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Molina Healthcare of Ohio
Nursing Facility Orientation – Molina Dual Options MyCare Ohio 2014

Eligibility

Long Term Care (LTC) is the provision of medical, social, and personal care services on a recurring or continuing basis to persons with chronic physical or mental disorders and can be provided formally or informally. Facilities that offer formal LTC services typically provide living accommodations for people who require on-site delivery of around-the-clock supervised care, including professional health services, personal care and services such as meals, laundry and housekeeping. These facilities may go under various names, such as nursing home/facility, personal care facility, residential continuing care facility, etc.

Long Term Care Eligibility -

- Eligibility requirements and processes have remained the same in order for someone to move into a LTC facility on a permanent basis.
- Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. The PASRR process will be done as it is today via the AAA's, the Ohio Department of Mental Health and Drug Addiction, and the Ohio Department of developmental Disabilities.

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Minimum Data Set

The Minimum Data Set (MDS) contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident's functional status. The MDS is used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups). The RUG classification system is used in SNF PPS for skilled nursing facilities, non-critical access hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.

- NF providers will still use the MDS for the Molina Dual Options Members

- Section A will continue to be coded the same as if the members were not enrolled in MyCare Ohio. For example, if the person has been in the facility for over 100 days and would normally be on Medicaid fee for service, then they should still be coded as "Medicaid".

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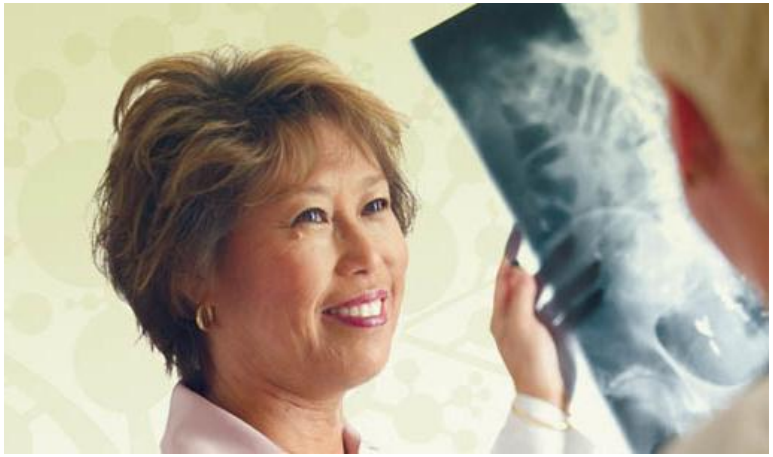
Transition of Care

The State has developed the following requirements to aid the transition process. This process allows the member to continue services while transitioning into the Molina Dual Options MyCare Ohio:

- In order to minimize service disruption, Molina will honor the individual's existing service levels and providers for a pre-determined amount of time, depending upon the type of service
    - Assisted Living Waiver: Provider will be retained at current rate for the life of Demonstration.
- Molina will receive files of all existing authorized waiver services
- Providers can use the MITS provider portal to see if a consumer is enrolled in MyCare Ohio, which plan the member has selected, if the member is a Molina Dual Options MyCare Ohio Member or Molina Duals Medicaid only member.



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Home and Community-Based Services (HCBS)

- Individuals with HCBS needs who have enrolled in any of Ohio's NF Level of Care (LOC) Medicaid waivers on a fee-for-service (FFS) basis prior to ICDS enrollment will carry their LOC determination with them for the period it would have been effective in their previous waiver, absent a change of condition.

- Their LOC is determined using assessment tool(s) that features the essential elements of the JFS 03697 form. While the tools are different than the JFS 03697 form, the outcomes of the evaluations are equivalent because the elements used to determine LOC are the same.

- Once an individual is enrolled in the ICDS, their LOC will be determined annually using the JFS 03697 form.

- To ensure that level of care functions are performed according to required standards, Ohio will monitor level of care redeterminations through two performance measures directly related to level of care.

- The JFS 03697 form will also be used to determine the LOC for individuals enrolled with Molina who, prior to their enrollment in the demonstration, did not have a need for HCBS services.

