Don’t Let Your Billing Be Managed By Managed Care
June 29, 2015

<table>
<thead>
<tr>
<th></th>
<th>Fee-for-Service (FFS)</th>
<th>Managed Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who does Medicare or Medicaid pay?</td>
<td>Pays each provider for each service rendered</td>
<td>Pays a flat monthly fee (capitation) to insurance plan</td>
</tr>
<tr>
<td>Who does provider bill?</td>
<td>Provider bills Medicare or Medicaid directly</td>
<td>Bills the Managed Care plan which pays from a monthly capitation rate from Medicare or Medicaid</td>
</tr>
<tr>
<td>Providers available</td>
<td>Any provider who accepts the insurance</td>
<td>Only providers in the insurance plan’s network</td>
</tr>
<tr>
<td>Permission needed for services?</td>
<td>Sometimes. Medicaid – need approval for PCS, CDPAP, etc. but not all medical care</td>
<td>Often. Plan may require authorization to see specialists or for many services. May not go out of network.</td>
</tr>
<tr>
<td>Policy – incentive to give too much/little care?</td>
<td>Incentive to bill for unnecessary care offset when authorization is needed for services</td>
<td>Plan has incentive to DENY services and keep part of capitation rate for profit</td>
</tr>
<tr>
<td>What package of services is available?</td>
<td>All Medicare and Medicaid services</td>
<td>Package of services may be “partial” (MLTC) or “full” (PACE = all Medicare and Medicaid services</td>
</tr>
</tbody>
</table>
Medicare Advantage
• Since 2010 national enrollment increased by 30%
• May 2015: NYS had 1.2 million enrollees (37% penetration)
  ✓ 15 counties with < 25% penetration
    o Clinton, Cortland, Dutchess, Essex, Franklin, Nassau, Orange, Otsego, Putnam, Rockland, St. Lawrence, Sullivan, Tompkins, Ulster and Westchester
  ✓ 11 counties with > 50% penetration
    o Bronx, Erie, Genesee, Livingston, Monroe, Niagara, Ontario, Orleans, Wyoming and Yates

Medicaid Managed Care
• MLTCP – Managed Long Term Care Plan
  ✓ Long term care and home care services
  ✓ Medicare or Medicare Advantage stays in place
• MA – Medicaid Advantage
  ✓ Includes Medicare services but has Medicaid coverage without LTC
• MMCP – Medicaid Managed Care Plan
  ✓ Managed care version of Medicaid
  ✓ Mandatory for most Medicaid recipients – dual eligibles are excluded
  ✓ Now covers LTC
Medicaid Managed Care

- MAP – Medicaid Advantage Plus
  - Traditional insurance model for age 18+, intensive case management model
  - If required to enroll in MLTC may choose to enroll in a MAP
  - Must enroll in the plan’s Medicare product
  - Long term care and health services coverage

Medicaid Managed Care – NY State April 2015

- Managed Long Term Care
  - MLTC PACE – 8 Plans over 12 counties; 5,451 enrollees
  - MLTC Partial Cap – 32 Plans over all counties; 123,552 enrollees
  - Medicaid Advantage
    - 7 Plans in 25 counties; 3,764 enrollees
    - 9 Plans in NYC; 5,325 enrollees
  - Medicaid Advantage Plus
    - 5 Plans in 7 counties; 415 enrollees
    - 9 Plans in NYC; 5,640 enrollees
  - Medicaid Managed Care and NYSOH
    - 16 plans; 4,553,222 enrollees
### Managed Long Term Care Phase-In

<table>
<thead>
<tr>
<th>Month</th>
<th>County</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 1, 2015</td>
<td>New York City – Bronx, Kings, New York, Queens, Richmond</td>
</tr>
<tr>
<td>April 1, 2015</td>
<td>Nassau, Suffolk, Westchester</td>
</tr>
<tr>
<td>July 1, 2015</td>
<td>All other counties</td>
</tr>
<tr>
<td>October 1, 2015</td>
<td>Voluntary enrollment in Medicaid managed care becomes available to individuals residing in nursing homes who are in fee-for-service Medicaid</td>
</tr>
</tbody>
</table>

