Nursing Home Billing January 2024

Agenda

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Billing Notes

- Submit for dates of service within the same month only
- Submit claim as 1 detail
- Date of discharge is not payable
- One financial per month for room and board
- If either Medicaid or Long-Term care eligibility is not on file contact DHS if stay is 30 + days

Timely Filing

365 days from date of service

If date of service is over 365 days old:

a) Submit claim on paper
b) Submit to provider representative attention
c) Submit proof of timely filing

Acceptable proof of timely filing:

a) EOB from primary within 90 days
b) LTC eligibility updates within 90 days of submitting claim
c) RUG updates in the system within 90 days of submitting claim

Long Term Care Eligibility can be viewed in the Healthcare Portal at https://www.riproviderportal.org if within 1 year from today

Note: You can only see LTC eligibility for an approved recipient in your facility.

- Enter the dates of service
- Verify correct spelling of recipient's name
- Verify that there is Medicaid Eligibility
- Verify there is a LTC segment on file for stays 30+ days
- If no LTC on file and needed or Medicaid eligibility missing, contact your LTC case worker

Skill Level –Types of Bills

Verify LTC segment on the Healthcare Portal:

Bill Type	Explanation
210	Medicare free days. Although there is no Medicaid payment, these days must be billed to set up payment for Medicare Co-insurance days or nonskilled days if the LTC segment is for the entire month and there is no discharge to the hospital. Pays $0
253	Medicare Co-Insurance days. Pays the coinsurance rate that applies to the dates of service for the year
263	Medicaid only days. Pays based on RUG
Hospice	Members who have elected hospice services

RUG Pricing Methodology

As of June 1, 2013, the Rhode Island Office of Health and Human Services (OHHS) adopted a new Medicaid method of paying for Nursing Home room and board services.

Minimum Data Set (MDS) 3.0 format with the CMS RUG IV V1.02 Grouper Version containing 48 RUG categories.

The MDS is a clinical tool used to identify all resident's strengths, weaknesses, preferences and needs in key areas of functioning.

For more information on RUG codes, review the Frequently Asked Questions document on the EOHHS website at:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/RUG_FAQ.pdf

