Requirements for Nursing Facilities to Submit Monthly Billing for Reimbursement Purposes – Updates for Reporting Medicare and Other Third Party Liability (TPL) – Revised 07/13/17

This document provides clarification and updated information regarding the reporting of Medicare and Other Third Party Liability (TPL). In response to concerns and questions from the provider community, HFS is providing the following instructions to help facilitate provider needs and result in an easier transition to the new Long Term Care (LTC) direct billing process.

These billing rules will be effective upon implementation of the new LTC direct billing process and will apply to service dates on and after December 1, 2016.

Claims for Recipients who have Medicare Part A Coverage Not Participating in a Medicare Advantage Plan

Services for recipients with traditional Medicare Part A coverage must be billed to Medicare prior to billing Medicaid. Claims submitted to Medicare will crossover to Medicaid through a fiscal intermediary. However, in the event that a Medicare claim is not successfully crossed over for Medicaid pricing, the provider should submit the claim with Medicare coverage directly to Illinois Medicaid for payment consideration.

Medicare claims that do not crossover to Medicaid include claims that are submitted to Medicare for reporting purposes only or for a benefit exhaust period. In addition, claims received from the fiscal intermediary may be rejected back to the provider by Medicaid. Some of the reasons a crossover claim may reject are:

- Medicaid system does not have a LTC admission for recipient, provider or date of service.
- Medicaid system does not have Medicaid eligibility for the recipient or the date of service.
- Medicare claim received has a statement period that crosses calendar months; i.e. 12/05/16 – 01/19/17

HFS will derive the Medicaid and/or Medicare covered days from received claim information as follows:

- Long Term Services and Support (LTSS) program participants:
  - Medicaid covered services must be billed to the MCO.
  - Medicare covered services must be billed to Medicare first and may be submitted to Medicaid after Medicare's adjudication.

❖ **Reporting of Covered Days for Claims for Medicare Part A Only and/or Combination Claims for the Month Medicare Coverage Ends:**

Claims directly billed to Medicaid showing Medicare benefits should be coded following the Medicare billing guidelines. The days reported as covered (Value Code 80) should reflect the total days covered as full Medicare and/or coinsurance Medicare days. Days reported

as non-covered (Value Code 81) should reflect any Medicaid covered days or leave of absence days.

- Value Codes
  - 80 – Covered Days = Full and Coinsurance Medicare Covered days
  - 81 – Non-Covered Days = Medicaid days and LOA days
  - 82 – Coinsurance Medicare Covered

Claims billed directly to Medicaid for Medicare benefits must show Medicare as the primary payer. The Medicare payment amounts should be reported as a claim level adjustment in loop 2320. The REF02 segment in loop 2330 must show the Medicare TPL code 909 followed by a 2-digit TPL Status Code. (List of TPL Status Codes is attached)

Claims billed directly to Medicaid that contain both Medicare and Medicaid benefits must show the date that the Medicare benefits ended using one of the following Occurrence Codes.

- Occurrence Codes
  - 22 – Date Active Care Ended (Last day of Medicare)
  - 25 – Date Benefits Terminated (First day of Medicaid)
  - A3 – Benefits Exhausted (Last day of Medicare)
  - B3 – Second Payer Exhaust (Last day of Medicare)

  - Medicare Medicaid Alignment Initiative (MMAI) program participants:
    - Both Medicare and Medicaid covered services must be billed to the MCO.

  - Long Term Services and Support (LTSS) program participants:
    - Medicaid covered services must be billed to the MCO.
    - Medicare covered services must be billed to the Medicaid first and may be submitted to Medicaid after Medicare's adjudication.

For recipients participating in the LTSS program, claims submitted directly to HFS should be for Medicare covered service periods only and must show the Medicare as the primary payer. The Medicare payment amounts should be reported as a claim level adjustment in loop 2320. The REF02 segment in loop 2330 must show the Medicare TPL code 909 followed by a 2-digit TPL Status Code. (List of TPL Status Codes is attached)

❖ **Reporting of Covered Days for Medicare Part A Beneficiary With No Medicare Covered Days to Report:**

If there is no Medicare coverage to report on a claim for a recipient who has traditional Medicare Part A coverage, all days except leave of absence days should be reported as covered days and Medicaid should be reported as the primary payer.

- Value Codes:
  - Value Code 80 – Covered Days = Medicaid days only
  - Value Code 81 – Non-Covered Days = LOA days only

For skilled nursing (Type of Bill 21X) claims submitted for Medicaid coverage only, Medicaid should be reported as the primary payer using an Occurrence Code A2 to indicate the first full day of Medicaid coverage, or an Occurrence Code (A3 or 22) stating the last day of Medicare coverage. The associated Occurrence Code A2 date should be equal to the recipient's admit date (if resident never had a qualifying stay) or the date Medicaid became the primary payer after Medicare coverage ends. The associated Occurrence Code A2 date must be prior to or equal to the Service From date of the claim. The Occurrence Codes (A2, A3 or 22) are not needed for claims submitted for intermediate care (Type of Bill 65X).

