Responses
9/13/2013
RIHCA work Group Questions for NHP RI September 5th-

Draft manual

1. Manual Draft is not specifically geared towards the LTC population. Will NHP be creating either a separate manual altogether or a separate section in the current manual that only pertains to the LTC setting? We do not need to know about the community information or items that do not apply, it can be confusing.

As discussed at the meeting, the Provider Manual is a work in progress. We will be revising to have a general section applicable for all product lines, and then a specific section for Long Term Services and Support providers that will describe anything unique for these providers relative to the Rhody Health Options (RHO) members. We have to have a final draft shortly and will provide updates at our operational meetings.

2. How will Medicaid Pending residents be handled?
   - Will they be approved by DHS and then transitioned to NHPRI? Or will NHPRI be handling the pending residents?
   - How will this work and what will the protocol be?
   - Once approved will there be a scheduled financial review (currently annual).

All eligibility remains with EOHHS, new eligibility determinations, annual re-certifications and patient share determinations.

3. For the Medicaid ONLY Residents on a SNF level of care or higher in the LTC facility, what is the technical criterion to meet this requirement?

Reference the SNF levels in the contract and the Clinical Medical Policy on skilled days.

4. Does custodial care need Prior Authorizations for anything other than the initial LTC authorization / Quarterly Authorization? (e.g. X rays, labs, meds, dental, rehab etc.)

Custodial stays are a notification process only. Some high tech radiology services, medication, rehabilitation services do need an auth and all this detail is posted on NHPRI.org. However our understanding is that these other services indicated are generally not performed or billed by the nursing home provider. In general, the obligation for
obtaining any necessary authorizations lies with the provider who is to be paid. We can
discuss this in more detail at our next meeting.

Note however that dental services are NOT A COVERED BENEFIT with Neighborhood.
Limited maxillofacial/ oral surgery is covered and is listed on NHPRI.org.

5. Will the payment schedule truly be 30 calendar days or less?

- Please note that this is 2 weeks longer than our current payment schedule from DHS
and will potentially create serious cash flow issues for some homes who rely on this
payment to pay bills and meet payroll.

Neighborhood intends to receive and process claims (including prospectively applying
patient share) within 10-14 days of receipt of a clean claim. Neighborhood may create a
specific schedule by service area in order to meet the financial expectations of the network.

6. When is the latest date a facility can bill NHPRI?

- What is the payment cycle? For example – bill by the 1st and get paid by the first of
the following month?

Neighborhood pays claims each Wednesday morning. Remittance Advice and checks/EFT
payments are sent on Friday, end of business.

7. Where are the actual criteria for custodial care? The only MCAP criteria we received
were related to skilled level of care.

There is no medical review decision. If they are LTC eligible and have no safe discharge
plan, then they meet custodial LOC.

8. For discharges that previously involved the transition team, will these referrals now be
made to NHPRI instead? Yes

- Are you contracted with the federal government as the Local Contact Agency to make
Section Q referrals to or will we still be using the transition team in addition?

They will go to NHPRI

- Who should be the first contact? NHPRI

9. Per draft manual – Authorization for care is required no later than 3 business days after the
service and anything later than that will be denied. Who will be responsible for obtaining
authorization prior to admission to a Nursing Facility - the Facility or the entity discharging
TO the nursing home?
As mentioned earlier, in general the provider who is getting paid for the service being rendered is responsible for obtaining any necessary authorizations.

- Is there an appeals process if the authorization is not obtained timely?

Yes there is an appeals process that is outlined in the provider manual.

10. For level of care authorization – we have several residents who have been “grandfathered” in for meeting the level care since June 2010 Global Waiver – Those residents will need to be excluded from reviews for authorization / discharge planning.

Agreed – we will need to know who these residents are after Nov 1

11. Draft Manual indicates there will be a 6 month authorization for current RHO members transitioning to NHP – will NHP be sending care managers to complete the authorizations and reviews over the 6 month period?

  – Will the facility be required to complete the authorizations?

See narrative at end

12. Manual indicates Custodial care authorizations will be issued on a Quarterly basis – What is the due date of these authorizations?

Notification only for custodial, see narrative at end

  - Will there be any grace period for submitting these authorizations?

  - Will this coincide with MDS quarterly / annual schedule?

  - What form and pertinent clinical documentation is needed for these quarterly reviews?

    o FYI We currently only complete one level of care review for the state upon admission.

13. How do we prove timely fax notifications of authorizations?

We have a time stamp on our end

14. Will NHPRI care managers be coming to the facilities to actually manage the care of the custodial members?

See narrative at end

  - What level of involvement will the care managers have for DC planning?
- Will they be attending facility care plan conferences?
- Will they be completing the Quarterly Authorization Reviews?
- Will they attend Discharge planning meetings?
- Will NHPRI be creating their own care plans similar to hospice or will they use the facility developed care plans?

