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Nursing Facility
Billing and Reimbursement Training

Topics of Discussion

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Nursing Home Overview

Nursing Facility services provide 24-hour medical and nursing care. This may be provided in a residential setting, institution, or a district part of an institution.

Per the Florida Medicaid Nursing Home Coverage and Limitation's Handbook:

Florida Medicaid reimburses 365/66 days of all-inclusive nursing facility services, per year, per recipient when the following occurs in accordance with 42 CFR 438.440:

- Services are prescribed by a physician licensed in the State of Florida
- Recipient occupies a Medicaid-certified bed (unless the recipient is covered by Medicare Part B, in which case, a Medicare-certified bed is allowed)

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Nursing Home Overview

The services provided are:

- On-site physician services
- Person-centered care planning
- Room and Board
- General nursing services, including restorative services
- Personal hygiene care
- Personal hygiene items, including incontinence supplies
- Laundry services
- Dressing and skin care items
- Medical supplies and equipment
- Non-prescription (over-the-counter) drugs, biologicals, and emergency drugs
- Dietary services, including therapeutic diets and special dietary supplements used for oral or tube feeding
- Rehabilitative services, including physical, speech, and occupational therapies
- Social services
- Activity services

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Case Managers

Case management services facilitate member access to needed medical, social, and educational services. Each Program member will be assigned to a case manager that will coordinate and ensure delivery of medical care and services available under the program.

Molina Healthcare of Florida case managers will:

- Develop individual plans of care that address identified programs, needs, and conditions
- Coordinate the delivery of covered services
- Issue authorizations for covered services
- Coordinate and integrate acute and long term care services
- Collaborate with member's physicians and other providers to arrange for needed care
- Provide frequent communication with members to evaluate and discuss needed care
- Promote independent living and quality of life

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Authorization Requests

Providers **must** request an authorization when a member requires admission toa Nursing Facility. This includes when leave days are necessary for hospitalization or therapeutic services. Notification must be given within 24 hours of knowledge of hospitalization.

To request an authorization, please **fax to:(866) 440-9791.**

For questions, please contact a Case Manager at (855) 322-4076

Note: An authorization does not guarantee payment. Member must be eligible at the time service were rendered. Services must be covered and medical necessary with prior authorization as per Molina's policies and procedures.

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Claims Submission

Providers must submit claims, whether paper or electronic, within 6 months after discharge. Claims may be submitted:

- Electronically, via the Molina Web Portal
- Electronically, via a clearinghouse, Payer ID #51062
- On paper, using a UB-04 from to:

Molina Healthcare
PO Box 22812
Long Beach, CA 90801

When Molina is secondary, claims, whether paper or electronic, must be submitted within 90 days from the final determination by the primary insurance carrier. If Medicare is the primary carrier, claims must be submitted to Molina within 36 months from discharte or 1(one) year from Medicare's determination, whichever is later.

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Claim Billing Requirements

Before filing a claim, please review the following:

- Member eligibility and ID#
- Claim's timely filing
- Primary versus secondary insurance
- A PASRR was obtained
- Patient Liability has been confirmed through DCF documentation or the DCF website
- Rendered services are covered
- Rendered services were authorized

Molina billing and reimbursement requirements are comprised of the following:

- Medicaid Provider Reimbursement Handbook, UB04
- Medicaid Nursing Home Coverage and Limitations Handbook
- Medicaid Nursing Home Fee Schedule
- Florida Medicaid Nursing Rates
- Medicaid Provider General Handbook
- Molina's Statewide Medicaid Managed Care (SMMC) contract
- Provider Services Agreement
- Molina's Provider Manual
- Current Procedural Terminology (CPT)
- Clinical Modification ICD-10-CM for diagnosis
- Medicaid Policy Transmittals and/or Notices, as appropriate

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Claim Billing Requirements (Cont.)