### Managed Care Options

#### Options if ONLY have Medicare OR Medicaid

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Fee for Service</th>
<th>Managed Care Model</th>
</tr>
</thead>
</table>
| **Have MEDICARE only** | Regular Medicare  
  • Original Medicare  
  • Part D plan  
  • Medigap (optional)** | **Medicare Advantage** plan usually covers Part D  
  • Voluntary but ~30% of Medicare beneficiaries join  
  • Pros: Cheaper than a Medigap premium and controls other out-of-pocket costs  
  • Cons: Must be in-network and obtain plan approval** |
| **Have MEDICAID only** | Regular Medicaid – only for people **excluded or exempt** from managed care (spend down, transitioning to Managed Care, etc.) | **Medicaid Managed Care**  
  • Mandatory for non-dual eligibles  
  • Covers primary, acute and long term care |
# Managed Care Options

## Options for Dual Eligibles

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Fee for Service</th>
<th>Managed Care Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IF DON’T NEED LONG TERM CARE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid &amp; Medicare (dual eligibles)</td>
<td><strong>Medicare</strong></td>
<td><strong>Medicaid Advantage</strong> – voluntary. Combines Medicare Advantage with Medicaid managed care plan in ONE. If in Medicaid Advantage can not join an MLTC.</td>
</tr>
<tr>
<td></td>
<td>• Original Medicare</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Part D plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Medigap (optional)</td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF NEED LONG TERM CARE SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid</td>
<td><strong>Medicaid</strong></td>
<td><strong>MLTC</strong> – Mandatory for most dual eligibles. Primary &amp; acute care thru Medicare, with CHOICE of Original Medicare/Part D or Medicare Advantage plus Medicaid through MLTC</td>
</tr>
<tr>
<td></td>
<td>• Medicaid card – only for primary, acute care</td>
<td><strong>Medicaid Advantage Plus (MAP) or PACE</strong> – voluntary option replaces all Medicare, Medicaid and MLTC coverage in ONE plan (full capitation)</td>
</tr>
</tbody>
</table>

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“Ready to walk the Reimbursement Maze?”
Discussion Points

• Pre-Billing
  ✓ Contracting considerations
  ✓ Credentialing
  ✓ Enrollment
  ✓ Insurance verification
  ✓ Authorizations

• Billing Department Changes
  ✓ Department re-design
  ✓ Clearinghouse
  ✓ Resident Fund Services
  ✓ Billing Calendar

• Billing and Post Billing
  ✓ Billing format
  ✓ Billing system
  ✓ Timely filing
  ✓ Appeals
  ✓ Payment accuracy

• Other Considerations
  ✓ Communication
  ✓ Clinical implications

Pre-Billing
Contracting

- Many facilities not prepared to handle contract reviews
- Many facilities don’t know what rate to ask for or to accept
  - Identify contracting spokesperson and team – include billing, nursing, prior authorization, medical department, etc.
  - Many key departments / staff don’t know what they need to know about signed contracts – poor communication and policies
  - The Bonadio Group working with groups across NY State to form IPA’s for Medicaid Managed Care (which includes contract review)
    - Non-IPA related contract reviews can be done as well

Contracting – Rates

- Medicare Advantage
  - Negotiated per diem rates or Medicare rate
- Commercial Plans
  - Negotiated rates
    - “Pay lesser of daily rate or billed UCC rate”
- Medicaid Managed Care
  - Rate – 3 year current FFS (benchmark) rate or negotiated rate
  - Must be increased if it falls below current benchmark rate
  - If previously negotiated rate: pay benchmark during transition unless other arrangement is agreed to

Does your billing department know what the rate should be?
Contracting – Pharmacy

• Medicaid Managed Care

✓ Unless otherwise negotiated: “During transition MCO must accept NH’s current arrangement with pharmacies for residents placed in the NH post 8/1/14.”
  - If a resident is receiving a pharmaceutical not on MCO formulary (s)he can continue to receive it for 60 days post enrollment into plan
  - Reimbursement covered thru Medicaid pharmacy program and therefore billed outside of benchmark rate (Medicaid only residents)
  - Benchmark continues to include OTC, J-codes, medical supplies, nutritional supplements, sickroom supplies, adult diapers and DME (Medicaid only residents)
  - Benchmark continues to include immunization services inclusive of vaccines and administration (Medicaid only residents)

Contracting – Bed Hold Methodology

• Medicaid Managed Care

✓ Bed hold methodology – unless otherwise negotiated, MCO required to follow current Federal/State Medicaid bed hold regulations (CFR 483.12 and 10YCRR 415.8 and 18NYCRR 505.9) – prior authorization may be required

