Nursing Facility Add On Training

When and How to Request Add-ons

Ad on Fees

- As of July 1, 2020, ARM 37.40.307 was updated
  - Allows Add-on fees for:
    - Bariatric Care
    - Traumatic Brain Injuries (TBI)
    - Behaviors
    - Wound Care

    - - Let's go over in detail when these fees can be requested and how to fill in the Add On /Rate Request form.

Add-On's Specific Criteria

Bariatric	**-Self Abuse** **-Hoards** **-Refuses assistance for bathing**	• **$2.05/day (350-600 lbs.)** • **$5.49/day (600+ lbs.)**
TBI	-Self-Abuse -Inflicts injury on others -Escapes -Makes disruptive sounds, noises, and screams	➢ $75/day: ➢ Must have TBI diagnosis. ➢ Minimum of 1 behavior/need that is not present in the average nursing facility resident.
Behaviors	-Inflicts injury on others -Self-Abuse -Verbal Aggression -Danger to self and others -Sexual Behaviors	➢ $75/day: ➢ Verbal Aggression and/or; ➢ Escapes more than 3X/week ➢ $80/day: ➢ -Sexual Behaviors ➢ $100/day: Case by case basis ➢ -Danger to self and/or others
Wound Care	-Refuses assistance to clean wound -Picks at wound/takes off bandages -Depends on whether the wound is open to assist in the healing process	➢ $20/day: ➢ Wound is currently open and/or; ➢ Wound requires wound dressing at least once a day ➢ -Supplies are separately billable.
Bariatric	-Self Abuse -Hoards -Refuses assistance for bathing	➢ $2.05/day (350-600 lbs.) ➢ $5.49/day (600+ lbs.)

- Services must be <u>Prior Authorized</u> for a specific date range.
- Detailed, itemized list with any add-ons not listed on fee schedule.
- Medical Care Plan documentation support.

Requesting Extra Care Hours

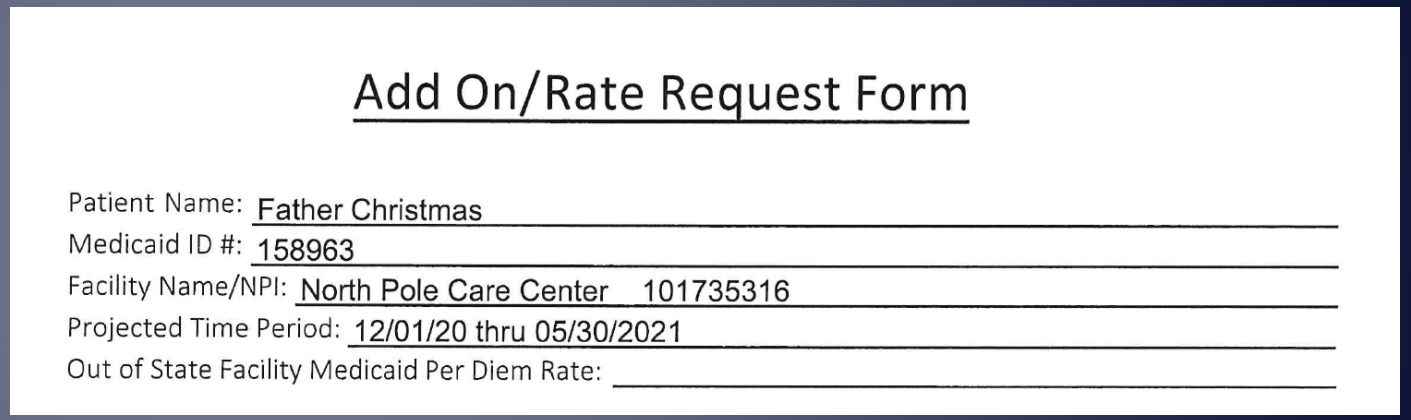
- Include a breakdown of hours and what it is needed for.
- Extra Care Hours are only for extraordinary cases on a short-term basis.

EXAMPLE

Resident requires 2-person team to reposition every 4 hours. CNA 15 minutes 5 times a day to assist with repositioning. CNA rate is $15/Hr. 1.25 hours per day. Daily cost of $18.75 is add on request.

