) in excess of three (3) times the Federal Benefit Rate, and the individual signs a DISCLAIMER and AGREEMENT FORM in which they acknowledge and accept the limitations of Expedited Services, and agree that all of the applicant's countable income over the Medically Needy Income Limit (MNIL) for one (1) one (less allowable deductions) must be contributed on a monthly basis towards the cost of these Expedited Services. (The MNIL is found in Sec. 0330.05)

3. a signed DISCLAIMER and AGREEMENT FORM MUST be included with ALL referrals for Expedited Services (even if they will not have to make any co-payment) in order to document their understanding of the limits of Expedited Services

4. The bank statements and declared assets (excluding the primary residence, and one (1) car used for medical transportation) do not exceed $4,000 for an individual or $6,000 for a couple

5. only one (1) real estate property, the primary residence, with no more than $536,000.00 in equity value.

6. The individual meets citizenship/registered alien Medicaid or State funded Medical Assistance criteria.

7. The individual is a Rhode Island resident.

8. The applicant meets a categorical requirement of age (65 years of age or older), blindness or disability or is applying for permanent and total disability status through the Social Security Administration or the DHS MART.

   If disability has not been determined by Social Security through S.S.I. or R.S.D.I., or by the R.I. DHS Medical Assistance Review Team (MART), the Disability Determination forms as specified on the Expedited Services forms MUST ALSO be completed and returned with the referral for Expedited Services.

II. The provider submits ALL the completed Expedited Services FORMS as specified by DHS.

The need for direct assistance, or supervision, in at least

one Activity of Daily Living must be documented in the physician's form.

A Referral / Turn-Around form must indicate which service(s) is/are being requested.

Reimbursement for services is available from the date approval is granted for Expedited Services by DHS based on satisfactory completion of established criteria

NOTE: If any of the above requirements are incomplete or missing, Expedited Services are automatically denied.

0300.45.20 REQUIREMENTS FOR REIMBURSEMENT

REV:10/2008

I. CERTIFICATION OF PROVIDERS OF EXPEDITED SERVICES
The payment for the Expedited Services listed in Section 0300.45.10 is only available to providers who have successfully completed a DHS training on the items and procedures necessary for a successful:

1. Long Term Care Medicaid application, and
2. request for Expedited Services.

Certification for providers will be on a time-limited basis.

II. REIMBURSEMENT OF THE PROVISION OF EXPEDITED SERVICES:

NOTE: PERSONS WHO ARE ALREADY IN RECEIPT OF ANY L.T.C. SERVICES (as specified in Sec. 0300.45.05) ARE NOT ELIGIBLE FOR THIS EXPEDITED SERVICES PROVISION.

Reimbursement for the provision of Expedited Services, while the decision on the application for LTC Medicaid is pending, is allowed in the following circumstances:

A. The provider has submitted to the DHS assigned staff a completed and signed Medicaid application with all required documentation as specified in 0300.45.15. These application materials MUST be received by the assigned DHS staff IN THE SAME MONTH THAT THE APPLICANT SIGNS the forms.

B. The provider must simultaneously submit to the DHS assigned staff ALL the COMPLETED forms required for Expedited Services, as specified by DHS. These forms must document the need for direct assistance in at least one Activity of Daily Living or, the need for supervision by another person.

C. Payment is made for assistance in filing an application for LTC Medicaid after DHS' receipt of the completed LTC Medicaid application, supporting documentation, and ALL fully completed Expedited Services forms. The service of assisting with a new LTC/Medicaid application is a

pre-requisite for the authorization of any Expedited Service.

NOTE: If in the course of assisting with the application, it becomes evident either:
1. that the applicant is obviously ineligible, or
2. that the obtaining/preparation of the materials required to qualify for Expedited Services will delay the filing of the application for LTC/Medicaid,

then the provider is required to forward the signed application to the appropriate LTC office.

No payment for Expedited Service will be made for applicants who are obviously ineligible, nor will payment be authorized when fulfilling the requirements of the Expedited Service process results in a delay of filing the application.

D. Reimbursement for the other Expedited Services is available from the date approval is granted for Expedited Services by DHS, based on satisfactory completion of established criteria.

III. R.I. DHS FOLLOW-UP PROCEDURES

A. The DHS assigned staff receives the entire request for Expedited Services and:

1. Date stamps the application and notifies the provider within two (2) business days of receipt whether the referral / application are acceptable or not acceptable for Expedited Services.

2. If the applicant is an SSI recipient, the DHS assigned staff confirms with the Office of Medical Review (OMR) whether or not they are active with Title XX services.

3. enters the Expedited Services beneficiary into the Stop-Loss tracking system.

4. if Expedited Services are denied, the assigned DHS staff notifies the provider using a Referral / Turn-Around form.

B. The DHS assigned staff then utilizes a transmittal sheet to forward the entire LTC application, including the physician's assessment, to the appropriate LTC office.

C. Upon receipt of both the social worker's assessment and the physician's assessment, the Office of Medical Review is responsible for determining whether a Level of Care is met, following all established processes, and notifying the LTC/AS/DEA worker assigned to the individual.

D. If ONLY Adult Day Care Services (ADCS) is authorized under Expedited Services, those requesting ADCS only will also

be forwarded to the appropriate LTC office for review:

1. If it appears that such an individual has a need for HCBS waiver services, AND might qualify for a "Level of Care" (LOC), the application is processed as an LTC/Medicaid waiver application.

2. If that is not the case, then the LTC office forwards all the received application materials to the appropriate DHS community Medical Assistance office, for the determination of eligibility according to the rules for Community based Medical Assistance.

E. For the cases they retain, the Long Term Care Office is responsible for:

1. determining eligibility for LTC Medicaid, following all established processes;

2. forwarding appropriate cases to a DEA Case Management Agency for their usual development of an assessment, LOC, and creation of a case plan;

3. retaining other appropriate cases for processing as usual for A+D waiver; and

4. notifying the DHS assigned staff person.

F. The DHS assigned staff person tracks all received applications for determinations and is responsible for authorizing Stop-Loss payments, and removing payment authorizations under the Stop-Loss provision at the time when eligibility determinations are made.