INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Long-Term Care

LIBRARY REFERENCE NUMBER: PROMOD00037
PUBLISHED: APRIL 11, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2016
(*Core*MMIS UPDATES AS OF FEBRUARY 13, 2017)
VERSION: 1.2

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: October 13, 2016	Semiannual update: • Edited and reorganized text throughout for clarity, and removed redundant information • Specified that PACE is only available in designated service areas • Listed individual forms that comprise *Form 450B* and standardized references to each form • Updated the *Completion and Certification of e-450B* section, including adding a note that the *e-450B* process will be changing and removing outdated link • Added the PASRR Level II form to Table 2 • Updated information in the *Member Level-of-Care Appeal Process* section • Updated the IAC reference under the *Application of Recalculated Case-Mix Indices and IHCP Rates* section • Updated reference from QMRP to QIDP in the *Case-Mix Reimbursement* section • Updated information on nursing facility special care unit add-on in the case-mix reimbursement calculation under *Nursing Facility Services*	FSSA and HPE

Version	Date	Reason for Revisions	Completed By
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 11, 2017	• Replaced Indiana*AIM* references with *Core*MMIS • Replaced Web interChange references with Provider Healthcare Portal (Portal) • Replaced LPI references with Provider ID • Revised billing instructions and claim field references to include electronic billing • Clarified the maximum amount of the Nursing Facility Quality Add-On in the *Case-Mix Reimbursement* section • Updated the *Autoclosure Billing* section and subsections • Updated EOB description and RA field names in the *Medicare Crossover Payment Policy* section • Added a note box in the *Type of Bill* section with information about an issue with small ICF/IID claim billing	FSSA and HPE

Table of Contents

Introduction 1
State Level-of-Care and *Form 450B* Reviews for Long-Term Care Members 1
- Indiana Preadmission Screening Objectives 1
- Form 450B 2
- Completion and Certification of e-450B 3
- OMPP 450B SA/DE Nursing Facility Level of Service – State Authorization and Data Entry 3
- Medicare to IHCP Processing 4
- Resident Changes from Private-Pay to IHCP Member 4
- Transfers between Nursing Facilities 4
- Transfers from Hospital to Nursing Facilities 4
- Retaining Forms in Patient Charts 8
- Preadmission Screening and Resident Review Process 8
- Review Procedures 12
- Member Level-of-Care Appeal Process 14
- MDS Review Findings and Rate Calculation Appeal Process 16
- Managed Care Considerations 18

Long-Term Care Reimbursement Methodologies 19
- Nursing Facility Services 19
- Intermediate Care Facilities for Individuals with Intellectual Disability Services 22

Billing Instructions for Long-Term Care Services 24
- Nursing Facility Services 24
- Intermediate Care Facility for Individuals with Intellectual Disability Services 34
- Preadmission Screening and Resident Review Billing Procedures 35

Introduction

The Family and Social Services Administration (FSSA) and the Centers for Medicare & Medicaid Services (CMS) design and define the following for the Long Term Care (LTC) program:

- Level of care (LOC)
- Preadmission Screening (PAS) and Preadmission Screening and Resident Review (PASRR)
- Case-mix reimbursement methodology

These safeguards are necessary to protect the health and welfare of institutionalized Indiana Health Coverage Programs (IHCP) members, as well as all individuals with mental illness, intellectual disability, or developmental disability (MI/ID/DD). This review system assists the FSSA in meeting its responsibilities under the law while effectively monitoring, processing, and ensuring appropriate payment of nursing facility (NF) claims.

Note:	*The IHCP offers the Program of All-Inclusive Care for the Elderly (PACE), effective January 2015, in designated service areas within the state. For more information about PACE, see the Member Eligibility and Benefit Coverage module.*

State Level-of-Care and *Form 450B* Reviews for Long-Term Care Members

The FSSA determines the appropriateness of the IHCP reimbursement for all placements of IHCP members in IHCP-certified NFs. For NFs subject to case-mix reimbursement, there are no longer skilled and intermediate levels of IHCP reimbursement. However, the criteria found in *Indiana Administrative Code 405 IAC 1-3-1* and *405 IAC 1-3-2* continue to define the threshold of nursing care needs required for admission to or continued stay in an IHCP-certified NF. The FSSA Division of Aging (DA), the PAS agencies, and Myers and Stauffer LTC review teams use these criteria.

The primary objective of the LOC review is to determine whether a resident needs NF care in accordance with the State LOC criteria set forth in *405 IAC 1-3-1* and *405 IAC 1-3-2*.

Indiana Preadmission Screening Objectives

All IHCP and non-IHCP applicants to IHCP-certified NFs are referred to the local PAS agency to initiate the PAS process. The PAS agency continues to render medical decisions about the need for NF care under the criteria in *405 IAC 1-3-1* and *405 IAC 1-3-2* for NF applicants. The local Aging and Disability Resource Center (ADRC), commonly referred to as the Area Agency on Aging (AAA) or the PAS agencies, processes the PAS and PASRR.

When all required information is submitted, the ADRC renders final decisions on the PAS cases pursuant to *455 IAC 1-1-12*. To expedite the PAS determination process, it is critical that the provider fully complete Section I: *Recipient Identification* and Section II: *Physician's Medical Evaluation* of the *Physician Certification for Long Term Care Services* form, referred to as *Form 450B*. The provider must include all appropriate information on *Form 450B*. When the physician completes and signs Section II of *Form 450B* or delegates this responsibility to the physician assistant (PA) or nurse practitioner (NP), no one else can make any changes or additions to Section II. All updated or additional information must be provided as an attachment with an explanation of the new or changed information provided and a signature or notation of the name of the individual providing the additional information. Attachments should support, or more fully explain, the information documented on the *Form 450B.*

Under the case-mix system of reimbursement, the physician must certify on *Form 450B* the need for NF care, rather than a specific LOC.

Form 450B

This section outlines *Form 450B* for IHCP reimbursement in an NF or for Home and Community-Based Services (HCBS) waivers. The section titled *OMPP 450B Nursing Facility Level of Service – State Authorization and Data Entry* provides information about the use of the *Nursing Facility Level of Service State Authorization and Data Entry* form *(State Form 49120 [11-98]/OMPP 450B SA/DE)*, referred to as *OMPP 450B SA/DE.*

Form 450B is required for the following:

- Admission to an NF
- Facility-to-facility transfers
- Placement on HCBS waivers
- Authorization for IHCP reimbursement for intermediate care facilities for individuals with intellectual disability (ICFs/IID)
- Authorization for IHCP reimbursement to NFs for residents who subsequently become eligible for IHCP services

Form 450B includes several sections and is divided into distinct State forms, as follows:

- *Physician Certification for Long Term Care Services (State Form 38143 [R5/6-93] Form 450B/PASARR2A)*

  This form includes Sections I and II, and is available from the *Forms* page at indianamedicaid.com.
- *PASRR Level I – Identification Evaluation Criteria Certification by Physician for Long-Term Care Services (State Form 45277 [R2/7-02]/Form 450B/PASRR2A – Sections IV and V, Part A)*
- *PASRR Categorical Determination for Short-Term Nursing Facility Care – Certification by Physician for Long Term Care Services (State Form 45932 [R/6-93] Form 450B/PASARR2A – Section V, Part B)*
- *Certification by Physician for Long-Term Care Services and Physical Examination for PASRR Level II (State Form 45278 (2-92)/Form 450B/PASARR2A – Section VI)*

Form 450B can be accessed online with the state of Indiana at the *State Forms Online Catalog* at in.gov.

Completion and Certification of e-450B

> *Note: The online e-450B process is changing effective July 1, 2016. For updates, see the PASRR page at in.gov/fssa.*

The DA has developed an electronic *450B* (*e-450B*) process. The *e-450B* process is required for the following assessment case types being submitted to the DA for review and processing:

- PAS requests for continued stay in the NF
- New Medicaid effective dates
- NF transfers
- Waiver to NF care
- PAS/PASRR not completed

> *Note: Nursing facilities not reimbursed by the case-mix methodology are subject to the same e-450B processing requirements.*

The *e-450B* process requires the following documentation for PAS requests for continued stay in the NF and for the PAS/PASRR not completed assessment types:

1. Completed *e-450B*
2. Copy of the *Indiana Pre-Admission Screening Program – Assessment Determination (State Form 707/Form 4B),* referred to as *Form 4B,* or *OMPP 450B SA/DE*
3. Copy of the current medication list including dosages and frequencies
4. Typed Resident Summary authored by a registered nurse (RN) or licensed practical nurse (LPN) or the nursing facility social worker

The *e-450B* process requires the following documentation for the new Medicaid effective dates, NF transfers, and waiver to NF care:

- Completed *e-450B*
- Copy of the *Form 4B* or *OMPP 450B SA/DE* or waiver letter

OMPP 450B SA/DE Nursing Facility Level of Service – State Authorization and Data Entry

The *Nursing Facility Level of Service State Authorization and Data Entry* form *(State Form 49120 [11-98]/ OMPP 450B SA/DE),* referred to as *OMPP 450B SA/DE,* is a State-authorized, computer-generated document that is initiated by the DA when the following conditions are met:

1. The PAS/PASRR assessment is completed by the PAS agency.
2. The individual has a valid IHCP Member ID (also known as Medicaid number, or RID).
3. The nursing facility name is identified.
4. The nursing facility admission date is entered.

After the four criteria are met and the PAS agency completes the export process to the DA, the DA will review and enter the information, as deemed appropriate, into the Medicaid Management Information System (MMIS). The NF will receive via email the DA's computer-generated *OMPP 450B SA/DE,* indicating the member's NF Medicaid effective date.

Medicare to IHCP Processing

If the resident has a State-authorized *450B* in place for the current facility and is receiving Medicare services while in the NF, a new State-authorized *450B* will *not* be required. The Medicare claim automatically crosses over from the Medicare reimbursement system to the Core Medicaid Management Information System (*Core*MMIS) for possible IHCP reimbursement of the coinsurance or copayment and deductible for dually eligible residents in NFs.

For new IHCP members, do not delay in submitting the *e-450B* when waiting for the Medicare coverage period to stop. Submit the *e-450B* immediately to DA for LOC processing.

If the resident does not have an approved *Form 450B* or *OMPP 450B SA/DE* for IHCP reimbursement for the current institutionalization, the facility must submit the *e-450B* and required documents to DA for review and processing.

Resident Changes from Private-Pay to IHCP Member

After the member has been notified of his or her Medicaid eligibility, the NF must complete the *e-450B* along with the required documents and submit the documentation electronically to DA for review and processing.

Transfers between Nursing Facilities

For IHCP members who transfer between NFs, the receiving NF must complete the *e-450B* along with the required documents and submit the documentation electronically to the DA for review and processing.

Transfers from Hospital to Nursing Facilities

The NF that has an IHCP resident who has been admitted to a hospital and returns to the same NF is not required to complete a new *e-450B*.

