INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER BULLETIN

BT200903 FEBRUARY 10, 2009

To: **Nursing Facility, Long-term Care Providers, and Intermediate Care Facilities for the Mentally Retarded**

Subject: **Autoclosure Billing**

Overview

This bulletin reminds all long-term care (LTC) providers of the appropriate billing practice for Indiana Health Coverage Programs (IHCP) residents discharged from LTC facilities. Although providers have been notified of this requirement in multiple publications, including Chapter 14 of the *IHCP Provider Manual*, the volume of calls received by the Office of Medicaid Policy and Planning (OMPP), the Division of Aging (DA), and EDS indicates that a reminder is necessary.

Using Correct Discharge Status Codes Is Important

To ensure that IHCP members receive all benefits to which they are entitled, it is the responsibility of each LTC provider to properly document the discharge of residents in a timely manner. Since January 1998, Indiana*AIM* has used the patient status code from the UB-04 claim form (locator box 22, STAT) to close the member's level-of-care (LOC) segment. This eliminates the need for submitting written discharge information to the OMPP.

During a recent review of claims, the IHCP noted that many LTC facilities are incorrectly coding claims for members leaving LTC facilities. Using incorrect status codes for claims leads not only to overpaying the facility, but also prevents members from receiving services such as supplies and pharmacy prescription fulfillment upon discharge from LTC facilities. Providers should be aware that overpayments to facilities are subject to recoupment.

The following discharge status codes are the only valid codes for members who are discharged from LTC facilities:

- 01 – Discharged to home or self-care, routine discharge
- 02 – Discharged or transferred to another short-term hospital for inpatient care

- 05 – Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution
- 07 – Left against medical advice or discontinued care
- 08 – Discharged or transferred to home care under intravenous provider
- 20 – Expired

Even though LTC providers do not receive reimbursement for the date of discharge, it is imperative that LTC providers carefully complete the UB-04 claim form to ensure that the "To Dates of Service" (TDOS) line on the claim form accurately reflects the actual date of discharge for the member. When billing practices do not accurately reflect the "TDOS" or the patient status code, the following situations cause difficulty for providers or members:

- When a member is discharged, but the LTC claim indicates a status code of 30 – *Still a patient,* the provider is stating the member is still a patient. EDS and the OMPP are not aware of the member's discharge from the LTC facility, and the LOC segment continues to show the member in an LTC facility. The member is unable to obtain medications, durable medical equipment (DME), and other items while in the community, possibly endangering the member's health and safety. Additionally, the LTC facility could be overpaid. These overpayments are subject to recoupment.

> ***Note:*** ***Status code 30* – Still a patient *is used by a facility only if the member is still a patient.***

- When the provider bills using the incorrect patient status code, indicating the member was discharged even though the member remains a resident of the facility, the member's LOC segment in Indiana*AIM* is closed, showing the "TDOS" on the claim form as the stop date. Subsequent claims submitted for the member deny with explanation of benefits (EOB) 2008 – *Recipient not eligible for this LOC for DOS.* Providers aware of paid claims listing incorrect patient status codes are instructed to submit adjustments or replacements to correct the patient status code. This ensures that the correct information is reflected in Indiana*AIM*.

In either situation described above, the following steps must be taken:

- Denied claims cannot be adjusted. If a claim is denied because of incorrectly billed patient status codes, contact the **Long Term Care Helpdesk at (317) 488-5094** and leave a voice message containing all pertinent information, including the member identification (RID) number; the provider name, Medicaid number, and telephone number; and the dates of service for the denied claims.
- During the third week of each month, an LTC analyst reviews the denials. If the claims indicate that an incorrect patient status code was billed, the level-of-care stop date can be manually removed. To have claims considered for payment, two steps must occur:

- First, the provider must adjust or replace paid claims that indicated an incorrect discharge status code.
- Second, the provider must call the Long Term Care Helpdesk to have the LOC updated.

Note: To avoid unnecessary recoupments, providers should not replace claims on Web interChange when more than one year has passed from the date of service.

After the LOC changes are made, the denied claims can be rebilled and considered for payment. If the denied claims are resubmitted prior to the LOC being updated, the claims will deny again with edit 2008 – *No LOC on File.*

- **EDS deactivates the autoclosure process for retro-rate adjustments**. This prevents claim denial and the creation of unnecessary accounts receivable for LOC segments that have previously been manually restored by EDS, following notification that the provider billed the incorrect patient status code.

Documentation Required When Past the Claim-filing Limit

To request waiver of the timely-filing limit, the provider must show documentation of reasonable and continuous attempts to resolve claim payment problems. This applies to claims submitted on paper, electronically using the 837 format, or through Web interChange.

