LTC

Billing Guidelines for Long-Term Care (LTC)

meridianhealth
A WellCare Company

Our History

1997

Dr. Cotton obtains Central Michigan Health Plan

2000

Health Plan of Michigan becomes an HMO

2004

Managed Care System (MCS) is created

2006

Caidan Management Company is established

2007

HQ moves to downtown Detroit

2008

MeridianHealth launches in Illinois

2011

MeridianRx launches

meridianRx

Medicare launches

meridiancare

2012

MeridianHealth opens in Iowa (closes in 2015)

Chicago office moves

2013

MeridianHealth - New Hampshire Opens (closes in 2014)

MeridianComplete (MMAI) launches operations in IL

meridiancomplete

2014

MeridianChoice launches

meridianchoice

Healthy Michigan Plan (Expansion) launches

2015

MeridianComplete (MI Health Link) launches operations in MI

Detroit HQ moves to 1 Campus Martius

2016

SentinelRx launches

SentinelRx

Meridian launches new logo and brand identity

About Meridian

Our Mission

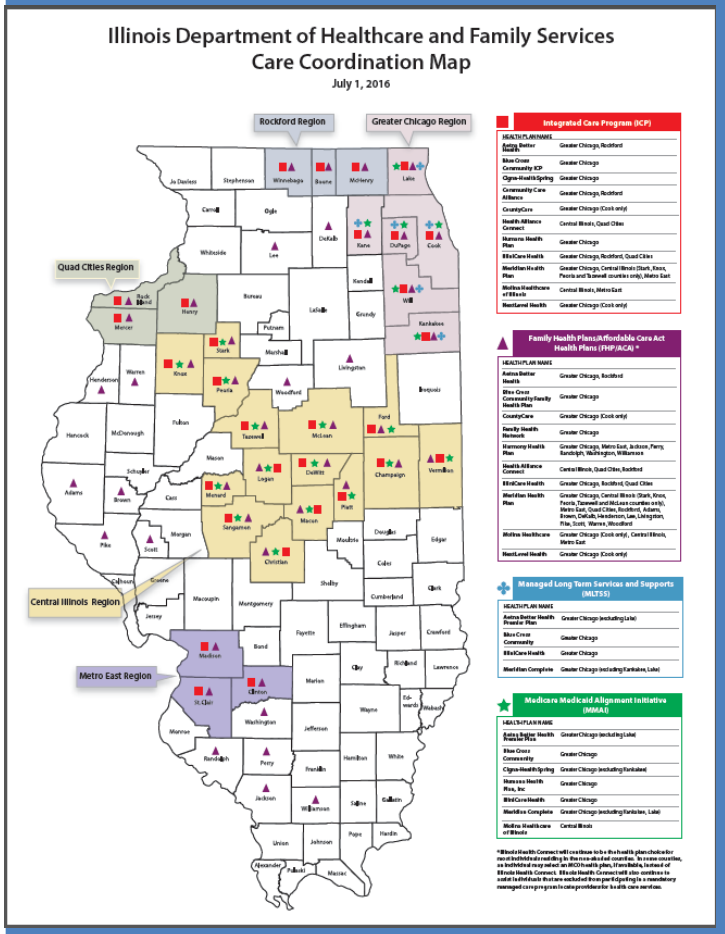
To continuously improve the quality of care
in a low resource environment