<table>
<thead>
<tr>
<th></th>
<th>Reimbursement</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOA temporary hospitalization / health care professional therapeutic</td>
<td>50%</td>
<td>Not to exceed 14 days in any 12 month period</td>
</tr>
<tr>
<td>LOA non-hospitalization / health care professional therapeutic</td>
<td>95%</td>
<td>Not to exceed 10 days in any 12 month period</td>
</tr>
</tbody>
</table>

Must have been resident for at least 30 days and unit to which recipient will return has a vacancy of no more than 5%
Contracting – NAMI Collection

- Medicaid Managed Care
  - Initial implementation shifts responsibility to MCO and MCO may delegate it to NH or other entity
    - Should be outlined/agreed to during contracting
    - Make sure you have an internal process in place if agreement is different than the current norm
    - LDDS will notify plan and NH of NAMI amount when re-budgeting is complete
    - Long term plan – State or designee will assume financial and operational responsibility to distribute NAMI and collect NAMI income

Contracting – Billing / Payment Cycle

- Medicare Advantage and Commercial
  - Billing cycle – monthly
  - Payment cycle – payer specific
  - Remittance retrieval options – payer specific

- Medicaid Managed Care
  - Billing Cycle – MCOs have indicated a willingness to allow the submission of clean claims at least every 2 weeks (bi-weekly) or twice a month
    - Not generally mentioned in provider/billing manuals – don’t make assumptions
    - Does billing department needs to change current process?
  - Payment cycle – payer specific
  - Remittance retrieval options – payer specific
Credentialing

• Medicaid Managed Care

✓ In order to minimize administrative burdens on NHs and MCOs it was decided that NHs must adhere to Federal and State laws as it relates to credentialing staff
  o Laws are difficult to find – some related laws:
    ➢ Title 10 – Nursing Homes - Minimum Standards (Section 415.26 - Organization and administration) and Medical Services (Section 415.15)
    ➢ Article 28 PBH – Section 2805-K

✓ DOH recommended that MCOs consider delegating credentialing to NH’s and “should minimize additional credentialing requirements”. If delegated:
  o MCO must have process to verify that the NH has completed the required credentialing

Credentialing – NCQA Standard and Guidelines

• NCQA (National Committee for Quality Assurance) sets “THE” standards

• http://www.ncqa.org/tabid/404/Default.aspx
  ✓ Credentialing Policies (CR1)
  ✓ Credentialing Committee (CR2)
  ✓ Initial Credentialing Verification (CR3)
  ✓ Application and Attestation (CR4)
  ✓ Initial Sanction Information (CR5)
  ✓ Practitioner Office Site Quality (CR6)
  ✓ Recredentialing Verification (CR7)
  ✓ Recredentialing Cycle Length (CR8)
  ✓ Ongoing Monitoring (CR9)
  ✓ Notification to Authorities and Practitioner Appeal Rights (CR10)
  ✓ Assessment of Organizational Providers (CR11)
  ✓ Delegation of Credentialing (CR12)
Credentialing – What to include?

- What criteria should be reviewed and what are the standards?
  - Valid and current licensure
  - Clinical privileges
  - Valid DEA
  - Appropriate education and training
  - Board certification
  - Appropriate work history
  - Malpractice insurance
  - History of liability claims

Credentialing Process

- Typically includes
  - Application (credentialing form)
  - Initial Screening (for completeness)
  - Site Visit
  - Primary Source Verification (PSV)
  - File Preparation (for presentation to Credentialing Committee)
  - Data Entry (in MCOs credentialing database)
  - Decision (to accept or reject application)
  - Re-credentialing
Re-credentialing

- Re-credentialing includes reviewing information from:
  - National Practitioner Data Bank (NPDB)
  - State Board of Medical Examiners
  - Medicare/Medicaid programs regarding sanctioning
  - Complaints
  - Quality Improvement/Utilization Management activity reports
  - Medical records reviews
  - Attestations from practitioner regarding his/her ability to perform the essential functions of the position and use of illegal drugs
  - Verify from the primary source the information that was checked at the time of credentialing

Credentialing – Organizational providers

- Overview of credentialing organizational providers
  - MCO must have policies and procedures for initial and ongoing assessment of organizational providers with whom it contracts
  - MCO must confirm provider is
    - In good standing with state and federal regulatory bodies
    - Has been reviewed and approved by an accrediting body
      - If not approved – must implement standards of participation
  - As per model contract between MCO and State: MCO must re-credential provider at least every three years by confirming the above
Delegated Credentialing

• What part is supposed to be delegated to the NH?
  ✓ Portion of the credentialing process, such as primary source verification (PSV) or just recredentialing?
  ✓ Multiple processes such as collection and review of the application and PSV?
  ✓ All credentialing activities?

