Frequently Asked Questions – LTC Cost Avoidance Implementation

Information posted February 25, 2013

Frequently-asked questions for Long-Term Care (LTC) Cost Avoidance, which is being implemented on February 22, 2013, are provided below for provider reference.

For questions not addressed below, the Texas Medicaid & Healthcare Partnership (TMHP) LTC Operations department (800-626-4117, Option 1) will respond to individual and provider LTC-related phone inquiries and problems regarding LTC cost avoidance claims processing and adjudication assistance. TMHP Third-Party Liability staff will have the tools to help providers determine when a policy is not LTC-Relevant; for questions related to the Other Insurance (OI) information on file at TMHP call 800-626-4117, Option 6, to speak with the TMHP Third-Party Liability (TPL) department.

1. Where can I find information about LTC Cost Avoidance?

Information about LTC cost avoidance can be found in the following LTC Information Letters:

- June 25, 2012 - No. 12-59, Cost Avoidance Project for Texas Department of Aging and Disability Services Long-Term Care
- October 26, 2012 - No. 12-82, Status of the implementation of the Cost Avoidance Project
- January 10, 2013 - No. 13-04, Implementation of the Cost Avoidance Project – February 2013

Providers should monitor the LTC homepage at www.tmhp.com/Pages/LTC/ltc_home.aspx for future information notices.

Information from the Texas Administrative Code can be found online:

- Texas Administrative Code 40 TAC §19.2609 NURSING FACILITY
- Texas Administrative Code 40 TAC §30.60 HOSPICE
- Texas Administrative Code 40 TAC §9.219 ICF-ID

2. Where can I get training?

TMHP Training Services Group has provided comprehensive cost avoidance training for the Long-Term Care (LTC) Provider Community by updating the current TexMedConnect computer-based training. For more information visit:
www.tmhp.com/Pages/Education/Ed_Home.aspx

3. What about Other Insurance and Medicare eligibility information on the MESAV (Medicaid Eligibility Service Authorization Verification)?

The Texas Medicaid & Healthcare Partnership (TMHP) maintains the insurance policies for Long-Term Care individuals. If you have questions related to the Other Insurance information on file at TMHP, call 800-626-4117, Option 6, to speak with the TMHP Third-Party Liability (TPL) department. When calling the Help Desk you will need to provide your NPI (National Provider Identifier) and TPI (Texas Provider Identifier) to validate your identity.

4. Do I have to submit a claim to the Long-Term Care-Relevant other insurance if I think the policy will not cover the service?

Yes. All Long-Term Care Medicaid claims (including Nursing Facility Daily Care, intermediate care facilities for individuals with intellectual or developmental disabilities [ICF/IID], Non-State Community Residential, and Hospice Nursing Facility [NF] - ICF/IID Room & Board) must first be filed with any existing other insurance (OI) that has been determined to be Long-Term Care-Relevant in the Texas Medicaid Health Partnership (TMHP) other insurance (OI) database. There is no exception to this requirement when the policy is categorized as a Medicare supplement. If the OI is determined to be LTC-Relevant, then that OI is a "probable" liability as indicated in 42 CFR, Subpart D, § 433.139(b) (1).

Refer to 42 CFR, Subpart D, § 433.139(b) (1):

If the agency has established the probable existence of third-party liability at the time the claim is filed, the agency must reject the claim and return it to the provider for a determination of the amount of liability.

If the claim is denied by the other insurance because the policy does not cover the service billed, LTC will require providers to bill the insurance policy as a once-a-year requirement only.

Providers must allow 110 calendar days to elapse after the date the claim was submitted to the third party before submitting the claim to Medicaid with an Other Insurance Disposition of No Response.

LTC will require that providers file Medicaid charges with any and all LTC-Relevant OI. If the OI response in regards to a Medicare supplement to the Medicaid daily care charges is "not a covered service," that OI denial response will be active for one year before another bill to the OI

is necessary. This is consistent with state law in Section 32.04242 of the Human Resources Code.

Sec. 32.04242. PAYOR OF LAST RESORT. The executive commissioner of the Health and Human Services Commission shall adopt rules to ensure, to the extent allowed by federal law, that the Medicaid program:

(1) is the payor of last resort; and

(2) provides reimbursement for services, including long-term care services, only if, and to the extent, other adequate public or private sources of payment are not available. Added by Acts 2011, 82nd Leg., R.S., Ch. 821, Sec. 1, eff. June 17, 2011.

5. When a hospice submits billing for Medicaid room and board, it is a pass-through payment for hospice and reimbursed to the facility. In the event a patient has insurance, can you please clarify if it is the responsibility of the nursing home or of the hospice to bill this insurance?

Effective February 2013, the Texas Medicaid & Healthcare Partnership (TMHP) Claims Submission and Processing systems will be updated to detect the existence of third-party insurance policies for individuals served by Long-Term Care (LTC) in nursing facilities, hospice, and non-state-operated intermediate care facilities for persons with intellectual or developmental disabilities (ICF/IIDs).