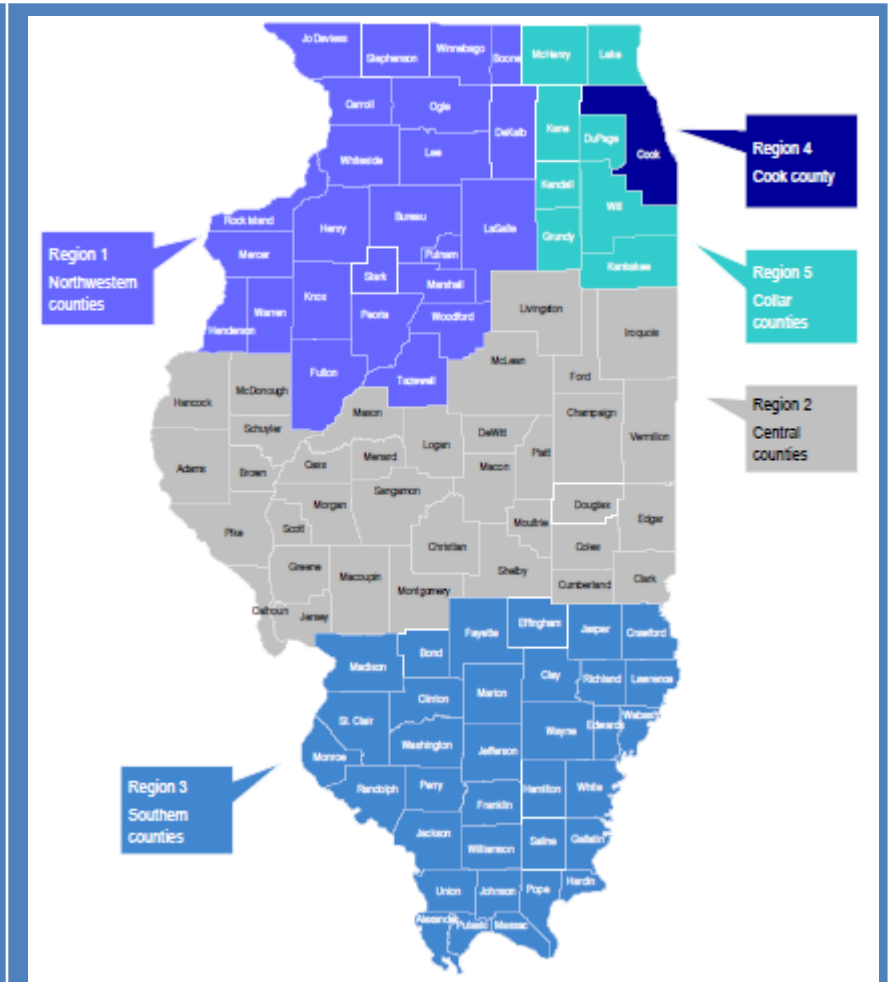
Our Vision

To be the premier service organization in government healthcare

To be the #1 health organization based on quality, innovative technology and service to our Meridian Family

Illinois Regions





Training Objective

- Review Current and New Billing Guidelines for Long-Term Care (LTC) Providers
- New Billing Requirement Effective Dates
- Acceptable Claim Formats
- Routes for Claim Submission
- Basic Billing Rules
- Claim Coding Specifications
- Coordination of Benefits
- PT/OT/ST
- Oxygen Claim Submissions
- Provider HFS and NPPES Enrollment and Registration Requirements
- Additional Sources of Information
- Top 10 Claim Denials
- FAQs

New Billing Requirement Effective Date

The new billing requirements outlined in this presentation will be effective for services rendered on and after:

December 1, 2016

Billing Guidelines

Provider	Provider Type Code	Taxonomy
Supportive Living Facilities (SLF) Participating Program	028	**311500000X** – Alzheimer/Dementia Center **310400000X** – Assisted Living Facility
Nursing Facilities Eligible to be Licensed as Specialized Mental Health Rehabilitation Facilities (SMHRF)	038	**310500000X** – Intermediate Care Facility, Mental Illness
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)	029	**315P00000X** – ICF Mentally Retarded **3140N1450X** – Nursing Care- Pediatric **320600000X** – Residential Treatment Facility, Mental Retardation and/or Dev. Disabilities
Nursing Facilities (NF)	033	**314000000X** – Skilled Nursing Facility **313M00000X** – Nursing Facility/Intermediate Care Facility **282N00000X** – General Acute Care Hospital (LTC Wing)

Acceptable Claim Formats

Meridian will accept the following claim formats for LTC providers:

- **EDI:** American National Standards Institute (ANSI) X12 837I Health Care Claim (5010) file format version 005010X223
- **PAPER CLAIM:** *UB 04-National Uniform Billing Committee (NUBC) data specifications*
- **CLAIMS PORTAL:** Direct claim entry in Meridian's Provider Portal
  - https://corp.mhplan.com/en/provider

Routes for Claim Submission

LTC providers can submit claims using **Meridian Payer ID 13189** with any of the following clearinghouse vendors:

Availity
Customer Support: 800-282-4548
http://www.availity.com

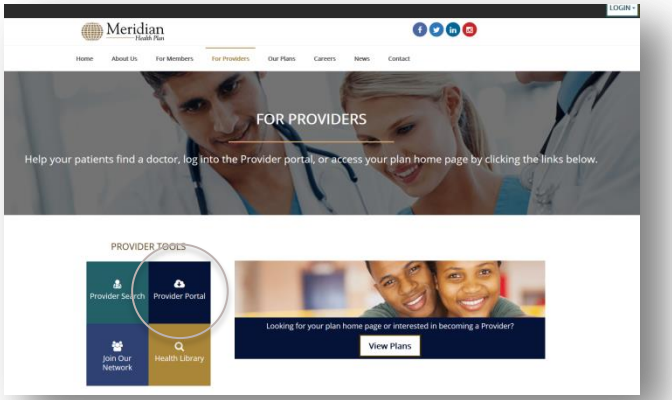
Emdeon
Customer Support: 800-845-6592
http://www.emdeon.com/claims/

RelayHealth
Customer Support: 866-735-2963
http://www.relayhealth.com

PayerPath
Customer Support: 877-623-5706
http://www.payerpath.com

The SSI Group
Customer Support: 800-880-3032
http://www.thessigroup.com

Register and enter claims in the Meridian Portal at our website: https://corp.mhplan.com/en/provider



Basic Billing Rules

- Claims submitted for LTC services must be for a single month of service and submitted in date sequence
- Medicaid Room and Board services provided by a LTC provider will be reported as Revenue Codes on the claim
- The monthly patient credit amount will be applied to the fee-for-service LTC or Hospice claims on a first come, first served basis. Patient credit amount is reported as Supported Living Facility claims under value code 23 (optional)
- The amount of patient credit applied will continue to be based on the amount of patient credit entered into the LTC patient credit segments by the Department of Human Services (DHS) caseworker under value code 23 (optional)
- Temporary leaves of absences or bed reserves must be reported on the submitted claim as a Revenue Code. Leave of absence days will be identified from the claim, using 'Leave of Absence' Revenue Codes with Occurrence Span Code 74

Enrollment and Registration Requirements

NOTE: LTC providers are required by IL HFS and Meridian to acquire a NPI (National Provider Identification) number with NPPES (National Plan and Provider Enumeration System)

- The corresponding taxonomy per provider type must be registered with NPPES
- The NPI used to submit claims must also be registered with IL Medicaid IMPACT system and MeridianHealth
- The NPI enrolled must be unique per each enrolled Medicaid Provider Identification Number (PIN)
- If the NPI used to submit claims is not registered with NPPES and/or cannot be matched with a IL Medicaid PIN, the claims will be denied reimbursement from MeridianHealth

Claim Coding Specifications

MeridianHealth will require all LTC providers to bill according to the **claim coding specifications** outlined on the following slides.

IL HFS and MeridianHealth claim coding specifications vary by combination of **provider type** and **corresponding rendered services.**

PT/OT/ST Billing Guidelines

- **PT/OT/ST Billed to Medicare**
  - **EDI**: AEDI-American National Standard Institute (ANSI) X12 837I Health Care Claim (5010) file format version 005010X223
  - **PAPER CLAIM:** *UB 04-National Uniform Billing Committee (NUBC) data specifications.*
  - Direct claim entry in Meridian's Provider Claims Portal
- **PT/OT/ST Billed to Medicaid**
  - **EDI**: AEDI-American National Standard Institute (ANSI) X12N 837P Health Care Claim (5010) file format version 5010A1
  - **Paper CLAIM:** CMS 1500-National Uniform Billing Committee (NUCC) data specifications
  - Direct claim entry in Meridian's Provider Claims Portal