When an IHCP resident has been admitted to the hospital from one NF and then transfers to another NF, the new NF is required to submit the *e-450B* along with the required documents electronically to the DA for review.

Table 1 provides more information.

Table 1 – Initial PAS and PASRR Process when Client Is an IHCP Member

Note: New Medicaid effective dates, NF transfers, and waiver to NF care assessment types trigger the short e-450B version of the e-450B. The short e-450B document does not require the physician, PA, or NP signature.

Scenario	Required Forms	NF Responsibility	DA Responsibility	Official Form to Be Retained on Chart
1. PAS and PASRR assessments are completed by the PAS agency.	• Form 4B		The DA completes the computer-generated *OMPP 450B SA/DE* form from the data provided by the AAA. The following information is required: • IHCP Member ID (Medicaid number [RID]) • Admission date • Admitting nursing facility named The NF receives via email the approved *OMPP 450B SA/DE* from the DA that reflects the Medicaid effective date.	Computer-generated *OMPP 450B SA/DE*
2. PAS and PASRR are not completed by the PAS agency (for example, discharged from NF prior to full assessment being completed).	• Form 4B • *e-450B* process (includes the *e-450B*, Resident Summary, *Form 4B*, and medication/treatment list)	NF completes the *e-450B* process.	The DA receives and reviews data, and enters the Medicaid effective date into the LOC segment of the MMIS.	State-authorized *e-450B*
3. From the HCBS waiver to an NF	• Waiver letter • Short *e-450B*	NF completes the *e-450B* process unless DA has issued the State-authorized *OMPP 450B SA/DE*.	The DA completes the computer-generated *OMPP 450B SA/DE* form using the data provided by the AAA. The following information is required: • IHCP Member ID (Medicaid number [RID]) • Admission date • Admitting nursing facility named The NF receives via email the approved *OMPP 450B SA/DE* from the DA that reflects the Medicaid effective date.	Computer-generated *OMPP 450B SA/DE*
			If the computer-generated *OMPP 450B SA/DE* form is **not** completed by the DA, the NF completes the *e-450B* process; the DA receives and reviews data, and enters the Medicaid effective date into the LOC segment of the MMIS.	State-authorized short *e-450B*

Scenario	Required Forms	NF Responsibility	DA Responsibility	Official Form to Be Retained on Chart
4. PAS and PASRR assessments are completed by the PAS agency. (PAS agency does not have an admission date, NF listed, or IHCP Member ID [Medicaid number/RID] for member.)	• Form 4B • Short *e-450B*	NF completes the short *e-450B* process.	The DA receives and reviews data, and enters the Medicaid effective date into the LOC segment of the MMIS.	State-authorized short *e-450B*
5. Request for continued stay: a. PAS cases, regardless of payer source (DA issues determination) b. PASRR cases, regardless of payer source (PAS agency issues determination).	a. PAS cases: ➢ Form 4B ➢ *e-450B* process (includes the *e-450B*, Resident Summary, *Form 4B*, and medication/ treatment list) b. PASRR cases: NF may complete the process by using either of the following two options: ➢ Submit the required *e-450B* documentation. ➢ Submit paper *Form 450B*, minimum data set (MDS), nurses' notes, progress notes, and *Form 4B*.	a. PAS cases: NF completes the *e-450B* process for PAS cases b. PASRR cases: NF completes the *450B* process and submits PASRR paperwork to the local AAA for review and decision *Note for PASRR cases: The AAA will export the approvals to the DA for processing and MMIS data entry, as deemed appropriate.*	a. PAS cases: ➢ The DA receives and reviews data, and issues LOC determination. – If the decision is to approve the continued stay of the Medicaid member, the DA will enter the Medicaid effective date into the LOC segment of the MMIS and electronically return the approved *e-450B* to the NF. – If the Medicaid member is denied a continued stay, the *e-450B* will be electronically returned to the NF. – If the individual is non-Medicaid, the DA receives and reviews data, and issues LOC determination and the *e-450B* is electronically returned to the NF. ➢ Regardless of payer source, an *e-450B* can be rejected by the DA, which requires the NF to submit a new *e-450B.* ➢ The DA may issue a request for additional information. The NF has 14 days to submit the requested information for a continued stay. If the information is not received within the required time frame, the DA will reject the *e-450B*. b. PASRR cases: ➢ The DA receives and reviews data, enters Medicaid effective date into the LOC segment of the MMIS, and electronically sends the computer-generated *OMPP 450B SA/DE* to the NF.	a. PAS cases: State-authorized *e-450B* b. PASRR cases: Authorized computer-generated *OMPP 450B SA/DE* or the AAA reconsideration letter

Scenario	Required Forms	NF Responsibility	DA Responsibility	Official Form to Be Retained on Chart
6. Transfer from NF to NF with or without intervening hospitalization	• Short *e-450B* • Form 4B	NF completes the *e-450B* process.	The DA receives and reviews data, and issues determination. • If the decision is to approve the transfer of the Medicaid member, the DA will enter Medicaid effective date into the LOC segment of the MMIS and electronically return the approved *e-450B* to the NF. • If the determination is denied, the *e-450B* will be electronically returned to the NF. • If the NF failed to submit accurate and complete documentation, the DA can reject the *e-450B*, which requires the NF to submit a new *e-450B*.	State-authorized short *e-450B*
7. Resident change from private pay (non-Medicaid) to Medicaid status	• Short *e-450B* • Form 4B	NF completes the *e-450B* process.	The DA receives and reviews data, and issues determination. • If the decision is to approve the submission, the DA enters Medicaid effective date into the LOC segment of the MMIS and electronically returns the approved *e-450B* to the NF. • If the determination is denied, the e-*450B* is electronically returned to the NF. • If the NF failed to submit accurate and complete documentation, the DA can reject the *e-450B*, which requires the NF to submit a new *e-450B*.	State-authorized short *e-450B*

Note: For IHCP members enrolled in managed care, nursing facilities must contact the member's managed care entity (MCE) immediately for determination of the initial admission.

Retaining Forms in Patient Charts

The facility must retain the specific *Form 450B, e-450B (short or long version),* or computer-generated *OMPP 450B SA/DE* approved by the State, or the State representative, authorizing the current admission.

Preadmission Screening and Resident Review Process

The PASRR process remains a requirement in all IHCP certified NFs. Residents, regardless of known diagnoses or methods of payment, IHCP or non-IHCP, who reside in an IHCP-certified NF are subject to the PASRR process. The Level I Identification Screen, *Form 450B*, Section IV, must be completed for each applicant or resident by the NF prior to or at the time of pre-admission screening. The form is completed to identify individuals who may have a mental illness (MI), intellectual disability/developmental disability (ID/DD), mental illness/intellectual disability/developmental disability (MI/ID/DD), or related condition.

Significant Change Referral by Nursing Facility

If a significant change occurs in the resident's MI/ID/DD condition, the NF is responsible for referring the resident to the appropriate agency, such as the community mental health center (CMHC) or Diagnostic and Evaluation (D&E) team through the local Bureau of Developmental Disabilities (BDDS), within 21 days from the date the change is identified or documented. The full resident review (RR) assessment and determination must be completed within an annual average of seven to nine working days from the date of referral. If this change meets the criteria of *significant change* per the *Resident Assessment Instrument (RAI) Manual*, the NF is also responsible for completing a Significant Change minimum data set (MDS) within 14 days of the change in condition.

PASRR Level II Exclusions and Categorical Determinations

This section details the PASRR program for NF admission of members identified as possibly having an MI or ID/DD diagnosis. Categories of PASRR Level II exclusions and categorical determination criteria of *Form 450B*, Section V, are located in *Code of Federal Regulations 42 CFR 483 Subpart C* and *E (483.100* through *483.206*).

Exempted Hospital Discharge

This exemption is limited to stays of up to 30 days. It is allowed only when all the following circumstances exist:

- The resident has been hospitalized for acute inpatient medical care.
- The resident requires NF services for the condition for which care was received in the acute inpatient hospital.
- The attending physician certifies **before admission to the facility** that the resident is expected to require fewer than 30 days of NF services.

The physician certification must be in writing on Section V, Part A, of *Form 450B* (PASRR Level I). Following the admission, if a change in condition causes the resident to require more than 30 days of NF services, the NF must notify the PAS agency in writing that the individual needs additional time in the facility. The PAS agency will complete the PAS portion and make the required Level II referral to the appropriate entity. The PAS agency will issue the final determination within 40 calendar days from the date of the initial admission. If the Level II evaluation determines the resident is inappropriate for NF placement, only 40 days are reimbursable.

The IHCP does not reimburse for more than 40 days unless the individual is appropriately placed in the NF. However, the IHCP does not reimburse for inappropriate use of *Exempted Hospital Discharge* placements. This category is not allowed for the admission of any member whose stay is *anticipated to exceed 30 days at the time of the request* for the NF admission. In the final PASRR regulations, the CMS noted that, "…not all convalescent care admissions from hospitals will be able to fit the prerequisites for a PAS-exempt hospital discharge. For instance, convalescence from a broken hip would normally be expected to require longer than 30 days." In such a case, the PASRR Level II MI or ID/DD assessment must be completed *prior to* any NF admission.

Under no circumstances is this category allowed for admission of residents whose stay in any NF is anticipated to exceed 30 days at the time of the admission request.

Respite Short-Term 30-Day

Admission to an NF from *home* for short-term respite care must not exceed 30 calendar days per quarter. There must be a break of at least 30 days between stays of 15 or more consecutive days of respite care. To qualify for *respite* care, on admission there must be an *expressed intention of leaving the NF* by the expiration of the approved respite time period.

These admissions are allowed solely for respite care, not for the previously allowed *acute recuperative care*, for residents who are *expected to return home* following the NF stay. *Respite care* is defined as a temporary or periodic service provided to a functionally impaired individual for the purpose of *relieving* the regular caregiver. This short-term stay applies solely to residents who have a caregiver and who originate from a noninstitutional, community-based setting, including foster care homes. Respite care is not allowed for a person coming from an institution such as a hospital, NF, large intermediate care facility for individuals with intellectual disability (ICF/IID), or a group home.

Note:	*This admission must be authorized by the local PAS agency prior to the admission on Form 450B/PASARR2A – Section V, Part B.*

Adult Protective Services

An Adult Protective Services (APS) admission is designated as a *maximum stay of seven days* in accordance with *42 CFR 483.130(d)(5)*. This admission must be authorized jointly by an APS investigator and the PAS agency **prior to** the admission, and must be the placement of last resort. The individual must be in need of intensive emergency intervention or in imminent danger.

Reimbursement Limitations for Preadmission Screening and Resident Review Placements

In accordance with *42 CFR 483.122(b)*, IHCP reimbursement for new admissions is available only for the NF services furnished *after* any required screening or review has been performed and the placement is determined to be appropriate for the resident.

