

Administrator Alert

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

Office of Licensing & Quality — Oregon Department of Human Services

September 2, 2011

NURSING FACILITY COMPLEX MEDICAL ADD-ON BILLING

Dear Administrator,

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

Effective May 2011, a new Complex Medical Add-On (CMAO) reporting process was established for providers to submit CMAO monthly reports and supporting medical documentation in order to receive payment for CMAO services. A new CMAO billing process was also put in place at that time for providers to use Revenue Code **229** (CMAO Rate \$295.59 minus Basic Rate \$212.12 = \$83.47) for billing CMAO activity.

We were successful in implementing our internal review processes and establishing Revenue Code 229 as a supplemental rate described above. Unfortunately, CMAO claims are not consistently paying from the MMIS correctly.

In order to prevent further payment delay, we have taken the following steps effective immediately:

- Nursing facility providers may bill for Medicaid residents identified by the nursing facility to meet CMAO criteria for dates of service provided on or after May 1, 2011.
 - Facilities will use Revenue Code 100 to bill the Basic Rate for Medicaid residents.
 - In addition, facilities may use Revenue Code 229 to bill the CMAO rate.
- Facilities **no longer** need to submit completed Monthly CMAO Reports or supporting documentation via fax or email.
- The Department will no longer enter Revenue Code 229 in the MMIS Plan of Care for CMAO dates of service.



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What does this mean? For dates of service occurring on or after May 1, 2011, Nursing Facilities may continue to bill the Basic Rate using Revenue Code 100 for all Medicaid residents. The facility may also bill Revenue Code 229 for an additional CMAO rate (currently \$83.47 per day) if the client meets CMAO criteria.

The Department will be evaluating alternative options for ensuring CMAO billing integrity in the future.

The provider is responsible for ensuring and monitoring the following:

- Providers must verify a resident's Medicaid eligibility and long term care eligibility, and ensure a Medicaid eligibility Plan of Care (POC) is in place prior to billing.

Please note, if you go into MMIS to check eligibility, MMIS will not necessarily have breaks in the eligibility date segments. This should not affect CMAO claim or claim adjustment processing.

- Providers are responsible for accurate billing with strict adherence to the CMAO criteria and documentation outlined in OAR 411-070-0091.
- 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.
- All claims are subject to post payment review, and recovery if any overpayment determined.

For CMAO claim questions please call Vivien VanHatten, DMAP Provider Services at 503-947-5368 or email Vivien.VanHatten@state.or.us For CMAO questions regarding OAR criteria and required documentation call Becky Callicrate, SPD Program Analyst at 503-945-5714 or email Becky.Callicrate@state.or.us

