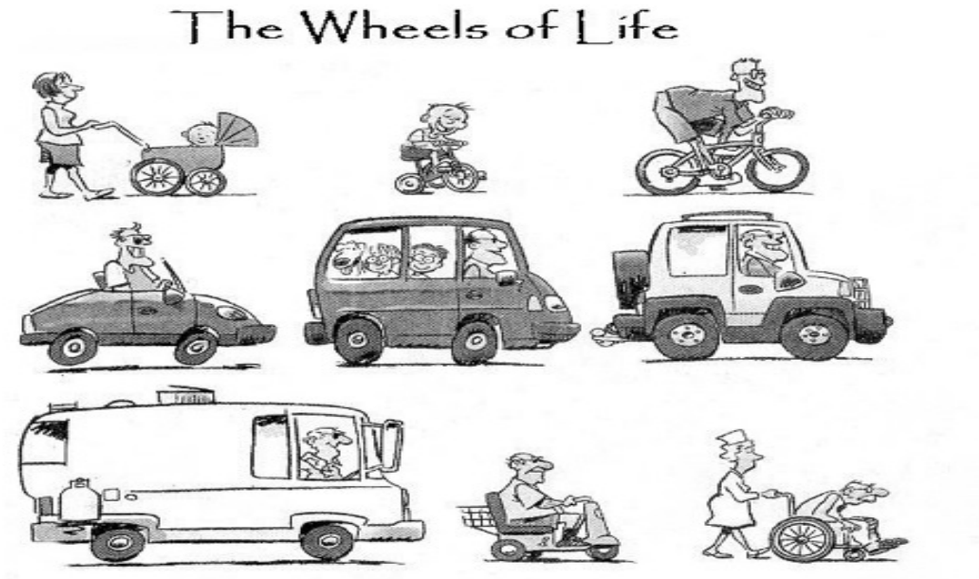


Better Together | Alaska Nursing Homes Together (ANHT) Conference

Paola Smith | LTC Program Coordinator

Lori Campbell | Presenter

Health Care Services

January 9-10, 2017

Your Long Term Care Partners

Alaska Department of Health and Social Services

- Division of Health Care Services (DHCS) – regulatory and operational oversight of Medicaid programs
  - Conduent State Healthcare (Alaska Medicaid's fiscal agent contractor, formerly Xerox) performs all claims processing functions
- Division of Senior and Disabilities Services (DSDS) – determines medical necessity and level of care
- Division of Public Assistance (DPA) – determines eligibility for Medicaid and other assistance programs
- Office of Rate Review (ORR) – establishes Medicaid payment rates

Division of Health Care Services Role

- DHCS in conjunction with DSDS is responsible for oversight of the Medicaid Long Term Care(LTC) program

- DHCS is responsible for:
  - developing regulations and policy in accordance with federal regulations and state statute
  - providing Medicaid billing assistance and resolving billing issues
  - serving as liaison between LTC providers and the fiscal agent

Challenges for Medicaid LTC

- Coordinating with residents and family to apply for Medicaid
- DPA eligibility determination back logs
- Coordination of Benefits
- Cost of Care (Patient Liability)
  - Determination and maintenance
  - Claims processing
- Documentation to meet medical necessity

Overcoming LTC Hurdles

- Coordination of benefits
  - Medicare crossover claims and claims with other third party liability are now processing correctly
- Cost of Care (Patient Liability)
  - Cost of Care is now transferring timely and correctly from DPA's Eligibility Information System (EIS) to MMIS
  - DHCS is working closely with Conduent (formerly Xerox) to resolve remaining MMIS Cost of Care issues
- Ancillary Charges
  - MMIS is now correctly processing room & board and ancillary charges

Guide to Cost of Care for Medicaid LTC

- Medicaid recipients may be responsible for a portion of their LTC costs in the form of Cost of Care, which is paid directly to the LTC provider
- Medicaid residents are exempt from Cost of Care under the following circumstances:
  - Month of admission to LTC from hospital or home
  - Month of discharge from LTC to home
  - Month of death
- Full Cost of Care is the responsibility of the recipient for
  - Each full month of approved Medicaid LTC stay
  - All bed hold days and patient convenience days
- Cost of Care is prorated when a recipient
  - is transferred to/from another LTC or an assisted living home
  - has a change in payer source (e.g., Medicare to Medicaid, TPL to Medicaid)

Common Denial Edits

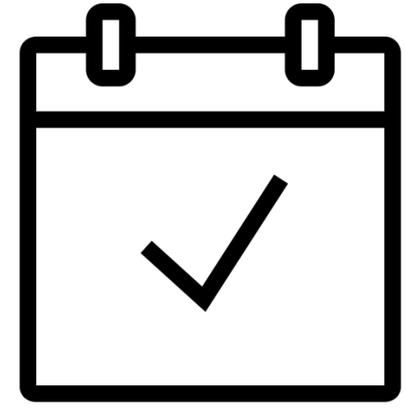
- Member ineligible for LTC on date of service
- Dates of Service not covered on member LTC authorization
- Revenue code on line does not match approved level of care
- Provider not authorized by Long Term Care span
- Member notice of exclusion of Medicare benefits
- Patient status/Bill frequency conflict
- Missing or invalid covered/non-covered days
- Duplicate claim
- Timely Filing

