Statewide Medicaid Managed Care (SMMC)
Requirements for Reimbursement of Nursing Facility Medicare Part A Coinsurance Claims

I. Overview of Requirements for Nursing Facility Medicare Part A Coinsurance Claims

Medicare Part A benefits cover up to 100 days of rehabilitative care in a nursing facility. There is no Medicare Part A coinsurance during the first 20 days of a nursing facility stay. The Medicare Part A coinsurance period is day 21 through 100 of the nursing facility stay.

SMMC plans must pay a portion of the Medicare Part A coinsurance when Medicare has paid less than the Medicaid per diem minus the patient responsibility. SMMC plans must reduce payments for nursing facility Medicare Part A coinsurance claims by the amount of the enrollee’s patient responsibility except if the enrollee is dually eligible for Medicare and Medicaid and is receiving Supplemental Security Income (SSI) or is Qualified Medicare Beneficiary (QMB).

- LTC plans cover nursing facility Medicare Part A coinsurance claims for their enrollees.
- MMA plans cover nursing facility Medicare Part A coinsurance claims for their enrollees that are not enrolled in LTC.

SMMC plans must reduce payments for nursing facility Medicare Part A coinsurance claims by the amount of the enrollee’s patient responsibility except if the enrollee is dually eligible for Medicare and Medicaid but is not receiving SSI or is not QMB. An enrollee with SSI (MS aid category) and Medicare Part A is automatically QMB, but the QMB may not always show up as a separate category of eligibility.

II. Medicaid Aid Category Required for Nursing Facility Medicare Part A Coinsurance Claims

SMMC plans may only adjudicate nursing facility Medicaid Part A coinsurance claims after DCF has determined the amount of the enrollee’s patient responsibility, except if the enrollee is dually eligible and receives SSI or is QMB. DCF has determined the enrollee’s patient responsibility when the enrollee is approved for one of the MI benefit codes: MI A, MI I, MI M, MI P, or MI S. The following chart provides a description of these the MI aid category codes.

<table>
<thead>
<tr>
<th>MI A</th>
<th>Institutional Care Medicaid Supplemental to Medicaid for ‘Low Income Families’</th>
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</thead>
<tbody>
<tr>
<td>MI I</td>
<td>Stand Alone Institutional Care Medicaid</td>
</tr>
<tr>
<td>MI M</td>
<td>Institutional Care Medicaid Supplemental to MEDS for Aged or Disabled (MMS)</td>
</tr>
<tr>
<td>MI P</td>
<td>Institutional Care Medicaid Supplemental to Protected Medicaid</td>
</tr>
<tr>
<td>MI S</td>
<td>Institutional Care Medicaid Supplemental to SSI Medicaid (MS)</td>
</tr>
</tbody>
</table>

Information about verifying an enrollee’s eligibility is accessible on the Agency for Health Care Administration’s website [http://ahca.myflorida.com/](http://ahca.myflorida.com/). Select Medicaid, select Statewide Medicaid Managed Care, select News and Events, and then select Event and Training Materials.
The description of the aid category code MI T is: Institutional Care Medicaid Failed Due to Transfer of Assets. An aid category code MI T means DCF has determined a penalty period of ineligibility due to improper transfer of assets. SMMC plans may not reimburse nursing facilities for services provided during any month the recipient has a Medicaid benefit code of MI T.

III. Level of Care X Required on Nursing Facility Medicare Part A Coinsurance Claims

Nursing facility Medicare Part A coinsurance claims must be billed with the level of care alpha value code X.

IV. Revenue Center Code Required on Nursing Facility Medicare Part A Coinsurance Claims

Nursing facility Medicare Part A coinsurance claims are billed with revenue center code #0101 regular room and board days, regardless of the revenue center code billed on the Medicare claim.
- No other revenue codes are billed on nursing facility Medicare Part A coinsurance claims.
- No procedure codes are billed on nursing facility Medicare Part A coinsurance claims.

V. Covered Days Required on Nursing Facility Medicare Part A Coinsurance Claims

Nursing facility Medicare Part A coinsurance claims must be billed with dates of service that do:
- include days 21 through 100 of a Part A stay when a Medicare coinsurance is due; and
- not include days 1 through 20 of a Part A stay when no Medicare coinsurance is due.