Services provided *prior to* final determination *may* be reimbursable if the resident is found to be eligible for NF services. A person with MI or ID/DD who does not meet the previously listed requirements for a short-term admission is subject to the preadmission screening assessments prior to admission. IHCP reimbursement does not begin until the required assessments are completed *and* it is determined that the individual is *appropriately* placed in an NF.

See the *Preadmission Screening and Resident Review Requirements for Nursing Facility Transfers and Readmissions* section of this document for information about members subject to RR requirements, rather than to the PAS assessments.

Preadmission Screening and Resident Review Forms

The following are current PASRR forms:

- *PASRR Level I – Identification Evaluation Criteria – Certification by Physician for Long-Term Care Services (State Form 45277 [R2/7-02] Form 450B/PAS RR2A – Sections IV and V, Part A)*

  NFs, hospitals, physicians, and PAS agencies use this form. The Level I is required for the PAS process and any time there is a change in the mental health condition that would warrant a change to the Level I (for example, an NF is required to retain a Level I that accurately reflects the condition of the individual). Completion is no longer required annually:

  – Section IV: Additional instructions are provided on the back of the form. This section is used for PAS screening assessment.

  – Section V, Part A: Part A includes only the Exempted Hospital Discharge Level II exemption. The physician must certify this exemption prior to the placement in an NF; however, to qualify for IHCP reimbursement for the NF placement, the placement must meet the specific requirements of the Exempted Hospital Discharge as defined in Section V, Part A, and in the instructions on the back of the form. Note that Section V is applicable only for exempted hospital discharges.

- *PASRR Categorical Determination for Short-Term Nursing Facility Care (State Form 45932 [R/6-93] Form 450B/PASARR 2A – Section V, Part B)*

  This form can be used only by the local PAS agencies and APS investigators authorizing the short-term NF placements.

  – Section V, Part B: Part B includes the signed authorization for Respite Short-Term (30-day) and Adult Protective Services (seven-day) short-term placements. Respite care is an exclusion from PAS, but APS is not. APS allows temporary admission while PAS is being completed for residents applying for continued stay in the facility, rather than moving to an alternative placement.

The PAS agency (AAA) completes *Form 4B.* This form may **not** be altered after it is issued by the PAS agency.

Ordering Preadmission Screening and Resident Review Forms

When placing an order for PASRR forms, the full title name and State form number should be specified, as shown in Table 2.

Table 2 – PASRR Form Orders

Title	Form
PASRR Level I – Identification Evaluation Criteria – *Certification by Physician for Long-Term Care Services*	State Form 45277 (R2/7-02)/Form 450B/ PASRR2A – Sections IV and V, Part A
Indiana PASRR Program – Screen for Depression	State Form 47179 (R/7-98)/BAIS 0026
PASRR Level II – PASRR/MI Mental Health Assessment	State Form 47185 (R5/4-99)/BAIS 0036

The *PASRR Level I – Identification Evaluation Criteria* form contains the evaluation criteria and the *Exempted Hospital Discharge* admission category, as shown in Table 3. The Indiana PAS agencies, NFs, hospitals, and physicians use this form.

Table 3 – PASRR Level I Identification Evaluation Criteria

Title	Form
PASRR Categorical Determination for Short-Term Nursing Facility Care	State Form 45932 (R/6-93) Form 450B/PASARR 2A – Section V, Part B

The *PASRR Categorical Determination for Short-Term Nursing Facility* form is ordered only by the Indiana PAS agencies. NFs, hospitals, and physicians are not authorized to use this form.

Providers can access the forms from the *State Forms Online Catalog* at in.gov/iara.

Preadmission Screening and Resident Review Requirements for Nursing Facility Transfers and Readmissions

Transfers

PASRR requirements for transfers between NFs, *42 CFR 483.106(b)(4),* specify that an interfacility transfer occurs when an individual is transferred from one NF to another, with or without an intervening hospital stay. Interfacility transfers may be subject to RR unless IPAS has not yet been completed.

> *Note: Each NF is responsible for ensuring that RRs are timely and that transfers are accepted only for residents whose needs the NF can meet. Prior to the admission, the NF must obtain the current status of the resident, including the following:*
>
> - *The most recent PASRR Level II form*
> - *Current medical information, including nursing notes, to ensure that the transfer placement is appropriate*
> - *The PAS Form 4B for residents with an NF admission less than one year*
> - *The RR letter determination form*
>
> *These copies **must** accompany the transferring resident to the new facility. The current PASRR Level II from the transferring facility must be a part of the record. The NF is responsible for meeting any recommendations listed on the PASRR Level II.*

See Table 1 for procedures to follow regarding transfers between NFs.

Readmissions

PASRR requirements for readmission to an NF following hospitalization, *42 CFR 483.106(b)(3),* are as follows:

- A resident is a readmission if readmitted to a facility from a hospital to which he or she was transferred to receive care.
- Readmissions are subject to RR rather than PAS.

> *Note: This procedure places no limit on the length of the hospitalization when the readmission to the NF is directly from the hospital. The NF readmission is also not limited by the type of care received in the hospital, as long as the prior NF admission was approved under PASRR requirements.*

- Readmissions following care in a psychiatric unit of an acute care hospital or in a psychiatric hospital for MI are equally exempt from PAS, as are readmissions following acute medical care in an acute care hospital bed. For residents who have received inpatient psychiatric services, the NF is responsible for obtaining the following at readmission to an NF:
  - Written assurances from the hospital that the patient is stable and not a danger to self or others
  - Information about the mental health services the individual requires

  This information must be retained in the resident's active record at the NF, in addition to the PASRR-MI Level II (*State Form 47185 (R5/4-99)/BAIS 0036*) and all other documentation regarding the individual's mental health condition.

- The resident remains subject to the RR if the following exist:
  - RR is due during the hospital stay
  - RR must be performed within the quarter following the readmission to the NF

Expedited Resident Review

If the RR is not due and there has been a significant change in the mental health condition of the resident, an immediate RR is required to determine whether the continued stay is appropriate. If the assessment indicates a substantial change in the condition of the resident that would have a bearing on the resident's mental health or overall functioning needs, the NF must immediately refer the resident for an RR as follows:

- The NF submits a written referral to the local CMHC for MI residents or to the BDDS/D&E team for ID/DD or MI/ID/DD residents, as appropriate.
- The written referral must contain the rationale for requesting the RR, specifying the areas of change.

This expedited RR policy applies to residents who are being readmitted or transferred to an NF, as well as to residents in an NF who have undergone a substantial change in mental health condition, regardless of interfacility transfer or readmission.

Review Procedures

A periodic minimum data set (MDS) review is completed for IHCP-enrolled and IHCP-pending residents and residents with other payer sources residing in IHCP-certified nursing facilities (NFs).

The following risk criteria are used in selecting NFs for review:

- Review every NF at a minimum of once every three years based on the following criteria: (Year is defined as the state fiscal year – July 1 through June 30.)
  - Low-risk provider
    - Previous review score of 90–100% – Review at a maximum of every three years
  - Medium-risk provider
    - Previous review score of 80–89.9% – Review at a maximum of every two years
  - High-risk provider
    - Previous review score of 79.9% or lower – Review at a maximum of every 12 months

The FSSA reserves the right to perform additional MDS reviews as deemed necessary at any time.

The purpose of the review is to ensure that the IHCP is reimbursing for the appropriate Resource Utilization Group (RUG) classification as demonstrated by the MDS version 3.0 and supporting documentation.

The Myers and Stauffer Long Term Care (LTC) review team also performs reviews of LOC and PASRR documentation for LTC residents.

The objectives of the LTC reviews are as follows:

- Determine whether residents continue to have needs requiring NF placement in accordance with State LOC criteria defined by *405 IAC 1-3-1* and *405 IAC 1-3-2.*
- Ensure all services recommended by the Level II assessments are provided.
- Determine whether IHCP is reimbursing the provider for the appropriate RUG-III classification, reflective of resident needs.
- Verify that the MDS responses that impact the RUG score are accurate and supported with the appropriate documentation within the assessment reference period.

NFs *may* be notified up to 72 hours prior to the scheduled case-mix/LOC/PASRR review. The LTC review team conducts an entrance and exit conference to apprise the facility staff of the nature, purpose, and sequence of events of the review, as well as the review results. The review teams make themselves available to address facility questions and concerns. These review teams consist of registered nurses.

The facility is responsible for ensuring that all resident medical records are complete, up-to-date, and available to the review teams and for assisting with resident observations. Each resident's medical record documentation must support all notations made on the MDS form.

Minimum Data Set Review Process

Myers and Stauffer periodically conducts reviews of MDS supportive documentation using review parameters established in the case-mix rules. At a minimum, Myers and Stauffer reviews a sample of the facility's MDS assessments. Myers and Stauffer determines whether any records in the sample are unsupported. If the percent of unsupported MDS records in the sample exceeds the 20% threshold set forth in *405 IAC 1-14.6-4(j)(2)*, Myers and Stauffer expands the scope of the review to include the greater of an additional 20% or 10 assessments.

Resident Review Process

Determining the need for a resident review assessment is based on the following:

- A finding of the prior Level II that a yearly review is required.
- A finding that a Level II was required but was never completed, such as a missed referral.
- A significant change in the individual's mental illness (MI), intellectual disability/developmental disability (ID/DD), or mental illness/intellectual disability/developmental disability (MI/ID/DD) condition.
- A determination made by the LTC review team that a Level II assessment is required.

Residents identified as possibly having an MI diagnosis are referred by the NF to State-contracted CMHCs. Residents identified with a possible ID/DD or dual diagnoses as MI and ID/DD are referred by the NF to the D&E team through the local BDDS field office. A comprehensive Level II assessment of the resident's mental and physical needs is completed by the appropriate agency.

Level II Referral Process

When the LTC review team finds a resident in need of Level II MI or ID/DD referral, the team will complete a Level II referral form and present the form to the provider at the time of exit. The provider should then contact the appropriate Level II assessor for the resident. The date of assessor notification will be recorded on the referral form in the "Date of Referral"column. After the Level II assessment has been

completed and certification received by the LTC provider, the "Date Level II Received" column should be completed. The completed referral form, along with copies of the completed Level II and certification, must be completed and submitted within 45 days of the exit conference, via United States Postal Service certified mail to:

Lynn Snider, BSN, RN, RAC-CT
Myers and Stauffer LC
9265 Counselors Row, Suite 100
Indianapolis, IN 46240

Regardless of payment source, names of any resident identified as having an MI, ID/DD, or MI/ID/DD diagnosis, verified by the Level II, must be presented to the LTC review team in the form of a requested list at the time of the IHCP on-site review. The following resolutions can occur:

- If the prior Level II recommendations include mental health services for MI residents and the resident is being followed by the CMHC for the delivery of those services, the team does not refer this resident for a yearly RR.
- The most current Level II states geriatric or medical needs take precedence over programming or treatment needs. The resident is not referred for a yearly RR.