• MCO must evaluate NHs ability to perform the activities

• Need mutually agreed upon document describing MCOs responsibilities vis-à-vis the delegated entity

• MCO must annually evaluate delegated entity’s performance

Delegated Credentialing

• Questions to ask yourself

  ✓ Do you really want to do delegated credentialing?
  ✓ Can you meet delegation requirements?
  ✓ Will you sub-delegate?
    o Contract with a third party to perform a delegated function
      ➢ PSV can be delegated to a CVO (Credentials Verification Organization)
      ➢ If CVO is NCQA certified:
        ➢ NH/MCO is exempt from due-diligence oversight
If Not Delegated Credentialing

- Is CAQH UPD (Council for Affordable Quality Healthcare Universal Provider Datasource) utilized by payer?
- What providers will need to be credentialed?
- Do you have contracts for professional services and will those providers need to be credentialed and become participating providers?
  - Who is responsible for ensuring credentialing is completed?
- Quality scores will most likely be requested during facility credentialing/re-credentialing
- Will Medicare Advantage/Commercial plans change to delegated credentialing?

Credentialing – Internal Considerations

- Who will complete forms and monitor credentialing progress?
  - Time consuming – Already overworked staff?
  - If other department (not billing) – must communicate status with billing
- Understand contract/payment implications of rendering care before credentialing is completed:
  - If payer will back date:
    - Enter charges and hold claims, OR
    - Wait to enter charges – will they get lost?
  - If payer won’t back date:
    - Render care knowing no payment?
Credentialing – Community PCP

- Medicaid Managed Care
  - Enrollees may keep PCP when transitioning from community
  - NH is responsible for credentialing or granting privileges but MCO is responsible to credential all providers participating in the plan
    - If NH won’t: resident may see PCP in PCP’s office in community
  - All MMCP enrollees must have a PCP and enrollees may retain their community PCP. MMCP may use the NH physician but must inform DOH and ensure that the NH physician follows network responsibilities.
  - A transitioning resident may see their PCP for 60 days if the PCP is an out of network PCP.

Enrollment – New Eligible/Not in a Medicaid MCO

- Coming from home to NH: Apply for Medicaid following all current regulations, including physician recommendation, PASRR process, Patient Review Instrument (PRI), etc.
- LDSS has 45 days to complete determination for long term Medicaid eligibility
- Once approved and any penalty period has elapsed and NAMI amount is identified resident has 60 days to choose an MCO
- NY Medicaid Choice (Maximus) will assist in education, plan selection and enrollment (in a plan with which the nursing home contracts)
- Auto enrolled if not select
- No lock-in so enrollment may change
Enrollment – Already Medicaid MCO Enrolled

- MCO must authorize all long term placements and pay the NH while long term eligibility is being conducted by LDDS
- NH and MCO assist with submitting documentation to LDDS
- Member has 90 days from date long term placement is determined to submit the application for coverage of long term custodial placement to the LDSS
- LDSS will notify MCO, enrollee and NH
  - If eligible – MCO keeps paying NH and NAMI is collected
  - If ineligible – MCO recoup payment from NH and coordinate safe discharge into the community

Enrollment – Medicaid Managed Care Other Considerations

- If a permanent NH FFS resident (prior to date of mandatory managed care) is hospitalized and ineligible for NH bed hold, upon return the resident will be viewed as a new permanent placement and will be required to enroll in a managed care plan
- Medicaid re-certifications – the resident or designated representative is still responsible for submitting a Medicaid recertification. NHs and MCOs are encouraged to assist.
  - “If an enrollee does not appear on the plan’s 1st or 2nd roster the plan is not obligated to pay the nursing home”
Enrollment – Internal Considerations

• How do you track open enrollment changes?
• How will you track initial Medicaid managed care enrollments?
• How will you track enrollment changes?
  ✓ Provider must check eligibility at the time of service and before billing
  ✓ Who?
  ✓ Develop policies and procedures and provide staff training
  ✓ Failure to track will likely result in the inability to bill correct payer
  ✓ Will payer provide a roster?