Oxygen Claims

Oxygen for Long Term Care Residents

Long Term Care (LTC) facilities have the option of 1) billing the department directly for oxygen for their residents or 2) obtaining oxygen from an enrolled DME provider. If an LTC facility elects to bill the department directly for oxygen they must enroll as a DME provider and will be assigned a provider number ending in an "800" series. The facility, enrolled as a DME provider, is not required to obtain prior approval to supply oxygen to its residents. DME providers that supply oxygen to LTC residents must request prior approval.

Concentrators are not to be used unless the resident has an ongoing need for oxygen that requires a minimum of one liter of oxygen per minute continuously or a minimum of eight hours nocturnally. The resident must have no more than an 88 percent oxygen saturation level on room air. No other method of oxygen delivery is reimbursable for a resident during a month in which an oxygen concentrator is reimbursed by the department for that same resident.

When an LTC facility obtains oxygen equipment and supplies from a DME provider, **both** providers must exercise care to ensure that the department is not billed twice for the same service. The LTC facility is responsible for the cost of the first tank of oxygen used by a resident each month. The first tank is defined as:

- One "H" tank (6900 liters) or
- Two "E" tanks (623 liters) or
- 20 pounds of liquid oxygen.

The DME provider may not bill the cost of this first oxygen tank fill for each resident each month to the department. Oxygen fills beyond the initial first fill may be billed to the department by either the DME provider or the LTC facility, but not by both.

Supportive Living Facilities (SLF) Participating Program

- Bill Frequency Codes
- Revenue Codes
- Occurrence Span Codes and Dates
- Value Codes
- Leave of Absence (LOA) Days and Bed Reserve (BR) Days

Supportive Living Facilities (SLF) Participating Program

Type of Bill	Must be 89X – Special Facility Other - Outpatient Claim
Type of Bill Frequency Code	1 - Admit Through Discharge 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 - Interim – Last Claim 5 – Late Charge(s) Only
Revenue Codes	0240 – All Inclusive Ancillary, General Classification ~~0180 - Leave of Absence days, General Classification~~ (Effective 3/27/2017) 0182 – Leave of Absence Days, Patient Convenience 0183 – Leave of Absence Days, Therapeutic 0185 – Leave of Absence Days, Hospitalization
Occurrence Span Codes and Dates	74 – Non-Covered Level of Care/Leave of Absence Dates
Value Codes	80 – Covered Days 81 – Non-Covered Days 23 – Recurring Monthly Income (Patient Credit Amount) *Optional*
Leave of Absence (LOA) Days and Bed Reserve (BR) Days	LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates even though some bed reserve days may be payable. The total of "non-covered" days must also be reflected with a value code of 81. • LOA days 1 – 30 in fiscal year (FY) - Payable at 100% of facility Per Diem LOA days 31 or over in FY – Non-payable The count of LOA days reported on prior claims will be utilized to determine if the LOA days reported on each submitted claim for services within the fiscal year are payable or non-payable.

Nursing Facilities (NF)

- Bill Types
- Bill Frequency Codes
- Revenue Codes
- Occurrence Codes
- Occurrence Span Codes and Dates
- Value Codes
- Leave of Absence (LOA) Days and Bed Reserve (BR) Days

Nursing Facilities (NF)

Type of Bill	011X Hospital Inpatient (Including Medicare Part A) 021X Skilled Nursing Inpatient (Including Medicare Part A) 022X Skilled Nursing Facilities (Including Medicare Part B) 065X Intermediate Care - Level I – Inpatient Claim ~~066X Intermediate Care - Level II – Inpatient Claim~~ (Effective 3/27/2017) 079X Clinic-Other (Developmental Training) - Outpatient Claim
Type of Bill Frequency Code	1 - Admit Through Discharge 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 - Interim – Last Claim 5 – Late Charge(s) Only Calculation of accommodation days: The total accommodation days will be based on service from and service through dates, and Type of Bill Frequency. ~~If~~ Type of Bill Frequency Code is 2 or 3, will include service through date. ~~If~~ Type of Bill Frequency Code is 1 or 4, will not include the date of discharge unless the patient discharge status is 20.