Note:	*If the condition of the resident changes such that programming or treatment needs should take precedence, the NF is responsible for making a referral to the proper agency in a timely manner.*

The LTC review team refers cases to the Indiana State Department of Health (ISDH) and the appropriate agency, CMHC, or D&E team, for follow-up if the services recommended by the current Level II are not being provided to the resident. Such services must be evidenced in the medical documentation for the resident. Delivery of recommended Level II services is a condition of IHCP certification.

Member Level-of-Care Appeal Process

This section addresses the NF LOC discharge appeal process for the member. The member can appeal the LOC transfer or discharge decision to the FSSA Hearing and Appeals Section, pursuant to *470 IAC 1-4-3*.

Notification Process

After completion of the IHCP on-site review conducted by the LTC review team, a letter containing the results of the review is generated from Myers and Stauffer and posted to the Provider Healthcare Portal (Portal). The letter contains the name of any IHCP member who does not meet the NF criteria found in *405 IAC 1-3-1* or *405 IAC 1-3-2*. The member name, member identification number, and effective date of discharge from IHCP reimbursement are included.

A letter addressed to the member, outlining the proposed discharge and appeal information, is enclosed in the review letter packet sent to the NF. The NF is responsible for forwarding the letter to the member, legal guardian, or power of attorney, as appropriate, for notification.

If the member recommended for discharge has a diagnosis of MI, ID/DD, or MI/DD, as confirmed by a Level II assessment, a final determination is made by the DA. Pursuant to *42 CFR 483.130*, the FSSA DA issues the final determination about the member's need for NF services.

When discharge recommendations are made, the following forms will be included with the review letter packet:

- *Form 1703 – Notification of Discharge/Transfer of Member to Approved Level of Care* is completed if there is agreement with the recommendation and the resident does not appeal. The form must be returned to the following address prior to the effective date of the NF LOC discharge:

  Lynn Snider, BSN, RN, RAC-CT
  Myers and Stauffer LC
  9265 Counselors Row, Suite 100
  Indianapolis, IN 46240

- *Form 1702 – Request for Reconsideration of Level of Care Change/Discharge Recommendation* is completed if the member's physician documents specific medical rationale based on *405 IAC 1-3-1* and *405 IAC 1-3-2* for retaining the resident at the LOC. Reconsideration can be requested on *Form 1702.* The *Form 1702* must be accompanied by appropriate supporting medical documentation as noted on the form and must be received at the Myers and Stauffer review address (indicated previously) prior to the effective date of discharge. In addition, the member appeal must be forwarded prior to the effective date of the discharge to the following office:

  MS04
  Family and Social Services Administration
  Hearings and Appeals Section
  402 West Washington Street, Room E034
  Indianapolis, IN 46204-2773

Note:	*Reconsideration must be requested and the appeal must be filed when there is disagreement with the recommendation.* *It is important that Form 1702 (appeal request) or Form 1703 be submitted before the effective date of discharge. The LOC ends on the effective date of the discharge if an appeal is not filed or Form 1703 is not submitted.*

Appeal Process

After *Form 1702* and the supporting medical documentation are received, the LTC review team reviews the information and determines whether the discharge decision should be rescinded. If the decision to discharge is rescinded, no change is made to the member LOC for reimbursement. The FSSA Hearing and Appeals Division notifies the member of the LTC decision.

If the member appeals the NF discharge, but the LTC review team does not rescind the discharge decision, reimbursement will *not* continue during the appeals process. If the administrative law judge (ALJ) decision favors the member, reimbursement will be restored to the *date of the original decision* of the LTC review team. If the ALJ decision favors the FSSA, the *date of the original decision* of the LTC review team stands regarding reimbursement.

Note:	*Pursuant to 405 IAC 1-1-5.1, the FSSA can instruct the fiscal contractor, Hewlett Packard Enterprise, to recover payment made during the appeal process if the hearing decision is favorable to the FSSA.*

Appeal Decision Notification

All parties – the member, the NF, the FSSA, and Myers and Stauffer – are notified of the ALJ decision by letter. If the decision favors the appellant, or member, there is no break in reimbursement to the facility.

If the decision favors the FSSA, the *date of the original decision* of the LTC review team for LOC stands regarding reimbursement.

If the member chooses to request the FSSA Hearing and Appeals Division to review the hearing decision, reimbursement does *not* continue during the pending agency review.

Agency Review Decision

If the agency review decision favors the appellant, or member, the member LOC segmentis reopened so the NF can again bill for the NF stay and be reimbursed at the appropriate case-mix rate.

If the decision is favorable to the FSSA, the member LOC segment is not changed, and the *date of the original decision* of the LTC review team stands regarding reimbursement.

For any questions related to the member appeal process, call the following number:

Myers and Stauffer LC
Lynn Snider, BSN, RN, RAC-CT
1-800-877-6927

MDS Review Findings and Rate Calculation Appeal Process

At the end of the MDS field review, Myers and Stauffer LTC reviewers conduct an exit conference with appropriate NF staff and review the preliminary results of the review and other comments and recommendations about the NF's clinical documentation systems.

Following the exit conference, Myers and Stauffer issues preliminary MDS review findings, including recommended discharges on residents that do not meet NF level of care. Myers and Stauffer documents these findings in writing and forwards them to the NF. The NF then has an opportunity to review the written preliminary review findings. If the NF disagrees with the findings, the NF can submit an informal, written reconsideration request to Myers and Stauffer within 15 business days. The informal, written reconsideration request must include specific review issues the NF believes were misinterpreted or misapplied during the review. MDS supporting documentation provided after the review exit conference will not be considered in the reconsideration process per *405 IAC 1-15-5(c)*. Myers and Stauffer then reviews the NF request and, within 10 business days, communicates the final MDS review findings to the NF in writing, along with a response to the issues raised.

After the informal reconsideration process, Myers and Stauffer communicates the final MDS review findings to the following:

- Nursing facility
- FSSA Office of Medicaid Policy and Planning (OMPP)
- Rate-setting contractor to use in the case mix rate-setting process

The MDS review concludes after Myers and Stauffer communicates the final MDS review findings to the NF.

Application of Recalculated Case-Mix Indices and IHCP Rates

The rate-setting contractor incorporates the final MDS review findings into the calculation of the facility's case mix index (CMI) used for IHCP rate-setting purposes on a quarterly basis. There is at least a one-quarter lag time between the MDS assessment reference date (ARD) and the impacted IHCP rate-effective date. Depending on the relationship between the assessment key dates and review completion date, application of the MDS review findings for some MDS records could result in retroactive rate adjustments.

The MDS ARD generally determines the calendar quarter during which each MDS assessment applies for case mix rate-setting purposes. The time-weighted guidelines are followed to calculate the number of calendar days each MDS record remains effective. The FSSA publishes the time-weighted user guide and updates the guide as needed.

A reviewed MDS record is considered supported unless the reviewed MDS values result in a different RUG-III classification group for that MDS assessment record, according to *405 IAC 1-14.6-2(nn).*

When a case-mix rate is established that includes the MDS review findings, in addition to questioning rate-setting issues, the NF can request a formal rate reconsideration, including raising MDS review issues with which they disagree, pursuant to *405 IAC 14.6-22(c).* The formal reconsideration request for rate setting and MDS review issues should be sent to the rate-setting contractor within 45 days after release of the IHCP rate by the rate-setting contractor.

The rate-setting contractor coordinates the MDS review issue review with the LTC review team and issues a written response to all rate-setting issues raised along with the LTC review team response to all MDS review issues raised within 45 days after receipt of the formal rate reconsideration request. If the formal reconsideration results in a recalculation of the previously established IHCP rate due to MDS review or rate-setting issues, the rate-setting contractor reissues the IHCP rate following the completion of the reconsideration process. If the NF disagrees with any determination resulting from the formal reconsideration process, the facility can appeal the determination pursuant *to Indiana Code IC 4-21.5-3-7* and *405 IAC 1-1.5.*

Application of Corrective Remedies

As provided in the FSSA case-mix rules, after the review, the percent of reviewed MDS records that are determined to be unsupported is computed.

Pursuant to *405 IAC 1-14.6-4(j),* for facility MDS reviews, a corrective remedy applies if the number of unsupported MDS records exceeds 20%. When an LTC facility achieves an unsupported Error Threshold percentage of more than 20% (such as 20.45%), this number is not rounded up or down, but instead is reported as exceeding the Error Threshold due to being more than 20%. The numbers are rounded up only when the Error Threshold percentage exceeds the allowed amount of 20%. Nursing facilities that score below 80% supported, as outlined in the *Indiana Administrative Code (IAC),* receive a 15% Administrative Component Corrective Remedy penalty applied for one quarter. The NF is required to respond to a Validation and Improvement Plan (VIP). All unsupported worksheets are reclassified, and the NF is subject to a case-mix review within 4–12 months.

The Supported Rate, which is stated in the LTC provider correspondence, refers to the percentage of supported records, and the Error Threshold represents the percentage of unsupported records. These two percentage measurements are conversely related.

Pursuant to *405 IAC 1-14.6-4(j),* the corrective remedy is applied when the scope of the MDS review is expanded to include the greater of an additional 20% or 10 assessments and the number of unsupported MDS records exceeds 20%.

The corrective remedy is applied as a percent of the administrative component of the IHCP case-mix rate using the percentage in Table 4. The corrective remedy takes effect beginning in the calendar quarter *following* the completion of the MDS review and remains in effect for one quarter.

Table 4 – Corrective Remedy Percentage

MDS Field Review for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field review	15
Second consecutive MDS field review	20
Third consecutive MDS field review	30
Fourth or more consecutive MDS field review	50

Example: An MDS review begins November 4, 2014, is finalized on December 30, 2014, and the findings indicate that more than 21% of the reviewed MDS records are unsupported; a corrective remedy is applied beginning January 1, 2015. The corrective remedy remains in effect for one calendar quarter. The facility may not recover any reimbursement lost due to the corrective remedy.

Managed Care Considerations

IHCP-covered LTC/LOC services are not included in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise programs. LTC/LOC services are not included in the scope of benefits provided to members in the managed care program. These services are covered under the IHCP fee-for-service (FFS) Traditional Medicaid program, which the Eligibility Verification System (EVS) identifies as *Full Medicaid* coverage with no managed care details. Managed care members must be **disenrolled** from their health plans before they become eligible for LTC/LOC. Upon disenrollment from managed care, **members' IHCP coverage continues under the Traditional Medicaid program.**

Member enrollment in managed care is effective on the first and 15th calendar days of the month. LTC providers should use any of the EVS described in the *Electronic Data Interchange*, *Interactive Voice Response System*, and *Provider Healthcare Portal* modules upon admission of a new patient, and on the first and 15th of every month for existing patients, to confirm IHCP eligibility and to confirm in which IHCP program the patient may be enrolled, for the purposes of care coordination and reimbursement.

The following narratives describe the MCE's responsibilities for HIP, Hoosier Care Connect, and Hoosier Healthwise members when LTC services are necessary.

