The 2017 Texas MCO environment

What you need to know to survive and thrive

Carrie Stroud
Consultant/Owner,
CC Consulting

Danny King
Director of Reimbursement,
StoneGate Senior Living

Jason Jones
Chief Technology Officer,
SimpleLTC

SIMPLELTC™

January 17, 2017

What we'll cover

- Updates from recent HHSC meetings
- Making sense of September rate changes
- The 120-day rule for room and board services
- The 95-day rule for add-on services
- Handling payment issues with different MCOs
- MCO billing best practices for 2017
- SimpleLTC tools for MCO claims scrubbing and analysis
- Q&A

SimpleLTC™

ATTENDEE POLL #1

September rate schedules

- Many providers in the Staff Enhancement Program received increased rates (in some cases, decreased rates)
- Incorrect payments
  - Critical: Notify your MCO ASAP if you are receiving incorrect reimbursement
  - In some cases, providers have received the correct enhancement rate; however, the MCO failed to add the additional $1.67/day for providers with professional/liability insurance
- If you are not being paid correctly
  - Contact your MCO representative and notify them in writing of the discrepancy.
  - Monitor weekly and send further notifications if they have not corrected the issue.
  - If MCO does not correct discrepancy, you may file a complaint with HHSC at HPM_complaints@hhsc.state.tx.us

SIMPLELTC™

95-day rule for add-on services

- All add on services must be billed within 95 days of the FROM date on the claim
- Add-on services are considered physician ordered Rehabilitation Services, customized power wheelchairs, augmented communication devices
- Important:
  - You must work your remittance advices within 95 days of the remittance advice date, and file appeals for claims that were paid incorrectly
  - If you file an appeal after the 95 days, your claim will be denied for timely filing

SIMPLELTC™

Specific issues: Amerigroup and United

- Amerigroup: Cash posting issues
  - Amerigroup is now including recoupments on the same remittance advice as they are recouped from; however, they are not providing the dates of service they are recouping
  - They are providing you with Resident Name, claim number, amount recouped and the date Amerigroup actually paid the claim
  - You must contact your provider representative and request a CCERT Negative Balance Reduction report. You will then have to match the resident name, recoupment amount and claim number to determine the correct dates of service to post the recoupment to.
- United: Remit summary page
  - in some cases United Healthcare is leaving off the summary page at the back of the remit which gives you the recoupment details
  - When the summary page is omitted, you must contact your provider rep and request the details

SIMPLELTC™

120-day denial for room and board services

- Per Provider/MCO contracts, we agree to follow billing guidelines/rules laid out in the MCO's Provider Manual
- Provider Manual states once a claim is submitted, providers have 120 calendar days from the printed run date on the Remit/EOP to correct or appeal the claim that was either denied, or Underpaid, at an incorrect rate
- Once a day is billed to an MCO, whether on a clean claim or by error, the countdown begins from the Remit date where the denial was shown
- HHSC confirmed that the MCOs are allowed this denial, and that it is an issue that falls within the contract between Provider and MCO
- Just because an MCO is not enforcing a denial currently, does not mean that they never will

SIMPLELTC™

120-day rule enforcement

- Excerpt from contract that allows MCOs to enforce 120-day rule

2.10 Complaints and Appeals

2.10.1 The processes and requirements for submitting Provider appeals regarding claims payment and complaints to the MCO are described in the MCO's Provider Manual.

SIMPLELTC™

120-day rules per MCO

- United Healthcare
  - Providers must file appeals or adjustment requests within 120 days from the date of disposition
- Amerigroup (keep in mind the easiest option is going through your Provider Representative)

1-800-454-3730. All appeals must be submitted in **writing** and received by us within 120 calendar days of the printed run date on the EOP. To submit a payment appeal, complete the payment appeal form located online at providers.amerigroup.com. All appropriate supporting documents (including the EOP, medical records, etc.) must accompany the appeal. Submit the documentation to:

SIMPLELTC™

120-day rules per MCO (cont.)

- Superior

  Superior must receive a provider's appeal of a claim within one hundred twenty (120) days from the date of disposition (date of the EOP). Superior will process the claim appeal within thirty (30) days from the date of receipt of the claim appeal.

