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Managed Long Term Care (MLTC)

The Billing Perspective

Bonadio Receivable Solutions, LLC has been a division of The Bonadio Group since 2008

The Bonadio Group is the only independent accounting firm with a division that specializes in accounts receivable management

What have we learned from Managed Care (Medicare Advantage Plans)?

- Since 2010 – national enrollment increased by 30%
- In 2013 included14.4 million Medicare beneficiaries or 28% of the Medicare program's enrollment
  - ✓ Resident Access = Contracting
  - ✓ Credentialing
  - ✓ Insurance verification
  - ✓ Prior-authorizations
  - ✓ Resource Utilization Group-based at Managed Care Rates or Daily Rates or Levels of Care
  - ✓ Understand plan requirements
  - ✓ Communication

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Resident Access = Contracts

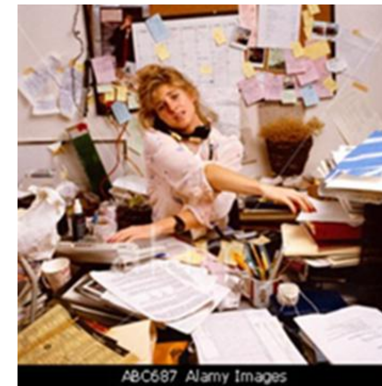
- Residents are no longer limited to those facilities that accept Medicare/Medicaid
- Requires participation by nursing home with specific payers
- ~75% of nursing homes in NY participate in one or more MMCP (non-residential and residential contracts)
- MMCP's select which nursing homes to contract with and will likely contract for residential services with homes with which they already have a contractual relationship

Resident Access = Contracts

- Per DOH: MMCP Network Requirements
  - ✓ 8 – Queens, Bronx, Suffolk, Kings, Erie, Westchester, Monroe
  - ✓ 5 – New York, Richmond
  - ✓ 4 – Oneida, Dutchess, Onondaga, Albany
  - ✓ 3 – Broome, Niagara, Orange, Rockland, Renesselaer, Chautauqua, Schenectady, Ulster
  - ✓ 2 – All other counties (or 1 if only one NH in the county)
- Out of network coverage options are required
  - ✓ Reimbursed at FFS rate

Credentialing

- Contracts will likely require credentialing
  - ✓ MMCP will credential NH but will “minimize additional NH requirements”
  - ✓ Are professional services billable or included in rate? Use vendors?
  - ✓ Who bills for professional services?
  - ✓ Will facility contracted providers be required and willing to participate with payers?
  - ✓ Is CAQH UPD (Council for Affordable Quality Healthcare Universal Provider Datasource) utilized by payer?
  - ✓ Will billing office complete forms and monitor credentialing progress?
    - Time consuming
    - Already overworked billing staff



Insurance Verification

- Medicare, Medicare Advantage Plan, Supplemental Plans, Commercial Plans, Medicaid, Medicaid Managed Care
- Medicare Common Working File
  - ✓ Need to check for each patient – not just Medicare admissions
  - ✓ CWF isn't always correct – follow up on inconsistencies
- Contact and verify <u>each</u> insurance
- Document every call/contact in your billing system
- Verification completed before admission
- Prevents submission to wrong payer and untimely filing

Prior-Authorization

- ALWAYS verify if an authorization is needed and for what services (routine and/or elective)
- Can be very time consuming
- Payer requirements change and payers may require prior-auths for some plans but not others
- Document contact and telephone numbers for future prior auth extensions and reassessments
- Document every call/contact
- Coordination between billing and prior-auth staff
  - ✓ When/how/does billing get the authorization number?
- Don’t just write off claims denied for no authorization
  - ✓ Attempt to obtain a retroactive authorization

How has time spent on prior authorizations changed?

86% Spend significantly more time

12% Spend somewhat more time

2% Stayed about the same

Source: Responses to *Urology Times* online survey, December 2013

Rates / Reimbursement

- MMCP must reimburse at either the:
  - ✓ Benchmark rate (fee-for-service)
  - ✓ Negotiated rate that is agreed to by both parties
- Reimbursement agreement until:
  - ✓ April 1, 2017 (Phase 1 counties)
  - ✓ January 1, 2018 rest of state
  - ✓ Afterwards, negotiated rate
- "As an emergency stop gap when there are unavoidable billing problems between MMCP and NH, the Department can eliminate or temporarily reduce the 2 week lag."

"Ready to walk the Reimbursement Maze?"