Short-Term Nursing Facility Placement

While LTC/LOC services are not covered in the managed care delivery system, an MCE can place its enrollees in an NF setting on a short-term basis. Members who require LTC or whose short-term placement becomes a long-term placement will be disenrolled from managed care when LTC/LOC is approved and entered into *Core*MMIS.

- The responsibility for verifying patient healthcare coverage lies with the NF or LTC facility that has direct access to the patient and the patient's IHCP Member ID (Medicaid number [RID]).
- If the NF or LTC facility determines, upon checking eligibility on date of admission on the first or 15th of each month, that the patient is enrolled in a Hoosier Healthwise MCE, the NF or LTC facility must notify the MCE within 72 hours after admission.
  - If the NF or LTC facility notifies the MCE within 72 hours, the MCE shall be liable for charges for up to 60 calendar days from the date of admission.
  - If the NF or LTC facility fails to verify a patient's coverage in managed care, or fails to contact the MCE within 72 hours of admission, the NF or LTC facility may be at risk for charges incurred until the NF or LTC facility has notified the MCE of the patient's status.
  - In the case of notification past the 72-hour deadline, the MCE shall only be liable for charges from the date of notification for up to 60 calendar days, beginning on the date of notification.
  - The MCE shall have a process that documents the NF or LTC facility notification to the MCE.
- If the member is still in the NF or LTC facility after 60 calendar days, the long-term LOC determination has not been implemented, and the member is still enrolled in an MCE, the NF or LTC facility becomes liable for any costs associated with the patient until LOC has been implemented.

The 60-calendar-day coverage requirement for the MCE is an extension of the current managed care continuity of care policy that requires the health plan that receives the member to honor authorizations of the previous health plan for the first 30 days. This period is intended to allow for the proper notifications and reviews to take place without interrupting the care being delivered to the member. The initial period of 60 calendar days in these cases is to allow sufficient time for the notification, pre-admission screening,

LOC determination, and disenrollment from managed care to take place and to ensure appropriate reimbursement to the facility for services rendered.

Long-Term Nursing Facility Placement

NFs and ADRCs must notify the MCE immediately when an MCE member is admitted to an LTC facility or undergoes the IPAS/PASRR. The MCE is financially responsible for all care provided to its members until enrollment termination is effective. IHCP FFS is financially responsible for LTC reimbursement after the member is approved for intermediate LOC, skilled LOC, or general case mix per *405 IAC 1-3-1* and *405 IAC 1-3-2*, and the member is disenrolled from the MCE.

LTC facilities shall coordinate with the MCE to allow members to use appropriate in-network services during the period in which the member is assigned to the MCE. Information about the specific MCE network in which a member is enrolled is available through the EVS.

Long-Term Care Reimbursement Methodologies

There are two reimbursement methodologies for LTC facilities based on the type of facility rendering the service. This section outlines the reimbursement methodologies for nursing facilities and ICFs/IID. Reimbursement of LTC facility services is not available for Hoosier Healthwise Package C members.

For reimbursement and billing information for long-term acute care (LTAC) facilities, see the *Inpatient Hospital Services* module.

Nursing Facility Services

Effective for dates of service from January 1, 2014, through June 30, 2017, the IHCP implemented a 3% reduction in reimbursement paid to nursing facilities. This reduction applies to nursing facility providers reimbursed under *405 IAC 1-14.6*. The reduction is to the Medicaid *per diem* rate before the reduction of any patient liability or third-party liability (TPL) on the claim. This reduction applies to all IHCP nursing facility claims, including Medicare crossover claims.

Case-Mix Reimbursement

The IHCP reimburses nursing facilities using a case-mix methodology system. This system is based on the principle that payment for nursing facility services should take into account a resident's clinical condition and the resources needed to provide appropriate care for that condition. Therefore, the case-mix system of reimbursement is based on one IHCP rate, adjusted each quarter for changes in a patient's acuity level, for all IHCP residents in an IHCP-certified or dually licensed nursing facility.

The case-mix system of reimbursement allocates greater IHCP payment to direct patient care, while continually responding to cost changes that occur with respect to the resources used in providing that care.

Under the case-mix reimbursement system, the IHCP rate is the sum of the following separate rate components:

- *Direct care* – Direct care includes the following:
  - All allowable nursing and nursing aide services
  - Medical supplies
  - Medical director services
  - Medical record costs
  - Nurse aide training
  - Nurse consulting services

- Oxygen
- Pharmacy consultants
- Rental costs for low-air-loss mattresses, pressure-support surfaces, and oxygen concentrators - subject to an overall $1.50 per resident day limit
- Support and license fees for software used exclusively in hands-on resident care support, such as MDS assessment software and medical records software
- Replacement dentures for Medicaid residents provided by the facility that exceed State Medicaid plan limitations for dentures
- Legend and nonlegend sterile water used for any purpose
- Educational seminars for direct care staff

- *Indirect care* – Indirect care includes the following:
  - Activity services and supplies
  - Allowable dietary services and supplies
  - Patient housekeeping services and supplies
  - Patient laundry services and supplies
  - Plant operations services and supplies
  - Raw food
  - Social services
  - Utilities
  - Repairs and maintenance
  - Recreational services and supplies
  - Cable or satellite television throughout the nursing facility, including residents' rooms
  - Pets, pet supplies and maintenance, and veterinary expenses
  - Educational seminars for indirect care staff
  - Nonambulance travel and transportation of residents

- *Administrative* – Administrative includes the following:
  - Allowable advertising
  - Allowable administrator and co-administrator services
  - Allowable home office services and supplies that are patient-related and appropriately allocated to the nursing facility
  - Legal and accounting fees
  - Liability insurance
  - License dues and subscriptions
  - Management
  - Office and clerical staff
  - Office supplies used for any purpose, including repairs and maintenance, and service agreements for copiers and other office equipment
  - Other consultant fees
  - Owners' compensation (including director's fees) for patient-related services
  - State gross receipts taxes
  - Telephone
  - Travel
  - Utilization review costs
  - Working capital interest
  - Qualified intellectual disabilities professional (QIDP)

  - Educational seminars for administrative staff
  - Support and license fee for all general and administrative computer software and hardware
  - Capital – Allowable capital-related items include the following:
  - Fair rental value allowance
  - Property insurance
  - Property taxes

> *Note: The administrative component reimbursement is adjusted to 100% of the average allowable median patient day cost.*

- *Therapy* – Direct cost for allowable therapy services
- *Nursing Facility Quality Add-On* – Based on a nursing facility's report card score using the latest published data as of the end of each state fiscal year and other quality measures defined by *405 IAC 1-14.6(7)(n)*
  - Facilities that are a new operation and do not have the required information to calculate their facility specific add-on will receive the statewide average.
  - The maximum amount of the Nursing Facility Quality Add-On is $14.30 per patient day.
- *Special Care Unit Add-On* – Nursing facilities with special care units (SCUs) that provide specialized care to residents with Alzheimer's disease or dementia, as defined by *405 IAC 1-14.6-2(hh)*, are eligible for increased reimbursement in the form of an SCU add-on. The SCU add-on is calculated using the facility's *Nursing Facility Schedule of SCU Qualifications Form* (Schedule Z) and MDS 3.0 information. This schedule should be completed on a calendar-year basis and is due to Myers and Stauffer by March 31 of the year following the report period. An updated Schedule Z form and instructions are available on the *Long-Term Care* page of the Myers and Stauffer website at in.mslc.com (under Nursing Facility > Forms). Note that, effective October 1, 2011, the "grandfathered" employment start date for an SCU director was revised to August 21, 2004, after which specific educational degrees are required.
- *Employee Turnover* – Nursing facilities need to submit an *Employee Turnover* report (Schedule X) on a calendar-year basis, with a submission due date of March 31 of the following calendar year. This report is submitted to Myers and Stauffer.
- *Ventilator Unit Add-On* – Nursing facilities that provide inpatient services to more than eight ventilator-dependent residents, as determined by MDS data, may receive additional reimbursement at a rate of $11.50 per Medicaid resident day.
- *Quality Assessment Fee Add-On* – This add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk-reviewed annual financial report.

The FSSA retains a contractor that establishes the applicable rate.

Quality Assessment Fee

Nursing facilities are required to pay a quality assessment fee (QAF) in the following amounts effective January 1, 2014, pursuant to *SPA 13-005* for nursing facilities specified at *405 IAC 1-14.6*:

- $16.37 per non-Medicare (for example, private pay and Medicaid) patient day if the nursing facility's total census is fewer than 62,000 patient days per year.
- $4.09 per non-Medicare (for example, private pay and Medicaid) patient day if the nursing facility's total census is at least 62,000 patient days per year or the nursing facility is nonstate government owned or operated that became nonstate government owned or operated before July 1, 2003.

- Additionally, if a nursing facility is hospital-based, a Continuing Care Retirement Center (CCRC) that meets the statutory requirements at *Section 486* of *HEA 1001(ss)-2009* or the Indiana Veterans' Home, no assessment fee applies.

A portion of the QAF will be used to increase nursing facility Medicaid reimbursement for initiatives that promote and enhance improvements in quality of care to nursing facility residents.

Leave Days

The IHCP does not cover "bed-hold" days in a nursing facility as a member benefit. This change affects all IHCP members. Providers must make members aware of their policies and that members cannot be charged for services that they do not request.

Intermediate Care Facilities for Individuals with Intellectual Disability Services

ICFs/IID are divided into two distinct categories:

- Large private ICF/IID – More than eight beds
- Small ICF/IID – Four to eight beds and are commonly referred to as community residential facilities for the developmentally disabled (CRF/DD), or group homes
  - Basic developmental
  - Child rearing
  - Child-rearing residences with specialized programs
  - Developmental training
  - Intensive training
  - Sheltered living
  - Small behavioral management residences for children
  - Small extensive medical needs residences for adults
  - Extensive support needs residences for adults

Proprietary Large Private and Small ICFs/IID

For non-state-owned ICFs/IID and CRFs/DD services with *from* dates of service of April 1, 2010, through December 31, 2013, a 3% reduction in reimbursement was in effect. For *from* dates of service of January 1, 2014, through June 30, 2015, the IHCP began implementing the reduction percentage amount from a 3% reduction to a 1% reduction.

Effective July 1, 2015, in accordance with Section 129 of *Public Law 213-2015*, reimbursement rates for non-state-owned ICF/IID and CRF/DD services were decreased 3% using the methodology in effect on December 31, 2013, and then increased by 3%. The result of first reducing the rate by 3% and then increasing that amount by 3% has the net effect of reducing rates by 0.09%.

