
Billing Instructions for Nursing Home Providers

1. All nursing homes must submit invoices to VNS Health no later than 90 days after the end of the month in which services are provided or from the date of the Medicare explanation of benefits (EOB), whichever is greater.
2. If payment is obtained from other sources to offset some or all of VNS Health billing responsibilities, documentation of these payments must be included with the claim.
3. VNS Health MLTC will pay all undisputed claims in accordance with New York State Prompt Pay regulations.
4. Medicare rules are unchanged, even if an individual is a member of VNS Health MLTC.

Bedhold

VNS Health follows New York State Medicaid Program policy regarding payment for bedholds. Upon member admissions to nursing facilities when VNS Health is the primary payer, VNS Health representatives provide the Care Manager with contact names and numbers. See Section 1 of this provider manual for contact information. It is essential that a nursing home notify the appropriate VNS Health regional office when a member is hospitalized. This allows the Care Manager to discuss Bedhold with the facility and to follow the member's care while in the hospital. The member must be in the facility for a minimum of thirty (30) days to be eligible for Bedhold payment, subject to a vacancy rate on the first day of the member's absence of not more than 5%. VNS Health must be notified at the time of member hospitalizations in order to authorize and approve Bedhold payments.

Payment to a facility for reserved bed days provided for **temporary hospitalizations** may not exceed **twenty days**. The twenty days are reset based on when the member's 12-month period began.

General Procedure:

1. On a monthly basis, the nursing home submits claims to VNS Health for services provided on a UB-04 CMS (HCFA)-1450.
2. A separate invoice must be submitted for each member. For members enrolled in Medicare or Medicare Managed Care Organizations ("MCO"), the Explanation of Benefits (EOB) must also be attached.
3. If Medicare or a Medicare MCO was NOT billed prior to billing VNS Health, then the Nursing Home must attach a copy of the "Ineligibility for Medicare Benefits" form to the invoice.

4. Depending on the type of health insurance the member has and the location of the member immediately prior to the nursing home admission, one of the following procedures should be followed:

If the member is admitted from a hospital:

A. The member has both Medicare Part A and Institutional Medicaid

- If the member was an inpatient of a hospital for at least 3 consecutive days and was admitted to the nursing home within 30 days of hospital discharge, then Medicare is usually the primary payer and VNS Health is the secondary payer. Medicare rules do not change when an individual is a member of VNS Health.
- The nursing home evaluates the member to determine if he/she meets Medicare coverage criteria. If so, Medicare or the Medicare MCO should be billed following the nursing home's standard procedures.
 - ❖ During days 1 through 20, Medicare covers 100 percent of the charges, with no co-payment
 - ❖ During days 21 through 100, Medicare pays a portion of the charges. For these days, VNS Health is responsible for all co-payments. The nursing home should submit an invoice to VNS Health and attach the Medicare or Medicare MCO remittance advice showing the co-payment that is due. If this is not attached, the invoice will be denied and returned to the nursing home with a request that Medicare be billed first.
 - ❖ It is understood that Managed Medicare plans may have a different cost sharing structure than Medicare fee for service. In those cases, the Managed Care's Remittance Advice will be used to determine what if any cost sharing will be reimbursed by VNS Health MLTC.

B. The member has Institutional Medicaid and there is no other eligible payer (including individuals who do not have Medicare Part A and those who are assessed as having no rehabilitation potential)

- If the member does not have Medicare Part A or is not expected to benefit from rehabilitation therapies, then VNS Health is responsible for paying all nursing home costs, beginning on the date of admission. The nursing home should submit its invoice to VNS Health at their current rate. The nursing home should submit documentation of its Medicaid rate as updated by the New York State Department of Health. The "Ineligibility for Medicare Benefits" form should be attached to the invoice.

C. The member does not have Institutional Medicaid

- A member without Institutional Medicaid is only eligible for nursing home care if they have Medicare Part A and meet the conditions for coverage under the Medicare program. The nursing home should bill Medicare or the Medicare MCO for its services and VNS Health for any co-payments, as described in section A above. If nursing home services are required beyond 100 days, the member will be required to disenroll from VNS Health and his/her family will have to pay privately for any ongoing care.
- A member without Institutional Medicaid is not eligible for long term nursing home care through the VNS Health program. If a nursing home placement is the only appropriate setting to care for this member, he/she will be required to disenroll from VNS Health and his/her family will have to pay privately for nursing home care.

If the member is admitted from the community:

D. The member has Institutional Medicaid

- VNS Health is responsible for paying all nursing home costs, beginning on the date of admission. The nursing home should submit its invoice to VNS Health at the agreed upon rate. The "Ineligibility for Medicare Benefits" form should be attached to the invoice.

DI. The member is not eligible for Institutional Medicaid

- A member ineligible for Institutional Medicaid is not eligible for long term nursing home care through the VNS Health program. If a nursing home placement is the only appropriate setting to care for this member, he/she will be required to disenroll from VNS Health and his/her family will have to pay privately for nursing home care.

Medicaid Eligibility and NAMI (Net Available Monthly Income)

Nursing Home Medicaid Eligibility

The New York City Human Resources Administration (HRA) published guidelines addressing nursing home admissions when a resident is a member of a Managed Long-Term Care (MLTC) program. The guidelines direct the MLTC programs to coordinate Medicaid eligibility functions with the nursing facility.

In order for HRA to properly capture NH days/stays, it is advised that your facility submit a Medicaid conversion for every long-term (permanent) placement admission and a discharge form when appropriate. (This is the same process that nursing homes use for all Medicaid admissions.) This will allow HRA to track admissions and days for MLTC members. HRA will process the admission, but the member will remain on VNS Health's roster. The resident will not appear on the nursing home's Medicaid roster.

VNS Health is the payer for the Medicaid portion of the nursing home bills of its members instead of Medicaid. As such, VNS Health coordinates all other Medicaid eligibility activities for its members with HRA, such as annual recertification. VNS Health may coordinate some of the necessary documents for financial recertification with the nursing home's staff but, again, VNS Health staff will manage the Medicaid eligibility issues with HRA.

Net Available Monthly Income (NAMI)

VNS Health will continue to collect any Medicaid surplus for its members placed in nursing homes until the placement becomes permanent. Once it is confirmed that the member is to remain in the nursing home for long-term care, the nursing home will be notified of the NAMI application and to begin the process of re-routing monthly income. VNS Health determines the NAMI amount and will coordinate with the nursing home's billing department regarding the timing and amount of the NAMI.

Each month, VNS Health sends contracted nursing homes a roster listing member who were residents in the facility during the previous month. The roster indicates:

- ❖ Member name
- ❖ Placement status, e.g. short-term or long-term
- ❖ NAMI amount (if applicable)
- ❖ VNS Health Care Manager's name
- ❖ Contact telephone numbers for VNS Health regional staff and Claims Department.

Guide to assist providers in understanding and complying with VNS Health billing requirements for Licensed Home Care Services Agencies (LHCSA) and Consumer Directed Personal Assistance Program (CDPAP)

https://www.vnsnychoice.org/sites/default/files/VNSNY_CHOICE_LHCSA-FI_Claim_Submission_Guide_3.19.19.pdf

Guide to assist Home care rate code definitions and Universal Billing codes and modifiers for Adult Day Health Care and Social Adult Day Care.

https://www.health.ny.gov/facilities/long_term_care/reimbursement/letters/docs/dal_2017-12-07_billing_codes.pdf