  - As of last week, Superior has updated their policy as follows:
    - Providers must submit all new claims within 365 days of the date of service. If a corrected claim is required, provider may submit it as a new claim if the original claim denied and within 365 days from the date of service. Providers may submit corrected claims that were paid or partially paid within 120 days from the EOP date. Providers may appeal claims within 120 days of the EOP date. **If the 365 days from date of service has exhausted, you will have 120 days from the last date of adjudication to submit a corrected claim.**
    - Nursing facility add-on services: 95 days from the date of service, corrected claims or appeal claims within 120 days of the EOP date.

SIMPLELTC™

120-day rules per MCO (cont.)

- Molina
  - The provider or practitioner is allowed **120 days** from the date of the initial denial notification to submit a first level appeal.
    - Note: Molina stated on their Jan. 13 webinar that their 120-day rule only applies to Add-on Services (to correct and appeal them, still 95 days to bill). For room and Board charges, you have 365 days to correct and appeal.
- Cigna
  - Providers must request Claim Appeals within 120 days from the date of remittance of the Explanation of Payment (EOP).

SIMPLELTC™

Claim bill time limits

	Jan-17	Dec-16	Nov-16	Oct-16	Sep-16	Aug-16	Jul-16	Jun-16	May-16	Apr-16	Mar-16	Feb-16	Jan-16	Dec-15
TMHP	365 days to submit claims from Date of Service													
Molina	365 days to submit claims from Date of Service													
Superior	365 days to submit claims from Date of Service													
United	No timely filing limit currently enforced, but on 2/28/2017 the 365-day timely filing limit will be enforced													
Cigna	No limit currently enforced													
Amerigroup	365 days to submit claims from Date of Service													

- Notes:
  - Claims in the gray or black
    - If never billed = Bad Debt
    - If MESAV changed – send reconciliation request using SimpleLTC's MESAV showing date changed*
      - *must be submitted within 30 days of the date changed to MCOs or Bad Debt
      - *TMHP may give you 12 months for reconsiderations (Note: I would send this on every one to get documentation for your write-off)
    - When in doubt, send request to Provider Reps to get denial = Bad Debt
  - United's RED: All balances billable until 02/28/2017
    - Need to resolve all balances on your books older than 02/2016 in the next 30 days
  - MCOs have 24 months to recoup credits. Claims that are recouped over 365 days old that create balances generally can be appealed within 30-120 days depending on the MCO's policy.

SimpleLTC™

Issues with no AI on MESAV or status on application

- For example:
  - MESAV not having AI, but you have it from the MEW
  - Do not know the status of a Medicaid Application
- Send a HIPPA-compliant email to oescccic@hhsc.state.tx.us
- Or send a fax to 877-447-2839
- Be sure to include:
  - All resident information know (SimpleLTC MESAV if you have one)
  - Your name and contact information
  - Very short and simple inquiry of what you have an issue with or need to know

SIMPLELTC™

State complaints

- This is the providers' way of notifying HHSC of the issues we are having with the MCOs
- Once you have had an unsuccessful resolution with an MCO, file a complaint via email to HPM_complaints@hhsc.state.tx.us
- You must follow HIPPA compliance when emailing claims issues

SIMPLELTC™

MCO billing best practices

- Bill as far behind as you possibly can without interrupting cash flow but no less than 2 weeks' behind.
  - Molina is the only MCO with a completely automated to process the SAS files, and retro adjustments. All other MCO's still process some or all of the retro data manually.
- Make certain you are creating two claims when you have a RUG split
  - Never bill two RUGS (even if they are the same RUG) on one claim
- Do not bill with any dementia or manifestation diagnosis codes
- Request your claims denials reports from your MCO providers to be sent on a weekly basis and work them weekly. Don't fall victim to the 120-day rule.

