NURSING FACILITY MEDICAID ADD-ON

TRAINING

February 9, 2024

DEPARTMENT OF
PUBLIC HEALTH &
HUMAN SERVICES

PRESENTATION OVERVIEW

- Introduction
- Updates to Medicaid Add-on structure
- Billing
- Resources
- MPQH

MEDICAID ADD-ON STRUCTURE

- As of January 1, 2024, Senior and Long Term Care has updated the Medicaid add-on structure for Nursing Facilities. Reimbursement for add-ons are for residents with extreme or complicated cases. These are residents with "**above and beyond**" the normal scope of care needed for Nursing Home residents. This program is for temporary help for these extreme cases; however, we do realize that it can be longer than short term help in some cases. The specific add-on requests are for:

1. Bariatric Care
2. Traumatic Brain Injury (TBI) or Brain Injury
3. Behaviors
4. Wound Care

MEDICAID ADD-ON REQUIREMENTS

- Pursuant to Administrative Rule of Montana (ARM) 37.40.330 (2), Medicaid nursing facilities are eligible for an enhanced rate payment to assist with safe, effective, and appropriate service delivery to at-risk populations residing in long-term care facilities. The Senior and Long Term Care Division requires a prior authorization process to occur prior to the Department's authorization of eligible add-on funding for complex care. Mountain Pacific Quality Health (MPQH) program staff will evaluate the applications as documented by the requesting provider to determine that:
  - The request is for extreme cases that are medically necessary and relate specifically to the resident's diagnosis and documented plan of care.
  - The request will coincide with one of the Complex Care Levels and provide a direct medical or remedial benefit to the resident adhering to health and safety standards and clinical best-practices.
  - Resident is Medicaid eligible and enrolled.
  - Individuals with tracheotomy or ventilator care will continue to be evaluated for prior authorization per ARM 37.40.330 and are not covered in the structure below.

NEW MEDICAID ADD-ON COMPLEX CARE LEVELS

Complex Care Level	Description	Rate
Level I **Minimal Assist-Infrequent Intervention**	**Behavioral**: Low level of care and need for occasional assistance and support in one or more ADLs with conditions that require limited additional assistance. Have a diagnosed health disorder with history of demonstrated disruptive behaviors that occur on an infrequent basis of 1-4 times per week and require staff intervention.	$75.00
Level II **Stand-By Assist-Moderate Intervention or Assistance Care**	**Behavioral**: Moderate level of care with need for more assistance with ADLs compared to Level I. Level of assistance varies depending on resident needs. Have a diagnosed health disorder with history of demonstrated disruptive behaviors that occur on a regular basis of more than 4 times a week. Greater assistance is required to redirect and assure safety of the resident. **Bariatric**: Residents **over 350 pounds** but under 650 pounds who require ADL assistance from more than one staff member. May include wound care associated with skin breakdown due to weight. **Wound Care**: Interventions for residents with a stage 3 wound. Full thickness tissue loss. Subcutaneous fat may be visible, but bones, and tendons are not exposed. May include some undermining or tunneling. Dressing changes up to 2 times a day, pain management, pressure reductions and increased infection control.	$150.00
Level III **Total Assist-Direct Intervention and Assistance Care**	**Behavioral**: High level of care and extensive and frequent assistance. Residents with diagnosed severe mental or physical ailments that impact their ability to live independently. May need around-the-clock assistance from multiple caregivers to support them. Assistance needed with administering medications, performing medical treatments, help with all ADLs, and management of daily difficult behavior changes. Intense assistance is required to redirect and assure safety of the resident. **Bariatric**: Residents who are **over 650 pounds**. Require major assistance with ADLs and repositioning that require more than one staff member. May include some wound care associated with skin breakdown due to weight. **Wound Care**: Interventions for residents with stage 4 wound. Full thickness tissue loss. Subcutaneous fat, bones, tendons, and muscle are exposed. Eschar and slough are present. Greater than 2 dressing changes or use of wound VAC, frequent monitoring and pain management, pressure reduction and increased infection control.	$225.00

The following situations are not eligible for assignment to Levels II and III:

- Individuals at risk of elopement without aggressive or assaultive behaviors
- Individuals enrolled in Hospice care.

NEW MEDICAID ADD-ON APPLICATION

- Resident must meet the criteria for the minimum level requested.
- Fill out the applicant's name, Medicaid ID and the facility requesting the add-on.
- Mark if the request is new, or a continuation of a prior authorization.
- The level being requested should align with the appropriate description included on the Complex Care Levels table.
- Include diagnoses related to the level being requested.
- The 30-Day Summary should include an overview of the client's needs, conditions, and behaviors and include the goals relating to the request.

Applicant and Facility Information

Applicant Name ________________ Medicaid ID ____________

Facility Name ________________ Provider ID ____________

Type of Request

☐ New Request

☐ Continued Request – Provide Current Documentation from the last 90 days.

