DHS: SENIORS AND PEOPLE WITH DISABILITIES

Administrator Alert

Policy updates & rule clarifications for Assisted Living, Residential Care & Nursing Facilities

Office of Licensing & Quality — Oregon Department of Human Services

March 24, 2010

NURSING FACILITY COMPLEX MEDICAL ADD-ON BILLING AND OVERSIGHT

Dear Administrator,

Please share this Administrator Alert with the person responsible for billing and for oversight of the Medicaid Complex Medical Add-On Nursing Facility services.

<u>Please note:</u> Even if you do not bill Complex Medical Add-On Services, this Alert will affect your billing process if any of the facility's usual and customary charges are above the contracted rates.

In December 2009, the Complex Medical Add-On Program completed a Rapid Process Improvement (RPI) as part of the DHS Transformation Initiative. The RPI was a collaborative effort with the nursing facility industry and the Department, and together we looked at the steps the nursing facility and complex medical unit must go through to allow a nursing facility to receive complex add-on payment. The goals of the RPI was to increase efficiency, minimize or eliminate duplicate or unnecessary steps, ensure the nursing facility receive timely payment, and ensure program integrity.

On December 23, 2009, an Administrator Alert with a standardized Excel spreadsheet was sent out. The Alert requested facilities submit their outstanding account receivables for Medicaid residents identified by the facility to meet CMAO criteria, with dates of service between

November 1, 2008 – December 31, 2009, for which the facility was either not reimbursed, or was reimbursed at the Basic rate.

An outcome of the RPI was to identify ways to change CMAO to a post-payment review process. We have carefully considered processes to work through the aging complex medical reports, through use of MMIS, to work toward our goal of a total post-payment review process. As part of this work, DHS has identified a temporary solution to allow facilities the ability to receive payment in a more efficient manner.

Effective immediately DHS has implemented the following temporary solution change within MMIS:

- Increased the max allowable for the basic rate in MMIS to match the CMAO rate on a temporary basis so providers can bill for CMAO and get paid for CMAO without requiring the CMAO Unit to change the level of care manually.
- The temporary solution will be in place from March 24, 2010 through May 31, 2010.

Effective immediately facilities can submit claims or claim adjustments for Medicaid residents, identified by the facility to meet CMAO criteria, for which the facility was either not reimbursed according to facility records, or was reimbursed at the Basic rate.

- Facilities will be allowed to submit claims or claim adjustments for their outstanding account receivables for Medicaid CMAO residents, with dates of service between November 1, 2008 – December 31, 2009.
    - For any dates November 1, 2008 – June 30, 2009, the facility must use the correct rate schedule for the complex medical rate. (see Attachment A)
    - For any dates July 1, 2009 to current, the facility must use the correct rate schedule for the complex medical rate. (see Attachment B)
    - Please note, if you go into MMIS to check eligibility, the MMIS will not necessarily have breaks in the eligibility date segments. This will not affect claims processing while this temporary solution is in place.

  - For any outstanding account receivables prior to November 1, 2008, the facility must email the Complex Medical Unit at complex.medical@state.or.us
  - Facilities should no longer request transitional payments for complex medical.

- The temporary solution will also apply to those Medicaid residents, whose needs were identified by the facility to meet CMAO criteria for dates of service between January 1, 2010 – May 31, 2010, for which the facility was either not reimbursed, or was reimbursed incorrectly at the Basic rate.
- Facilities will be responsible to bill accurately and according to the CMAO criteria outlined in OAR 411-070-0091.
- Facilities must continue to submit completed Weekly Complex Medical Add-On Reports as required via fax.
  - Please do not include supporting documentation with the Weekly CMAO report. Please refer to the following link for further information: http://www.oregon.gov/DHS/spd/provtools/admin_alert/091210.pdf

- Facilities must continue to maintain the required documentation in the medical record per OARs 411-070-0027(3), 411-070-0091, and make it available upon request.
- These claims will be subject to post payment review and recovery if any overpayment(s) are determined. Post payment review information will be obtained through paid CMAO claims, record review, facility spreadsheets, and/or facility weekly reports.

As part of this temporary solution, it is imperative **the provider must be responsible for ensuring and monitoring the following:**

- **General Billing:** Providers accurate bill with strict adherence to the CMAO criteria and documentation outlined in OAR 411-070-0091.
- **DHS Contracted Rate:** Billing at or below the DHS contracted rate for the appropriate level of care as determined by the provider.
- **Usual and Customary Charges:** Providers will no longer be able to bill usual and customary charges for the basic rate if it is above the DHS contracted rate.

  - This temporary solution increases the basic rate in MMIS. Providers with usual and customary charges above the basic rate therefore would be inappropriately paid above the DHS contracted rate for basic. **Note: If this occurs, the provider is responsible and MUST immediately adjust the claim to reflect the DHS contracted rate.**
- **Level of Care Changes:** The provider must submit a new claim for paper billing, or a new detail line for electronic billing, each and every time there is a change in the resident's level of care. Although the MMIS will allow providers to bill CMAO days and basic days on one paper claim, or on one detail line on the web, DHS policy is that these claims **MUST** be broken up based on changes in the level of care.

  - Example: Resident is at the facility for the entire month of January 2010. The resident met CMAO criteria from 1-1-10 through 1-10-10.
  - If submitting a paper claim, the provider must submit 2 paper claims; one for 1-1-10 through 1-10-10, and one for 1-11-10 through 1-31-10.
  - If billing electronically through the web portal, the provider can submit two separate claims (with the dates noted above); or one claim with header dates as 1-1-10 through 1-31-10 and two separate detail lines, 1-1-10 through 1-10-10 and 1-11-10 through 1-31-10, using the corresponding charges based on the DHS contracted rates.
- **Spreadsheets for Outstanding Claims:** If you have not submitted a report of all outstanding CMAO claims, you must submit that to the Complex Medical Unit before you bill for these claims. These spreadsheets will be used to audit your claims and must be complete and accurate. Please refer to the following links for additional information.
  http://www.oregon.gov/DHS/spd/provtools/admin_alert/091223.pdf
  http://www.oregon.gov/DHS/spd/provtools/admin_alert/091223-spdsht.xls

As we continue to move toward a more streamlined Complex Medical program, nursing facilities will be informed of program changes through Administrator Alerts. Please refer to the following link if you'd like to subscribe to receive automatic notices of Alerts.
http://www.oregon.gov/DHS/spd/provtools/newsletters.shtml#aa