Edit 2105 – Member ineligible for LTC on date of service

- All LTC Medicaid recipients require an approved authorization to be admitted to a LTC facility
- Confirm that a LTC authorization was approved by DSDS
- Verify correct LTC span is reflected in MMIS prior to billing
  - If LTC authorization has been approved but not entered into MMIS, contact the DHCS LTC Program Coordinator for assistance

Edit 2100 – Date not covered on member's LTC

- Review LTC Authorization for approved date span
  - Confirm dates of service **billed** are within the **approved dates of service authorized**
  - Contact DHCS LTC Program Coordinator if MMIS is not consistent with approved LTC authorization



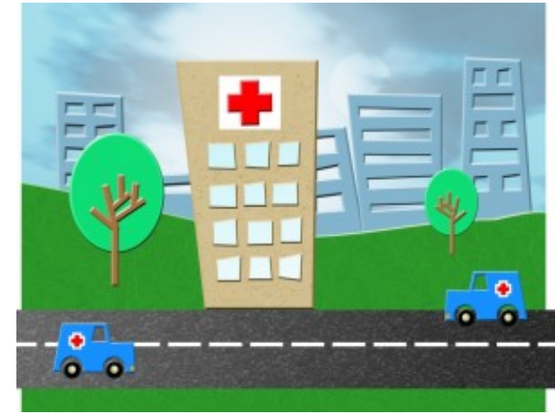
Edit 2310 - Revenue code on line does not match member LTC

- Confirm approved level of care on LTC Authorization prior to billing claim
  - Contact DHCS Program Coordinator for assistance if there is a discrepancy between the LOC in MMIS and the LOC on the approved LTC Authorization

- On Remittance Advice: If an incorrect revenue code for room and board is billed along with ancillaries, the processed claim will indicate a paid status but the claim will be paid at $0.00
  - Complete a void request
  - Void must be processed prior to rebilling corrected claim with the approved level of care (otherwise, the claim will deny as a duplicate)

Edit 2109 - Provider not authorized by nursing home span

- This denial edit is most common when a LTC facility is associated with hospital
- Review the approved LTC Authorization
  - Ensure that the authorization was submitted with the correct **LTC facility's Medicaid ID number** (*a common mistake is to submit with the **hospital's** Medicaid ID number*)
- Contact DHCS LTC Program Coordinator if a discrepancy is found between approved LTC Authorization and MMIS

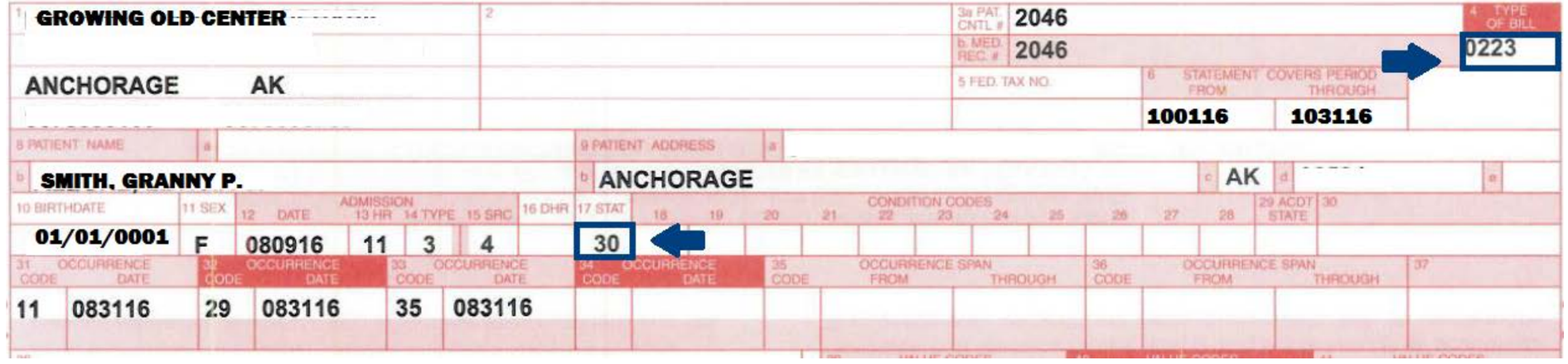


Edit 6090 - Member's notice of exclusion from Medicare benefits

- Long Term Care facilities are required to provide Medicare beneficiaries and DHCS with notices of non-coverage under the following circumstances:
  - The Medicare beneficiary is admitted into a skilled level of care but does not meet the qualifying hospital stay prior to admission
  - Exhausted the Medicaid LTC benefit period (100 days)
  - SNF LOC was not ordered or certified by physician
  - Daily skilled care is not needed
  - SNF transfer requirement not met
  - Facility/bed not certified by Medicare