Nursing Facilities (NF)

Revenue Codes	**Bill Type 021X and 022X** 0110-0160—Priced as General Room and Board ~~0180 - Leave of Absence Days, General Classification~~ (Effective 3/27/2017) 0182—Leave of Absence Days (Patient Convenience) 0183—Leave of Absence Days (Therapeutic) 0185—Leave of Absence Days (Hospitalization) 0191—Sub Acute Care Level I 0192—Sub Acute Care Level II 0193—Sub Acute Care Level III 0194—Sub Acute Care Level IV (Vent) **Bill Type 065X and 011X** 0110-0160—Priced as General Room and Board 0182—Leave of Absence Days (Patient Convenience) 0183—Leave of Absence Days (Therapeutic) 0185—Leave of Absence Days (Hospitalization) **Bill Type 079X** 0942—Education/Training 0022 – Skilled Nursing Facility – PPS (RUG)
Occurrence Code	A3 – Benefits Exhausted 22 – Date Active Care Ended 24 – Insurance Denied 50 – Assessment Date **If Recipient has Medicare Part A
Occurrence Span Codes and Dates	70 – Qualifying Stay Dates for SNF 74 – Non-Covered Level of Care/Leave of Absence Dates **NOTE:** MDS Assessment date is required when Revenue Code 0022 is reported. The MDS Assessment date will be submitted with an Occurrence Code of 50 along with an associated Occurrence Code date. Occurrence Code 50 can be reported multiple times with multiple assessment dates.

Nursing Facilities (NF)

Value Codes	**80 – Covered Days Calculation of Medicaid Covered Days and Medicare Covered Days for Legacy COS Coding and Pricing:** Value Code 80 – Total Medicaid Covered days (Medicaid and Medicare Covered days) Value Code 81 – Non-covered Medicaid days (LOA days only) Value Code 82 = Coinsurance Medicare Covered If Value Code 80 > Value Code 82 an Occurrence Code and Occurrence Date showing when Medicare exhausted must be reported to show the date Medicare coverage ended. The Statement From Date through the Medicare coverage end date will be identified as Medicare Covered Days. The Medicare Covered Day – Coinsurance Days (Value Code 82) = Full Covered Medicare Days (COS 065) starting from Statement From Date. The Days Reported as Coinsurance (Value Code 82) (COS 072) will be applied beginning with the first date not determined to be Medicare Full Coverage. If there are Leave of Absence Days reported for date(s) within the Medicare Covered period they should be included in Non-covered Days reported in Value Code 81 and will be considered coded as non-payable bed reserves. Value Code 80 days – the Medicare Covered Days = Medicaid Days (COS 070) beginning the day after the reported date Medicare coverage ended. If there are Leave of Absence Days reported for date(s) within the Medicaid covered period they should be included in Non-covered Days reported in Value Code 81 and will be considered coded as non-payable bed reserves. If Value Code 80 = Value Code 82, then the days are all coinsurance days. All Coinsurance days COS 072 81 – Non-Covered Days 82 – Coinsurance Medicare Covered

Nursing Facilities (NF)

Leave of Absence (LOA) Days and Bed Reserve (BR) Days	**Leave of Absence (LOA) Days and Bed Reserve (BR) Days:** LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates. The total of "non-covered" days must also be reflected with value code 81. LOA reported as Revenue Codes 0180, 0182 and 0183 will be considered Therapeutic bed reserve days. All are non-payable. LOA reported as Revenue Code 0185 will be considered Hospitalization bed reserve days. All are non-payable.

