MyCare Ohio Nursing Facility Orientation

Molina Healthcare

MOLINA HEALTHCARE

Your Extended Family

Long Term Care

Long Term Care (LTC) is continuous care to persons with chronic physical or mental disorders. Facilities with LTC typically provide living accommodations for people who require 24/7 supervised care. They may be known as:

Nursing Home/Facility

Personal Care Facility

Residential Continuing

MOLINA HEALTHCARE
Your Extended Family

Long Term Eligibility

Eligibility requirements and processes have remained the same for someone to move into a permanent LTC facility.

Preadmission Screening and Resident Review (PASRR) is a federal requirement for placement in nursing homes with LTC. PASRR is completed by:

- Area Agency on Aging (AAA),
- Ohio Department of Mental Health and Drug Addiction, and
- Ohio Department of Developmental Disabilities.

Minimum Data Set (MDS)

MDS contains items that reflect the acuity level of the resident, including diagnoses, treatments, and an evaluation of the resident 's functional status.

- Used as a data collection tool to classify Medicare residents into RUGs (Resource Utilization Groups)
- RUG is used in Prospective Payment System for SNF, 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 reimbursement

Minimum Data Set (MDS)

Nursing facility providers will use the MDS for Molina Dual Options members.

Section A will be coded as if the members were not enrolled in Molina Dual Options MyCare Ohio.

Example: If the person has been in the facility for more than 100 days and would normally be on Medicaid fee for service, they should still be coded as "Medicaid."

Transition of Care

The State's guidelines for members transitioning into Molina Dual Options MyCare Ohio:

- Molina Healthcare will honor the individual's existing service levels and providers **for a predetermined** amount of time, depending upon the type of service.
- **Assisted Living Waiver**: Providers will be retained at current rate for the life of demonstration.
- Providers can use the Provider Web Portal to check member enrollment status, which plan was selected, and if the member is opt-in or opt-out.

MOLINA HEALTHCARE
Your Extended Family

Home and Community-Based Services

Individuals with home and community based services (HCBS) needs, enrolled Ohio's NF Level of Care (LOC) Medicaid waivers on a fee-for-service (FFS) basis prior to Integrated Care Delivery System (ICDS) enrollment, will carry their LOC determination for the effective period of their previous waiver, absent a change of condition.

MOLINA HEALTHCARE
Your Extended Family

Level of Care (LOC)

LOC is determined using assessment tool(s) that feature the essential elements of the JFS 03697 form.

The tools are different than the JFS 03697 form, but the outcomes and the elements are the same.

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

MOLINA HEALTHCARE
Your Extended Family

Level of Care (LOC)

To ensure standard LOC, Ohio will monitor LOC redeterminations through two performance measures directly.

The JFS 03697 form be used to determine the LOC for members who, prior to their enrollment in the demonstration, did not a need HCBS services.

Services in the Per Diem Rate

Costs incurred that are reimbursed through the nursing facility per diem:

- Physical therapy
- Occupational therapy
- Speech therapy
- Audiology services provided by therapists or therapy assistants
- Licensed psychologists
- Physician ordered administration of aerosol therapy by a licensed respiratory care professional

Services in the Per Diem Rate

Reimbursement for psychologists will not be made to:

- A provider other than the nursing facility
- A community mental health center certified by the Ohio Department of Mental Health

Reimbursement for respiratory services will not be made to:

- A provider other than the nursing facility

MOLINA HEALTHCARE
Your Extended Family

Services in the Per Diem Rate

Services provided by an employee of the community mental health center:

- Must be billed directly to Molina Healthcare by the community mental health center

MOLINA HEALTHCARE
Your Extended Family

Hospice Coverage

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

Hospice Coverage

Must bill the Ohio Department of Medicaid (ODM) 95 percent of the Medicaid NF or the ICF-MR 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 room and board

Nursing Facility Room and Board

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

- Intermediate level of care (ILOC) that provides:
- Hands-on assistance with the completion of at least two activities of daily living (ADL)
- Skilled level of care (SLOC) ordered by a physician that provides at least one SNF at least seven days per week, and/or a skilled rehabilitation services at east five days per week