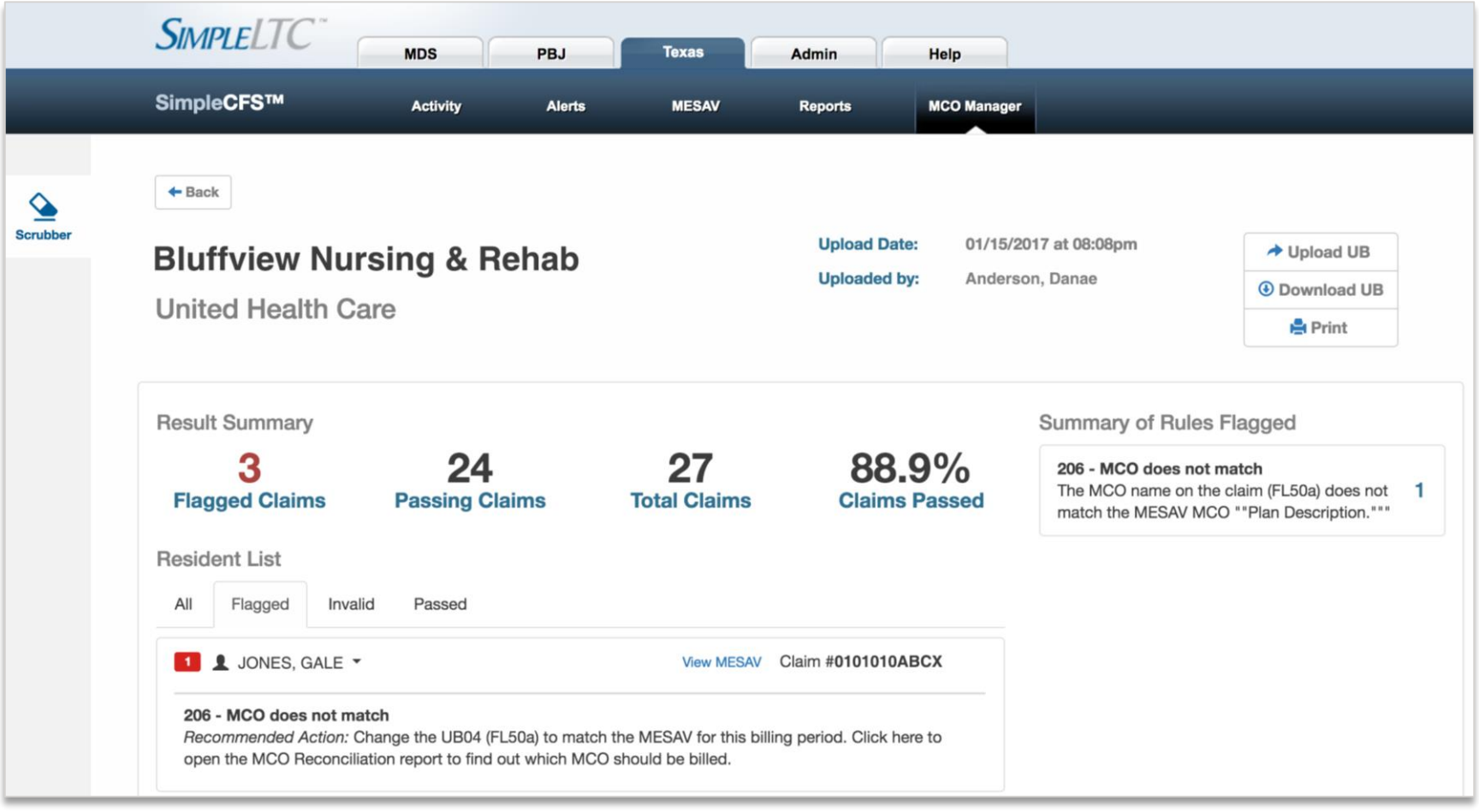
SimpleLTC™

SimpleLTC MCO Manager™

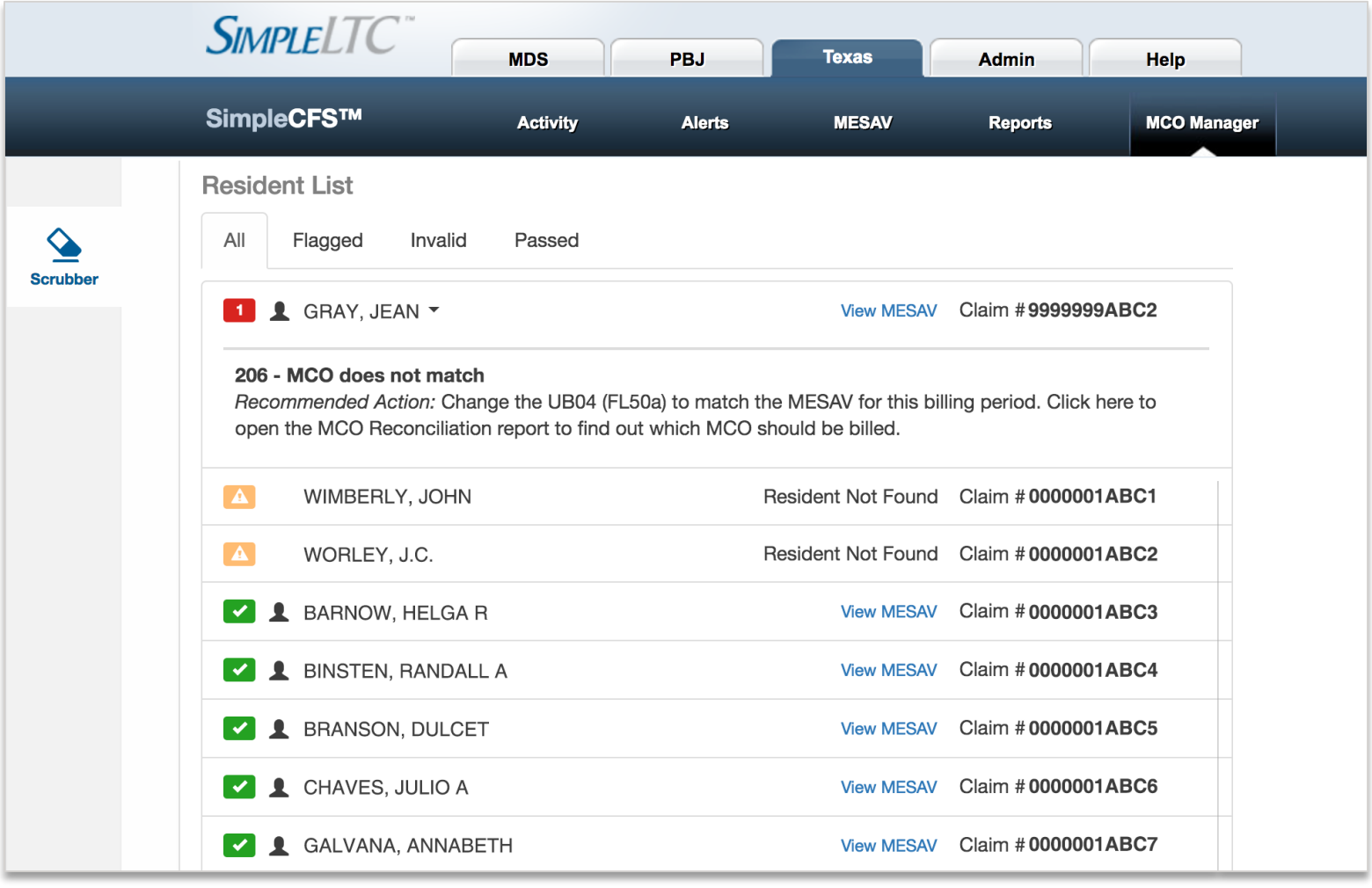
- What is it and why did we build it?
- Update on development
  - MCO claims scrubber
  - Revenue analysis view
  - What's coming?