VI. Medicaid Rate Used to Adjudicate Nursing Facility Medicare Part A Coinsurance Claims

LTC plans use the facility specific Medicaid nursing home rate to adjudicate nursing facility Medicare Part A coinsurance claims.

VII. Medicare Rate Used to Adjudicate Nursing Facility Medicare Part A Coinsurance Claims

Nursing facility claims for Medicare Part A coinsurance must be billed with the Medicare per diem rate in the UB-04 Form Locator Box 47. If the Medicare per diem rate for the enrollee changed during the month, the nursing facility is to submit a weighted average Medicare per diem rate (weighted based on the number of days each rate is paid).

Note: The Medicare Part A coinsurance amount is not billed in UB-04 Form Locator Box 47.

Note: The net Medicare paid amount (meaning the amount of the Medicare rate less the amount of the Medicare Part A coinsurance) is not billed in UB-04 Form Locator Box 47.

VIII. Claim Status and Explanation of Benefits Code Required for Nursing Facility Medicare Part A Coinsurance Claims Paid at Zero Dollars

When SMMC plans calculate a zero dollar payment amount for a nursing facility Medicare Part A claim, the claim must have a ‘PAID’ status with an explanation of benefits code that explains the calculated payment is zero because other insurance paid more than the Medicaid allowable.
IX. Logic for Reimbursement of Nursing Facility Medicare Part A Coinsurance Claims

The following examples illustrate the logic used to calculate the reimbursement of nursing facility Medicare Part A coinsurance claims.

Example 1

- Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- The SMMC plan’s per diem for this nursing facility is $200 per day. The Medicare payment exceeds the facility’s per diem rate.
- The SMMC plan owes $0 coinsurance payment.
- The enrollee’s patient responsibility amount is $0 and the SMMC plan would pay the nursing facility claim $0, because no payment amount is due.

Example 2

- Medicare paid $2,200 (after the coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- The SMMC plan’s per diem for this nursing facility is $225 per day. The Medicare payment is less than the facility’s per diem rate.
- Medicaid owes $5 X 10 Days = $50 total coinsurance payment.
- If the enrollee is QMB eligible, the patient responsibility amount is $0 and the SMMC plan would pay the nursing facility claim at $50. If the enrollee is not QMB eligible, see example 3.

Example 3

- Medicare paid $2,200 (after the Medicare Part A coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- The SMMC plan’s per diem for this nursing facility is $225 per day. The Medicare payment is less than the facility’s per diem rate.
- The SMMC plan owes $5 X 10 Days = $50 total coinsurance payment.
- The enrollee is not QMB. The enrollee has a monthly patient responsibility of $500.
- The nursing facility collects $50 of the 10 days pro-rated patient responsibility from the enrollee and the SMMC plan would pay the nursing facility claim at $0.

Example 4

- Medicare paid $2,200 (after the Medicare Part A coinsurance is subtracted) for 10 days. This calculates out to $220 per day.
- The SMMC plan’s per diem for this nursing facility is $235 per day. The Medicare payment is less than the facility’s per diem rate.
- The SMMC plan owes $15 X 10 Days = $150 total coinsurance payment.
- The enrollee is not QMB. The enrollee’s pro-rated patient responsibility for 10 days is $125.
- The nursing facility collects $125 of the patient responsibility from the enrollee and the SMMC plan would then pay the nursing facility claim the additional $25.
Note: The amount of the enrollee’s patient responsibility is zero during nursing facility Medicare Part A coinsurance days if the enrollee is QMB eligible or if the amount of the Medicare Part A coinsurance amount that Medicaid owes per day is less than or equal to $0.

Note: If Medicaid owes any amount of a nursing facility Medicare Part A coinsurance per day and the enrollee is not QMB eligible, the amount of the difference owed can be taken from the patient responsibility up to the total amount owed. If the patient responsibility does not totally pay the amount owed, the difference can then be paid by the SMMC plan.

Note: SMMC plans and nursing facilities cannot collect any amount of patient responsibility that is in excess of the amount applied to the provider’s payment.

### X. Critical Billing Fields

<table>
<thead>
<tr>
<th>Required Data</th>
<th>UB-04 Paper Claim</th>
<th>EDI 837I Submission</th>
</tr>
</thead>
</table>
| Monthly Patient Responsibility| Form Locator Box 39-41

  → Requires entry of Value Code 31 in the first field, followed by the monthly amount of patient responsibility in the second field.