15. Draft Manual indicates Nursing Facility responsibilities include providing NHPRI staff with access to the MDS in a format that is mutually agreed upon – what does this mean?

We are working with EOHHS and CMS to get MDS feeds from EOHHS
- How often will you review the MDS? **When on site and at least quarterly**
- Do your care managers understand what is on the MDS? **Yes**

16. Will NHPRI be adding more access to Assisted Living Facility beds?

**Yes we are actively recruiting Assisted Living providers to our network.**

17. What if the Facility Medical Director does not want to be or is not credentialed by NHPRI?

We will need to discuss why this would be the case. We are required to insure the quality of the providers in the network and a component of this includes the reviewing of the credentials of the Medical Directors of the nursing homes.

18. Draft indicates Vendors need to be participating in NHP? Why?

For continuity of care and care coordination, we are asking for the names of the vendors seeing our members so that we may invite them to participate in our network.

- How will NHP be paying these vendors?

We will pay them comparable to like providers already in the network.

19. What if we send a Medicaid only resident out to an appointment (wound clinic / MRI / CT scan etc.) will NHP restrict where the resident can go for these services?

We have a very robust network and most likely have contracts with places where you refer your patients. You can see our current network directory at NHPRL.org.
This is why we are asking to whom you refer so we can add them to the network as needed so as to not disrupt your referral patterns.

- How will NHP pay for these outside services?

If contracted, we will pay these providers comparable to like providers already in the network.

20. What about Dental? Currently we are using the Wisdom tooth program, will NHP continue to utilize the Wisdom Tooth program in the same manor it is currently run?

Dental is not a covered benefit so any current programs in use should continue.

– How will NHP be paying for dental services?

We have a limited benefit for oral maxillofacial surgery only and this detail is posted on our website. We will not be paying for dental services.

21. Draft indicates NHPRI will require copies of Medical records. IF you have access to our electronic medical records, why would NHP need copies?

If your facility is chosen for an audit, we will work with you to schedule a time so that we can come on site to conduct the audit.

22. Will nursing homes be required to send a copy of the NHP card with the resident any time they go out to an appointment or hospital?

Yes ideally the member will need to identify their insurance coverage at the time of any medical appointments.

23. How does WC transportation work?

The same as it currently does, this is a Medicaid benefit that is paid for by EOHHS, and Neighborhood only assists members as needed. If we receive a request we forward a fax to Logisticare, the nursing homes can call Logisticare to confirm it has been arranged. If a van is not available the Nursing home is contacted by Logisticare. (In most cases the day before the appointment).

- Currently we set up though EDS, will NHP have a similar process?

They can continue to arrange transportation for members directly by contacting Logisticare. The question references EDS, but HP contracted with Logisticare to handle the arranging of transportation so we assume that is who you are calling.

- Can the services be set up on a recurring basis for services such as 3x/week dialysis?
The facilities will need to reach out directly to Logisticare on this request.

- What kind of authorization will be required?

Same as what is required under the current process they follow. Members have the option of requesting assistance with transportation from us, or contacting Logisticare directly. Actually if a member contacts us for transportation, they are required to give Logisticare an additional days’ notice. Therefore it is to their advantage to call for the member if time is short.

24. Will all medications be covered in a Nursing facility or will a formulary have to be followed like in the community?

Our understanding is that routine medications are covered under the per diem. We will put this topic on the agenda for the meeting and we will include our pharmacy team at the meeting so that we can be sure we understand all the processes and issues related to pharmacy for nursing home patients.

How does this coverage affect Medicare Part D Plans?

- Are there any outliers for expensive meds / IV’s/ Injectables etc.?

- How will NHP be paying for Meds?

Will generics be required?

  o What if MD indicates no generics?

25. Billing – UB04 – What do you consider a complete claim from the Nursing Home?

See the contract document that we added with this detail

26. Discharges / Midnight rule – Will you follow the MDS rules for DC?

  - If you do follow the rules for MDS DC, and the resident does not meet the criterion for MDS DC, will NHP pay the facility for the time spent in the hospital under observation if it is over a midnight?

For phase one of the implementation we are only paying the Medicaid benefit for the RHO members. Most of the RHO members will have Medicare primary and that payment will continue. If NHPRI is the primary payer we will pay the hospitals according to the rules of our hospital agreement.
27. When you reference improper Diagnosis in the manual – Are you referring to codes that require 6 digits but only have 4 etc. or are there certain diagnosis codes that cannot be used?

Providers are expected to follow industry standard for all coding and billing of services rendered. Coding should be a valid number of characters, valid character content, valid for the facility performing the service and supportive of services rendered. Neighborhood’s coding requirements are similar to current coding requirements from EOHHS.

- Will V codes be allowed? Yes
- What if NHP’s plans for the transition to ICD 10?