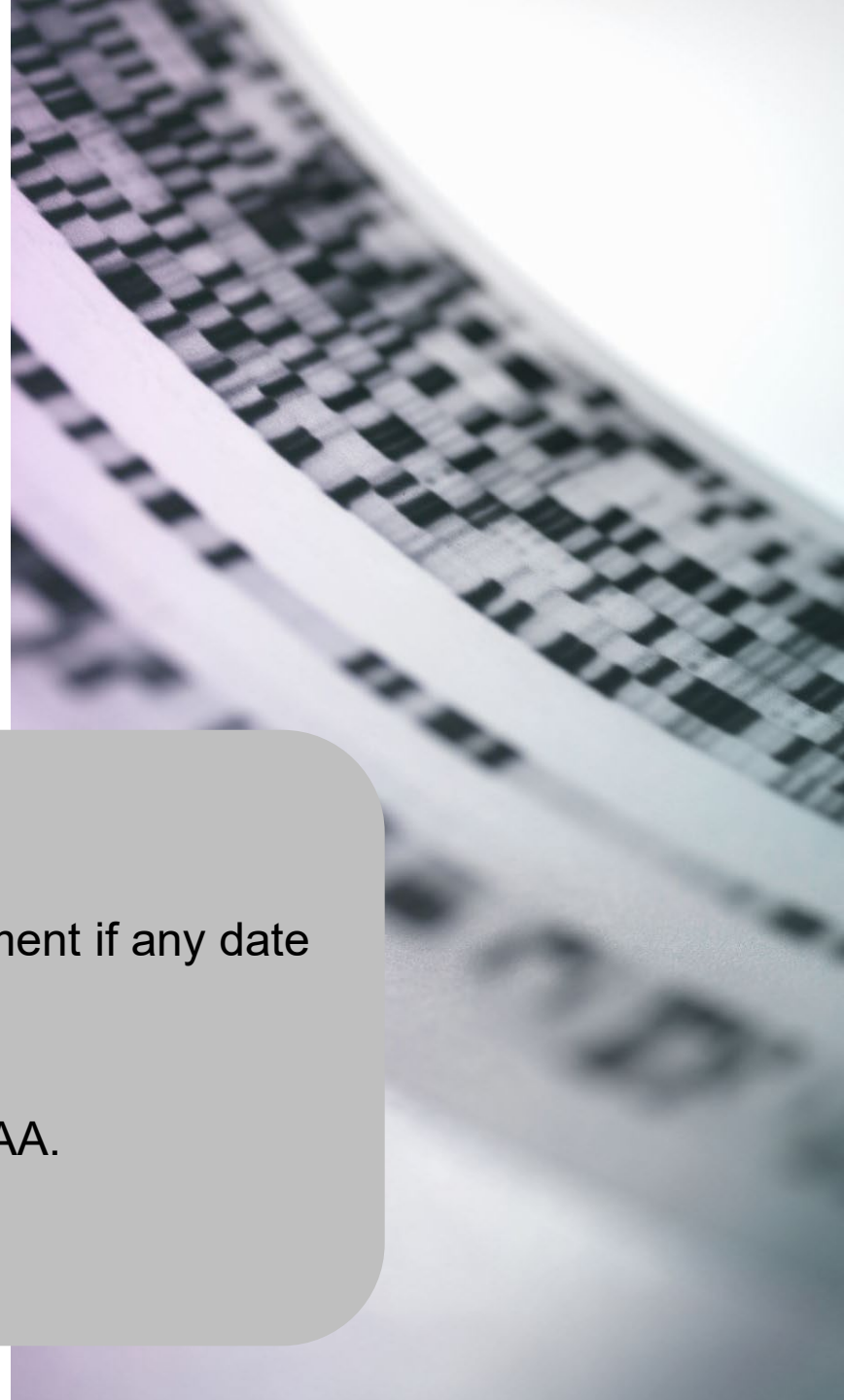
RUG Codes

The RUG Grouper software reads MDS assessment in Sections B through P for clinical data and calculates the RUG code. Incomplete assessment will result in determining an incorrect and/or no RUG. The RUG code will appear on your Remittance Advice Report.

The default RUG code AAA will be selected for claim payment if any date during the time period being billed

has a RUG of AAA on file.

The entire claim will process with a RUG of AAA.



RUG Code Changes within the month

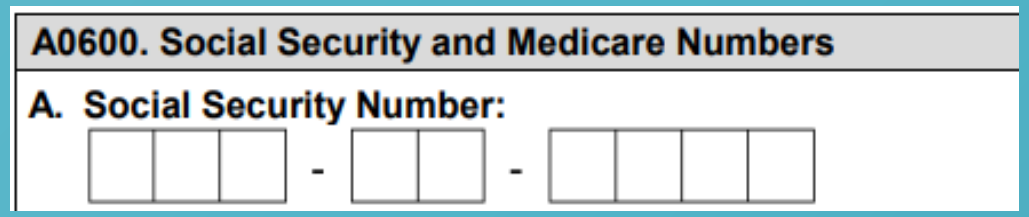
- If only one RUG code is effective for all the dates of service on the claim, that RUG code will be utilized.
- If multiple RUG codes are effective in a month, and the dates of service span the 15th, the one effective on the 15th will be utilized.
- If the Date of Service on the claim does not span the 15th, the RUG code on the “To” date of service will be utilized.

RUG Code Differences

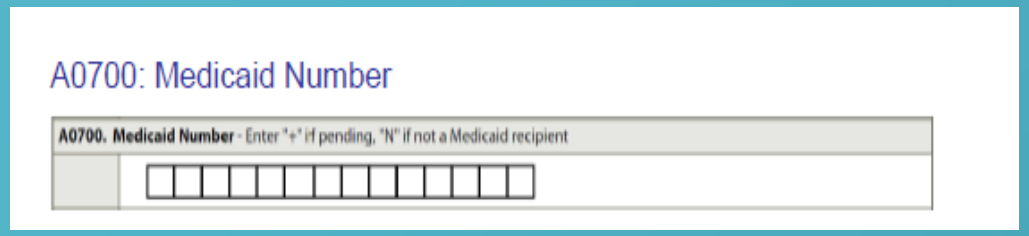
- The State's software calculates the RUG score based on the MDS record that the nursing facility submits
- 5% of the time the RUG may not be what the facility was expecting
- Fields on the MDS record (Z0200 or Z0250) RUG score not used
- State's software uses the score that their software determines
- The software used is: RUG-IV DLL Package (V1.04.0 FINAL)

RUG Code Missing

Verify that the SSN in field A0600 of the MDS record is the same SSN that is in the Medicaid system.