The all-inclusive *per diem* rate for these facilities includes the following services:

- Durable medical equipment (DME) – All DME, except customized items and associated repair costs, **including but not limited to the following**:
  - Bed rails
  - Canes
  - Crutches
  - Ice bags
  - Traction equipment

  - Walkers
  - Wheelchairs, standard

- Customized equipment includes any piece of equipment designed for a particular member that cannot be used by other members. The equipment contains parts that are specially made and not readily available from a DME provider.
- Medical and nonmedical supplies – All medical and nonmedical supplies and equipment including those items generally required to ensure adequate medical care and personal hygiene of residents
  - The facility, pharmacy, or other provider may not bill these items to the IHCP separately.
- Mental health services – Including behavior management services and consulting, psychiatric services, and psychological services
- Nursing care – Nursing services and supervision of health services
- Room and board – Room accommodations, all dietary services (including routine and special dietary services and school lunches), and personal laundry services
- Therapy services – Physical and occupational therapy, speech pathology, and audiology services provided by a licensed, registered, or certified therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate
  - Therapy services provided away from the facility must meet the criteria outlined in *405 IAC 5-22*. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.
- Transportation – Reasonable cost of necessary transportation for the member, which is included in the *per diem* rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services
  - Emergency transportation services must be billed to Medicaid directly by the transportation provider.
- Habilitation – Habilitation services provided in an FSSA-approved setting that are required by the resident's program plan of active treatment developed in accordance with *42 CFR 483.440*, including, but not limited to, the following:
  - Training in activities of daily living
  - Training in the development of self-help and social skills
  - Development of program and evaluation plans
  - Development and execution of activity schedules
  - Vocational/habilitation services

Note:	*The all-inclusive per diem rate for small ICFs/IID also includes day habilitation services.*

Leave Days

Reimbursement is available for reserving beds for members in a private ICF/IID, provided that the criteria set out in *405 IAC 5-13-6* are met.

Providers must use the appropriate room and board revenue code for the days the member was a patient in the ICF/IID and use the applicable leave of absence revenue code for the days the member was out of the ICF/IID.

The two types of reimbursed leave days are as follows:

- Hospitalization – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/IID. If the member is discharged from the ICF/IID following a hospitalization in excess of 15 consecutive days, the ICF/IID is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/IID does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/IID level-of-care services. The facility must maintain a physician's order for hospitalization in the member's file at the facility. **Providers must use revenue code 185 to denote a leave of absence for hospitalization**.
- Therapeutic leave of absence – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member's habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician's order for the therapeutic leave in the member's file at the facility. **Providers must use revenue code 183 to denote a therapeutic leave of absence**.

Use revenue code 180 when the hold days are not eligible for payment.

Tax Assessment

Large and small private ICFs/IID are assessed a 6% tax on the total annual revenue of the facility for the facility's preceding fiscal year. The assessment on provider total annual revenue is an allowable cost for cost reporting and audit purposes. Total annual revenue is determined from the provider's previous annual financial reporting period.

Billing Instructions for Long-Term Care Services

Instructions for billing LTC facility services are separated into two subsections, based on the type of facility rendering the service. This section outlines billing instructions for NFs and ICFs/IID.

NFs and ICFs/IID may bill using the institutional claim (*UB-04* claim form, 837I electronic transaction, or Portal institutional claim). Providers should mail LTC paper claims to Hewlett Packard Enterprise at the following address for processing:

HPE Institutional Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Nursing Facility Services

Inpatient LTC services are available to IHCP members who meet the threshold of nursing care needs required for admission to, or continued stay in, an IHCP-certified nursing facility.

Billing Procedures

NFs must follow the general instructions for completing the institutional claim, as well as the specific instructions that follow:

- NFs bill for room-and-board charges using the applicable room-and-board revenue code. Acceptable room-and-board revenue codes include 110, 120, and 130. Revenue codes 180, 183, and 185 for leave-of-absence days are no longer reimbursable.

- The FSSA uses a case-mix reimbursement methodology based on the RUG-III Classification of that member. The facility must maintain documentation in the medical record that substantiates the physical or behavior needs of the member as identified on the MDS. The RUG-III Classification is based on the MDS.
- All long-term care providers must have a State-approved *Form 450B* or *OMPP Form 450B SA/DE* on file in *Core*MMIS for the appropriate provider number before billing services provided to a member.
- Nursing facilities cannot bill separately for medical and nonmedical supply items, personal care items, or therapies. Providers can bill parenteral or enteral services and therapies received by dually eligible (Medicare and Traditional Medicaid) members to Medicare and, subsequently, the IHCP as crossover claims on the appropriate claim type for these services.
- Inpatient care crossover services must be billed on the *UB-04* claim form, 837I electronic transaction, or Portal institutional claim. Any inappropriate billing and reimbursement is subject to recoupment by the FSSA Program Integrity team.
- Providers can bill short-term stays of less than 30 days upon discharge of the patient. Providers can bill long-term stays of 30 days or more monthly, or more frequently if desired.

Member Liability

Member liability is the term applied to the monetary amount that an IHCP resident must contribute toward his or her monthly care in the facility. The term *personal resource contribution* also indicates member liability.

The local county office of the FSSA Division of Family Resources (DFR) calculates and assigns the member liability amount.. Member information, including member liability or personal resource contribution reflected in *Core*MMIS, is updated daily from the information relayed by the Indiana Client Eligibility System (ICES) at the county offices. Providers are not required to send the *C-519* form.

Providers must apply current income to current needs. As an example, a Social Security benefit check received in October must be applied to October charges. The only exception is the direct deposit benefit check that is sometimes recorded by the bank at the end of one month instead of early in the next month when it would normally be received. Because most resources are available on a calendar month basis, all accounts that involve resource deductions must be billed on a calendar month basis, for example, June 1 through June 30, or July 1 through July 31.

Note:	*Deduct patient resources from the payment in the month that the resources are received.*

The IHCP automatically deducts the member's liability amount from the total reimbursement of the claim. The provider must not indicate the resource contribution anywhere on the claim form. When a member transfers between facilities during a billing period, the member liability is deducted from the first claim received and processed by *Core*MMIS. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

Leave Days

The IHCP does not reimburse for bed-hold days in a nursing facility as a member benefit unless the member is under the care of hospice. All IHCP members residing in an NF are directed to talk with their individual provider regarding any type of "bed-hold" or leave-day policy that may exist in that facility. Providers must make members aware of their policies and that a member cannot be charged for services the member does not request. There is no requirement that nursing facilities hold beds.

The facility must inform a resident in writing prior to a hospital transfer or departure for therapeutic leave that Medicaid does not pay for bed holds; the facility must also communicate its policies regarding bed-

hold periods. A nursing facility is required to follow a written policy under which a resident, whose hospital or therapeutic leave exceeds Medicaid coverage limitations, is readmitted to the facility upon the first availability of a bed in a semiprivate room, if the resident requires NF level services and is eligible for Medicaid NF services. (See *42 CFR 483.12(b)(3)* and *410 IAC 16.2-3.1-12(a)(27)*.) Regardless of the length of leave, if the individual remains eligible for NF level of care and Medicaid, he or she must be readmitted to the facility to the first available bed.

Because Medicaid does not pay to hold beds in nursing facilities except for hospice care, all bed holds for days of absence are considered noncovered services for which the resident may elect to pay. If the facility offers this option, the facility must include this information in its written policy, as well as on the written information provided to the resident prior to hospital transfer or departure for therapeutic leave.

Facilities cannot establish a minimum bed-hold charge, such as a certain number of days, because this could overlap with covered services if the resident returns before the minimum period lapses. The facility must also follow the requirements for billing members for noncovered services set forth in the *Charging Members for Noncovered Services* section of the *Provider Enrollment* module. Further, it is the resident's choice to elect to pay for this service. Facilities can charge residents only for items and services requested by the resident. See *42 CFR 483.10(c)(8)*.

Nursing facilities are also obligated to inform residents upon admission of services for which the resident may be charged and the amounts of those charges. Residents must also be informed of any changes to available services and any charges. See *42 CFR 483.10(b)(5)–(6)*. Facilities must provide 30 days' advance written notice to residents of any changes in rates or services the rates cover. See *410 IAC 16.2-3.1-4(i)*.

It is not necessary to submit claims for bed-hold days under any circumstances, even for revenue code 180 – *Bed-hold days not eligible for payment*.

Code any leave day on the claim using one of the codes listed in Table 5.

Table 5 – Noncovered Bed-Hold Revenue Codes

Revenue Code	Description
180	Bed-hold days not eligible for payment
183	Therapeutic bed-hold days eligible for payment
185	Hospital bed-hold days eligible for payment

Autoclosure Billing

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. *Core*MMIS uses the patient status code from the institutional claim (field 22, STAT, on the *UB-04* claim form) to close the member's LOC segment. This process eliminates the need for submitting written discharge information to the FSSA.

If the LOC is not updated, it 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 patient 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/transferred to a short-term general hospital for inpatient care*
- 05 – *Discharged/transferred to a designated cancer center or children's hospital*

- 07 – *Left against medical advice or discontinued care*
- 20 – *Expired*

LTC providers do not receive reimbursement for the date of discharge. Therefore, it is imperative that LTC providers carefully complete the claim to ensure that the *through* date for the period covered (the second date in field 6 on the *UB-04* claim form or the second date in the Covered Dates field in the Portal claim header) accurately reflects the actual date of discharge for the member.

Autoclosure of Member Level of Care

*Core*MMIS uses the patient status code on the claim (field 17, STAT, on the *UB-04* claim form) to close out the member LOC segment for selected discharge patient status codes. Automation of this process eliminates the need for providers to notify the FSSA Division of Aging (DA) of all residents discharged from a NF or ICF/IID during a given month. The DA requests that facilities not submit monthly discharge information for residents whose discharge information is noted on the claim.

It is imperative that the NF or ICF/IID provider submits the patient status code applicable to the *through* date of service indicated on the claim. *Core*MMIS closes out the member LOC segment for a member whose claim has one of the patient status codes listed in the *Long-Term Care Codes* on the *Code Sets* page at indianamedicaid.com.

> ***Important:*** *When filing a claim for a resident who has been admitted to the hospital,* ***do not*** *use a discharge code on the claim. The discharge patient status code closes the member LOC segment and all future claims are denied for explanation of benefits (EOB) 2008– Member is not eligible for this level of care for dates of service.*

Examples:

- A resident was in an LTC facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the LTC on July 2. The LTC facility should bill for June service dates as follows: 23 days of *per diem* for the LOC. The status code would be 30 – *Still a patient*, because the member is still a resident of the LTC while in the hospital.
- A resident was in an LTC facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the LTC on July 10 and remained in the facility the remainder of the month. The LTC facility should bill for June service dates as indicated previously. The July claim should reflect July 1 through July 31 dates of service, a patient status code of 30, and 22 units of *per diem* for the LOC.
- If the same resident was discharged to home or to another facility from the hospital and did not return to the LTC facility on the anticipated date of July 2, the July bill should reflect discharge on July 2 with a status code of 02 – *Discharged or transferred to another short-term general hospital for inpatient care*. 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.
- Providers that have previously received payment for a particular resident but have recently received claim denials for EOB 2008 should contact the **Provider Relations help desk** at **(317) 488-5094**. **Providers must not contact the DA or send in a new *Form 450B*.** If the member's LOC was discontinued as a result of the discharge status code, Provider Relations will review the claims to determine which claim caused the autoclosure. If an incorrect status code was used, Provider Relations will advise the provider of any action that should be taken *so that the LOC, when deemed appropriate, can be manually restored by Hewlett Packard Enterprise*.