The following are examples of supporting documentation that can be submitted with the request:

- Records of action taken to collect from other insurers, the IHCP, or the person who received the services
- Dated paper remittance advice (RA) statements with internal control numbers (ICNs) that note filing timeliness; dated statements, bills, and claim forms; letters to and from insurers or the insured; and collection notices
- Records of action taken if a third-party payer fails to respond:
  - The provider must indicate 90-Days NO RESPONSE on an attachment
  - The third-party liability (TPL) form locator must be completed appropriately for carrier information
  - A copy of the letter, bill, or statement to the insurance company is appropriate documentation to waive the one-year filing limit. Detailed information is located in Chapter 5 of the *IHCP Provider Manual*.
- Records of action taken to resolve the claim problem. Examples include:
  - Written Inquiry responses
  - Indiana Prior Review and Authorization Request Decision forms
  - Letters to and from the county office
  - Letters to the regional EDS field consultant or the member

- The results from the Claim Status Inquiry window in Indiana*AIM* showing all submissions of the claim for proof of timely filing
- For waiver providers, proof that a Plan of Care was issued late or copies of the review findings letter from an audit

> *Note: Computer or handwritten ledger collection-tracking records are sources of history about attempts to resolve claim issues. While these are not adequate proof of filing, collection-tracking records indicate documentation that may be available from other sources.*

How to Submit Claims for Filing-limit Waiver

Paper claims sent for filing-limit waiver processing should be structured as follows:

- Legible and signed paper claim; photocopies are acceptable.
- Required supporting documentation, such as sterilization consent forms, Medicare or third-party liability (TPL) denials, and invoices; photocopies are acceptable.
- Documentation attached in chronological order that illustrates the provider's attempts to resolve extenuating circumstances. Examples are IHCP RA statements, returned IHCP written inquiries, letters from the local county office, letters from other insurance carriers, and returned prior authorization (PA) forms. A chronological narrative is also helpful.
- Documentation trail attached to each claim. Each claim stands on its own merit, so multiple claims must have individual documentation trails attached. Multiple claims with only one set of documentation are not acceptable for filing-limit processing.
- Correct address for the claim type. Send filing-limit claims to the routine claims-processing address for the respective claim type:

  EDS LTC Claims
  P.O. Box 7271
  Indianapolis, IN 46207-7271

  EDS Adjustments
  P.O. Box 7265
  Indianapolis, IN 46207-7265

> *Notes: Any gap in filing-limit documentation must be addressed in the attachments.*
>
> *Requests for waiver of the timely-filing limit will be forwarded to the State for consideration.*

> *For providers using copies of claims for attachments: The UB-04 claim form has a bar code at the top. The bar code indicates a new claim, and thus a new sequence number, to the scanner in the EDS mailroom. When sending copies of claims as attachments, the provider must place a large X through the claim copy to indicate to the processor that it is a claim copy being used for filing-limit documentation.*

Clarification Regarding Billing Bed-hold Days

Hospital bed-hold days **must be billed** using revenue code 185 or 180, based on the facility's occupancy percentage. The claim must reflect the actual date of discharge as the "to" date of service.

> *Note: When the 15-day bed-hold period has expired, the resident **is no longer required** to be discharged.*

The following examples show correct billing of bed-hold days:

- A resident was in an LTC facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the facility on July 2. The LTC facility should bill for June service dates as follows: 23 days of *per diem* for the appropriate LOC and seven days of hospital bed hold per revenue code 185. The status code would be 30, because the member is still a resident of the facility during the bed-hold days.
- If the same resident was discharged from the hospital to home or to another facility and does not return to the LTC facility on the anticipated date of July 2, the July bill should reflect one day of bed hold and discharge on July 2 with a status code of 02.
- Although the date of discharge is not reimbursed, the claim must reflect this date with the appropriate status code reflecting true disposition of the resident.
- **Bed hold cannot be billed when the resident's return is not anticipated.**
- Providers must bill nonpaid leave days using revenue code 180. This is appropriate when the occupancy rate is below 90 percent.

Providers that have previously received payment for a particular resident, but have recently received claim denials for Edit 2008, should contact the **EDS Long-Term Care (LTC) Unit** at **(317) 488-5094**. **Providers must not contact the Division of Aging directly or send in a new Form 450B**. An EDS LTC analyst can review the denial reasons specific to the claim. If the member's LOC was discontinued as a result of the discharge status code, the analyst reviews the claims to determine which claim caused the autoclosure. If an incorrect status code was used, the analyst advises the provider of any action that should be taken and, in many cases, manually reopens the LOC. If the resident exhausted bed-hold days, it is no longer necessary for the

provider to submit a new Form 450B. Unless instructed to do so by the EDS LTC Unit, providers should not submit new Form 450Bs for bed-hold days.

Contact Information

If you have questions about this bulletin, please contact Customer Assistance at (317) 655-3240 in the Indianapolis local area or toll-free at 1-800-577-1278.

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