ADD ON REQUEST FORM

- Top half: straight forward.
  - -Fill in name
  - -Medicaid ID
  - -Facility name
  - -NPI
- Projected time: most requests up to 90 days.



Add On/Rate Request Form

Patient Name: Father Christmas

Medicaid ID #: 158963

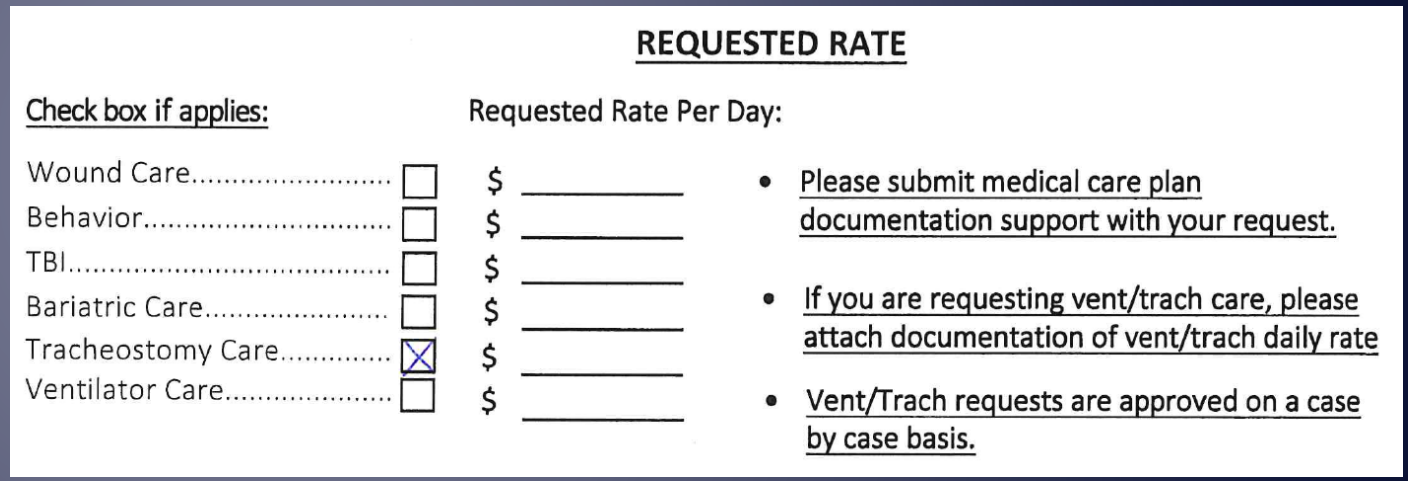
Facility Name/NPI: North Pole Care Center 101735316

Projected Time Period: 12/01/20 thru 05/30/2021

Out of State Facility Medicaid Per Diem Rate:

ADD ON REQUEST FORM

- Middle Section:
  - -Indicate Fees
  - -Add Required documentation.
- Vent and Trach care indicated here.
- No facilities at this time.
- Offer services?



REQUESTED RATE

Check box if applies:		Requested Rate Per Day:
Wound Care.....	☐	$ _____
Behavior.....	☐	$ _____
TBI.....	☐	$ _____
Bariatric Care.....	☐	$ _____
Tracheostomy Care.....	☒	$ _____
Ventilator Care.....	☐	$ _____

- Please submit medical care plan documentation support with your request.
- If you are requesting vent/trach care, please attach documentation of vent/trach daily rate
- Vent/Trach requests are approved on a case by case basis.

ADD ON REQUEST FORM

- Vent/Trach Section

  -Indicate Totals for each area requested if any needed.