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Rates / Reimbursement

- Pharmacy excluded from FFS rate
  - ✓ During 3 year transition MMCP to honor current NH/Pharmacy arrangements
  - ✓ Residents to transition to formulary, if possible, within 60 days
- Bed Holds
  - ✓ Current methodology unless alternative is negotiated
    - Reimbursed @ 50% - hospitalizations
    - Reimbursed @ 95% - non-hospital
- NAMI
  - ✓ MMCP required to collect but can delegate to NH
  - ✓ Distribution of Personal Needs Allowance handled via contract

Enrollment

- Auto-assign
  - ✓ New enrollees have 60 days from LT Medicaid eligibility to select plan
  - ✓ If not will be auto-enrolled in plan nursing home contracts with
  - ✓ NY Medicaid CHOICE assists with education, selection and enrollment
- How will you track enrollment?
  - ✓ Who?
  - ✓ Schedule?
  - ✓ Develop P&P
  - ✓ Failure to track will result in in-ability to bill correct payer

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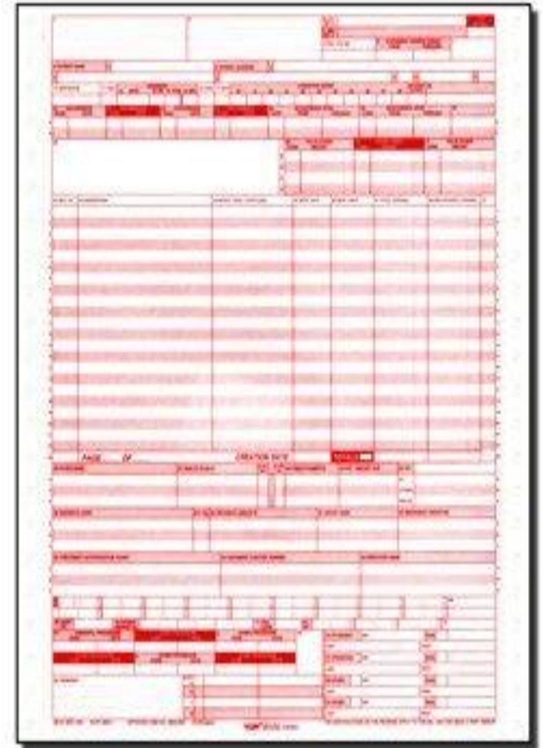
Understand the Plan/Contract

Billing Format Considerations

- Billing Format
  - ✓ Bill like Medicare or insurer specific format?
  - ✓ UB-04 for all services or CMS1500 for professional?
    - New CMS1500 form effective 4/1/14
  - ✓ Traditional revenue codes?
  - ✓ What rate – Usual and customary or negotiated?
  - ✓ Which modifiers? Which CPT / HCPCS codes?
  - ✓ What gets itemized? Just a room/board line?
  - ✓ What are the exclusions and if/how they get billed?
  - ✓ Are physician services billed?
  - ✓ Remits: Standard remittance advice remark codes?



- Maintain a file/binder in the billing office with valid examples of how to bill different claims under different contracts

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Understand the Plan/Contract

Billing System Considerations

- Billing Systems
  - ✓ Can my billing system easily produce a “clean” claim?
  - ✓ How many human interventions are required to get a clean claim?
  - ✓ Electronic or paper submission?
  - ✓ Can rates be loaded so accurate contractual adjustments are calculated at billing leaving a zero balance when payment is posted?
  - ✓ How does system handle rate variations within same plan, i.e., higher rates for additional therapy utilization?
  - ✓ Can system produce payer and plan specific billing reports?

Understand the Plan/Contract

Billing System Considerations

- Billing Systems Continued
  - ✓ Clearing House
    - Does my clearinghouse submit to this payer?
    - What payer ID is used?
    - Can my clearinghouse submit claims in required format?
  - ✓ Can system perform electronic billing and payment posting?
- Invest time/money in billing system to save even more time/money

Understand the Plan/Contract

Timely Filing Considerations

- Timely Filing
  - ✓ Know timely filing requirements
  - ✓ Easiest way to file timely - Bill Monthly!
    - Claims should be sent by the 15th of the following month
  - ✓ Keep claims alive through follow up
    - Document every submission, mailing, phone call, letter, etc. in the billing system
    - Make sure claim is received – fax, registered mail, deliver in person, clearinghouse acknowledgement reports
    - Appeal before write off if claim denied for timely filing and claim has been kept alive

Understand Plan/Contract

Ongoing Authorization Considerations

- Ongoing Authorizations
  - ✓ When updated?
  - ✓ What forms are used?
  - ✓ What triggers a reassessment?
  - ✓ Is there a portal or other electronic method used?
  - ✓ What department oversees the authorizations?
  - ✓ Does/when/how billing department get/need/use the authorization?

Understand the Plan/Contract
Appeals

- Know each payer's appeal process
  - ✓ Time limits
  - ✓ Specific forms
- Internal Process
  - ✓ Who gathers necessary documents?
  - ✓ Who submits?
  - ✓ Who monitors progress?
  - ✓ Report final decision to interested parties?
    - What can be learned from denials?