Whether paper or electronic, processing of cleans must include but not limited to the following:

- Provider Name and Address must match W9 on file
- Fictitious or "Doing Business as" Pay-to Name and Address (if applicable)
- Tax ID must match W9 on file
- NPI must match our files and NPI registry
- Bill Type
- Source of Referral for Admission
- Patient Discharge Date Status
- Condition Codes
- Value codes and Amounts
- Revenue codes
- Units of Service
- Prior Payments and copy of Primary Insurance Carrier
- Explanation of Payment for crossover claims

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Patient Responsibility

Patient Responsibility is determined by the Department of Children and Families (DCF) as the portion the member must pay for Nursing Home Facilities. DCF must determine the monthly amount for the member's responsibility even if the amount is determined as a zero-dollar value. For this reason, Molina requires the patient responsibility must always be billed even when the amount is Zero.

Patient Responsibility must be billed as a **Value Code of 31** on a VB04 or **Loop 2300/CAS01** for an electronic claim. The amount entered should be the entire month patient responsibility even when partial days are billed. Molina will prorate the amount when partial dates are billed. If the member is admitted and discharge the same day, Molina will count this billed services as one (1) day.

If the patient responsibility is **Zero,** the amount for Value code 31 should be billed as $0.

Covered days – A **Value code of 80** and the amount is the number of days the covered by the primary payer as qualified by the payer.

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Leave Days

If a member residing in a Nursing Facility requires hospitalization or therapeutic services and will be returning to the Nursing Facility, the provider may be reimbursed for leave days. An **authorization** is required for these leave day services.

Leave Days are billed with **Revenue Code 185 for Hospital Leave Days or Revenue Code 182 for Home Leave Days (therapeutic leave days)** with the following **benefit limitations:**

For Hospitalization – **8 days** per medically necessary hospital stays
For Therapeutic – **16 days** per state fiscal year

Billing Example: Room & Board and Leave days on the same claim:

Scenario:
Member is residing in a Nursing Facility and requires hospitalization on March 24th. The revenue codes require authorization and are to be billed as follows:

Revenue code **101** for date of services 3/1/21 through 3/23/21
Revenue code **185** for date of services 3/24/21 through 3/31/21

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Preadmission Screening and Resident Review (PASRR)

All providers rendering Nursing Facility services but complete Preadmission Screening and Resident Review **(PASSR)**

A completed and signed PASRR must be received with the nursing facility authorization request.

Preadmission Screening and Resident Review – Federal requirement mandated by 42 CFR 483.100-483.138. For this reason, Molina will **NOT** reimburse claims for nursing facility services provided prior to the date of completion of PASRR requirements.

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Medicare Crossover claims

Medicare Part A benefits cover up to 100 days of rehabilitative care in a Nursing Facility. The Medicare Part A coinsurance begins on day 21 through 100 nursing facility stay. Long Term Care covers nursing facility Medicare Part A coinsurance claims.

Nursing facility Medicare Part A coinsurance claims are billed with **Revenue Code 101,** regular room and board days, regardless of the revenue codes billed on the Medicare claim.

These crossover claims must include :

- **Revenue code 101** – Day 21 through 100 when a Medicare Part A coinsurance is due, and
- **Revenue code 022** – Day 1 through 20 where no Medicare Part A coinsurance is not due

Note: A Medicare Explanation of Payment is required with the claim

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Medicare Crossover Claims (Cont.)

The specific Medicaid nursing home rate is used to process a nursing facility Medicare Part A coinsurance claim.

