LTC Questions and Answers

Question Type	Question	Answer
Enrollment	How do we handle our current residents? Should we contact Client Enrollment Services and get them enrolled?	Client Enrollment Services has a mailing schedule and therefore your residents will be receiving their packets during that time.
Enrollment	Is there a roster that can be provided to the LTC facilities that show which residents are in each MCO?	At this time, that roster is not available. We recognize the value of that roster, and would like to collaborate with you and HFS to try and expedite the LTC approval process, to make that roster available and more accurate.
Enrollment	If there is a status change with a member, does the LTC make those changes?	If you are currently making changes in MEDI or Rev, then continue to do so. For the MCO's our access is read only. The information is populated by HFS.
Enrollment	I have someone in my facility who is a dual member and has already received their enrollment packet. I thought that wasn't happening until later in the year.	If this is a new resident, HFS may not have received their notification from DHS that this is a LTC resident, so it is very possible, you will have individuals that are in your facility receiving mailings they have the opportunity to enroll in MMAI, ICP starting as early as 3/1/14
Enrollment	How do I know which MCO the member is assigned to?	MEDI, Rev, HIQA (if you have access to this Medicare system), and the MCO's may have websites and call centers can all provide enrollment verification for their plan. It is not ideal, when the member has the ability to change MCO's every month if they are MMAI, the burden falls to the LTC facility to determine who to bill.
Enrollment	While the member is in a prospective stage, they don't have a RIN, how can the LTC bill the MCO?	There will not be a time when a resident is enrolled with an MCO if they don't have a RIN. Billing for LTC to the MCO begins after the resident has elected to join, or has been assigned to an MCO. Anything prior to that, is the state's responsibility and you would follow your normal procedures.
Care Coordination	Are pre-auth's and case management going to be the same as it is today?	Care coordination and the pre-authorization are specific to each individual health plan. There are new health plans beginning on March 1st. It is possible you might see something new with the new plans.
Care Coordination	Why do the MCO's have people coming into the LTC facility all the time?	HFS has several strict quality and reporting requirements that they need to comply with. One of those being the completion of the Health Risk Assessment. In addition to visits and quality. We would like to build strong collaborations with the LTC facilities to improve health outcomes and reduce costs.
Billing	Do the plans have a common list of rejections or denials?	Each plan will have similar rejections and denials, the codes themselves between the plans will be unique. The MCO's could provide this information to you during an information overview that is plan specific.
Billing	How do you know if the therapy cap has been met?	This could be accomplished in two ways. The first would be to continue to bill the MCO until you receive the denial the maximum allowed has been reached. Secondly, you can call the health plan and speak with provider services to determine the number of services applied.

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Billing	We have submitted our claims to MCO's but they haven't been paid yet, who is responsible for payment, the MCO or HFS?	Lack of payment could be attributed to several factors:
		1) Was the claim rejected and never received or processed by the MCO? If so, you would need to correct any information on the claim that is causing the rejection and resubmit.
		2) Was the claim denied for some reason like not a covered member? Duplicate? Timely filing? If so, understand why the claim was rejected, or call the provider services line to understand your next steps.
		3) Was the denial as a result of the resident not being on the patient credit file that the MCO's receive from HFS? Work with the MCO's to determine if those members have since showed up on the file and are the claims now able to be adjusted for payment?
		4) Are these oxygen claims? If so, is the LTC a registered provider type 63 for DME? Were the oxygen claims billed on a professional claim form? If so, work with the MCO to get claims adjusted. If not, resubmit corrected claims. If not DME provider, claims denied correctly.
Billing	Can we use Clearinghouses to submit our claims?	Absolutely. We encourage electronic claims submissions and clearinghouses are a great choice.
Billing	Do claims need to get submitted monthly or can we group them together?	Claims need to be submitted to the MCO's on a monthly basis. So in March, you would be for Feb. In April you would bill for March, etc. Each month needs to be on a separate claim.
Billing	Why do you have to wait until the resident is on the patient credit file? They have been in my facility for 2 months, and you have visited them.	HFS has given the directive to the MCO's that the patient credit file is our official notification that the resident has been approved to be at the facility and has passed all LTC eligibility requirements. We are not to pay any LTC claims unless that member is on the patient credit file. This file also contains the patient credit responsibility.
Billing	Will each MCO have their own provider manual?	Yes. The MCO's will cover the information contained therein during their orientation with the LTC facility. You might also find the information on their website.
Billing	Will we receive notice of claim rejections or just denials.	You will receive notification of both; however, they will be received differently. Since a rejection does not produce a claim, your clearing house will receive a report of all of the rejected claims and the reasons why, or you mail receive a letter if your claims are submitted via paper. For denied claims, those denial reason codes will be on your explanation of payment, either paper or electronically. Some MCO's might also have a provider portal for you to use.
Prior Auth	Will the MCO's require authorizaton for the LTC?	Yes. MCO's need to account for all days a member is inaptient, whether it be a LTC facility or a hospital. When a member changes MCO's, returns from the hospital, or is a new member, you should contact the MCO for authorization.