Nursing Facility Room and Board

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

- Hands-on assistance with at least one ADL, and is unable to perform self-administration of medication; medication must be administered by another person
- One or more skilled nursing or skilled rehabilitation services at less than an SLOC
- 24-hour supervision to prevent harm due to cognitive impairment, including but not limited to dementia

Directly Reimbursed Providers

Providers may be directly reimbursed for the following services provided to a resident of a nursing facility:

- **Covered services provided by licensed podiatrists**
- **All covered dental services provided by licensed dentists**
- **All laboratory and x-ray procedures covered under the Medicaid program**
- **Services that are reimbursed directly to the medical supplier provider**
- **Certain durable medical equipment items**
- **Hospice: will be a covered benefit**

Non-Covered Services and Days

MMP Medicare does not cover:	Non-covered days:
Non-skilled level of care and services	Indicated by Value Code 81 in box 39 of the UB; the value code amount indicates the number of non-covered days
Services of a private-duty nurse or other private-duty attendant	Amount billed will be in box 48 "Non-covered charges"
Non FDA-approved drugs	Not payable

MMP Medicare Benefits

Skilled nursing facility (SNF) care includes, but is not limited to, the following covered services:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered as part of the plan of care
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/practitioner services

MMP Medicare Coverage

- No prior hospital stay is required
- MMP covers up to 100 days each benefit period
- A "benefit period" starts the day a member enters a hospital or SNF
- It ends when the member goes for 60 days in a row without hospital or skilled nursing care
- If the member goes into the hospital after one benefit period has ended, a new benefit period begins
- There is no limit to the number of benefit periods

Medicare Billing

SNF Inpatient Revenue Codes and Bill Type

- Use this information to report services for extended care furnished to inpatients of a Medicare certified SNF:
  - Patients must require daily skilled care on an inpatient basis.

Medicare Billing

SNF Outpatient Revenue Codes and Bill Type

- Physical therapy, speech language pathology services and occupational therapy are subject to the SNF Part B consolidated billing requirement and must be billed by the SNF for its Part B residents on a 22x type of bill.

Medicare Billing

SNF Outpatient Revenue Codes and Bill Type

- SNF residents falling below Medicare skilled LOC may be moved to the Medicare non-certified area of the facility.
- These residents are no longer subject to the SNF consolidated billing rule and therapy services may be billed directly to Medicare by the provider or if billed by the SNF, and submitted on a 23x type of bill.

Medicare Billing

SNF Outpatient Revenue Codes and Bill Type

- If the entire facility qualifies as a Medicare-certified SNF, all Part B therapies must continue to be billed by the SNF on a 22x type of bill.

Medicaid Billing

Swing Bed Inpatient Revenue Codes and Bill Types

Revenue Codes	Type of Bill
0101	21x
0160	
0169	
0183	
0185	
0189	
0220	

- Revenue Codes 183 and 185 (Therapeutic Leave/Bed-Hold Type of Bill 28X days and Hospitalization Leave) exclude PA1/PA2 Acuity level
- Long Term Care facility room and board claims do not require procedure (CPT/HCPCS) codes.

Medicare Part A does not cover the costs of custodial care.

For Skilled Nursing Facilities, billing a custodial level of care revenue codes 12x and 19x are invalid.

