

Nursing Home Stay for 30 Days or Less

Without Long Term Care Approval



Agenda

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Rule under the Federal Affordable Care Act

- Per EOHHS rule 210-RICR-50-00-1.7, Medicaid Long-Term Services and Supports Overview and Eligibility Pathways, Qualifying for Medicaid LTSS, states that, “With the enactment of the federal Affordable Care Act of 2010, federal law requires that Medicare, commercial health insurers, and group health plans provide as part of the primary care essential benefit package up to thirty (30) days of subacute and rehabilitative care for persons who have had an acute care incident requiring services in a health institution. Medicaid is also required to provide this benefit. Both existing beneficiaries and new applicants must have established a continuing need for LTSS -- that is, for an institutional level of care -- to qualify for Medicaid LTSS once the thirty (30) days of essential benefit coverage is exhausted.”



Eligibility

- Must have RI Medicaid Eligibility
- This is for members who do not have Long Term Care approval only (there will be no long term care segments)
- Member was discharged from a hospital setting
- This does not include members who require hospice services
- This is for dates of service 11/01/21 and forward only

Billing Requirements

- Must have RI Medicaid Eligibility
- Nursing home stay is for 30 days or less
- Members *may have* more than one consecutive 30-day period of nursing home services but there *must be* a gap between the “To” date of service on the last claim and the “From” date of service on the new claim
- RUG/PDPM score must be on file and claims will pay based on the score
- Claims for members with primary insurance including Medicare will need to be submitted to the primary insurance and submitted with the EOB
- You **must** use a claim filing indicator of MB for both Medicare Part A or Part B when reporting Medicare primary payments
- This new billing process is for dates of service 11/01/21 forward only
- ***Important Note:*** If the RUG/PDPM calculation is greater than the billed amount, the claim will only pay the billed amount. (lessor of logic)



Claims Overview

- Claim will be submitted on an 837 Professional Medical claim
- Claims will follow the same standard Professional Medicaid billing logic of paying lesser of the “billed amount” or the “allowed amount”
- Procedure Code S9976 (Lodging, Per Diem, Not Otherwise Classified)
- Claims for members with primary insurance including Medicare will need to be submitted to the primary insurance and submitted with the EOB
- Claims for members with Integrity and PACE will deny as they do today
- Rhody Health Partners and Medicaid Expansion will deny. The primary insurance is responsible for the initial 30 days of the nursing home stay
- Use your existing NPI and taxonomy for billing
- If a retroactive long term care approval is entered, rebilling the nursing home claim is not necessary as the professional claim was already priced utilizing the RUG/PDPM Pricing methodology

Claim Overview (continued)

- These claims will process in ALL financials
- The claims may be billed over a calendar month, so it is expected that it be billed in its entirety after the stay has completed
- Claims can only be submitted for 30 units (days) or under
- These claims will be manually priced by EOHHS based on current RUG/PDPM logic
 - What the RUG/PDPM is on the 15th of the month, or what the RUG/PDPM is on the “To” date of service if the claim does not span the 15th of a month
- Clients may have a patient share on file, but it will not be automatically deducted unless it is reported on the claim by the provider
- Claims can be submitted using [PES](#) (Provider Electronic Solutions). Instructions for using PES to create your claim are on the www.eohhs.ri.gov website under Providers & Partners>Billing & Claims>Provider Electronic Solutions Software
- If you choose to use your own nursing home vendor software, it may require an update to include this new claim type



Example 1

A Professional Medical claim is submitted with one detail, for a 30-day period 7/1/23-7/30/23.

- Claim billed amount is \$8000.00
- No long-term care, Medicare or OI on file
- no patient share reported on claim
- RUG/PDPM code is on file with a rate of \$253.92 per day x 30 days = \$7617.60 (allowed amount)

Result:

- Claim will suspend for edit 433 (manual pricing) and will be priced by EOHHS staff utilizing RUG/PDPM pricing methodology
- After the claim is priced, edit 433 will be processed and the claim will pay \$7617.60
- EOB 093 (Payment Amount Reduced to Maximum Allowed Amount)



Example 2

A Professional Medical claim is submitted with one detail, for a 25-day period 7/1/23-7/25/23.

- Claim billed amount \$7000.00
- No long-term care, Medicare or OI on file
- Patient share is \$250.25 reported on claim using a carrier code of 450 for the patient share
- RUG/PDPM code is on file with a rate of \$233.99 per day x 25 days=\$5849.75-
\$250.25 (patient share)=\$5599.50

Result

- Claim will suspend for edit 433 (manual pricing) and will be priced by EOHHS staff utilizing RUG/PDPM pricing methodology
- Claim should be processed to pay \$5599.50
- EOB 095 (Claim Cutback Due to Other Insurance Payment)



Example 3

A Professional Medical claim is submitted with one detail, for a 22-day period 8/1/23-8/22/23.