- Occurrence Codes
  - A2 – Effective Date of Policy (First day of Medicaid) = Admit date or date Medicaid became primary payer)

In the event that a new Qualifying Stay begins in the middle of a month, Medicaid will expect a separate Medicare primary claim beginning with the day the recipient returned to your facility. The date of return should be reported as the admission date on the claim.

Claims for Recipients Who Have Commercial Insurance Coverage

HFS previously indicated that if Department records showed a recipient to have commercial insurance coverage, the Third Party Liability (TPL) payment information must be reported on the claim. Because LTC services are often not covered by insurance plans, HFS has determined that TPL payment information will **not** be required to be reported on the claim.

However, HFS will still allow TPL payments to be reported as a reduction from payable charges when submitted on the LTC claim in the "Other Payer" loop. The Department will also continue to seek collection of non-reported TPL payments through the current collection process.

Commercial insurance payer (TPL) payment amounts should be reported as claim level adjustments in claim loop 2320. The REF02 segment in claim loop 2330 must be the 3-digit TPL Code followed by the 2- digit TPL Status Code. Providers may refer to the "Source Code" field found in the TPL section of the MEDI eligibility verification for a recipient's three-digit TPL code. A list of assigned TPL codes can be located in the Provider Handbook Chapter 100, Appendix 9 A list of HFS accepted TPL Status Codes is attached.

Claims for Recipients with Medicare Advantage Plans (MAP) Coverage

Medicare Advantage Plans are not considered "traditional Medicare Part A" and are not sent to Medicaid through the fiscal intermediary. Although Medicare Advantage Plans operate much like traditional Medicare coverage, HFS will treat MAP coverage like a commercial insurance in the Medicaid payment system. HFS has assigned all Medicare Advantage Plans the TPL code of 920 to be used when reporting MAP payment information.

❖ **Claims billed directly to Medicaid for recipients who have MAP coverage on the system and are also a participant in a Managed Care Program through a Managed Care Organization (MCO):**

- Medicare Medicaid Alignment Initiative (MMAI) program participants:
  - Both Medicare and Medicaid covered services must be billed to the MCO.

- Long Term Services and Support (LTSS) program participants:
  - Medicaid covered services must be billed to the MCO.
  - Medicare covered services must be billed to the MAP first and may be submitted to Medicaid after MAP adjudication.

  For recipients participating in the LTSS program, claims submitted directly to HFS should be for coinsurance period covered by the MAP only. Provider may submit the claim as a skilled nursing (Type of Bill 21X) and show the MAP as the primary payer. The TPL code of **920** must be reported in the REF02 segment, in claim loop 2330, followed by the 2- digit TPL Status Code. The amount paid by the MAP should be reported as claim level adjustment in claim loop 2320.

❖ **Claims billed directly to Medicaid for recipients who have MAP coverage on the system and are <u>Not</u> a participant in a Managed Care Program through a MCO:**

Claims for recipients who have MAP coverage on the system but are not participating in a Managed Care Program will be sent directly to HFS as a straight Medicaid claim. The MAP provider must be shown as the other payer if payment is received from the MAP. The TPL code of 920 must be reported in the REF02 segment, in claim loop 2330, followed by the 2- digit TPL Status Code. The amount paid by the MAP should be reported as claim level adjustment in claim loop 2320.

If none of the monthly services being billed were covered by the MAP, a skilled nursing (Type of Bill 21X) claim may be submitted showing Medicaid as the primary payer using an Occurrence Code A2 to indicate the first full day of Medicaid coverage. The associated Occurrence Code A2 date should be equal to the recipient's admit date (if resident never had a qualifying stay) or the date Medicaid became the primary payer after MAP coverage ends. The associated Occurrence Code A2 date must be prior to or equal to the Service From date of the claim. The Occurrence Code A2 is not needed for claims submitted for intermediate care (Type of Bill 65X).

- Occurrence Codes
  - A2 – Effective Date of Policy (First day of Medicaid) = Admit date or date Medicaid became primary payer)

Questions regarding this document may be directed to the Bureau of Long Term Care at (217)782-0545 or 1-844-528-8444 (toll free).

TPL Status Codes

01 – TPL Adjudicated – total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 – TPL Adjudicated – patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 – TPL Adjudicated – services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

05 – Patient Not Covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 – Services Not Covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 – Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, thirty (30) days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 – Estimated Payment: TPL Status Code 08 may be entered if the provider has billed the third party, contact was made with the third party, and payment is forthcoming but not yet received. The provider must indicate the amount of the payment estimated by the third party. The provider is responsible for any adjustment, if required, after the actual receipt of the payment from the third party.

10 – Deductible Not Met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

99 – Zero or Negative Payment: TPL Status Code 99 identifies a zero or negative payment by Medicare on a crossover claim.