Insurance Verification

• Medicare, Medicare Advantage Plan, Medicare Part D, Supplemental Plans, Medigap, Commercial Plans, Medicaid, Medicaid Managed Care, Medicaid Long Term Care
• Dual Eligible with original Medicare, Medicare Part D, Medigap and MLTC will have 5 insurance cards
Insurance Verification

• Medicaid Managed Care Internal Considerations
  - Provider must check eligibility at the time of service and before billing
    - Currently may not be checking eligibility before billing Medicaid
    - Is this going to be a new process?
    - Will you do it for all payers?
    - Who is going to do it?
    - What resources will they use?

Insurance Verification

• How to verify
  - ePACES / WMS / Plan Rosters
    - Carefully look at eligibility and Restriction/Exemption codes (institutional Medicaid, spend down)
    - Follow up as needed
  - Medicare Common Working File
    - Check for each resident – not just Medicare Part A admissions
    - CWF isn’t always correct – follow up on inconsistencies
  - Payer websites or phone calls to each insurance
  - Clearinghouse insurance verification portal
Insurance Verification

- Best Practice Suggestions
  - Staff training
  - Identify type of coverage (MA, MLTC, Dual Advantage, MAP, etc.) AND name of plan (to be able to easily reference payer manuals)
  - Document every call/contact in your billing system
  - Complete verification before admission and billing

Authorization Requirements – Admission

- Medicare Advantage and Commercial
  - Authorization is generally required
    - Revenue Code level or Level of Care
- Medicaid Managed Care
  - If enrolled in a plan, MCO must authorize all long term care placements and will pay the NH while long term eligibility is being conducted by LDSS
  - Authorization is generally required
Authorization Requirements

- UAS-NY assessment completed by Medicaid MCO – required when individual enrolls in a plan and every 6 months thereafter or when significant change in condition occurs
  - MCO required to compare the UAS-NY assessment needs with the MDS assessments conducted by NH and consider both when authorizing services, equipment and supplies
  - The care plan, MDS, UAS-NY, medical record and input from care management team will provide the MCO with the information needed for authorization of services
  - Although reassessment using UAS-NY is required at above schedule, MCOs may authorize for shorter time periods

Authorization Requirements

- All Managed Care
  - Always verify if an authorization is needed and for what services – admissions, routine services, supplies, equipment, etc.
  - Payers may require authorizations for some plans but not others
    - You will need to know type of plan to know authorization requirements
  - Document contact person and telephone numbers for future authorization extensions and reassessments
  - When is re-authorization required? What form? Portal or paper?
  - Can current staff handle the increase in work due to Medicaid Managed Care?
  - Coordination between billing and prior authorization staff
    - When/how/does billing get the authorization number?

**Authorizations will become more complicated and time consuming**
### Billing Format – Revenue Code

- **Medicare Advantage and Commercial**
  - Billing formats may vary

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Excellus Medicare Advantage and Commercial</th>
<th>UHC EverCare</th>
<th>MVP</th>
</tr>
</thead>
<tbody>
<tr>
<td>191</td>
<td>Skilled Nursing</td>
<td>Level I</td>
<td>Level A – Continuing Care</td>
</tr>
<tr>
<td>199</td>
<td></td>
<td>Level Ia</td>
<td></td>
</tr>
<tr>
<td>192</td>
<td>Sub-acute Therapy</td>
<td>Level II</td>
<td>Level B – Low Rehab</td>
</tr>
<tr>
<td>193</td>
<td>Sub-acute Rehabilitation</td>
<td>Level III – Intensive Service Delivery</td>
<td>Level C – High Rehab</td>
</tr>
<tr>
<td>194</td>
<td></td>
<td></td>
<td>Level D – Medically Complex</td>
</tr>
</tbody>
</table>
Billing Format – Revenue Code

- Medicaid Managed Care
  - Uniform billing codes addressed in budget
  - Law requires standard billing codes by January 1, 2016

<table>
<thead>
<tr>
<th>Description</th>
<th>Fidelis Care at Home Revenue Code</th>
<th>Healthfirst Revenue Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Hold – Temporary Hospitalization</td>
<td>0185</td>
<td>0185</td>
</tr>
<tr>
<td>Bed Hold – Therapeutic LOA</td>
<td>0183</td>
<td>0183</td>
</tr>
<tr>
<td>Bed Hold – Other Therapeutic LOA</td>
<td>0189</td>
<td>N/A</td>
</tr>
<tr>
<td>Room and Board + Ancillary Services</td>
<td>0190, 0191, 0192, 0193</td>
<td>0100 (all inclusive custodial &amp; respite)</td>
</tr>
<tr>
<td>Room and Board Only</td>
<td>0190, 0191, 0192, 0193</td>
<td>0100 (all inclusive custodial &amp; respite)</td>
</tr>
</tbody>
</table>