- Billed amount is \$6750.00
- No long term care or Medicare on file
- Commercial Insurance is on file
- OI payment is \$100.00
- RUG/PDPM code is on file with a rate of \$245.76 per day x 22 days=\$5406.72-\$100.00 (OI payment)=\$5306.72

Result

- Claim will suspend for edit 433 (manual pricing) and will be priced by EOHHS staff utilizing RUG/PDPM pricing methodology
- Claim should be processed to pay \$5306.72
- EOB 095 (Claim Cutback Due to Other Insurance Payment)



Medicare Professional Crossover Logic

A claim is considered a “Crossover Claim” when:

- A member has either Federal Medicare or a Medicare Replacement plan like United Health Senior Care
- There is a payment **or** an allowed amount from Medicare towards a coinsurance and/or a deductible
- The claim must be submitted as a crossover claim using Medicare Part B as the primary payer with a **claim filing indicator** of MB

Below is the logic that is used to pay that claim

1. RI Medicaid Allowed Amount (-) Medicare Payment=\$X.XX
2. Medicare Reported Coinsurance (+) Deductible=\$X.XX
3. RI Medicaid Payment= Lesser of #1 or #2



Example 4 Professional Medicare Crossover Logic

A Professional Medical crossover claim is submitted with one detail, for a 15-day period 8/1/23-8/15/23.

- Billed amount is \$4300.00
 - No long-term care on file, no patient share reported
 - Medicare payment is \$97.14 Total of deduct/coins is \$21.35
 - RUG/PDPM code is on file with a rate of \$253.92 per day x 15 days=\$3808.80 (the allowed amount is **more than** the Medicare payment of \$97.14)
1. RI Medicaid Allowed Amount (-) Medicare Payment=\$3808.80-\$97.14=\$**3711.66**
 2. Medicare Reported Coinsurance (+) Deductible=\$**21.35**
 3. RI Medicaid Payment will be the lesser of #1 or #2 calculation Result=\$21.35

Example 4 Medicare Crossover logic continued

Result

- Claim will suspend for edit 433 (manual pricing) and will be priced by EOHHS staff utilizing RUG/PDPM pricing methodology **and** lesser of logic
- Claim will be processed to pay \$21.35 (total duct/coins)
- EOB 195 (Claim Cutback Due to Medicare Payment) and 293 (Medicaid paid Ded/Coins amount)

Example 5

A Professional Medical crossover claim is submitted with one detail, for a 19-day period 8/1/23-8/19/23.

- Billed amount is \$7,700.50
- No long-term care on file, no patient share reported
- Medicare payment is \$5600.00, and the total deduct/coins is \$5.00
- RUG/PDPM code is on file with a rate of \$175.20 per day x 19 days=\$3328.50 (the allowed amount is **less than** the Medicare payment of \$5600.00)

Result

- Claim will suspend for edit 433 (manual pricing) and will be priced by EOHHS staff utilizing RUG/PDPM pricing methodology
- Claim will be processed to pay \$0.00 due to Medicare payment being greater than the Medicaid allowed amount
- EOB 195 (Claim Cutback Due to Medicare Payment)



Edits and EOBs

Edit 101 (Recipient Has Active LTC for DOS) will set on claims:

If a Professional (Medical) or Professional (Medical) crossover claim with procedure code S9976 is submitted by a nursing home provider, and the member has a long-term care segment on file for any of the dates of service on the claim. Claim will auto deny with

EOB 545-Recipient Has Active LTC, Please Submit a NH claim

Edit 102 (Nursing Home Services Limited to 30 Consecutive Days) will set on claim:

If a Professional (Medical) Or Professional (Medical) crossover claim with procedure code S9976 is submitted by a nursing home provider for greater than a consecutive 30-day period, the claim will auto deny with

EOB 546-Nursing Home Service Limited to 30 Consecutive Days



Edits and EOBs

Edit 494 (RUG Code/PDPM Missing OR Invalid):

Claim will suspend if there is no active RUG/PDPM code on file for the member.

EOB 916- RUG/PDPM Code Cannot Be Determined

Edit 495- (RUG/PDPM Provider Rate Not On File)

Claim will suspend if the provider does not have an active RUG/PDPM rate on file

EOB- 918-RUG/PDPM Provider Rate Not On File



Edits and EOBs

Edit 250 (Provider Not Authorized For Service Billed) will set on claims if:

Any other service is billed by a nursing home provider on a Medical or Professional Crossover other than procedure code S9976

EOB 357 Provider Not Authorized For These Services

Edit 433 Manual Pricing – No price on file

This edit will set when the claim is submitted. The claim will be manually priced by an EOHHS staff member

EOB 436 Claim Requires Manual Pricing. Inadequate or Insufficient Information Provided.



Questions



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