Claims Forwarding, Dental Billing, and Other Changes Related to the Nursing Facility Transition to Managed Care

Information posted February 5, 2015

Beginning March 1, 2015, Nursing Facilities (NFs) residents will transition to STAR+PLUS managed care. Medicaid-eligible adults who are 21 years of age and older residing in Nursing Facilities, and who meet STAR+PLUS criteria, will become mandatory managed care clients. Children and young adults who are 20 years of age and younger residing in Nursing Facilities, individuals residing in the Truman W. Smith Children’s Care Center, and individuals residing in a state veteran’s home will be excluded from the transition to managed care. Individuals receiving hospice services or Preadmission Screening and Resident Review (PASRR) specialized services who meet STAR+PLUS criteria will become mandatory managed care clients.

- **Enrollment in STAR+PLUS**

  Nursing Facility residents covered by Medicaid should select a STAR+PLUS managed care organization (MCO) by telephone, by February 11, 2015. Residents may have questions about how to pick and enroll in a STAR+PLUS plan. The Department of Aging and Disability Services (DADS) encourages Nursing Facility staff to answer questions residents may have about the enrollment process. While Nursing Facility staff may not select an MCO for a resident, the staff can answer questions, provide general information, and encourage residents to choose the STAR+PLUS MCO that best suits their needs by phone, by the February 11, 2015, deadline. Providers can refer to DADS Information Letter 15-06, for more information.

- **Nursing Facility Services**

  Long-term care services provided to individuals excluded from STAR+PLUS as outlined above will continue to be billed as fee-for-service (FFS) to Texas Medicaid & Healthcare Partnership (TMHP). Hospice services and PASRR specialized services will continue to be billed as FFS to TMHP despite the individual’s managed care enrollment. Dual eligible Nursing Facility residents (those receiving Medicare and Medicaid) enrolled in STAR+PLUS will receive their acute care services through Medicare and their long-term care services through STAR+PLUS.

- **Claims Forwarding**

  Nursing Facility new-day claims submitted to TMHP will be validated and forwarded to the STAR+PLUS MCO of the member for processing and payment. TMHP will calculate informational pricing for claims with Daily Care, Service Code 1, and claims with Medicare coinsurance, Service Code 3. All adjudication status of managed care member claims must be obtained through the MCO portal system or MCO Remittance and Status (R&S) Report. The Nursing Facility may choose to submit claims directly to the MCO.

- **Adjustments to Claims**

  If adjustments are needed on a claim associated with a managed care member, the Nursing Facility will need to submit the adjustment to the MCO. All claims adjustments must be submitted to the entity that paid the claims.
• **Daily Care and Add-on Services Must be Submitted on Separate Claims**

NF Daily Care (Service Group 1) will no longer be billable on the same claim as any other NF service. Beginning March 1, 2015, any claim submitted to TMHP with both Daily Care and Add-on services will be rejected.

• **Emergency Dental Services Claims Must be Submitted to Dental Subcontractors**

Emergency dental claims for managed care members must be submitted by the dentist to the appropriate dental subcontractor. Beginning March 1, 2015, any emergency dental claim for a managed care member submitted to TMHP for dates of service on or after March 1, 2015, will be rejected.

• **Custom Power Wheelchair Prior Authorization Requests**

  o Effective March 1, 2015, Custom Power Wheelchair (CPWC) prior authorization requests for managed care members will not be reviewed by TMHP. These prior authorization requests must be submitted to the appropriate MCO.

  o All authorization requests in progress at TMHP for managed care members as of March 1, 2015, will be completed by TMHP and/or the appropriate MCO. Nursing Facilities can continue to review the status of authorization requests in progress as of March 1, 2015, on the Long Term Care (LTC) Online Portal. Nursing Facilities should **not** submit claims for reimbursement to TMHP for the managed care member after March 1, 2015.

• **Other Durable Medical Equipment (DME) Prior Authorization Requests**

  o Effective March 1, 2015, other DME prior authorization requests for managed care members will not be reviewed by DADS. These prior authorization requests must be submitted to the appropriate MCO.

  o All authorization requests in progress for managed care members as of March 1, 2015, will be completed and paid by DADS. Nursing Facilities should **not** submit claims for reimbursement to TMHP after March 1, 2015, for the managed care member. DADS will provide the details of payment to the Nursing Facility in a subsequent communication.