Billing Format – Rate

- What rate is used?
  - Medicare or Medicaid Rate
  - Negotiated Per Diem
  - UCC (Usual and Customary Charge)
  - Pays lesser of daily rate or billed UCC rate
Billing Format

• Every new format creates added work
  ✓ Set up like another payer or plan?
  ✓ Which revenue codes?
  ✓ What rate?
  ✓ Which modifiers?
  ✓ Itemized or just R&B?
  ✓ Excluded services?

Billing Format

• Medicaid Managed Care
  ✓ Claim format may be similar to Medicaid format because rate code is required
  ✓ Claim format may be similar to HMO because authorization number is required

• Look at each plan and determine if a new claim format needs to be built
  ✓ Requires testing

Maintain a binder in the billing office with examples of claims that show how to bill different services under each payer and plan
Billing System

- Consider the structure/design of your billing system
  - Example: If only have Fidelis as a financial class it may be insufficient because there may be multiple Fidelis plans (not just MLTC plans) in your area and each plan is likely to have different claim requirements
  
  ✓ How does system handle rate variations within the same plan for level of care billing (higher rates for additional therapy utilization or nursing care)?
  
  ✓ Can rates be loaded so contractual adjustments calculated at billing will result in $0 balance when payment is posted?
    - Are contractual allowances correct for each plan/payer?
      - If incorrect — relies on billing to know if paid correctly and requires additional time at payment posting to enter contractual adjustments

Billing System

- Can my billing system easily produce a “clean” claim?
  - How many human interventions are needed to get a clean claim?

- Electronic or paper submission? Direct Data Entry (DDE)?
  - All Medicaid MCOs must be able to accept electronic claims

- Medicaid Managed Care
  - Need to submit multiple batches of claims to multiple payers – no longer just 1 weekly batch to Medicaid
  - More time needed for submission and acceptance monitoring

- Can system produce payer and plan specific billing reports?

- Need to focus on structure, tables, dictionary modifications?
Timely Filing

- Know timely filing requirements for each payer
  - Most payers have a 90 day timely filing requirement
- Bill at least monthly – no later than the 15th
- Bill as often as payer will allow
- Maximize billing and payment cycle
  - For Example: Medicaid Cycle
    - Start date = Thursday, 6/25/15
    - End date = Wednesday, 7/1/15
    - Check date = Monday, 7/6/15 (2 business days after end date)
    - Check release date = Wednesday, 7/22/15 (3 weeks after end date)

Timely Filing

- Medicaid Managed Care
  - Changes in billing cycles and submissions will alter your cash flow
  - Plan for increased time spent on follow up
    - Medicaid is straight-forward and ePACEs makes it easy to check status and determine next steps
    - Not all payer sites will be as useful and phone calls will be necessary
- Keep all claims alive with follow up
  - Document every submission, mailing, phone call, etc.
  - No more than 30 days between follow up attempts
  - Verify receipt of claim – acceptance reports, fax confirmation, registered mail
## Appeals

<table>
<thead>
<tr>
<th>Payer and Plan</th>
<th>Appeals/Disputes/Reconsiderations (on-line Provider Manuals)</th>
</tr>
</thead>
</table>
| **Fidelis Care**                 | Medical necessity appeal - Submit within 60 days  
Administrative denial reconsideration (timely filing, co-insurance, eligibility, lacking pre-auth, other errors on claim, underpayments) – Submit within 60 days  
Timely filing – penalty of up to 25% may be imposed |
| **WellCare**                     | Timely filing, incidental procedures, bundling, unlisted procedure codes, non-covered, etc. – Submit within 6 years of the date of denial |
| **VNSNY CHOICE – MCare and MCaid Advantage Plans** | Disputes resulting from claim adjustments or denials:  
Standard reconsideration request – denial of payment or medical necessity – per contract |
| **VNSNY CHOICE – Medicaid MLTC** | Disputes resulting from claim adjustments or denials:  
Standard reconsideration request – denial of payment or medical necessity – per contract  
Request for denial of payment due to claim coding – Submit within 90 days  
Request for denial of payment due to no authorization – Submit within 90 days |