To have claims considered for payment, two steps must occur:

1. The provider must adjust or replace paid claims that indicated an incorrect discharge patient status code.
2. The provider must call the Provider Relations help desk to have the LOC updated.
   – 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 EOB 2008.

Providers should not submit a new *Form 450B* unless instructed to do so by the Provider Relations help desk.

> *Note: NF providers must not discharge residents via the patient status code on the claim when the resident elects the hospice benefit while remaining in the NF. To eliminate autoclosure of the LOC segment and provide continuity of reimbursement, the provider should use a patient status code of 30 and reflect the date the resident began hospice coverage as the "through" date for the period covered on the claim.*

Autoclosure Process for Inpatient Crossover Claims

*Core*MMIS uses the patient status code (field 17, STAT, of the *UB-04* claim form) of inpatient crossover claims to close the member LOC segment.

If an accommodation code is billed on the crossover claim, the *through* date of service is less than or equal to the end date of the member LOC segment, and the patient status code indicates discharge as listed in the *Long-Term Care Codes* on the *Code Sets* page at indianamedicaid.com. *Core*MMIS will close the member LOC segment using the *through* date of service from the claim as the LOC end date and use the stop reason K98. The K98 stop reason communicates that the LOC segment was systematically closed based on the patient status code on an inpatient crossover claim submitted by the NF provider on file.

This change in the autoclosure process enables dually eligible members who are discharged from an NF while on a Medicare Part A stay to readily receive services in the community that are not available to members with an active NF LOC.

> *Note: Inpatient crossover claims indicating the patient status code "02 – Discharged or transferred to another short-term general hospital for inpatient care" will not be included in the autoclosure process for members on a Medicare Part A stay. In the event the member does not return to the NF from the hospital stay, the NF must notify either Hewlett Packard Enterprise or the DA so the LOC can be manually end-dated.*

Retro-Rate Adjustments

If a provider experiences claim denial in conjunction with a retro-rate adjustment, and the Provider Relations help desk has reviewed and manually reopened an LOC segment, the provider may rebill denied claims on paper. If the denied claim is past the filing limit, the provider should attach a letter stating that the claim was denied due to an autoclosure of the LOC during a retro-rate adjustment. The letter should also indicate that the provider has spoken with the Provider Relations help desk, and that the LOC segment for the member has been reinstated. The letter is sufficient to waive the filing limit and allow the claims to be processed.

Providers that previously received payment for claims with an incorrect status code should initiate adjustments that reflect the correct status codes. This ensures that the correct information is reflected in *Core*MMIS and alleviates any future denial of claims during retro-rate adjustments.

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

> *Note: Hospice providers are not required to submit individual claim adjustment forms to Hewlett Packard Enterprise for retro-rate adjustments for room-and-board payments under the IHCP hospice benefit. Hewlett Packard Enterprise implemented changes to the claim-billing system to allow mass adjustments for NF room-and-board rate of hospice claims billed under bill type 822 and for hospice revenue codes 653, 654, 659, 183, and 185. The system change permits hospice claims under these revenue codes to be mass adjusted on the same date that the NF retro-rates are mass adjusted. This change expedites hospice claims payments to contracted NFs. Hospice and NF providers are reminded that mass adjustments to the room-and-board rate under the IHCP hospice benefit for members residing in NFs are reflected on the hospice provider's Remittance Advice (RA). Hospice and NF providers are encouraged to develop coordination and payment procedures to address this retro-rate adjustment issue in their contracts.*

EOB 1024

All LTC providers must have a State-approved *Form 450B, e-450B (short or long version),* or computer-generated *OMPP 450B SA/DE* on file for their members before billing for services. The billing provider's IHCP Provider ID on the LTC claim must cross walk to the provider's number from the State-approved *Form 450B, e-450B* (short or long version), or computer-generated *OMPP 450B SA/DE* listed for the member's LOC in *Core*MMIS for the dates of service being billed. If an LTC claim is billed before information from the approved *Form 450B, e-450B* (short or long version), or computer-generated *OMPP 450B SA/DE* has been entered in *Core*MMIS, the claim is denied for EOB 1024 – *Billing provider is not member's listed Long Term Care provider. Please verify provider number and resubmit*.

When an LTC claim denies for EOB 1024, the provider should verify the status of the *Form 450B, e-450B* (short or long version), or computer-generated *OMPP 450B SA/DE*. If the facility has a State-approved *Form 450B* or *OMPP 450B SA/DE* with the correct provider number for the billing facility for the dates of service billed, the approved *Form 450B, e-450B* (short or long version), or computer-generated *OMPP 450B SA/DE* should be resubmitted to the DA. A cover letter requesting that the information is entered in *Core*MMIS due to claim denial for EOB 1024 should be submitted via secure email to the DA using their dedicated email address: DA.NFinforequest@fssa.in.gov.

If the LTC facility does not have a State-approved *Form 450B, e-450B* (short or long version) or computer-generated *OMPP 450B SA/DE* with the correct IHCP Provider ID for the dates of service billed, the facility must follow the established procedures for obtaining *Form e-450B* LOC approval from the DA. The *Form e-450B* or computer-generated *OMPP 450B SA/DE* process for NFs is outlined in Table 1. ICFs/IID should direct *Form 450B* eligibility questions to the local BDDS field office.

> *Note: If the LTC provider has already submitted a Form e-450B (short or long version) or the State-authorized SADE is being processed by DA, the provider must wait until the Form e-450B (short or long version) has been processed by the DA and returned before resubmitting the claim.*

Medicare Crossover Payment Policy

The IHCP makes a payment only when the Medicare payment amount is less than the IHCP rate on file at the time Hewlett Packard Enterprise processes the crossover claim. This change in payment policy for Medicare crossover claims is addressed in *405 IAC 1-18-2*. A paid claim can have an amount of $0.

When a nursing facility resident elects Medicare benefits for room and board at the beginning of the month, the nursing facility collects liability at the beginning of the month, as if the resident was not using Medicare days. If the resident uses Medicare room-and-board benefits for the entire month, the nursing facility places the liability collected at the beginning of the month in the resident's personal needs allowance account. If the resident uses Medicare benefits for room and board for several months, this may exhaust the resident's personal resources. In this case, the nursing facility must notify the county caseworker, who redetermines the financial eligibility of the resident and may end-date the resident's IHCP eligibility until personal resources are again exhausted. The resident may then reapply for Medicaid and must complete a new *Form 450B*. If the resident uses only a portion of the month for Medicare room-and-board benefits, the liability collected by the nursing facility is only for the days that Medicaid paid the nursing facility room and board. The nursing facility places the remaining liability in the resident's personal needs allowance account. If the dollar amount in the personal needs account exceeds the limit allowed, the nursing facility must notify the county caseworker.

Medicare payment policy permits coinsurance or copayment and deductible amounts that cannot be collected by the NF to be treated as a *Medicare bad debt* and are generally eligible for reimbursement by Medicare to ensure that any adverse financial impact on the NF is minimal. See the *Claim Submission and Processing* module for additional claim billing information.

The FSSA has received inquiries from providers about what claims can be submitted to Medicare as bad debt when EOB 9004 – *Pricing adjustment – amount paid is zero* has posted to an adjudicated claim on the provider's Remittance Advice (RA). Providers must send bad debt information to Medicare for review. Providers must submit a copy of the IHCP RA to reflect that the claim was adjudicated by the IHCP and paid at zero. The RA reflects member liability deductions included in the adjudicated claim by indicating the specific dollar amount in the patient liability field (PATIENT LIAB) on the RA, which is located between the other insurance amount field (OTH INS AMOUNT) and the PAID AMOUNT field. If an amount is indicated in this field, this amount of member liability was deducted from the claim. EOB 9004 should **not** be used as the basis for determining whether a member liability amount was deducted from the claim.

In addition, some LTC providers have misused resident personal resource account funds to satisfy a coinsurance, copayment, or deductible cost.

> *Note:* *The IHCP does not allow an LTC facility to use any portion of a member's personal resource account to cover any portion of the coinsurance, copayment, or deductible amount that is not paid by the IHCP program.*

For example, if the Medicare payment is *greater than* the IHCP-allowed amount and the claim is paid at zero, the coinsurance, copayment, or deductible cannot be collected by the LTC facility from the member's personal resource account. Similarly, if the Medicare paid amount is *less than* the IHCP amount, allowing a portion of the coinsurance, copayment, or deductible to be paid, the difference between the payment amount and the difference in the coinsurance or copayment amount or deductible cannot be collected from the member's personal resource account. Providers that have not been following the correct policy must begin doing so immediately.

Nursing Facility Room and Board

When an NF resident elects Medicare benefits for room and board at the beginning of the month, liability is collected at the beginning of the month, as if the resident were not using Medicare days. If the resident uses Medicare room-and-board benefits for the entire month, the liability collected at the beginning of the month is placed into the resident's personal needs allowance account. If the resident is using Medicare benefits for room and board for several months, the resident could exceed his or her personal resources. In this case, the caseworker must be notified. The resident could be taken off Medicaid until personal resources are exhausted. The resident could then reapply for Medicaid, and a new *e-450B* would have to be completed. If the resident uses only a portion of the month for Medicare room-and-board benefits, the liability collected by the NF is only for the days that Medicaid paid the NF room and board. The remaining liability is placed in the resident's personal needs allowance account. If the dollar amount in the personal needs allowance account exceeds the limit allowed, the caseworker must be notified.

Nursing Facilities Not Medicare-Certified

IHCP-enrolled nursing facilities that are not Medicare-certified must comply with the following:

- The nursing facility must use the Certification Statement available on the *Forms* page at indianamedicaid.com to certify to the FSSA that it will not request payment from the IHCP for services rendered to dually eligible IHCP members who are eligible to receive Medicare Part A nursing facility benefits. For as long as a nursing facility elects not to become Medicare-certified, the NF must submit this certification annually to the FSSA's rate-setting contractor, Myers and Stauffer. NFs must send the Certification Statement with the facility's regularly scheduled cost report submission.
- The nursing facility must maintain clinical, payment, and benefit records in sufficient detail to substantiate to the FSSA that a member for whom IHCP payment was requested is not also entitled to or eligible for Medicare Part A nursing facility benefits. The facility must contact the Medicare fiscal intermediary to determine the availability of Medicare.

Comprehensive Care Beds

Senate Enrolled Act 460, Section 155 prohibits the State Department of Health from approving: (1) the licensure of comprehensive care health facilities; (2) new or converted comprehensive care beds; or (3) the certification of new or converted comprehensive care beds for participation in the state Medicaid program, through June 30, 2018.