Specialized Mental Health Rehabilitation Facilities (SMHRF)

- Bill Types
- Bill Frequency Codes
- Revenue Codes
- Occurrence Span Codes and Dates
- Value Codes
- Leave of Absence (LOA) Days and Bed Reserve (BR) Days

Nursing Facilities Eligible to be Licensed as SMHRFs

Type of Bill	065X Intermediate Care - Level I – Inpatient Claim ~~066X Intermediate Care - Level II – Inpatient Claim~~ (Effective 3/27/2017)
Type of Bill Frequency Code	1 - Admit Through Discharge 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 - Interim – Last Claim 5 – Late Charge(s) Only
Revenue Codes	0110 -0160 – Priced as General Room & Board 0182 – Leave of Absence Days, Patient Convenience 0183 – Leave of Absence Days Therapeutic 0185 – Leave of Absence Days Hospitalization
Occurrence Span Codes and Dates	74 – Non-Covered Level of Care/Leave of Absence Dates
Value Codes	80 – Covered Days 81 - Non Covered Days 23 – Recurring Monthly Income (Patient Credit Amount) *Optional* ~~24 – Medicaid Rate Code (DT Agency Code)~~ (Effective 3/27/2017)
Leave of Absence (LOA) Days and Bed Reserve (BR) Days	LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates. The total of "Non-covered" days must also be reflected with a value code of 81.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

- Bill Types
- Bill Frequency Codes
- Revenue Codes
- Occurrence Span Codes and Dates
- Value Codes
- Leave of Absence (LOA) Days and Bed Reserve (BR) Days

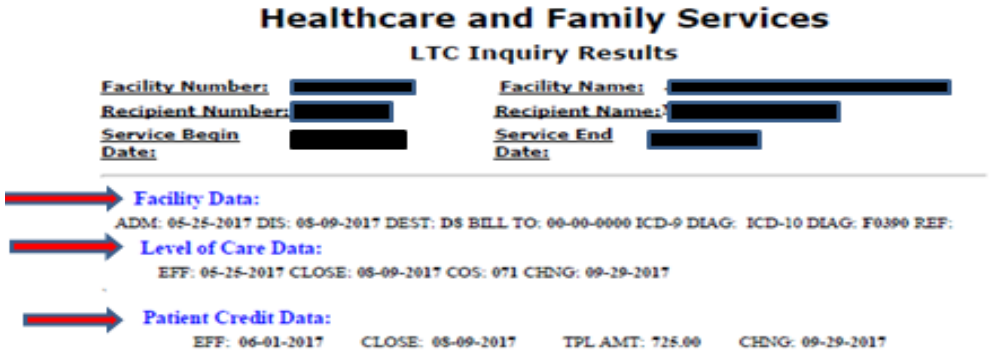
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Type of Bill	~~065X Intermediate Care - Level I – Inpatient Claim~~ (Effective 3/27/2017) 066X Intermediate Care - Level II – Inpatient Claim 079X Clinic - Other (Developmental Training) - Outpatient Claim
Type of Bill Frequency Code	1 - Admit Through Discharge 2 – Interim – First Claim 3 – Interim – Continuing Claim 4 - Interim – Last Claim 5 – Late Charge(s) Only
Revenue Codes	**Bill Type 066X** 0110 - 0160 – Priced as General Room & Board ~~0180 - Leave of Absence Days, General Classification~~ (Effective 3/27/2017) 0182 – Leave of Absence Days, Patient Convenience 0183 – Leave of Absence Days, Therapeutic 0185 – Leave of Absence Days, Hospitalization1 0190 – Sub-acute Care – General Classification **Bill Type 079X** 0942 – Education/Training
Occurrence Span Codes and Dates	74 – Non-Covered Level of Care/Leave of Absence Dates
Value Codes	80 – Covered Days 81 – Non-Covered Days 23 – Recurring Monthly Income (Patient Credit Amount) *Optional*