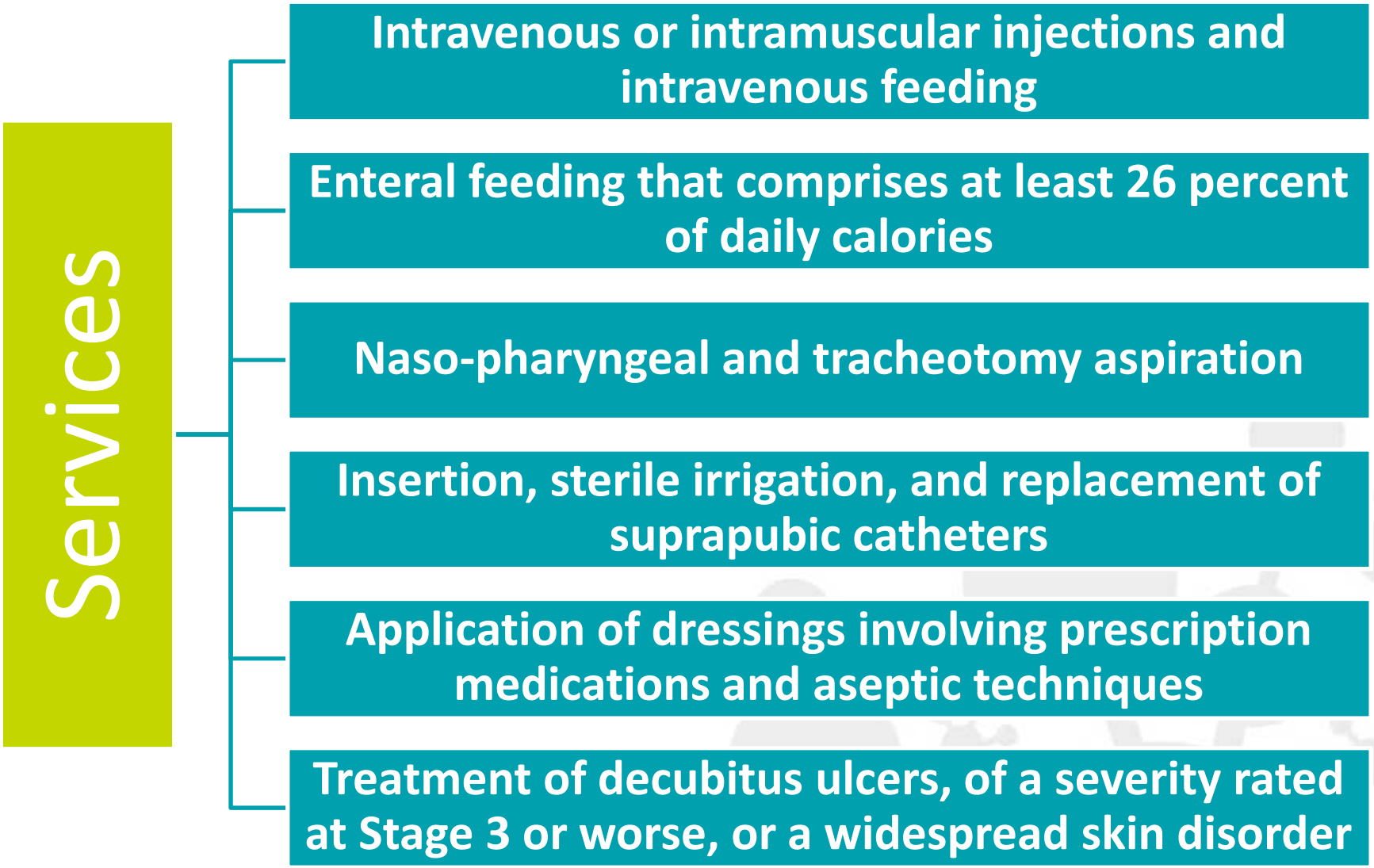
Skilled Nursing Services

Nursing services are considered skilled when:

1)They are inherently complex and can only be safely and effectively performed by or under the supervision of a registered nurse, or

2) When, provided by regulation, a licensed practical (vocational) nurse supervises the service

Direct Skilled Nursing Services



MOLINA HEALTHCARE
Your Extended Family

Bed Hold Days

A bed hold day, or "NF leave day," is when a bed is reserved for an NF resident while he or she is temporarily absent from the NF for one of the following reasons:

- **Hospitalization**
- **Therapeutic leave days**
- **Visitation with friends or relatives**

Payment for NF bed hold days are only made if the resident has the intent and ability to return to the same NF. This resident is not considered discharged from the NF.