### Appeals

- Know each payers appeal process for each type of appeal
  - Time limits
  - Specific forms
- Review your process for each type of appeal
  - Who gathers the necessary documents?
  - Who submits?
  - Who monitors status?
  - Are outcomes shared with all?
    - Are you learning from denied appeals?
Payment Accuracy

- Are claims being paid correctly?
  - Know what you should be paid
- Develop process to ensure payments are correct
  - Payment exception reports, random sampling, follow up on outstanding balances
  - Review staff handling of underpayments/overpayments
    - Updated rates needed in billing system?
    - Don’t automatically write off as a contractual allowance
Payment Accuracy

- Underpayment Concerns
  - Losing out on money

- Overpayment Concerns
  - Are you sure it’s not your money?
  - Refunds required – processing costs time and money
    - Issue check?
    - Request retraction
    - Recoup from future remittance

Billing Department Changes
Staff Re-Design

- Current silo structure may become ineffective
  - Medicaid Managed Care
    - May be too much work for one person to handle
    - Medicare Advantage/Commercial blurring into Medicaid Managed Care
  - Consider alpha-split or shift additional FTE to Medicaid managed care billing

Clearinghouse

- Implement a clearinghouse
  - Vendor that serves as a middleman between facility and payer for claims submission and payment processing
  - Improves efficiency and facilitates other valuable revenue cycle services
    - Can “fix” numerous claim formatting issues
      - Claim scrubbing, insurance verification, resident statements, on-line resident payment processing, etc.
  - Conduct cost – benefit analysis
Resident Fund Services
• Resident Fund Management & Direct Deposit Management
  ✓ Direct Deposit
  ✓ Automated care cost payments and resident allowance retention
  ✓ Direct debits from family member accounts at any bank to pay for care
  ✓ Automatic return of direct deposits when a resident expires or transfers
    o National Datacare Corporation
    o Built into some EMR/Billing Systems

Billing Calendar
• Make modifications to billing calendar
Other Considerations

Communication – Internal

• Inter-departmental – must understand key components of plan and how they impact reimbursement and resident care/coordination

• Contract, provider manuals, billing manuals available to all key players

• Develop summary page of each plan
  ✓ Need to keep updated
Communication – External

- Families
  - Enrollment status updates
  - NAMI collection

- Payers
  - Make sure you are assigned a provider representative
  - Develop a *partnership* with each payer representative
  - Hold regular meetings
  - They would much rather help up front than deal with you when you are frustrated

Clinical Implications – Medicaid Managed Care

- Authorizations/notifications for transfers and other care services (routine, elective, urgent)
  - Clinical staff will have to coordinate with payer case manager for many more residents
  - Significant increase in time

- Coordination with vendors/suppliers
  - More time required to coordinate coverage and benefits

- Clinical Appeals
  - More time spent by clinical, HIM, others

- Documentation changes needed?
Andrea Hagen, Director

Bonadio Receivable Solutions, LLC
171 Sully’s Trail
Pittsford, NY 14534

Office (585) 662-2270
Cell (585) 967-3716

ahagen@bonadio.com

www.bonadio.com/brs
**EXCELLUS MEDICARE ADVANTAGE PLAN**

PO BOX 22999
ROCHESTER, NY 14692

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- **Level of care billing required**
- **Was there a qualifying hospital stay?**
- **Ancillary services required**
- **Authorization required**

**Will this claim pay?**

---

**EXCELLUS MEDICARE ADVANTA**

**00804**

**MA1173032**

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**038746-SN-001**

**0214**

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**Creation Date:** 041415

**Total:** 6979.43
MVP Healthcare  
Claims Submission  
PO Box 1083  
Schenevuctady, NY 12301

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Non level of care billing  
ARD date required  
Is this active skilled care?  
How many coinsurance days?  
Authorization required  
Will this claim pay?

0001  PAGE 1 OF 1  CREATION DATE 031715  TOTALS 12834.20

MVP Health Insurance 14165  5402.74

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**Certifications:**

- The certifications on the reverse apply to this bill and are made a part hereof.
AETNA
P O BOX 981106
EL PASO, TX 799981106

Non level of care billing required

What is ARD?

Is there a qualifying hospital stay?

How many covered days versus coinsurance days?

Authorization required

Will this claim pay?

Aetna

0001  PAGE 1  OF 1  CREATION DATE  031715  TOTALS  13289.75

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