Note: Only the **Medicare Per Diem** rate must be included in the UB-04 claim box 47. If the Medicare per diem rate changes during the month, submit a weighted average Medicare per diem rate (weighted based on the number of days each rate is paid)

Claim calculation example:

- Medicare Paid $2,000 (after the coinsurance is subtracted) for 10 days. This calculates to $200 per day.
- The Nursing Facility per diem is $180 per day. The Medicare payment exceeds the facility's per diem rate. - **$0 coinsurance payment is due**

- Medicare Paid $2,000 (after the coinsurance is subtracted) for 10 days. This calculates to $200 per day.
- The Nursing Facility per diem is $230 per day. The Medicare payment is less than the facility's per diem rate.
- Medicaid owes $30 X 10 days **= $300 coinsurance is due**

Note: Patient Liability is deducted, as applicable

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Medicaid Members Not Enrolled in Long Term Care

The managed care plan is responsible for providing coverage of nursing facility services under the MMA benefit to enrollees who are not enrolled in the LTC program, in accordance with Section VI., Coverage and Authorization of Services, of Attachment II and Exhibit II-A. **The purpose of this contract interpretation is to clarify the responsibility for coverage and payment of nursing facility services for MMA enrollees in a long-term nursing facility stay prior to their enrollment in the LTC program.**

The first general amendment to the SMMC contract provided the managed care plan with greater detail on coverage provisions for nursing facility services for **MMA enrollees eighteen (18) years of age and older** who had not transitioned to the LTC program.

Authorization is required for the service; providers should follow the below process:

-Submit an Authorization request up to **6 month** from start date of services.

-Fax it to 866-440-9791

-Submit Molina Prior Authorization form, PASRR, Admission Face sheet, LOC to cares information or ICP pending information, and 3008 Form.

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Medicaid Members Not Enrolled in Long Term Care (Cont.)

The provisions of this amendment required the managed care plan to provide coverage for up to **one hundred twenty (120) days** from the date of nursing facility admission or the date of receiving Institutional Care Program (ICP) Medicaid, whichever is later, regardless of payer, when:

- The enrollee needs long-term nursing facility services and is not receiving nursing
- facility services in lieu of inpatient hospital services nor admitted for rehabilitation services.
- The enrollee has completed all PASRR requirements.
- The Department of Children and Families has determined the enrollee is eligible for ICP Medicaid; and
- The enrollee is not yet enrolled in the LTC program.

Note: **DNSP Coverage:** Dual Eligible members have the **Short Term 120 Days** benefit covered under their Medicaid coverage. Members need to have medical benefits coverage included on their Medicaid to qualify for it.
QMB only members do not apply.

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Medicaid Members Not Enrolled in Long Term Care (Cont.)

With **Medicare as primary payer** for skilled care in a nursing facility, the Agency received requests for guidance on calculating **120-day coverage and MMA plan responsibility for dual eligible individuals.** The chart below presents several scenarios, which focus on two specific areas whether the member was:

1) ICP eligible upon admittance or received ICP eligibility later during the nursing facility stay, and

2) Receiving skilled or custodial care.

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Medicaid Members Not Enrolled in Long Term Care (Cont.)

To assist identifying **payor responsibility**, here are the following scenarios

Number	Scenario	MMA Plan Responsibility
1	Member with Medicare coverage and ICP coverage admitted to nursing facility as skilled care and remained skilled care for over 120 days.	Medicare is responsible for 100 days and MMA is responsible for the remaining 20 days.
2	Member with Medicare coverage and no ICP coverage upon admission to nursing facility and received skilled care for over 120 days.	Medicare is responsible for 100 days and MMA would begin counting 120 days from the time the ICP eligibility was authorized. Example: Member became ICP eligible on day 50 of a 180-day stays. Although the MMA plan would start counting the 120-day benefit on day 50, since Medicare is responsible for the first 100 days, the MMA plan would not be responsible for payment until day 101 at which point there is still 70 days remaining of the 120. For this reason, the MMA plan would be responsible for days 101 through 170.

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Medicaid Members Not Enrolled in Long Term Care (Cont.)

Number	Scenario	MMA Plan Responsibility
3	Member with Medicare coverage and ICP coverage admitted to nursing facility as custodial care and remained for over 120 days.	Medicare does not cover custodial care. The MMA plan is responsible for the 120 days of the nursing facility stay from admission.
4	Member with Medicare coverage and no ICP coverage upon admission to nursing facility and received custodial care in the nursing facility for over 120 days.	Medicare does not cover custodial care. The MMA plan is responsible for 120 days from the time the ICP eligibility was authorized. Example: Member became ICP eligible on the 31st day of the custodial stay. The MMA plan is responsible for day 31 through day 150 of the custodial stay.