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Leave of Absence Days (LOA) and Bed Reserve (BR) Days	Leave of Absence Days (LOA) and Bed Reserve (BR) Days: LOA days will be reported with LOA Revenue Codes and must have a corresponding non-covered occurrence span code 74 with the appropriate LOA dates even though some bed reserve days may be payable, the total of "non-covered" days must also be reflected with value code 81. LOA reported as Revenue Codes 0180, 0182 and 0183 will be considered Therapeutic bed reserve days. Days 1 – 10 in FY - Payable at 100% of facility Per Diem Days exceeding 10 in a FY – Payable at 75% of facility Per Diem LOA reported as Revenue Code 0185 will be considered Hospitalization bed reserve days. For recipients under 21 years of age: Days 1 – 10 of a consecutive Hospital stay – Payable at 100% of facility daily Per Diem Days 11 – 30 of a consecutive Hospital stay – Payable at 75% of facility daily Per Diem Days 31 – 45 of a consecutive Hospital stay – Payable at 50% of facility daily Per Diem Days 46 – on of a consecutive Hospital stay – Non-Payable The count of LOA days reported on prior claims will be utilized to determine if the LOA days reported on each submitted claim for services within the fiscal year are payable or non-payable.

Submitting MEDI Screens



Healthcare and Family Services

LTC Inquiry Results

Facility Number: [redacted] **Facility Name:** [redacted]

Recipient Number: [redacted] **Recipient Name:** [redacted]

Service Begin Date: [redacted] **Service End Date:** [redacted]

Facility Data:

ADM: 05-25-2017 DIS: 08-09-2017 DEST: DS BILL TO: 00-00-0000 ICD-9 DIAG: ICD-10 DIAG: F0390 REF:

Level of Care Data:

EFF: 05-25-2017 CLOSE: 08-09-2017 COS: 071 CHNG: 09-29-2017

Patient Credit Data:

EFF: 06-01-2017 CLOSE: 08-09-2017 TPL AMT: 725.00 CHNG: 09-29-2017

https://medi.hfs.illinois.gov/ltcedi/LTCServlet.do 11/13/2017

Timely Filing

- In-network providers have 365 days from the date of service to submit an initial claim, and
- 120 days from the last remittance date to resubmit the claim if the claim is initially received within one year timeframe.
  - If a claim is submitted for a second time and denied within that year, providers have up to one year from the last adjudication date to make corrections, however it cannot exceed two years from the date of service.
  - *No claim will be paid past two years from the date of service.*
- There are two exceptions to the timely filing guideline, which include:
  - Retroactive eligibility: These claims must be accompanied by a Notice of Decision and received within 365 days of the notice date and reimbursed under a retrospective payment system
  - Third-party related delays: These claims must be accompanied by a third-party liability (TPL) explanation of benefits and also received within 365 days of the TPL process date

**All information on this slide is also available in our Claims Billing Submission Manual on our website.*

Additional Sources of Information

- https://www.illinois.gov/hfs/MedicalProviders/ltss/Pages/LongTermCareDirectBilling.aspx
- https://nppes.cms.hhs.gov/NPPES/Welcome.do
- http://www.nubc.org/subscriber/index.dhtml
- http://www.wpc-edi.com/reference

Top 5 Claim Denials

1. No authorization
2. Not on-patient credit file
3. Other insurance
4. Invalid or missing member ID
5. Income reduction is higher than charge amount

FAQs

- **Q: If a member goes from LTC to I/P then back to LTC, will the facility be paid for the day the member was discharged from the hospital?**
  - A: Yes, the emergent and custodial authorizations would overlap for the discharge date from the ER and readmission into the LTC.
- **Q: Does Meridian place backdated custodial authorizations on file?**
  - A: No, Meridian cannot backdate anything from Medicare.
- **Q: Where can claim examples be found for LTC provider?**
  - A: Please access the link below: http://www.illinois.gov/hfs/MedicalProviders/ltss/Pages/LongTermCareDirectBilling.aspx

Questions?

Provider Support

ProviderHelp.IL@mhplan.com

Or visit our website at www.mhplan.com