• **Goal-Directed Therapy Prior Authorization Requests**

  o Goal-Directed Therapy (Service Codes 7, 8, and 9) prior authorization requests for managed care members will no longer be submitted to DADS. These prior authorization requests must be submitted to the appropriate MCO for approval.

  o Prior authorizations in progress when a NF resident is enrolled in managed care will require prior authorization with the associated MCO. Contact the associated MCO or visit the MCO website/portal for information related to their prior authorization process.

  o MCOs will receive open service authorizations as of March 1, 2015, for managed care members.
o NFs should submit claims to TMHP, to be paid as fee-for-service, for dates of service prior to March 1, 2015, for managed care members.

o NFs or therapists should submit claims for services incurred on or after March 1, 2015, to the associated MCO for payment.

- **Medicaid Eligibility and Service Authorization Verification (MESAV)**

  The MESAV will continue to indicate Service Authorization, Level of Service, and Applied income. The MESAV will display utilized units for FFS claims only. Beginning February 18, 2015, the MESAV will display the effective dates of the resident’s enrollment in managed care and their associated MCO.

- **R&S Reports**

  The R&S Report provided by TMHP will continue to display FFS claim information. Providers will need to contact the MCO for final forwarded claim adjudication and reporting.

- **Other Insurance**

  o The billing of Long Term Care (LTC) Nursing Facility (NF) claims with other insurance through TexMedConnect will change with the implementation of managed care.

  o Between now and March 1, 2015, the LTC Relevant indicator in the TMHP system will be removed for each NF resident who is a candidate for managed care. This means the individual’s LTC Relevant other insurance coverage will no longer auto-populate on the claim in TexMedConnect. Providers are no longer required to report other insurance denials on the claim; however, providers must continue to maintain third-party insurance documentation on file and report the other insurance paid amount on the claim. Watch for an upcoming DADS information letter for additional information.

- **Claim Submission changes in TexMedConnect and Electronic Data Interchange (EDI)**

  Beginning February 1, 2015, changes are being made to the institutional claims process via both TexMedConnect and Electronic Data Interchange (EDI). For further details on the upcoming changes to institutional claims, see the DADS Information Letter 14-68, Nursing Facility Changes to the Medicaid Claims Submission Process – Revised, Information Letter 14-82, Upcoming Updates to Institutional Claim Submission for TexMedConnect and Electronic Data Interchange Transactions, and Information Letter 14-83, Upcoming Updates to Institutional Claim Submission for TexMedConnect and Electronic Data Interchange Transactions.

- **TMHP Medical Necessity Determinations**

  o The process for determining Medical Necessity (MN) for the Minimum Data Set (MDS) has not changed. TMHP is responsible for reviewing submitted MDS assessments to determine MN. Providers are encouraged to review the MDS Assessments section of the LTC Nursing Facility/Hospice User Guide here for additional information.

- **Training offered by HHSC and TMHP**

  o Providers are encouraged to take advantage of the transition training offered by both the Health and Human Services Commission (HHSC) and TMHP. Training offered by HHSC can be accessed through the website at www.hhsc.state.tx.us/news/meetings.asp.
Providers also are encouraged to participate in training offered by the STAR+PLUS MCOs. Contact the MCOs to find out more about MCO provider training opportunities.

- TMHP offers an updated TexMedConnect for Long Term Care Providers computer-based training (CBT). The updated TexMedConnect for Long Term Care Providers CBT can be accessed on the TMHP Learning Management System (LMS) website at http://learn.tmhp.com.

- Users must have a User name and Password to access CBTs in the LMS. To obtain a User name and Password, providers must create an account by clicking the Registration link at the top left-hand corner of the LMS home page. After creating an account, providers can access all available CBT materials in the LMS.

- TMHP will also conduct webinars specifically directed to Nursing Facilities transitioning to managed care. The webinars will address the changes to TexMedConnect and the claims forwarding process.

- These webinars are scheduled for February 19, 2015, at 10:00 a.m., February 25, 2015, at 10:00 a.m., March 3, 2015, at 1:00 p.m., and March 9, 2015, at 1:00 p.m. Providers can register for these webinars by clicking here, and choosing their preferred date.

For more information call the Long Term Care Help Desk at 1-800-626-4117, Option 1.