  → Entry of an amount for patient responsibility is required, even if that amount is a zero dollar value, except if the recipient is QMB or SSI. |
|                                | 2320 Loop AMT Segment                                                           |                      |
| Covered Days                   | Form Locator Box 39-41

  → Requires entry of Value Code 80 in the first field, followed by the number of covered days in the second field.

  → There is no Medicare Part A coinsurance due on days 1 through 20 of a nursing facility stay. Nursing facilities should only bill for dates of service when a Medicare Part A coinsurance is due, which would be on days 21 through 100 of a Medicare Part A stay. |
|                                | 2320 Loop AMT Segment                                                           |                      |
| Revenue Center Code            | Form Locator Box 42

  → Requires entry of the four digit revenue center code #0101 for room and board per diem. |
|                                | 2400 Loop AMT Segment                                                           |                      |
| Level of Care And Medicare Per Diem | Form Locator Box 81 d

  → Requires entry of Qualifier Code 02 in the first field, followed by level of care code ‘X’ in the second field, followed by the amount of the Medicare per diem in the third field. |
|                                | Level of care: 2300 Loop CN segment reference CN 104.  
Medicare per diem: 2300 Loop CN segment reference CN 102. |
XI. Timely Filing Limits for Medicare Coinsurance Claims

The filing limit for Medicare coinsurance claims is the greater of 36 months from the date of service or 12 months from Medicare’s claim adjudication date.

XII. Additional Information About Nursing Facility Reimbursement

Refer to the following handbooks for more information about reimbursement policies for nursing facility services. Florida Medicaid handbooks are accessible on the Public Provider Web Portal at www.mymedicaid-florida.com:

- Florida Medicaid Provider General Handbook;
- Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook;
- Florida Medicaid Provider Reimbursement Handbook, UB-04; and
- Florida Medicaid Hospice Services Coverage and Limitations Services Handbook.

Contact your local Medicaid area office if you have any questions about nursing facility reimbursement policies. You may access contact information for your local Medicaid area office on the Public Provider Web Portal at www.mymedicaid-florida.com.
Frequently Asked Questions

1. Is additional information available about Statewide Medicaid Managed Care (SMMC)?
   There are many different ways to learn about this new program. The Agency has a website with questions and answers and training events with a live chat feature to ask questions. The website is at http://ahca.myflorida.com/SMMC. The local Medicaid Area Office can also answer questions about the program.

2. Are “patient responsibility” and “share of cost” the same thing?
   No. While these terms are often used interchangeably, ‘patient responsibility’ and ‘share of cost’ are not the same.

   ❖ The term ‘patient responsibility’ is used to refer to the amount of the individual’s income that the Department of Children and Families (DCF) determines is the amount a recipient must pay towards the cost of Medicaid long-term care services.

   ❖ The term ‘share of cost’ is used to refer to the amount of medical expenses the individual must incur each month before DCF can determine the individual eligible for the Medicaid ‘Medically Needy’ program. A recipient must submit the appropriate medical bills to the DCF before DCF can determine the recipient has met their ‘share of cost’ and is eligible for the Medicaid ‘Medically Needy’ program for that month. A recipient eligible for the Medicaid ‘Medically Needy’ program cannot be determined eligible for Medicaid nursing facility services.

3. If the individual is enrolled in the Long-term Care (LTC) program, does the Managed Medical Assistance (MMA) plan cover the nursing facility claims for Medicare Part A coinsurance and Part B coinsurance?
   No. The MMA plan does not cover nursing facility Medicare Part A and Part B coinsurance when the individual is also enrolled in the LTC program. If the individual is enrolled in the LTC program, the LTC plan is responsible for covering the enrollee’s nursing facility Medicare Part A coinsurance and Part B coinsurance claims.

4. If the individual is not enrolled in the Long-term Care (LTC) program, does the Managed Medical Assistance (MMA) plan cover the nursing facility claims for Medicare Part A coinsurance and Part B coinsurance?
   Yes. If the individual is not enrolled in the LTC program, the MMA plan is responsible for covering the enrollee’s nursing facility Medicare Part A and Part B coinsurance claims.