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Medicaid Members Not Enrolled in Long Term Care (Cont.)

Number	Scenario	MMA Plan Responsibility
5	Member with Medicare coverage and ICP coverage upon admission to nursing facility and received skilled care but then changed to custodial care a month later.	Medicare is responsible for skilled care but not custodial. Medicare would pay for the skilled days and then the MMA plan would be responsible for payment of the custodial days. The 120-day count begins with the date of admission in this scenario since the member already had ICP coverage. In this scenario, the MMA plan would be responsible for day 31 up to day 120.

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Excluded Services

Services are **not** reimbursed when any of the following apply:

- Services does not meet medical necessity criteria
- Authorization was not obtained
- Member is not active at the time services were rendered
- Services duplicate another provider's service

The following are **not** reimbursed:

- Services when a member is enrolled in a Home Community-Based Waiver, excluding SMMC Managed Care Program.
- Leave days once a facility receives information that the member will not be returning to their facility

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Provider Disputes/Appeals

Providers disputing a denial or underpayment of a claim must know the following:

- Request must be received within **one (1) year** of Molina's original remittance advice date.
- All Claim disputes must be submitted on the Molina Provider Dispute/Appeal Form found on Provider website and the Provider Portal. The form must be filled out completely in order to be processed.
- Providers should submit the following documentation:
  - Any documentation to support the adjustment and a copy of the Authorization form (if applicable) must accompany the reconsideration request.
  - The Claim number clearly marked on all supporting documents

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Provider Disputes/Appeals (Cont.)

Molina has a dedicated staff for providers available to receive and resolve claim dispute and appeals.

Molina offers the following submission options:

- Submit requests directly to Molina Healthcare of Florida via the Provider Portal. https://provider.molinahealthcare.com.
- Submit requests directly to Molina Healthcare of Florida via fax at: 877-553-6504
- Submit Provider Disputes impacting more than 25 claims can be submitted via email to: MFLClaimsDisputesProjects@MolinaHealthCare.Com
- Submit Provider Appeal request to MFL_ProviderAppeals@MolinaHealthcare.com Submit Provider Disputes through the Contact Center at 866-472-4585 (Monday – Friday, 8am – 5pm)
- Submit requests via mail to:

Molina Healthcare of Florida
Provider Dispute and Appeals
P.O. BOX 527450
Miami, FL 33152-7450

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Provider Resources

Patient Responsibility and Reimbursement of Nursing Facility Services
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Snapshot_Nursing-Facility_Overview-of-Patient-Responsibility_30Sept2014.pdf

Requirements for Reimbursement of Nursing Facility Medicare Part A Coinsurance Claims
https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/SMMC_Snapshot_Nursing-Facility_Medicare-Part-A-Coinsurance_30Sept2014.pdf

Medicaid Provider Reimbursement Handbook, UB-04
https://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_UB-04_ver1_3.pdf

Medicaid Nursing Facility Provider Information
https://ahca.myflorida.com/medicaid/nursing_fac/index.shtml

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Provider Resources

Medicaid Provider General Handbook
https://ahca.myflorida.com/medicaid/review/General/59G_5020_Provider_General_REQUIREMENTS.pdf

Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy
https://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf

Medicaid Provider Handbook, Coverage Policies, and Fee Schedules
https://ahca.myflorida.com/medicaid/review/Promulgated.shtml

Preadmission Screening and Resident Review FAQ
https://ahca.myflorida.com/medicaid/PASRR/Docs/PASRR_FAQs.pdf

Preadmission Screening and resident Review Process (PASRR)
https://ahca.myflorida.com/medicaid/pasrr/index.shtml

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