Edit 1520 - Patient status/bill frequency

- **Common billing error:** Verify that fourth digit on bill type is consistent with patient status listed on claim



1	2	3a PAT. CNTL #	2046	4 TYPE OF BILL
GROWING OLD CENTER		b. MED. REC. #	2046	0223
ANCHORAGE AK		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 100116 THROUGH 103116	

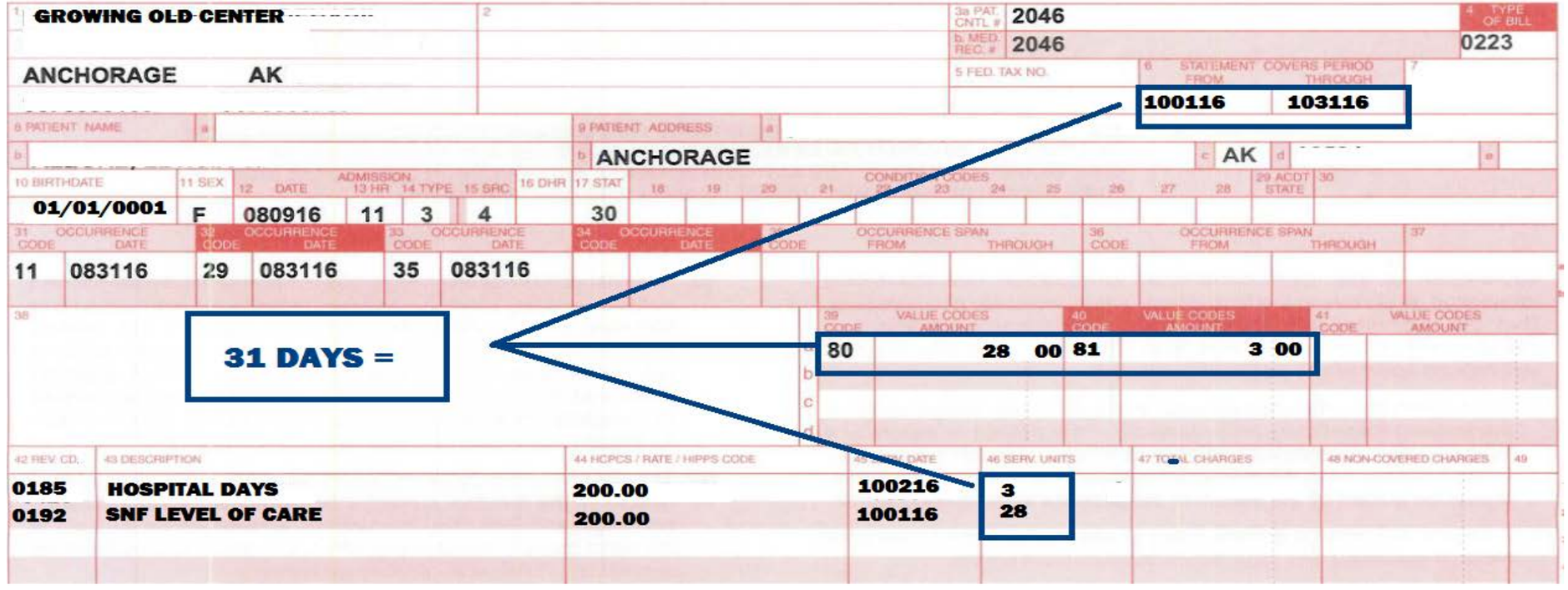
8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b SMITH, GRANNY P.		b ANCHORAGE	c AK d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30
01/01/0001	F	080916	11	3	4		30													

31 CODE	31 DATE	32 CODE	32 DATE	33 CODE	33 DATE	34 CODE	34 DATE	35 CODE	35 OCCURRENCE SPAN FROM	35 THROUGH	36 CODE	36 OCCURRENCE SPAN FROM	36 THROUGH	37
11	083116	29	083116	35	083116									

Edit 1510 – Missing/Invalid covered or non-covered days

- **Common billing error:** Verify dates-of-service spans, value codes and service units all reflect the same total number of days



Edit 6600 series - Duplicate Claim

- Check to see if a previous claim was paid in MMIS

- If a claim is paid but reimbursed at $0.00
  - Complete void request of original TCN and attach corrected UB-04
  - Mail to DHCS for processing

Edit1882 - Timely filing limit exceeded

- LTC facilities are encouraged to implement processes to review Remittance Advices to determine why claim was denied
  - Usually only the LTC facility can correct and resubmit the claim
- Denied claims must be corrected and resubmitted timely by the LTC facility
  - Untimely resubmissions will be denied for timely filing

QUESTIONS?

Paola Smith
LTC Program Coordinator
Division of Health Care Services (DHCS)
907.334.2428
907.561.1684 – fax

Thank You