Nursing Home Helpful Hints for Billing

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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 within 90 days of submission to HP
b) LTC eligibility update within 90 days of submission to HP

Long Term Care Eligibility

Long Term Care Eligibility can be viewed in the Healthcare Portal on the EOHHS website.
https://www.riproviderportal.org

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 skill level. If it does not match your expectation, contact your LTC worker.

Skill Level –Type of Bill

Verify skill level in IWS web portal:

Bill Type	Explanation
210	Days 1-20. Medicare free days. Although there is no Medicaid payment, these days must be billed to set up payment for Medicare Co-insurance days.
253	Days 21-99. Medicare Co-Insurance days.
263	Day 100+ . Medicaid only days
Hospice	Only the Hospice provider can submit claim for recipient under Hospice care.

RUG Pricing Methodology

Effective 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

- If the RUG code changes during the month, the code that is on file as of the 15th of the month will be used to process the claim for that month.
- If only one RUG code is effective for the entire length of service on the claim, that RUG code will be utilized.
- If multiple RUG codes are effective in a given 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.

MDS Assessment

- If a recipient's length of stay is expected to be less than 14 days, an assessment is required at 5 days, consistent with Medicare guidelines.
- If a recipient's acuity changes status, a new MDS assessment should be submitted, marking add in Field A0050 with a value of 1 (add new record) and marking 4 in Field A0310A (significant change in status assessment).

Patients who are re-admitted after a discharge assessment require a new MDS assessment only if they are due for a OBRA MDS assessment or meet the qualifications for a significant change in status or acuity upon return to the facility.

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 we allow, claim will be “paid” at zero.
- If the other insurer paid less than we allow, we 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 in the event that 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

008
Recipient Number Missing or Invalid

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

Corrective Action

- Validate MID reporting on Remittance Advice is the correct MID for the recipient
- Validate the MID in the Interactive Web Services (IWS) on the EOHHS website
- If MID does not come up in the IWS, 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 EOHHS website, re-bill with the corrected information

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 Interactive Web Services (IWS) 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

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

Corrective Action

- Validate LTC eligibility in IWS
- 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, re-bill claim

Common Denials

230

Service not covered for this recipient

Corrective Action

- Verify eligibility for this recipient in IWS
- If recipient is in Rhody Health Partners or Rhody Health Options, contact the appropriate Rhody Health Plan

Common Denials

270
Bill type inconsistent with LTC authorization

The type of bill you are billing is not valid for the skill level as identified in interactive services

Corrective Action

- Validate skill level in IWS for the Dates of Service you are billing
- If the skill level is correct, re-bill with the correct type of bill
- If the skill level is not correct, contact your LTC worker
- Once it is corrected, re-bill with the corrected information
- Skill level:
  - Skilled (Medicare) – Allowable bill types are 21* and 25*
  - Non-skilled (Medicaid) – Allowable bill type is 26*

Common Denials

633
Gap in Billed Days

All approved days are not accounted for in the billing

Corrective Action

- Validate eligibility for month you are billing
- If eligibility is for the whole month and you are only billing a portion:
  - Validate eligibility is correct
  - If eligibility is not correct and the recipient was not there for the whole month, contact your LTC worker
  - If eligibility is correct, re-bill including all dates of service

Example of 633- Gap in Billed Days

- DOS billed 01/15/15-01/31/15 – type of bill 253
- LTC eligibility in IWS shows recipient eligible for skilled care for 01/01/15-01/31/15
- If LTC eligibility is correct, and you are only looking for co-ins days for 01/15/15-01/31/15, then you must submit a claim for:
  - 01/01/15-01/14/15 as a 210
  - A second claim for 01/15/15-01/31/15 as a 253
- If LTC eligibility is not correct and the recipient should not be eligible until 01/15/15
  - Contact your LTC worker so they can update the eligibility
  - Once that is completed, you can re-bill

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 paper

- 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 by HP if the claim submitted was for an entire month (i.e.: 01/01/15-01/31/15)
- Liability adjustments will happen on the NH adjustment financial (usually the 2nd financial of the month), the month following the update
- If claim was for entire month, you do NOT have to send in a request to have the claim reprocessed
- If claim was not billed for entire month (i.e.: 01/01/15-01/10/15 & 01/11/15-01/31/15), 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

Adjustments and Recoups - *continued*

Split Billing of Claims

Some situations require one claim to be divided into 2 claims

Example: Recipient is skilled 11/01/14-11/30/14
Claim was billed and paid 11/01/14-11/30/14 as 253 (co-insurance)

Claim should have been billed
as 210 from 11/01/14-11/10/14 (Medicare free days)
as a 253 from 11/11/14-11/30/14
You can submit
An adjustment to change paid claim to be 11/01/14-11/10/14,
changing the type of bill to a 210
Then you must submit a new claim for 11/11/14-11/30/14
as a bill type 253

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

Provider Responsibilities

Stay current with RI Medicaid and CMS initiatives

Claim submission by deadline every month
(Generally on a Thursday at noon)

Use the website www.eohhs.ri.gov to receive updates:
Provider re-validation, ICD-10, Provider Electronic Solutions (PES) Upgrades, monthly *Provider Updates*, etc..

Download Remittance Advices **EVERY** financial
(Only 4 most current are available for download)

Helpful Links

Healthcare Portal

https://riproviderportal.org

PAYMENT AND PROCESSING SCHEDULE

http://www.eohhs.ri.gov/ProvidersPartners/BillingampClaims.aspx

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 deborah.meiklejohn@hp.com. Put **subscribe** in the subject line of your email.*

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	401-784-3805
Kelly Leighton	Provider Services Manager	401-784-8013

Thank you