Nursing Facility Transition to Managed Care Frequently Asked Questions (FAQ)

1. Can the DADS LTC Bill Code Crosswalk be updated to identify which codes remain Fee-For-Service (FFS) vs. Managed Care?

   All Service Group 1 codes found in the DADS LTC Bill Code Crosswalk will continue to be utilized for Fee-For-Service claims submitted for individuals or services not transitioning to managed care. For this reason, the DADS Bill Code Crosswalk cannot be modified to reflect a distinction between FFS and managed care services.

   Below are services which will remain carved-out of managed care:
   - Hospice services
   - Preadmission Screening and Resident Review (PASRR) Specialized Services
   - Nurse Aid Training

2. Is the current process for establishing permanent medical necessity changing?

   No changes have been implemented to Texas Administrative Code Title 40, Part 1, Chapter 19, Subchapter Y, RULE §19.2403, section e


3. Will there no longer be Applied Income adjustments for Emergency Dental?

   There is no current process to utilize an individual’s applied income to pay for emergency dental services. These are actually two distinct processes.

   Applied income may be utilized, following the Medicaid Incurred Medical Expense process, to cover expenses that will not be paid by a third party. These expenses may include Medicare and other health insurance premiums and deductibles; remedial care expenses; and routine dental services. This process will continue after 3/1/2015 as it does today.

   Emergency Dental services are services provided in an emergency situation by a dentist upon the orders of a physician. Emergency Dental services will remain a Medicaid benefit and, for those enrolled in STAR+PLUS, will be facilitated by an individual’s managed care organization (MCO). For individuals not enrolled in managed care, the process in place at DADS Provider Claims Services will remain unchanged.

4. Is Patient Discharge Status only applicable if the patient was actually discharged from service?

   Discharge Status is always applicable and required. The field allows the provider to indicate the location of the individual on the last date being billed in the particular claim. There are several
options for indicating where an individual has discharged to, if that is the case. However, option **30 Still Patient** is expected to be the most common selection.

5. When an Individual who is enrolled in Star Plus elects hospice, does his coverage revert to “regular” Medicaid?

   All Hospice services – including Nursing Facility Room & Board – remain carved-out of the managed care model and will be paid in the same manner as today (Fee-for-Service via TMHP). However, individuals receiving Hospice services who qualify for STAR+PLUS managed care will continue to be enrolled with a Managed Care Organization (MCO) and the MCO is responsible for service coordination and claim processing for all services not related to the terminal illness. Just as today, election of hospice will not dis-enroll an individual from managed care, nor will enrollment in managed care impact the hospice provider’s ability to submit claims for services.