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Prior Auth	Does prior authorization guarantee claims payment? Does it override the patient credit file?	Prior authorization is not a guarantee of payment. All claims are still subject to the claims processing rules.
Billing	Are MCO's required to follow the State's prompt pay rules?	Yes. Clean claims are subject to the prompt pay rules. All necessary information must be available to qualify as a clean claim. Members missing from the patient credit file would be an example on when this does not apply.
Billing	My claims keep rejecting, and it is frustrating, what do I do?	You should engage the MCO as early as possible to help identify and correct the problem.
Billing	It currently takes 6-8 months for DHS to approve eligibility. Am I to bill the MCO during this time?	Yes. Continue to check MEDI to determine if a resident has elected to join, or is currently enrolled in an MCO. If so, submit the bills to the MCO starting with their effective date. When DHS approves eligiblity, they will notify HFS, who in turn will notify the MCO's through the patient credit file. Once received on the file, the claims will be adjusted.
Billing	If a resident is in MMAI, do I need to submit 2 bills? One for Medicare and one for Medicaid?	If the resident is an MMAI member, and enrolled with an MCO, "No" you do not need to submit two bills. The MCO will process the claim with Medicare as the primary payer and will then process the claim as a Medicaid claim. You will only need to submit 1 claim. Coordination of benefit rules will apply to the claims processing.
		If the member is a Dual Eligible member however, and they have "Opted Out" of the MMAI program, then you would need to submit a claim to Medicare for primary payment (if it was a Medicare stay) and then to the appropriate MCO for their Medicaid stay.
Billing	Our facility also has a SLF with it. How do we bill for those services?	SLF will be different. Services are a per diem rate that does not include room and board services. For those, you would bill with Procedure Code T0233.
		While bed holds are not reimburseable to LTC facilities, they are for SLF's so should you have a bed hold, you would need to use procedure code T0233-U1. (U1 is a modifier).
		SLF claims are considered a professional claim since no room and board services are being provided under the benefit plans. Claims should be submitted on an 837p or a CMS1500
		SLF providers need to be contracted with the MCO
Reimbursement	Are we paid the same rate from the MCO's as Medicaid.	As MCO's, we have individually agreed to not pay less than the current fee schedules.
Reimbursement	There is often retro-activity regarding the patient credit/responsibility. How do we address that, after a claim has been processed?	Contact the MCO to understand their process regarding retro activity.
Reimbursement	Will the MCO determine the resident's personal income?	The MCO does not determine the personal income. This information is provided to the MCO from HFS on the monthly patient credit file.
Reimbursement	For members who are enrolled in LTSS, who is responsible for the acute care payments?	You would need to bill Medicare for medical services and then Medicaid for secondary processing. LTC will be billed to the MCO in which they are enrolled.

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Reimbursement	How do we become a provider type 63 (DME) with HFS	http://www2.illinois.gov/hfs/MedicalProvider/Enrollment/Pages/default.aspx
		Once you become a registered DME provider, you should notify the MCO's so they can add your new provider type to ensure timely payments of claims
Reimbursement	If the MCO doesn't get the patient credit file until the 10th of the month, should we wait and submit claims after that?	While that may be a good practice, it may not be necessary. Many of the health plans will have processes in place to address this. Just be sure to submit those claims on a monthly basis to avoid timely filing denials