ILLINOIS DEPARTMENT OF Healthcare and Family Services

MCDD Reimbursement Effective April 1, 2019

April 9, 2019

Public Act 100-0646 Requirements

- Designates Healthcare and Family Services (HFS) as the responsible State agency for reimbursement calculations and direct payment for services provided by medically complex for developmentally disabled (MC/DD) facilities.
- Establishes a new Exceptional Care reimbursement methodology for MC/DD facilities.
- Is effective for services starting on April 1, 2019.

HFS Responsibilities

- HFS will establish rate methodologies and calculate all reimbursement rates paid to MC/DD facilities.
- All payments to MC/DD facilities will be paid from HFS appropriations.
- Expedited payment status will be determined from HFS administrative rules.
- HFS will handle all billing questions from MC/DD providers.

Exceptional Care Reimbursement Changes

- Reimbursement for Exceptional Care services will be based on a tiered structure.
- There are three tiers of reimbursement depending on the services being provided.
  - Tier 1 rate is $326 per day for residents receiving at least 51% of their caloric intake via a feeding tube.
  - Tier 2 rate is $546 per day for residents receiving tracheostomy care without a ventilator.
  - Tier 3 rate is $735 per day for residents receiving tracheostomy care with ventilator care.

Claim Submittal Coding Changes

- For services starting on April 1, 2019, the following revenue codes should be used:
  - Revenue code 0191 for Tier 1 services.
  - Revenue code 0192 for Tier 2 services.
  - Revenue code 0193 for Tier 3 services.
- Revenue code 0190 should continue to be used for exceptional care services prior to April 1, 2019, but will not be allowed for services after that date.
- There are not any changes to the Revenue codes used to bill for non-exceptional care services or developmental training services.

Claim Submittal Coding Changes

- All claims from MC/DD providers must be submitted using Taxonomy Code 3140N1450X.
- Claims submitted with the Taxonomy Code for ICF/IID facilities will be rejected.
- The HFS payment system has been programmed to accept and reimburse claims at the new tiered rates.

Expedited Payments

- Providers with expedited payment status typically have their claims paid within a few days of being sent to the Comptroller, while non-expedited providers wait longer for payment.
- HFS has a standardized process to apply for expedited payment status. Administrative rules are located at *89IAC140.71(b)*.
- LTC providers must be 80% Medicaid and submit a cash position statement demonstrating financial need (assets/liabilities < 1.5).

Post Payment Reviews

- HFS regionally based nursing staff will conduct on site reviews of exceptional care services.
- HFS staff will verify that documentation exists to support the exceptional care services billed to the State Medicaid program.
- All documentation to support the services billed must be provided at the time of the onsite review.

Post Payment Reviews

- Each review will start with an Entrance Conference. HFS provides an Entrance Conference Form that details the review process.
- Services not adequately documented will be noted to providers on a Document Request List (DRL). Providers must provide the necessary documentation prior to HFS staff leaving the facility.
- It is imperative that providers respond to each request on the DRL in order to adequately document the services. Providers should attach all documentation to the DRL even if they believe they have provided it to HFS staff previously.

Post Payment Reviews

- Providers can appeal the review findings, but cannot submit documentation in addition to what was provided while HFS staff were on site.
- Providers should maintain a copy of the DRL and the supporting documentation provided for appeal purposes.
- If the Exceptional Care services cannot be verified, the claims will be voided and the provider will need to resubmit claims to be paid at the provider's base rate.

Facility Documentation Requirements

Providers of Ventilator Services:

- Emergency electrical backup system. Maintenance records/checks of the system. Staff are familiar through quarterly in-services.
- At least one registered nurse 24 hours a day 7 days per week.
- A certified Respiratory Therapist on staff or contract.
- At least 1 full time nurse who has successfully completed a course in the care of individuals receiving ventilator services. A course is defined as a scheduled, structured, learning sessions with recognition/certificate of completion.
- All staff caring for the individual with a ventilator has in-service training annually by Respiratory Therapist. The in-service documentation should include name/qualifications of the trainer, date and duration of the training, contents of the training, and signatures/positions of staff attending.

Providers of Tracheostomy and/or Ventilator Services:

- All staff caring for individual with trach should have in-services on trach care, infection control, universal precautions.
- Written agreement/service contract with oxygen supplier, trach supplies, vents.
- Policies and procedures addressing emergency needs of the individual (i.e., power outage, trach comes out, etc).

Resident Documentation Requirements

- All documentation must be signed and dated. Signature includes title.
- Documentation shall consistently support the services/care related to the symptom or problem (i.e., nursing notes, Respiratory Therapist evals, treatment sheets, etc.).
- Documentation shall cover the timeframe services were provided.
- Feeding tube documentation supports the presence of, care of, proportion of calories received.
- Trach documentation supports the presence of and care of a trach.
- Documentation shall support the use of the ventilator. Does not include when CPAP or BIPAP services are delivered using a ventilator.

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