Additional Staffing- Use only for Vent/Trach requests:

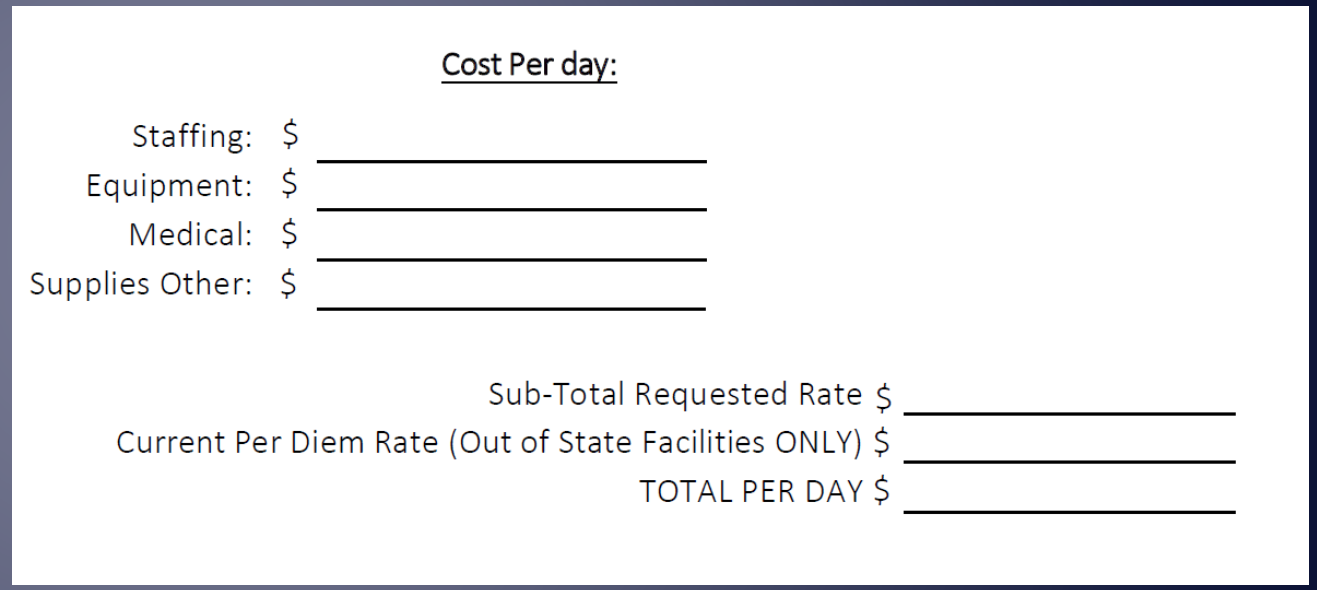
	Number of Staff:	Cost Per Hour:	Cost Per Day:
LPN		$	$
RN	2	$ 36.00	$ 72.00
CNA	1	$ 12.75	$ 12.75
R.T.		$	$

ADD ON REQUEST FORM

- Last section:

  -Totals for each column

- In-state facilities only need "Subtotal Requested Rate" and "Total per day".
- Out of state facilities use middle line for "Per Diem Rate".



Cost Per day:

Staffing: $ _____

Equipment: $ _____

Medical: $ _____

Supplies Other: $ _____

Sub-Total Requested Rate $ _____

Current Per Diem Rate (Out of State Facilities ONLY) $ _____

TOTAL PER DAY $ _____

ADD ON REQUEST FORM

EXAMPLE

Add On/Rate Request Form

Patient Name: Father Christmas
Medicaid ID #: 158963
Facility Name/NPI: North Pole Care Center 101735316
Projected Time Period: 12/01/20 thru 05/30/2021
Out of State Facility Medicaid Per Diem Rate: _____

REQUESTED RATE

Check box if applies:		Requested Rate Per Day:
Wound Care.....	☐	$ _____
Behavior.....	☐	$ _____
TBI.....	☐	$ _____
Bariatric Care.....	☐	$ _____
Tracheostomy Care.....	☐	$ _____
Ventilator Care.....	☐	$ _____

- Please submit medical care plan documentation support with your request.
- If you are requesting vent/trach care, please attach documentation of vent/trach daily rate
- Vent/Trach requests are approved on a case by case basis.