Verify that the 10 digit MID is in field A0700 of the MDS record. If it is N, Blank or a + sign and Medicaid does not have the RUG modify the record by adding it and resubmit MDS



Rhody Health Partners and Medicaid Expansion

Claims for beneficiaries admitted to nursing facilities who are enrolled in Rhody Health Partners or Medicaid Expansion plans must be submitted to the primary coverage for the first 30 days of the stay regardless of the skill level

- Days 31+ are billed to RI Medicaid FFS.
- Submit an admission slip as of day 31 of the stay to match what you will be submitting FFS
- When claims are received by RI Medicaid, they will suspend with 670 (Recipient has other insurance on date(s) of service) while they are researched to determine if the first 30 days were paid by the primary carrier.
- The claims will then be processed to pay or deny, based on the findings.
- Please allow two financial cycles for the process to be completed.

Other Insurance Billing

Medicaid will pay the lesser of “allowed amount – OI payment” or the co-pay.

The following information must be included on the claim:

- Other Insurance paid date
- Other Insurance payment
- Co-pay amount

If the other insurer paid more than Medicaid allows, claim will be “paid” at zero.

If the other insurer paid less than Medicaid allows, it will process the “lesser of” calculation to determine payment.

Medicaid allowed amount will be calculated based on skill level.

- If recipient is skilled, allowed amount used is the Medicare co-insurance rate per diem.

Common Edit

715
Tad Control and Stacking

All nursing home claims hit this edit.
This edit “holds” all nursing home claims in suspense so that they can be processed in chronological order if there are multiple claims for the same person in one month.

Corrective Action
None, if the claim is only in 715, it should process on the next NH financial cycle

Common Denials

This indicates the MID you are billing does not exist in our system

008
Recipient Number
Missing or Invalid

Corrective Action

- Validate MID reporting on Remittance Advice is the correct MID for the recipient
- Validate the MID in the Healthcare Portal
- If MID does not come up in the portal, the MID is either incorrect or the recipient is not enrolled in RI Medicaid
- Once you have the correct MID and have validated it on the Healthcare portal, submit a new claim with the corrected information. You must use the ten 10 MID
- If you have the member's SSN you can use that to retrieve the 10 digit MID

Common Denials

009
Recipient Name
Missing or Invalid

This indicates the name you are billing does not match the name of file for that MID

Corrective Action

- Validate name submitted on the Remittance Advice
- Validate name in the Healthcare Portal for the MID you are billing
- If name is not correct at all, contact your LTC office to have them validate and possibly update the recipient's name
- Once the appropriate corrections to the name have been made, re-bill with the corrected information

Common Denials

230

Service not covered for this recipient

Corrective Action

- Verify Medicaid eligibility for this recipient in the Healthcare Portal

Common Denial

300

Claim Denied, Research Indicates Incorrect Billing

- EOB 300 Claim Denied, Research Indicates Incorrect Billing if the claim dates of service that are approved to pay do not match the dates of service on the claim

Common Denial

408

Please Bill Other Insurance Carrier

- Claims will deny with EOB 408 if you are submitting for days 1-30 for members with Medicaid Expansion or Rhody Health Partners
- If the members has CMS Demo (Integrity)
- EOB 300 Claim Denied, Research Indicates Incorrect Billing if the claim dates of service that are approved to pay do not match the dates of service on the claim

Common Denials

626/631
No Long-Term Care on file for date of service

Corrective Action

- Validate LTC eligibility in the Healthcare Portal for stays 30+ days
- If no eligibility is found for LTC, contact your LTC worker
- If eligibility is found, validate that it is correct
  - Note: This denial may have occurred due to the claim being processed prior to the eligibility being updated
- Once any corrections are made, submit a new claim