Level Requested

☐ Level I ☐ Level II ☐ Level III

Diagnoses

30 Day Summary of Clients Needs/Conditions and Behaviors (include resident goals relating to the request)

APPLICATION PROCESS

- The Complex Care Levels Request Form and applicable records need to be sent to Mountain Pacific's website at: https://www.mpqhf.org/corporate/Medicaid-portal-home/.
- All documents required to process the request must be submitted with the application. You will be contacted if additional information is needed to review and/or process the application. Please make sure to send all required documents pertaining to the request, or it can be denied for insufficient information.
- No more than 3 months of notes, that are specific to the requested level, are required to be submitted with the application.
- For HIPAA compliance, it is not advisable that providers submit more medical records than requested.
- Applications cannot be backdated, the date they are submitted to MPQH is the date they are eligible to start from.
- A specific timeframe for approvals is set forth for each specific category. Authorizations related to wound care will be authorized for 90 days and all other services for 180 days. For continuation of any services, updated documentation must be submitted and reviewed at the end of each set timeframe.
- Denial letters will be sent if there is missing information that is not received by the due date, as well as if your add-on does not meet the qualifications for approval. Denials, or approvals at a lower level than requested will be explained in the acceptance/denial letter.

MEDICAID ADD-ON COMPLEX CARE REQUIRED DOCUMENTATION

Required Documentation

- Face/demographic sheet
- History and physical (most recent)
- Care plan
- **Applicable** progress/chart notes
- Current medication and treatment orders
- Behavior chart log (behavior only)
- Behavioral plan (behavior only)
- Nutritionist order with current documented weight (bariatric only)
- Wound care team notes (wound care only)

Documentation should include information from the last 1-3 months. Documentation submitted must reflect frequency and severity of the behaviors and each behavior must be documented separately. Facilities must demonstrate that the resident has a history of persistent disruptive behavior that is not easily altered and requires an increase in resources from nursing facility staff. Additional documentation may be requested as necessary and failure to submit the required documentation could result in denial. For HIPAA compliance, it is not advisable that providers submit more medical records than requested.

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Medicaid Utilization Review and Ambulance Provider Portal

Portal Sign In

Portal Registration

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Home

Welcome to the Mountain Pacific Medicaid Provider Portal, powered by Telligen, an Iowa-based company with extensive experience providing utilization management services.

Using this Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant portal, providers will have 24/7 access to:

- Electronically submit new requests using "drag and drop" functionality vs. faxing or mailing documents
- Upload supporting documentation, e.g., medical records, letters, etc.
- Review status of pending requests
- Review determinations (Notification of determinations are emailed to requesters.)
- Retrieve history of previous requests, determinations and prior authorization numbers

This portal provides a two-way, secure data exchange between requesting providers and Mountain Pacific. We are always looking for ways to improve our partnership with providers. Our goal is to save time and gain efficiencies, and this portal helps do that.

Telligen

Sign In

Username

Password

Keep me signed in

Sign in

Reset Password

OR

Sign in with Telligen SSO

Sign in with CWOPA SSO

REMINDERS

- Ensure that a Level Of Care (LOC) is submitted to Mountain Pacific Quality Health (MPQH) for eligibility determination to be made first. Residents must be eligible and enrolled in Medicaid to participate in the add-on program.
- Nursing Home Spans are **required** for ALL Swing Bed and Nursing home facilities and need to be in place before any add-ons can be billed/paid to Medicaid. They must also be current through the application and billing date span.
- Add-ons are a "MEDICAID ONLY" program. Billing to Medicare is not necessary.
- Reimbursement for add-on rates can only occur while resident resides at the facility. If the resident leaves for any length of time, MPQH must be notified.
- Resident's transferring from one facility to another that already have an approved add-on will be able to transfer the remainder of the add-on authorization to the receiving facility. This also applies to any facilities that have change of ownerships. However, in order to make this continuity of care happen MPQH **must** be notified of the transfer/CHOW to make sure the authorization is updated to reflect the new changes. If notification is not done, claims will not process.

BILLING FOR MEDICAID ADD-ONS

1. All add-on requests require prior authorization
2. Fill out all highlighted areas of the 1500 form.
3. Enter all resident info in the sections highlighted, make sure to check the "NO" box on if the resident has any TPL. This claim is for MEDICAID ONLY - TPL is not relevant.
4. Enter your auth number above the charges.
5. Enter the diagnosis code/pointer on line 1.
6. Make sure your dates are exactly within the span you were authorized.
7. Enter the place of service - for nursing facilities you enter 31.
8. The code for add-ons is A9999.
9. The dollar amount you were authorized is multiplied by the days that were authorized to get your total charges. (30 days X $ amount per day)
10. Enter your tax ID in box 25.
11. ONLY enter the address of the facility the resident resides. The facility info must be the only information on this claim at the bottom in box 32 and 33 to be valid. DO NOT enter any other provider info anywhere on this claim.
12. Your taxonomy code must be submitted in box 33b at the bottom right of the claim with a "ZZ" modifier in front to process.
13. You MUST sign and date this form for it to be valid.
14. Any questions on how to fill out this form call Jenifer Thompson, claims specialist, at Senior and Long-Term Care: 406-444-3997

MONTANA DPHHS DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

SPECIAL NOTE:

- Current authorizations for add-ons will continue at the rate they were approved until they expire.
- Authorizations that were in effect as of January 1, 2024 forward can be re-evaluated for the appropriate level by submitting a new request to MPQH.
- For authorizations that were approved since January 2024, the authorization will only be dated back to the date it was originally authorized.
- Re-evaluations must be submitted by March 15, 2024, to be authorized for the new rate.

RESOURCES

- MPQH: https://www.mpqhf.org/corporate/Medicaid-portal-home/
- MPQH Contact #: 1-800-219-7035
- Nursing facility website: https://medicaidprovder.mt.gov/26