Additional Staffing- Use only for Vent/Trach requests:

	Number of Staff:	Cost Per Hour:	Cost Per Day:
LPN	_____	$ _____	$ _____
RN	2	$ 36.00	$ 72.00
CNA	1	$ 12.75	$ 12.75
R.T.	_____	$ _____	$ _____

Cost Per day:

Staffing:	$	84.75
Equipment:	$	
Medical:	$	
Supplies Other:	$	

Sub-Total Requested Rate $ 84.75
Current Per Diem Rate (Out of State Facilities ONLY) $ _____
TOTAL PER DAY $ 84.75

QUESTIONS?

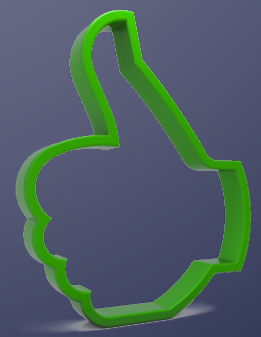

why
when
who
where
what
why
QUESTIONS
who
how
where
who
what
how
how

PRIOR AUTHORIZATION!

What does this mean to facilities?

Authorizations

- All add-on requests require prior authorization.
  - Protects Medicaid
  - Protects Facility
- If add-ons are approved, an approval letter with a prior auth number is sent to the facility.
- Auth number needs to be used when billing for the services requested.
- Please note, for current residents who develop behavior problems, or severe wounds, Add-ons can be requested, but approvals will not be backdated.

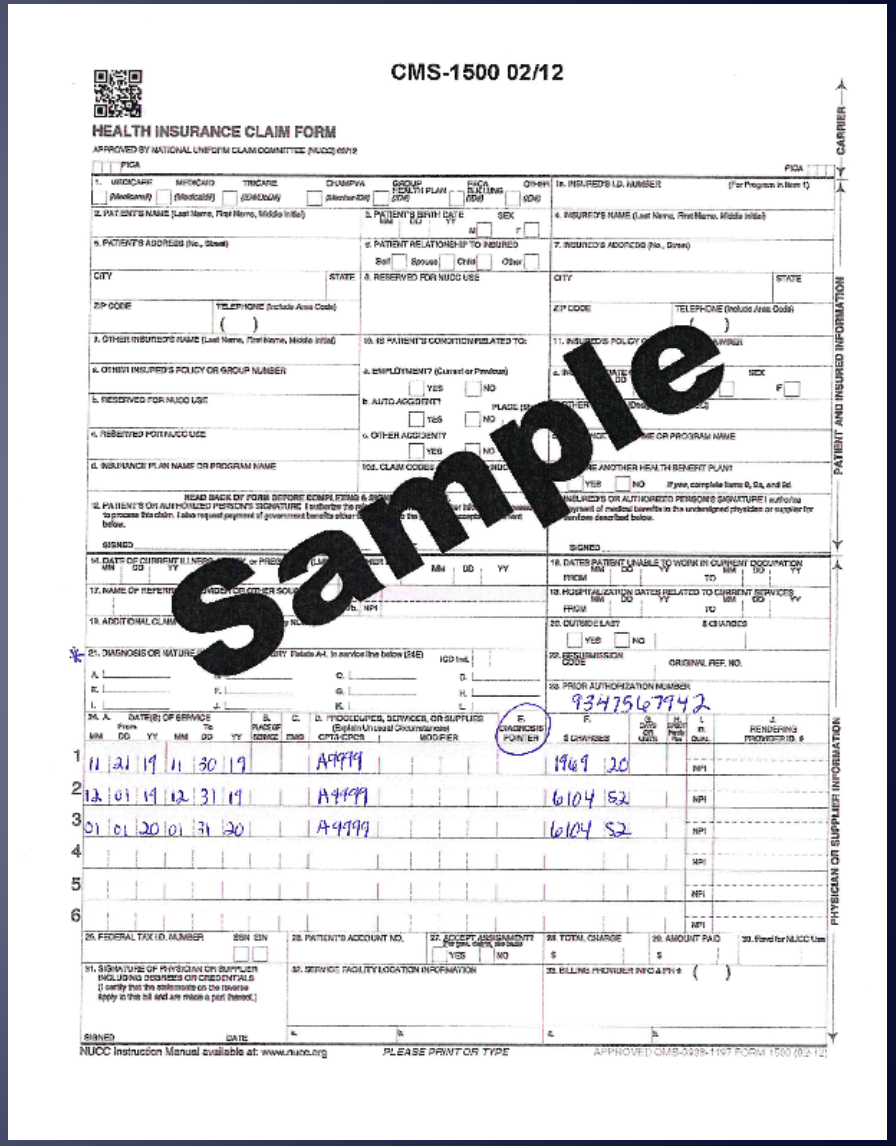


- Prior to resident's arrival date, or prior to expected date of billing for add-on:
- Add-On form needs to be sent to Jenifer Thompson at: Jenifer.Thompson@mt.gov
- Can be faxed to:

  406-444-7743
- All pertinent medical documents need to be included with request.

- Ensure that a Level Of Care (LOC) is submitted to Mountain Pacific Quality Health (MPQH) for eligibility determination to be made.
- **Approval of Add-ons is not an approval of Medicaid eligibility.**

- In order to expect payment BOTH must be approved.
- Takes up to 3 days, or more, to review.
- If resident is accepted into facility before approval, and is denied, facility will not be paid for any provided services.
- Add-on Charges need to be billed on a CMS 1500 form.



SWING BED (https://medicaidprovider.mt.gov)

PARTICIPATION REQUIREMENTS

- Be a licensed hospital.
- Be a licensed medical assistance facility (MAF).
- Be a critical access hospital (CAH) which is Medicare certified to provide swing bed services.
- Enroll as a Medicaid swing bed hospital provider.
- Have fewer than 50 hospital beds, excluding beds for newborn and intensive care, beds in a distinct part of psychiatric or rehabilitation unit, beds in a separately certified nursing facility, and beds that are not consistently utilized by the hospital.

SWING BED (https://medicaidprovider.mt.gov)

ADMISSION REQUIREMENTS

- Swing beds are to be used only when there is no appropriate nursing facility bed available within a 25-mile radius of the swing bed critical access hospital, that can meet the resident's needs.
- Swing Bed Critical Access Hospital must canvas all the nursing facilities within the 25-miles, the Swing Bed facility must first attempt placement at the nursing facility and document the denial date, and reason prior to admission.
- Swing bed hospital and critical access hospitals must include in medical record, documentation that supports that no nursing facility bed was available to document the appropriateness of the admission into the swing bed and the milling to Medicaid.
- Medicaid recipient must meet level of care (LOC) requirements based on screening completed by the Mountain Pacific Quality Health.

SWING BED

BILLING REQUIREMENTS

- Swing bed providers bill the per diem rate established by Medicaid on the Form MA-3.
- Swing bed facilities may bill Montana Medicaid electronically for per diem charges.
- Services that are included in the swing bed per diem rate, and the services that can be billed in addition to the per diem, are the same as for nursing facility providers.
- Ancillary Services are billed to Medicaid on a CMS-1500 form.
- Ancillary Services/Fees: Require Prior Authorization. Refer to Ancillary fee schedule for covered services.
- These may include Oxygen with certificate of Medical Necessity, Nutritional Solutions, routine supplies used in extraordinary amounts, dental care, Durable Medical Equipment (DME), therapy services (restorative), and transportation.

ELECTRONIC BILLING

There are two ways to submit claims to the Montana Healthcare programs, electronic and paper.

Electronic claims are processed much faster.

Please use the website below to enroll your facility.

https://medicaidprovider.mt.gov/claims

Conduent is the clearing house for Montana Medicaid. Electronic billing must be set up with them. Any questions you may have on electronic filing will be covered in this section of the Provider's Manual.

COVID SUPPLEMENTAL PAYMENTS

- At this time, payments will continue until December 31st. No information as to if this will continue into 2021.
- Payments are calculated on paid, clean claims within a pre-determined time frame. This time frame is the 1st through the 15th, and 16th through the end of the month.
- Facilities will be paid $40 for each day these claims represent.

CLOSING:

- Contact information:
  - For questions, please contact Dee Burnham at: 444-4129, or Dee.Burnham@mt.gov, or Jenifer Thompson at: 444-3997, or Jenifer.Thompson@mt.gov.
  - Fax: 444-7743

- Questions?