Common Denials

945
Attending Provider
Missing/Not Enrolled
or Same as Billing

Corrective Action

- The attending provider's NPI is a required field on a nursing home claim
  - For electronic claims 837I, the attending is sent in loop 2310A
  - For UB04 paper claims, Field 76 should contain NPI, Last Name and First Name. The corresponding taxonomy should be in Field 81CC row A with a preceding qualifier of B3
- Validate that the attending is enrolled as a RI Medicaid Provider either as a billing provider or as an Ordering, Prescribing, Referring physician
- The attending's NPI on the claim must be the NPI of the individual and cannot be a group NPI
- Once corrections are made, submit a new claim

Common Denials

574
Referring/Ordering Provider required and missing or invalid

Corrective Action

- The Ordering, Prescribing, Referring (OPR) provider's NPI is a required field on a nursing home claim
  - For electronic claims 837I, the OPR is sent in loop 2310F
  - For UB04 paper claims, Field 79 should contain NPI of the OPR. The corresponding taxonomy should be in Field 81CC row D with a preceding B3 qualifier
- Validate that the OPR is enrolled as a RI Medicaid Provider either as a billing provider or as an OPR physician
- The OPR's NPI on the claim must be the NPI of the individual and cannot be a group NPI
- Once corrections are made, submit a new claim

Common Denials

633
Gap in Billed Days

All approved days are not accounted for in the billing

Corrective Action

- Validate LTC segment for the month you are billing on the Healthcare portal
- If eligibility is for the whole month and you are only billing a portion, did the member discharge to the hospital for 30 days or less:
  - If so, use revenue code 0160 for the first claim back to the same facility using the appropriate type of bill
- If the segment is for the entire month and the member did not discharge:
  - Are you submitting a claim for the entire month
  - Use a 210 type of bill if you are not expecting payment for a portion of the stay
- Submit new claims including all dates of service for the month

Example of 633- Gap in Billed Days

DOS billed 01/15/24-01/31/24 – type of bill is a 253

LTC eligibility on the Healthcare Portal shows recipient has a LTC segment for 01/01/24-01/31/24 (full month)

If LTC eligibility is correct, and you are only looking for coins days or Medicaid days for 01/15/24-01/31/24, then you must submit a claim for:

- 01/01/24-01/14/24 as a 210 type of bill (no pay)
- A second claim for 01/15/24-01/31/24 as a 253

If LTC eligibility is not correct and the recipient should not be eligible until 01/15/24

- Contact your LTC worker so they can update the eligibility
- Once that is completed, you can submit a new claim

Discharges to hospital 30 days or less with LTC

- Members have long term care approval in place
- Hospital admission is for 30 days or less
- Readmission is back to the same facility that they were discharged from
- Do not submit a discharge and admit slip in CSM
- Submit bill type 263, 210, 253 based on the members skill level with a **revenue code of 0160** when submitting the first claim back to the same facility
- Important: If a member discharges to the hospital for more than 30 days, then it is required that you submit both discharge and admission slips

Example: Discharges to hospital 30 days or less

Member discharges to the hospital on 1/10/24 and returns to the same facility after a 10-day inpatient stay

- Submit a claim (263,253,210) based on their skill level for 1/1/24-1/10/24 with a patient status 02 (discharged to Hospital).
- Member then returns to the same facility on 1/19/24
  - Submit a nursing home bill type based on their skill level for 1/19/24-1/31/24 with revenue code 0160.
- Do not submit a discharge and admit slip in CSM

Important: If a member discharges to the hospital for more than 30 days, then it is required that you submit discharge and admission slips and then bill using revenue code 0100

Adjustments and Recoups

If date of service is within 365 days (1 year), submit electronically

If date of service is over 365 days (1 year),
they **MUST** be submitted on a paper adjustment form and not on a claim form

- Adjustments and recoups submitted on paper can take up to two NH adjustment cycles to process. Once submitted, please allow sufficient time for processing
- Adjustments and recoups submitted on paper should be sent to the address on the form, not to your provider representative's attention
- If submitted electronically, processing is much quicker