Neighborhood has developed a detailed road map for ICD 10 implementation for our network. Regular updates will be posted on our provider website, the Navinet website and network mailings.

- Will NHP accept non specified codes? (NOS)

Services billed with unlisted procedure codes or a “not otherwise classified” code require supporting documentation prior to consideration of payment. Most sections of the CPT® code book contain codes for billing procedures and services that are not otherwise classified or described within the codes. Unlisted procedures should only be billed when no other code is appropriate. Providers should bill with the closest or most similar unlisted code.

28. How will Medicare Co pays be handled days 21-100?

- How are facilities to bill these copays?

Providers should bill any secondary services to Neighborhood on paper. Please forward a complete claim form and the corresponding Medicare EOB which shows any patient responsibility. Neighborhood is working toward automation of this process. Automation of the CMS COBA file will not be implemented for November 1, 2013.

Contract

29. Time limitation for billing services is 180 days – We currently have a year.

- Is this based on Medicaid approval date or from retroactive approval date?

We are asking that claims be submitted within 180 days of the services being rendered and this is to assist us in our reporting claims liabilities to the state in a timely manner. An
appeal process is available should there be extenuating circumstances that preclude that from happening, like retroactive eligibility approvals.

30. What kind of auditing will be done on custodial care authorizations?

We do not audit the authorizations, but the medical records. All of the audits conducted by the Claims and Quality Auditing area focus on determining if the documentation supports the level of coding being billed as well as determining if CMS documentation guidelines are being followed. We also refer to any state and federal requirements that are available on state website.


We should discuss this at the next meeting. We do not see these as services Nursing Homes directly provide. Providers rendering the services will bill us and be paid as they are today if the services are covered benefits.

32. How will applied income work with NHP?

Everything remains the same as it is today. The state will provide us with the applied income amounts on the eligibility file and we will be subtracting this amount from the nursing home payments, as is done today.

- Who will be determining this? State still determines this
- Who will be notifying the resident? State informs the members
- Will they still get their $50 per month out of their income? No change on this

Attachment 7 – we reviewed this at the meeting and made requested changes- please see final contract version as I think we addressed these concerns

33. Notification re MDS data – Do you want information every time an MDS or tracking form is completed on a resident?

- Via what method do you want to be notified? We will develop a process for Section Q referrals

34. Bullet 2 indicated MDS to be completed within timeframes required by Medicare – what do you mean by this? OBRA guidelines
There are two different schedules required for MDS completion – skilled Medicare part A residents have a different calendar of completion than what is required for the rest of the nursing home population.

35. For Medicaid only SNF Levels of care and higher, what MDS schedule will be required?

For phase 1 – OBRA requirements for all NHPRI members

36. MDS must be submitted to NHP within 3 business days of completing the survey. By what means do you want these MDS’s submitted?

   a. What will they be used for? To meet our EOHHS contract for comprehensive assessments and to assess for discharge potential

   b. We have 14 days from completion to submit them to the federal repository – why do you want them in 3 days?

   We are working with EOHHS and CMS to get MDS feeds from EOHHS

37. Bullet 4 indicates for a transition plan of care a 24 hour discharge visit be completed – what is the definition of this visit?

   This needs to be in the discharge plan. NHPRI will coordinate a 24 hour post discharge home visit

38. When care managers come to the facility – will we know a schedule of when they will be coming and will they be meeting with the facility to review residents and findings?

   We will develop a process of notification of when we will be on site or come on site

39. How will hospice residents with Medicaid Room and board be handled?

   We should discuss this in more detail at the next meeting. Our understanding is that the hospices will be billing us directly (instead of billing the state) and then the hospices pay the nursing homes.

   - Who will be paying them?

   - Can they be on NHP and still access Hospice benefit or will they have to give up the NHP?
40. What will the method of communication be between the nursing facility and NHP?

- Will we be able to talk to a person or will there be automated telephone calls and fax communication only? As discussed at the meeting, you will be dealing with our care management team in person during business hours.

**Narrative – Summary of Care Management discussion that occurred during meeting**

All Neighborhood members will be seen face to face within 180 days of enrollment for review of the comprehensive needs assessment (MDS) and assessment for any discharge opportunity. If an opportunity is present (resident wants to go to the community AND there is a feasible, safe plan), NHPRI care managers will work with facility staff to build a discharge plan. If no opportunity is evident at that time, NHPRI will assess every 90-180 days (MDS). Neighborhood’s plan of care will be built of the facility plan of care.

For custodial members, NHPRI requires notification and we will confirm every 90 days if not sooner, that the resident is still residing at the facility. As long as LTC eligibility remains in effect, then there are no ongoing coverage concerns. If eligibility changes, we will work with facility to find a safe discharge plan.

For skilled members, Neighborhood will review on a weekly basis, either on site or telephonic, to assess skilled level of care criteria.