

# Nursing Home Helpful Hints for Billing

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**Hewlett Packard**  
Enterprise



# Agenda

- **Timely Filing**
- **LTC Eligibility**
- **Skill level**
- **Rug pricing methodology**
- **MDS**
- **Other insurance billing**
- **Common edit**
- **Common denials**
- **Adjustments and recoups**
- **Refunds**
- **Provider responsibilities**
- **Helpful links**

# 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 Hewlett Packard Enterprise (HPE)
- b) LTC eligibility update within 90 days of submission to HPE
- c) RUG updates in the system within 90 days

# 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 Healthcare 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	Days 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](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 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 15<sup>th</sup>, the one effective on the 15<sup>th</sup> will be utilized.
- If the Date of Service on the claim does not span the 15<sup>th</sup>, the RUG code on the “To” date of service will be utilized.

# 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 Medicaid allows, claim will be “paid” at zero.
- If the other insurer paid less than Medicaid allows, it 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 Healthcare Portal on the EOHHS website
- If MID does not come up in the portal, 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 Healthcare Portal 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 the Healthcare Portal
- 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 the Healthcare Portal
- 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 the Healthcare Portal

## Corrective Action

- Validate skill level in the Healthcare Portal 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 01/15/16-01/31/16 – type of bill 253
- LTC eligibility in Healthcare Portal shows recipient eligible for skilled care for 01/01/16-01/31/16
- If LTC eligibility is correct, and you are only looking for co-ins days for 01/15/16-01/31/16, then you must submit a claim for:
  - 01/01/16-01/14/16 as a 210
  - A second claim for 01/15/16-01/31/16 as a 253
- If LTC eligibility is not correct and the recipient should not be eligible until 01/15/16
  - Contact your LTC worker so they can update the eligibility
  - Once that is completed, you can re-bill

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# Rhody Health Partners and Medicaid Expansion

- Claims for beneficiaries admitted to nursing facilities who are enrolled in Rhody Health Partners or Medicaid Expansion plans must be submitted to the primary coverage for the first 30 days of a skilled visit.
- Days 31+ are billed to RI Medicaid FFS.
- When claims are received by RI Medicaid, they will suspend with 670 (Recipient has other insurance on date(s) of service) while they are researched to determine if the first 30 days were paid by the primary carrier.
- The claims will then be processed to pay or deny, based on the findings.
- Please allow two financial cycles for the process to be completed.

# 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 HPE if the claim submitted was for an entire month (i.e.: 01/01/16-01/31/16)
- Liability adjustments will happen on the NH adjustment financial (usually the 2<sup>nd</sup> 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.: 01/01/16-01/10/16 & 01/11/16-01/31/16), 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 11/01/15-11/30/15  
Claim was billed and paid 11/01/15-11/30/15 as 253 (co-insurance)

**Claim should have been billed**  
as 210 from 11/01/15-11/10/15 (Medicare free days)  
as a 253 from 11/11/15-11/30/15

**You can submit**  
An adjustment to change the paid 253 claim to dates of service  
11/11/15-11/30/15,  
Then you must submit a new claim for 11/01/15-11/10/15  
as a bill type 210

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](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

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# Provider Responsibilities

Check recipient eligibility on the first of every month  
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](http://www.eohhs.ri.gov) to stay up to date:  
Provider Revalidation, 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>



PROVIDER UPDATES –  
posted monthly on the 1<sup>st</sup> of  
every month

<http://www.eohhs.ri.gov/News/ProviderNewsUpdates.aspx>

*To receive the Provider Update electronically, send an email to [deborah.meiklejohn@hpe.com](mailto:deborah.meiklejohn@hpe.com).*

*Put **subscribe** in the subject line of your email.*

# Contact Information

<b>Customer Service Help Desk</b>	<b>First line of contact for eligibility or claims inquiry that you were not able to determine after consulting the website.</b>	<b>401-784-8100 (For local and long distance calls) 800-964-6211 (in-state toll calls)</b>
Marlene Lamoureux	Provider Representative	401-784-3805
Kelly Leighton	Provider Services Manager	401-784-8013

# Thank you