Bed Hold Days

Revenue Code 0183 or 0185, bed hold 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

SNF processing rules

- Day of admission is counted when calculating days.
- Day of discharge is not counted if it is the final day of the stay based on type of bill submitted.
- Claims will continue to be paid up to the date of discharge during the process of transitioning the member out of the facility.

SNF processing rules

- If a member is admitted and discharged on the same day, it is counted as one day.
- Bed holds (revenue codes 0183, 0185) are not to be reserved for more than 30 days per calendar year.
- 0185 is for hospital leave, 0183 is for therapeutic leave (reference OAC rule).

Occupied Day

NF “occupied day" means one of the following:

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

Reimbursement

The SNF is required to reserve a bed for a maximum of 30 days in any calendar year. Reimbursement for bed hold days is based on the individual SNF's occupancy rate the previous calendar

Occupancy Rate	Reimbursement at Facility's Per Diem Rate
95 percent or below	18 percent
Greater than 95 percent	50 percent

Acuity Level

If the patient had an acuity level of PA1 or PA2, then bed hold days are not reimbursable.

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

0183= therapeutic leave

0185 = hospital leave

Bill type: 43X, 21X-23X

MOLINA HEALTHCARE
Your Extended Family

Out-of-Home Respite

These services are delivered to individuals in an out-of-home setting, giving respite for the usual caregivers. The service must include an overnight stay, and the provider must make the following services available:

- **Waiver nursing**
- **Personal care aide services**
- **3 meals per day that meet the consumer's dietary requirements**

MOLINA HEALTHCARE
Your Extended Family

Out of Home Respite Limits

- Cannot be reimbursed separately
- Services and the provider must be identified on the waiver services plan
- Does not include services performed in excess of what is approved pursuant to the waiver services plan
- Do not duplicate coverage provided under the State plan or EPSDT services

Provider Type: Nursing Facility (NF) and other institutional providers (e.g., hospitals, etc.)
License: NF Licensure per OAC rule 5126-3-02
Facilities should bill HCPCS Code H0045 for this respite service.

MOLINA HEALTHCARE
Your Extended Family

Patient Liability (PL)

PL is the amount a Molina Dual Options member is required to pay toward the cost of LTC in nursing facilities, Hospice, assisted living and certain services from a community based provider. The following are examples subject to patient liability:

Medical Institution	Long-Term Care Facility
• Intermediate Care Facility for Mentally Retarded (ICF-MR)	• Home and Community Based Waiver Service (HCBCS)

Patient Liability (PL)

Patient liability applies to both opt-in and opt-out members in a custodial care setting.

The amount varies based on the income of the member and can change on a monthly basis as determined by ODM.

It applies to the first nursing facility claim received for the month.

If not satisfied with the first claim, the remaining patient liability should be applied to subsequent SNF claims for dates of service during the same month until the total amount is satisfied.

Patient Liability (PL)

If the Hospice and SNF are billing a partial month, then PL applies to the first claim received for the month.

A Hospice and SNF should not be billing room and board for the same date of service. It should be billed directly to Molina Healthcare.

All services that apply to PL reduction of claim payment may be applied to multiple claims in the month if the amount paid is less than the total monthly PL.

Patient Liability Disputes

Patient liability changes based on cost of living increases or changes by the County Department of Job and Family Services (CDJFS).

- Providers may dispute the amount of patient liability applied to a claim and prorated patient liability.
- To change it, a provider must submit an approved ODM JFS 09401 Form or a Cost of Living Allowance (COLA) Form with a Claim Reconsideration Form. Find the Patient Liability Form at www.MolinaHealthcare.com/Providers/OH.
- The standard dispute timeframe for claim reconsiderations is 120 days.
- All impacted claim(s) will be adjusted to reflect the revised patient liability amount.

Lump Sums

- Members who receive a lump sum of money (e.g. estate settlement, lottery winnings)can choose to spend down the lump sum in lieu of losing Medicaid eligibility.
- The member's amount is maintained by the provider and submitted on the claim form with the value code 31 "Patient Liability Amount."
- The lump sum must be taken on the claim after any applicable patient liability amount.