The insurance company claim disposition will be required for the Texas Medicaid claims to be submitted on your clients beginning in February 2013. Lack of Other Insurance claim dispositions will result in denied Medicaid claims.

The Hospice provider submitting a Medicaid claim via TexMedConnect or American National Standard Institute (ANSI) X12 is required to submit a claim to the third-party insurance on file for the client to determine the liability of the third-party payor. The provider is also required to keep all documentation of actions taken to determine the amount of third-party liability on file.

6. If the other insurance denies the claim because the policy does not cover the service billed, do I have to resubmit that claim on a weekly/monthly basis to keep getting the same denial?

No. If the claim is denied by the other insurance because the policy does not cover the service billed, LTC will require providers to bill the insurance policy as a once-a-year requirement only. The other insurance billed date can be used for 365 days.

Example: Provider files a Daily Care claim with other insurance on 3/1/2013 for dates of service 2/22/2013-2/28/2013. Other insurance sends a response on 3/10/2013 that the policy does not cover Daily Care. The provider does not have to resubmit the claim to other insurance for March 2013 dates of service.

To file the February 2013 claim with Medicaid, the provider will enter:

- Dates of service 2/22/2013-2/28/2013
- OI Disposition – Denied
- OI Disposition Reason – Not a Covered Service
- OI Billed Date 3/1/2013 (this date is good for 365 days)
- OI Disposition Date 3/10/2013

To file the March 2013 claim with Medicaid, the provider will enter:

- Dates of service 3/1/2013-3/31/2013
- OI Disposition – Denied
- OI Disposition Reason – Not a Covered Service
- OI Billed Date 3/1/2013 (same date as before)
- OI Disposition Date 3/10/2013

7. When should the LTC-Relevant indicator be changed on a Medicaid Recipient's other insurance policy?

Denial of one type of service billed does not determine the full liability of a third-party payor. The Third-party payor may be liable for a different type of service if the consumer moves to a different long-term care setting.

Example 1:

Provider billed Room and Board services to a Medicare Supplement Other Insurance policy. Other Insurance Disposition is Denied for Not a Covered Service.

The provider should not call TMHP to change the LTC-Relevant Indicator because the policy does cover a LTC-Relevant Service, skilled nursing facility Medicare coinsurance. This provider will use the OI billed date and OI Disposition of Denied for 365 days.

Example 2:

Provider billed skilled nursing facility Medicare coinsurance to an Other Insurance policy labeled Medicare Supplement on the client's MESAV (Medicaid Eligibility Service Authorization Verification). Other Insurance Disposition is Denied for Not a Covered Service with additional information that this is a Dental only policy.

The provider should call TMHP to update the policy and change the LTC-Relevant Indicator because the policy does not cover an LTC-Relevant Service.

Texas Medicaid & Healthcare Partnership Third-Party Liability (TMHP TPL) staff will have the tools to help providers determine when a policy is not LTC-Relevant. For questions related to the Other Insurance information on file at TMHP call 800-626-4117, Option 6, to speak with the TMHP Third-Party Liability (TPL) department.

8. Are providers now required to submit all claims to Medicare prior to Medicaid?

No, services not covered by Medicare are not required to be billed to Medicare. The new Medicare Part A, Part C fields, and Medicare Attestation are required when billing skilled nursing facility Medicare coinsurance.

9. What is the contact for questions about LTC cost avoidance claims processing and adjudication?

TMHP LTC Operations (800-626-4117, Option 1) will respond to LTC individual and provider phone inquiries and problems regarding LTC cost avoidance claims processing and adjudication assistance.

10. Will we be responsible for billing private insurance to get the EOB and denial code or will LTC know the denial code and give that code to us?

Providers must bill private insurance for their clients and keep the documentation on file. LTC will not bill for providers.

11. Will the Other Insurance information entered on the Medicaid claim be saved so the provider does not have to enter the denial code every week when we bill?

TMHP TexMedConnect will allow providers to save Other Insurance information on Institutional claim individual and group templates. **BE AWARE** that it is the responsibility of the provider to confirm that other insurance data saved to a Draft or Template is still true and accurate before attesting and submitting the claim to Medicaid.

12. Tell me how am I supposed to bill third-party insurance companies.

The steps and documentation required to file a claim vary between insurance companies. It is the responsibility of the provider to comply with the network participation and client preauthorization requirements of the third-party insurance carriers. Use the insurance company contact information on the MESAV (Medicaid Eligibility Service Authorization Verification) to reach out and become familiar with each company's requirements.

When filing the claim, do not subtract the client's Applied Income from the amount submitted to the Other Insurance. Providers must submit the full Medicaid rate to determine the full liability of the other insurance company policy. When billing Medicare skilled nursing facility coinsurance, submit the full Medicare approved daily rate.

13. Do I need to send in the OI paper EOB to file Medicaid claims?

While the Explanation of Benefits (EOB) from the insurance company is required to be on file at the facility, providers should not send the documentation to LTC or TMHP. The required information (OI Billed Date, OI Disposition date, OI Disposition, OI Paid Amount) will be captured electronically on the TMHP TexMedConnect LTC Online Portal and through Electronic Data Interchange (EDI).