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Inclusive Services

The following services are included in the NF per diem rate:

- Costs incurred for physical therapy, occupational therapy, speech therapy and audiology services provided by licensed therapists or therapy assistants are reimbursed through the nursing facility per diem.

- Costs incurred for the services of a licensed psychologist are reimbursable through the nursing facility per diem. No reimbursement for psychologist services shall be made to a provider other than the nursing facility, or a community mental health center certified by the Ohio department of mental health.

    - Services provided by an employee of the community mental health center must be billed directly to Molina Healthcare by the community mental health center.

- Costs incurred for physician ordered administration of aerosol therapy that is rendered by a licensed respiratory care professional are reimbursable through the nursing facility per diem. No reimbursement for respiratory therapy services shall be made to a provider other than the nursing facility through their per diem rate.

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Directly Reimbursed Providers

A provider may be directly reimbursed for the following services provided to a resident of a nursing facility by a physician:

- Covered services provided by licensed podiatrists are reimbursed directly to the authorized podiatric provider in accordance with Chapter 5160-7 of the Administrative Code. Payment is limited to one visit per month for residents in a NF or ICF-MR setting.
- All covered dental services provided by licensed dentists are reimbursed directly to the provider of the dental services in accordance with Chapter 5160-5 of the Administrative Code.
- All laboratory and x-ray procedures covered under the Medicaid program are reimbursed directly to the laboratory or x-ray provider in accordance with Chapter 5160-11 of the Administrative Code.
- Services that are reimbursed directly to the medical supplier provider, in accordance with Chapter 5160-10 of the Administrative Code, include:
    - Certain durable medical equipment items, specifically, ventilators.
    - "Prostheses," defined as devices that replace all or part of a body organ to prevent or correct physical deformity or malfunction, such as, artificial arms or legs, electro-larynxes, and breast prostheses.
    - "Orthoses," defined as devices that assist in correcting or strengthening a distorted part, such as, arm braces, hearing aids and batteries, abdominal binders, and corsets.
- Hospice will be a covered benefit. The Hospice provider must be a contracted provider with Molina healthcare for the Dual Options MyCare Ohio Line of Business for the Medicaid covered hospice services including room and board. Room and board should be billed by the hospice provider and will be paid by Molina Healthcare.

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Hospice

Medicare/Medicaid Coverage

- Medicare does not cover room and board for hospice care for patients living in a nursing home or a hospice inpatient facility.

- In order for the hospice provider to receive payment for Medicaid covered Hospice Care, A provider:

  - Must bill ODM the amount equal to ninety-five percent of the Medicaid NF or the ICFMR per Diem rate as obtained from the NF or the ICF-MR.

  - Must bill only for days that the consumer is in the NF or ICF-MR overnight

  - Can bill for consumers who have elected the hospice benefit under Medicare but are Medicaid eligible and reside in a Medicaid-reimbursed NF or ICF-MR for the room and board

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Nursing Facility Room and Board

All inclusive room and board charges for the following will be covered:

- Skilled level of care (SLOC) ordered by a physician that provides at least one skilled nursing service at least seven days per week, and/or a skilled rehabilitation services at least five days per week.

- Intermediate level of care (ILOC) that provides:

  - Hands-on assistance with the completion of at least two activities of daily living (ADL);
  - Hands-on assistance with the completion of at least one activity of daily living, and is unable to perform self-administration of medication and the medication must be administered by another person;
  - One or more skilled nursing or skilled rehabilitation services at less than an SLOC; or
  - Supervision by another person on a 24 hour-a-day basis to prevent harm due to a cognitive impairment, including but not limited to dementia.

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Medicare Billing

SNF Inpatient Revenue Codes an Bill Type

The below information should be used for reporting services rendered for extended care services furnished to inpatients of a Medicare certified skilled nursing facility. Patients must require daily skilled care on an inpatient basis.

Revenue Codes
- 0210
- 0211
- 0213
- 0214
- 0215
- 0217
- 0218

Type of Bill
- 22X

SNF Outpatient Revenue Codes and Bill Type

The below information should be used for reporting services rendered to a patient who no longer meets the Medicare skilled level of care (SLOC). It is also used when patients are moved to a non-Medicare certified area or distinct part unit of the facility because they no longer require a SLOC. Beneficiaries residing in such portions of the facility are considered outpatients of the SNF for Medicare purposes.