Understand Plan/Contract

Comparison of On-line Billing Manuals

	MLTC #1	MLTC #2	MLTC #3
Prior Auths	SNF, services outside of daily rate		
Timely Filing	120 days 121+ = up to 25% reduction 365 days max	30 days preferred; up to180 days Interim: within 90 days after last day of the month Final: within 90 days of last date of service	90 days after end of month
Appeals	45 days	45 days	90 days
Clearinghouse		Emdeon Only	
COB Claims		Within 18 months of date of service	90 days from primary EOB
Rate Codes			Specific rate codes
Rates			MCAID: Bill current rate attach NYSDOH rates and "Ineligible for Medicare Benefits" Form
Bed Hold			Up to 20 days

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Communication
Internal

- Inter-departmental: Admissions, Clinical, Case Management, Billing, HIM/Med Rec
  - ✓ All must understand key components of plan and how each impacts facility
    - Assessment changes but billing not informed = over/under billing
- Contract, provider manual and billing manual for each plan easily accessible to entire billing department
  - ✓ Develop summary page of key components for each plan
  - ✓ Updates – who/when/how?

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Communication

External

- Families
  - ✓ Enrollment status
  - ✓ Patient costs (NAMI) and time frames for payment
- Vendors
  - ✓ When to bill facility vs MMCP
    - Potential for additional reconciliation of services vs invoicing
- MMCP
  - ✓ Provider representative assigned to NH?
  - ✓ Billing training provided?
  - ✓ Ask questions – don't assume you know the answers

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Current Issues Impacting Billing Operations

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Does your billing department...

- Have a denial management program?
  - ✓ When worked?
  - ✓ Tracked/reported?
  - ✓ Reported to whom and what is done with information?
- Review and work electronic reports?
  - ✓ Claims submitted to clearinghouse vs claims received/rejected by clearinghouse vs claims received/rejected by payers
- Reconcile EFT's to remittances?
  - ✓ Post to system before $ is actually received?
  - ✓ How reconciled?
- Understand ICD10 Implementation and its role?
  - ✓ Oct 1, 2015

ICD-10

1. Planning

- 6 – 8 weeks
- Cross-functional team
- Detailed time line
- Risk Assessment
- Budget

2. Communication

- Plan
- Collaborate (team effort)
- Tools/Checklists
- Information dissemination
- Evaluate current vendors

3. Testing

- Hardware/Software
- Identify test data
- Identify test scenarios
- Conduct internal and external testing

4. Training

- Plan
- Evaluate knowledge
- Type of training (based on role/responsibility)
- Educational resources
- Documentation improvement opportunities

ICD-10 – Billing Involvement

- Planning
  - ✓ Billing representation on cross-functional team
  - ✓ Risk assessment: include billing system, EMR/clinical, registration, test ordering, therapy, others
  - ✓ Budget should include a 3 – 6 month post implementation financial impact
- Communication
  - ✓ Is billing system vendor ready?
  - ✓ Where does billing get codes – therapy vendors, physicians, HIM/Med Rec?
    - Are clinicians trained/ready?
  - ✓ Determine billing staff current ICD-9/10 knowledge
  - ✓ Review policy determinations (LCD's) and plan to re-review after updated with ICD-10 codes

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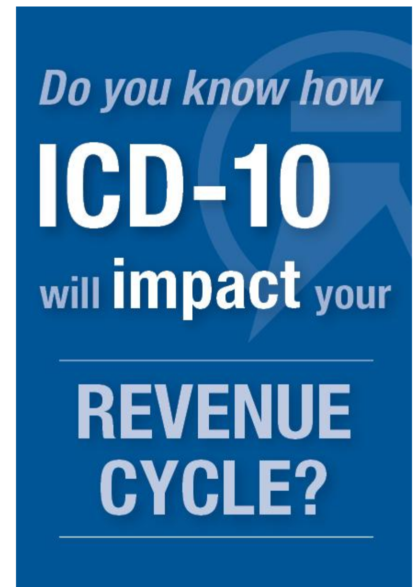
ICD-10 – Billing Involvement

- Testing
  - ✓ Payers have announced testing schedule
  - ✓ Need ICD-9 and 10 simultaneously (ICD-10 is date of service 10/1/14)
  - ✓ Internal – can you create a claim? External – can you submit a claim?
  - ✓ Test file data – include all payers if possible
  - ✓ Test scenarios
    - Room and Board
    - Therapy, ancillary, etc.
    - Professional
    - 3 – 7 digit ICD10 codes
  - ✓ Develop a claims submission contingency plan
    - Manual claim entry in FISS, ePACES, other proprietary?



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