Adjustments and Recoups - *continued*

Recipient Liability

- Recipient liability adjustments will be done automatically if the claim submitted was for an entire month (example: 01/01/24-01/31/24)
- Liability adjustments will happen on the NH adjustment financial (usually the 2nd financial of the month), the month following when the update was made
- If claim was for entire month, you do NOT have to send in a request to have the claim reprocessed
- If a claim was not billed for entire month as one claim type (01/01/24-01/10/24 & 01/11/24-01/31/24), you must submit an adjustment request
    - If claim is within 1 year old, you can do electronically.
    - If over 1 year old, must be completed on paper adjustment form

Adjustments and Recoups - *continued*

Split Billing of Claims

Some situations require one claim to be divided into 2 claims

Example: Recipient is skilled 11/01/23-11/30/23
Claim was billed and paid 11/01/23-11/30/23 as 253 (co-insurance)

Claim should have been billed
as 210 from 11/01/23-11/10/23 (Medicare free days)
And then as a 253 11/11/23-11/30/23
You can submit
An adjustment to change the paid 253 claim to dates of service
11/11/23-11/30/23,
Then you must submit a new claim for 11/01/23-11/10/23
as a bill type 210

Adjustments can only be processed on PAID claims
The adjustment form should not be used for “appeals”

Refunds

Preferred method to refund money is to process appropriate adjustment to the paid claim

If that is not possible and you must submit a refund,
please use the “refund log” found at:
http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/MA%20Providers/refund_log.pdf

You must submit the following information:

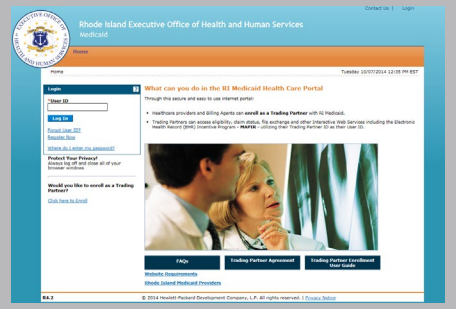
Name	Refund Amount
MID	Any comments
ICN	Check for payment
DOS	
RA Date	

Provider Responsibilities

- Check recipient eligibility on the first of every month including other insurance
- Stay current with RI Medicaid and CMS initiatives
- Renew license yearly with DOH
- Provide the new license number to RI Medicaid Provider Enrollment if the license number changes
- Claim submission by deadline every month
    - (Generally, on a Thursday at noon)
- Use the website www.eohhs.ri.gov to stay up to date on:
    - Provider Revalidation, Provider Electronic Solutions (PES) Upgrades, monthly *Provider Updates*, etc..
- Download Remittance Advices EVERY financial
    - (Only 4 most current are available for download)

Healthcare Portal

https://riproviderportal.org



PAYMENT AND PROCESSING SCHEDULE

Billing And Claims | Executive Office of Health and Human Services (ri.gov)

Rhode Island Medicaid Program

PROVIDER *update*

PROVIDER UPDATES – posted monthly on the 1st of every month

http://www.eohhs.ri.gov/News/ProviderNewsUpdates.aspx

*To receive the Provider Update electronically, send an email to riproviderservices@gainwelltechnologies.com. Put **subscribe** in the subject line of your email and include your NPI.*

Contact Information

Customer Service Help Desk	First line of contact for eligibility or claims inquiry that you were not able to determine after consulting the website.	401-784-8100 (For local and long distance calls) 800-964-6211 (in-state toll calls)
Marlene Lamoureux	Provider Representative	571-895-4938 Marlene.Lamoureux@gainwelltechnologies.com
Kelly Leighton	Provider Services Manager	571-348-5975
EDI Questions	EDI department	riediservices@gainwelltechnologies.com
CSM	Password Resets	1-844-718-0775 Rixix-ticket-systems@gainwelltechnologies.com
DHS	LTC Eligibility Issues	Help Line 401-574-8474 Dhs.ltss@dhs.ri.gov
OHHS LTSS Escalation Team	Eligibility Issues greater than 1 Year old	OHHS.LTSSEcalation@ohhs.ri.gov

Questions