SIMPLELTC™

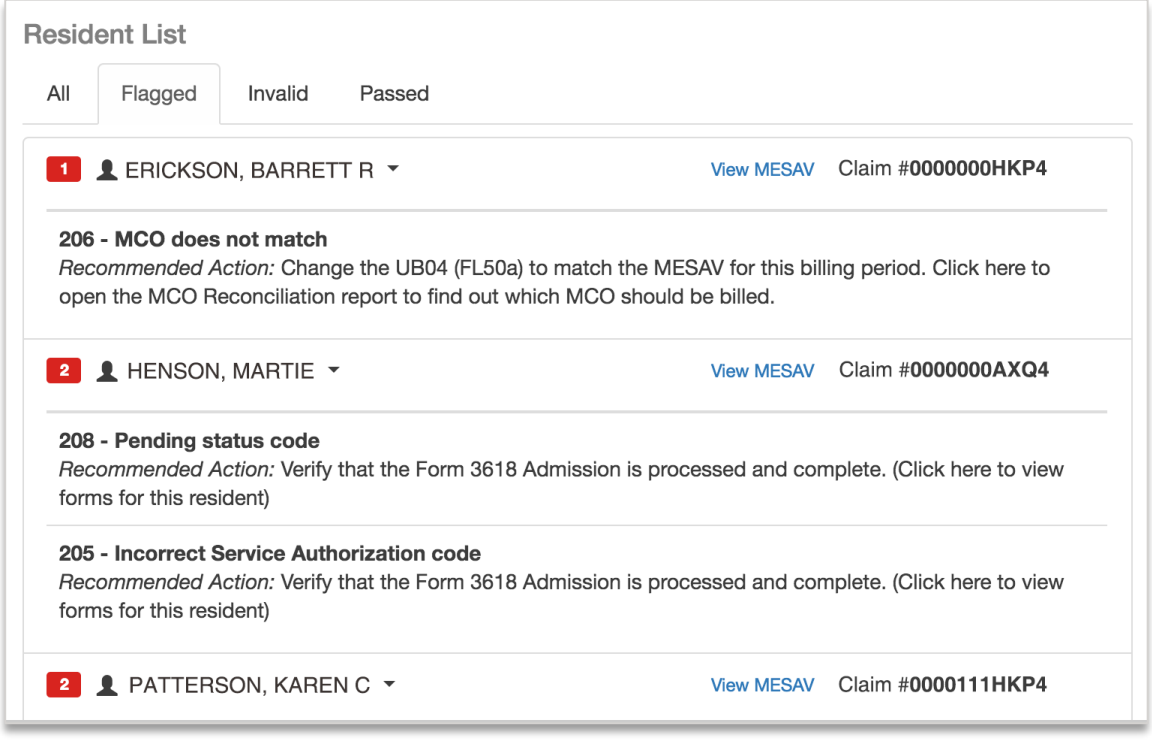
Simple MCO Manager: Scrubber landing page

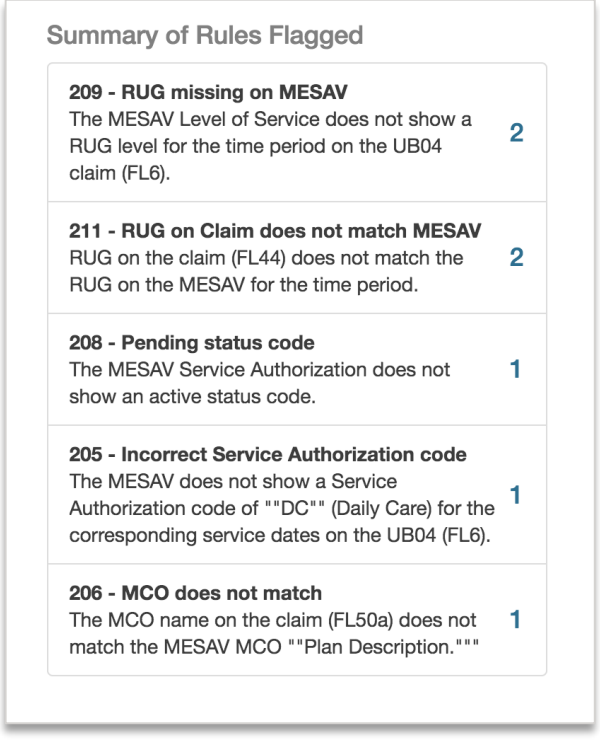


Simple MCO Manager: Reports view



Simple MCO Manager: Detail views





Simple MCO Manager™

- What's coming?
  - Revenue views
- Pricing
- How to get more info

SimpleLTC™

ATTENDEE POLL #2

QUESTIONS & ANSWERS

Thank you for attending!

For more info on Texas managed care:

simpleltc.com/mco

For further help:

support@simpleltc.com
469.916.2803

SIMPLELTC™