***Note: Lump sum payments are not monthly amounts. They are applied from date of creation until amount is exhausted.**

Prior Authorization Information

Nursing Facility Admission

Pre-certifications

The majority of pre-certifications are through the discharge planning process, when a member in need of post-acute nursing facility care is identified.

Molina Healthcare's Care Review Clinicians contact the acute inpatient facilities directly. Molina Healthcare assists with the discharge process and timely nursing facility admissions.

Prior Authorization Information

Requests for nursing facility admissions are reviewed and determined within 24 hours.

Molina Healthcare accepts next business day notification for members emergently admitted after normal business hours.

Clinical information is needed to support the admission.

MOLINA HEALTHCARE
Your Extended Family

Prior Authorization

Q: Who is responsible for calling in the requests for pre-certification?

A: The nursing facility is responsible for contacting Molina Healthcare to get precertification.

The hospital's discharge planner will work with Molina Healthcare to find a facility for the member.

The discharge planner should instruct the facility to call Molina Healthcare for the precertification.

MOLINA HEALTHCARE
Your Extended Family

Continued Stay Authorizations

Molina Healthcare requires:

- Skilled Nursing LOC: Notification every seven days or sooner, if clinical presentation changes
- InterQual Skilled Nursing guidelines used to determine medical necessity for skilled nursing stays
- Custodial Nursing LOC for LTC members who live in the nursing facility:
  - Notification required every six months or sooner, if the member moves to a skilled LOC
  - Molina Healthcare will reach out to your facility to confirm the original date of admission the LOC

Continued Stay Authorizations

Molina Healthcare requires ongoing contact for clinical updates depending on the member's LOC as follows:

- Contact Molina Healthcare for authorization when any therapies (physical, occupational or speech) billed under the member's Part B benefit are implemented
- For Hospice LOC, notification is only available every six months; no medical necessity review is required with a physician's order.

Medicare Part B Letter of Non-Coverage

According to the MyCare Ohio member handbook, members receiving services from the following must receive a Notice of Medicare Non-coverage (NOMNC) at least two calendar days before a Medicare - covered service is scheduled to end:

- Home health agencies (HHAs)
- Comprehensive outpatient rehabilitation facilities (CORFs)
- Skilled nursing facilities (SNFs)

Medicare Part B Letter of Non-Coverage

- Providers are responsible for delivering this notice.
- The NOMNC gives members access to a fast Medicare appeals process designed to prevent inappropriate termination of services or discharge from a facility.

The process was implemented in a 2003 litigation settlement and is not waived as part of the MyCare Ohio demonstration.

MOLINA HEALTHCARE
Your Extended Family

Medicare Part B Letter of Non-Coverage

- **If Medicare rules require the NOMNC only when Medicare-covered services are terminating, the rules don't apply to reductions in services.**
- **If the "Medicare-covered" portion of the benefit is ending, and the service is not being continued under the Medicaid benefit, the NOMNC should be issued.**
- **If the end of the "Medicare-covered" portion of the benefit results in reduced services, issue a NOMNC, specify how the member's services are changing and that a discharge or service termination is not occurring.**

Medicare Part B Letter of Non-Coverage

- If the “Medicare-covered” portion of a benefit ends, but the “Medicaid-covered” portion of the benefit provides unchanged coverage for the member, the NOMNC should not be issued.

- If a member is receiving skilled services beyond the usual 100 day benefit period for Medicare, do not issue the NOMNC if termination is on day 105. The NOMNC is not issued when a Medicare service is exhausted.

- In the context of the MyCare Ohio demonstration, there are circumstances where the NOMNC should be tailored or not be issued.

Assisted Living

The assisted living waiver pays for care in an assisted living facility for certain people with Medicaid, so that the individual uses his or her resources to cover “room and board” expenses.

Services Provided	Billing	Bed Hold Days
• Assisted living services • Community transition (for nursing facility residents only)	• Services must be billed on a CMS 1500 claim form and requires the correct HCPCs and modifier on every claim	• Bed hold days are not billable for assisted living waiver members

Assisted Living

Nursing and skilled therapy services are incidental, rather than integral, to the provision of the assisted living service.