MY CARE OHIO UPDATE NOVEMBER 2015

2016 Managed Care and Open Enrollment

Open Enrollment (OE) for Medicaid individuals in managed care programs is November.
The OE notices started going out in July with MyCare folks receiving notices first.
The last of the OE batches were done in early Sept.

Sources at ODM that MITS have not been correctly updating the Part C & D info under MEDICARE. If you see discrepancies, providers should go with Medicare's verification of coverage.

Recently, a correction at the state was put into production for the Part C issue. So hopefully when looking in MITS for verification NFs will not continue to see discrepancies.

Patient Liability and MyCare Plans---Adjustments and Corrections—"Reconciliation" Project

Nursing Facilities are expected to enter patient liability amounts to claims. However, when the MyCare plans process and pay claims, they use the patient liability from the Medicaid electronic file (834) and not what is on the claim. When there is a discrepancy, resolving the claim so it will pay accurately has been a challenge. The plans and associations, along with ODM staff, have been meeting to resolve the patient liability problems, and according to Medicaid they have devised a plan.

Summary of the patient liability dilemma and proposed solutions

Remember, other adjustments not specific to 9401s to the 834 data not matching should continue to be filed.

Phase 1 of the reconciliation process is where the MyCare plans were provided with a list of residents where -0- patient liability was passed to the plans and applied in error due to wrong information in the 834 file. Medicaid corrected the problem between the interface where recipients had an established patient liability in their CRISE budget yet the 834 file showed -0- The MyCare plans are recouping money from the Skilled Nursing Facilities for cases in which they incorrectly deducted zero patient liability as a result of these errors in the data provided by the Department of Medicaid (ODM). Providers may receive a list of the recipients affected, and should be checking remittances for these auto adjustments which are being done now.

Providers should not submit patient liability reconciliation spreadsheets with accompanying 9401s or other documentation to the MyCare plans while these adjustments are being completed. According to the state and the associations, if an adjustment has already been made the claim will not be adjusted a second time. We strongly recommend you watch remits carefully.

Phase 1A will cover MyCare members where MITS erroneously showed zero patient liability, yet the liability is now corrected in MITS. ODM provided the MyCare plans with a list of individuals affected.

For any other cases where the patient liability in the 834 transaction and the 9401 do not agree, or where there are interface problems, ODM intends to provide written direction to facilities.

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Additional information to be aware of:

The county caseworker cannot make any changes to the 834 electronic file forwarded to managed care plans. A monthly file is provided from the state with plan enrollment information, Medicaid eligibility, third party insurance, births and deaths, patient liability, etc). The plans extract the data and load it. The information is derived from MI where many of the updates come from CRISE. When the 834 and the 9401 differ, the 834 cannot be changed to match the 9401.

There are a number of reasons the 834 and the 9401 may differ. Examples--- caseworker error, a state hearing decision that PL was overcharged and the nursing facility is ordered to refund retroactively, or income was not reported correctly. CRISE cannot be corrected retroactively so the 9401 is the method for the county to inform the facility that an adjustment to PL is needed.

If you need to adjust a claim based on the 9401, and the MyCare plan will not process it, you can complete and forward the Medicaid complaint form. Here is the link to the Medicaid complaint form:
http://medicaid.ohio.gov/PROVIDERS/ManagedCare/ProviderComplaint.aspx

Plan specific issues:

Buckeye:
When billing Buckeye MyCare skilled claims or therapy claims, use the Buckeye ID # that begins with "C". Custodial claims are billed with the normal Medicaid ID #.

Molina:
Recently put a fix in place so claims that have exceeded the therapy cap will pay as long as there is a valid authorization in place.

Providers will need to file a claim reconsideration request to have the claim reviewed for Medical necessity if no authorization was obtained

CareSource:
Applies coinsurance to skilled days for dually enrolled when their policy has been to pay the skilled days with no coinsurance. Providers please check your contracts.

Aetna:
When processing adjustments, Aetna will often apply the current rate instead of applying the rate applicable to the date of service.

United Health Care:
Claims will deny if outside the billing timeframe which is short; check your contract to see what the timeframe for billing is (90 or 180 days) and adhere to it.

General Updates:

Patient Liability – Assisted Living: All the plans except Aetna are processing patient liability for Assisted Living residents. Again, plans are using the data from the 834 electronic file.

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Lump Sums: The plans are not processing lump sums correctly when entered on a claim, and are still trying to correctly process lump sum adjustments. All of the plans confirmed with the associations that lump sum amounts should be entered under Value Code 31 even if not used by the plan to process the claim.

Restricted Medicaid: Medicaid has provided the MyCare plans with a list of residents who were on “Restricted Medicaid” due to an improper transfer, and who were therefore not eligible for room and board payment. Plans are not able to monitor for the Restricted Medicaid. Therefore, claims, if billed, will pay in error. The plans are in the process of taking money back for these claims.

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