Revenue Codes
- 0231
- 0231
- 0233
- 0234
- 0235
- 0237
- 0238

Type of Bill
- 23X

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Medicaid Billing

Medicaid Inpatient Revenue Codes and Bill Type

Revenue Codes

- 0211
- 0212
- 0213
- 0214
- 0217
- 0218
- 0101
- 0183
- 0185
- 0160
- 0220
- 0169
- 0189

Type of Bill

- 22X

Please Note:

- Revenue Codes 183 and 185 (Therapeutic Leave/Bed-Hold Days and Hospitalization Leave) exclude PA1/PA2 Acuity level
- Long Term Care facility room and board claims do not require procedure (CPT/HCPCS) codes.

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Bed Hold Days

NF bed-hold day, also referred to as "NF leave day," means a day for which a bed is reserved for a NF resident while the resident is temporarily absent from the NF for hospitalization, therapeutic leave days, or visitation with friends or relatives. Payment for NF bed-hold days may be made only if the resident has the intent and ability to return to the same NF. A resident on NF bed-hold day status is not considered discharged from the NF.

NF occupied day" means one of the following:

- A day of admission; or
- A day during which a Medicaid eligible resident's stay in a NF is eight hours or more, and for which the facility receives the full per resident per day payment directly from Medicaid in accordance with Chapter 5101:3-3 of the Administrative Code.

Bed-hold, Revenue Code 0183 or 0185, days are not available to Medicaid eligible nursing facility residents in the following situations:

- Hospice
- Institutions for Mental Diseases (IMD)
- HCBS Waiver
- Program of all-inclusive care for the elderly (PACE) or other capitated managed care programs
- Restricted Medicaid coverage
- Facility closure and resident relocation.

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Bed Holds Days Cont.

According to section 5165.34 of the Revised Code, reimbursement for nursing facility bed-hold days shall be paid as follows:

- Fifty per cent of the nursing facilities per diem rate if the facility had an occupancy rate in the preceding calendar year exceeding ninety-five per cent; or

- Eighteen per cent of the nursing facilities per diem rate if the facility had an occupancy rate in the preceding calendar year of ninety-five per cent or less.

Reimbursement for nursing facility bed-hold days shall be considered payment in full, and the nursing facility provider shall not seek supplemental payment from the resident.

Bed hold days, Revenue Code 0183 or 0185, can not be more than thirty days in any calendar year

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Patient Liability

For members with patient Liability,

- ODM will submit the amount to Molina Healthcare in the eligibility file submissions.
- The patient liability is reduced from the payment to the NF monthly.
- It is the responsibility of the NF to collect the patient liability.
- Providers need to use box 54 to report patient liability

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Frequently Used Phone Numbers

DEPARTMENT	NUMBER
Case Management	(855) 322-4079 (follow phone prompts)
Claims Reconsideration	(855) 322-4079 / fax (800) 499-3406
Claims Inquiry – Customer Service	(855) 322-4079 (follow phone prompts)
Community Outreach	(855) 665-4623
Fraud, Waste, and Abuse Tip Line	(866) 606-3889/ fax (888) 665-0860
Member Eligibility Ohio Medicaid	(800) 686-1516
Member Services – Duals	(855) 665-4623/fax: (855) 266-5462
Member Services – Medicare	(866) 472-4584
Pharmacy (Medicare/Duals)	(855) 322-4079 / fax: (888) 858-3090
Prior Authorization (Inpatient)	(855) 322-4079
Prior Authorization (Outpatient)	(855) 322-4079
Provider Services	(855) 322-4079 / fax: (866) 713-1893
Provider Services – Web Portal Help Desk	(866) 449-6848
Utilization Management	(855) 322-4079 / fax: (866) 449-6843
24 Hour Nurse Advise Line	(888) 275-8750 / TTY: (866) 735-2929
Behavioral Health	(855) 322-4079 / fax(866) 553-9262

Main Phone
(855) 665-4623
TTY 711

Member Services
8 a.m. to 8 p.m.
Monday - Friday

Provider Services
8 a.m. to 8 p.m.
Monday - Friday

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Questions and Comments

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