Exceptions are made for certain facilities that are: (1) under development; (2) small house health facilities; (3) replacement facilities; (4) continuing care retirement communities; and (5) facilities located in counties whose comprehensive care bed occupancy rate exceeds 90%. Small house facilities are limited to 100 new licensed or Medicaid-certified comprehensive care beds per year.

Exceptions

Licensed Only Beds or Beds Licensed and Certified for Medicare Only

There is no restriction on the addition of newly licensed comprehensive care beds if they will be certified only for Medicare or not certified at all. Applications for licensure or certification for Medicare of these beds are to be submitted to the ISDH as usual.

Acute Care Beds and Specialized Service Beds

The restriction does not apply to acute care beds (usually found in hospitals) being converted to comprehensive care beds, except as restricted by current regulations, nor does it apply to comprehensive

care beds that are providing "specialized services" and are therefore subject to *IC 16-29*. Specialized services beds are used solely for patients who have been diagnosed with one of the following conditions:

- Ventilator dependent
- Brain and high spinal cord trauma or a major, progressive neuromuscular disease
- Infected by the human immunodeficiency virus (HIV)

Applications under these exceptions are to be submitted to the ISDH as usual.

Small House Health Facilities

The restriction does not apply to a new category of ISDH-licensed facilities, small house health facilities, as defined in a new section of law, *IC 16-18-2-331.9*, which was also created by *Public Law 229-2011*. Small house facilities are defined as having 10 to 12 private resident rooms in a residential dwelling of 8,000 square feet or less with specific requirements for private bathrooms for each resident, as well as a common living room, kitchen, and dining room. See *IC 16-18-2-331.9* for the complete definition. Applicants seeking Medicaid certification of small house health facility beds are limited to 50 comprehensive care beds per year; the state department may not approve Medicaid certification of more than 100 comprehensive care beds per year as small house health facility beds.

Replacement of Existing Beds

The restriction does not apply to beds that are meant to replace existing Medicaid-certified beds if the facilities comply with the following requirements. The facilities must:

- Submit an application to the DA following the procedures outlined in the *Application Procedures for "Replacement of Existing Beds" Exception* section.
- Meet the licensure, survey, and certification requirements of the ISDH (*IC 16-28*).

Beds may be replaced within a facility and between facilities. The beds must be certified at the time of the application, except in the case of an emergency or disaster.

Applicants requesting replacement of existing beds will be notified of the DA's decision. Upon DA's initial approval, the application packet is forwarded to the ISDH for its determination of compliance with licensure, survey, and certification requirements.

All bed count changes must be in accordance with *Chapter 3* of the *State Operations Manual at 3202 – Change in Size or Location of Participating SNF and/or NF*, which can be found on the Centers for Medicare & Medicaid Services (CMS) website at cms.gov [**Regulations & Guidance > Guidance > Manuals > Internet-Only Manuals (IOMs)**]. Changes must also be in compliance with ISDH requirements that can be found in the Administrator's Reference Guide located on the ISDH website at in.gov/isdh [**Long Term Care > Long Term Care Programs > Comprehensive Care Facility (Nursing Homes) Licensing and Certification Program**].

Application Procedures for "Replacement of Existing Beds" Exception

Submit applications for the replacement of existing beds to the FSSA DA. When submitting a request, provide the following items:

- A letter from the licensee that owns the Medicaid-certified beds that are being replaced or transferred to another licensee. The letter should state that the transferor agrees to transfer the beds to the receiving facility and should include:
  - The licensee's name and address (including county)
  - The licensee's IHCP Provider ID
  - The licensee's CMS Certification Number (CCN)

  - A contact person for each facility involved
  - The number of beds to be replaced or transferred

- A letter from the licensee that will receive the beds verifying the number of Medicaid-certified beds agreed to in the transaction described previously
- A completed *State Form (SF) 4332 – Bed Inventory*, reflecting bed inventory as it is prior to the requested replacement or transfer of beds for each facility involved (State forms are available online at *State Forms Online Catalog* at in.gov.)
- A completed *State Form (SF) 4332 – Bed Inventory*, reflecting bed inventory as it will be after the requested replacement or transfer of beds for each facility involved
- If the beds are being transferred to different ownership, a copy of the complete agreement about the bed transfer between the health facility transferring the beds and the health facility receiving the beds

Medicaid Certification of New Comprehensive Care Beds – Construction Begun after June 30, 2011

Comprehensive care beds in a new comprehensive care facility for which construction began after June 30, 2011, may not be certified for participation in the Medicaid program before July 1, 2016. This restriction does not pertain if one of the following applies:

- The comprehensive care bed for which the health facility seeks certification is a replacement bed for an existing certified comprehensive care bed. Follow the application procedures for the replacement of existing beds outlined in the *Application Procedures for "Replacement of Existing Beds" Exception* section.
- The facility meets the requirements of a small house health facility.
- The facility is a continuing care retirement community that seeks to add licensed beds to an existing facility.
- The facility is a continuing care retirement community that has executed at least 50% of the facility's continuing care agreements with individuals before December 31, 2011.

On approval of the exception by the DA, the application packet is forwarded to the ISDH, Division of Long Term Care, for its determination of compliance with licensure, survey, and certification requirements.

All information should be submitted to:

Yonda Snyder, Director
FSSA Division of Aging
402 West Washington Street, Room W454
Indianapolis, IN 46204

Telephone: (317) 232-7123
Email: Yonda.Snyder@fssa.IN.gov

Medicare Part D and Long-Term Resident Enrollment

Many LTC facility residents have cognitive conditions such as dementia. The LTC facility or pharmacy cannot require residents to join a particular prescription drug program (PDP). Only the member or the person who holds the power of attorney for the member can enroll the member in a PDP. The CMS recognizes state laws that authorize certain people under specific circumstances to enroll and disenroll Medicare members in PDPs.

CMS Fax Procedures for Multiple LTC Resident PDP Enrollment Information

LTC facilities may need PDP enrollment information for members residing in their facilities who are IHCP and Medicare members. NFs without Internet access or that need Medicare PDP enrollment information for multiple residents can use a special CMS fax-based procedure. NF representatives must provide the required authentication information for each of their Medicare members using the appropriate authentication form. Nursing facilities are required to fax the completed form to Medicare at (785) 830-2593, along with the appropriate cover sheet including the name and telephone number of a voice contact. Providers must use these forms to expedite fax requests for PDP information to the CMS. Failure to follow these procedures results in delayed response time. Medicare customer service representatives process the requests and fax them back to the nursing facility. To request these forms, cover sheets, and instructions, call 1-800-MEDICARE.

Claims for Durable Medical Equipment

Medical supplies, nonmedical supplies, and routine DME items billed to the IHCP for members residing in LTC facilities will deny. LTC facilities include NFs, ICFs/IID, and CRFs/DD. The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies, or routine DME items provided to an IHCP member residing in an LTC facility. The costs for these services are included in the facility *per diem* rate, and the medical supplier or DME company should bill the LTC facility for such services. For further information, refer to *405 IAC 5-13-3* and *405 IAC 5-31-4*.

Healthcare Common Procedure Coding System (HCPCS) codes for medical supplies, nonmedical supplies, or routine DME items billed to the IHCP for members residing in LTC facilities will deny with the EOB 2034 – *Medical and nonmedical supplies and routine DME items are covered in the per diem rate paid to the Long Term Care facility and may not be billed separately to the IHCP*.

For more information about DME and supplies, see the *Durable and Home Medical Equipment and Supplies* module.

Note:	*The LTC DME Per Diem Table is available at indianamedicaid.com.*

Intermediate Care Facility for Individuals with Intellectual Disability Services

ICFs/IID bill for room-and-board charges using the applicable room-and-board revenue code. Acceptable room-and-board revenue codes include 100, 110, 120, and 130.

The ICF/IID reimbursement rate is an inclusive rate. Therefore, ICFs/IID cannot bill separately for medical and nonmedical supply items, personal care items, or therapies. The small ICFs/IID reimbursement rate also includes day services as part of the inclusive rate. However, ICFs/IID can bill separately when billing crossover claims. Any inappropriate billing or reimbursement is subject to recoupment by the IHCP Program Integrity Department.

Type of Bill

Providers must use 66X in the Type of Bill field (field 4 of the *UB-04* claim form) to denote a large ICF/IID.

Type of bill 67X denotes a group home or small ICF/IID.

Note:	*The IHCP has identified an issue affecting small ICF/IID facility claims. Claims billed by small ICF/IID with a type-of-bill code in the 67X series are denying for EOB 274 – The type of bill is invalid. 67X is not a HIPAA-compliant code range for type-of-bill codes. The IHCP fiscal agent recognizes that this issue was not communicated prior to the implementation of the CoreMMIS system and has modified the system to temporarily allow use of this series until replacements are identified and published. Future changes to billing guidelines will be communicated in upcoming IHCP publications.*

Leave Days

Reimbursement is available for reserving beds for members in a private ICF/IID, provided that the criteria set out in *405 IAC 5-13-6* is met.

Providers must use the appropriate room-and-board revenue code for the days the member was a patient in the ICF/IID and use the applicable leave of absence revenue code for the days the member was out of the ICF/IID.

The two types of reimbursed leave days are as follows:

- Hospitalization – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/IID. If the member is discharged from the ICF/IID following a hospitalization in excess of 15 consecutive days, the ICF/IID is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/IID does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/IID level-of-care services. The facility must maintain a physician's order for hospitalization in the member's file at the facility. *Providers must use revenue code 185 to denote a leave of absence for hospitalization*.
- Therapeutic Leave of Absence – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member's habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician's order for the therapeutic leave in the member's file at the facility. *Providers must use revenue code 183 to denote a therapeutic leave of absence*.

Use revenue code 180 when the hold days are not eligible for payment.

Preadmission Screening and Resident Review Billing Procedures

This section provides billing and claim-processing guidelines for PASRR providers. PASRR claims use normal claim processing billing procedures and payment logic, although there may be minor differences.

New D&E Teams and CMHCs are approved only to conduct PASRR Level II assessments through contractual arrangements with the Division of Disability & Rehabilitative Services (DDRS) and the Division of Mental Health and Addiction (DMHA). The FSSA refers the names of new entities to the Provider Enrollment Unit for further enrollment processing. PASRR providers that are currently enrolled as IHCP providers do not need to re-enroll. The current IHCP Provider ID that has been assigned for Medicaid or other nonwaiver IHCP programs is the provider's PASRR Provider ID. If a current Provider ID does not exist, the provider must enroll as a PASRR provider.

To enroll as a PASRR provider and to obtain a valid Provider ID to submit PASRR claims, providers should see the *Provider Enrollment* module for more information on enrolling as a provider in the IHCP.

PASRR applicants or members may be dually eligible in the IHCP. When providers submit claims for PASRR, the provider must use the PASRR member ID, which consists of **800** plus the member's Social Security number (for example, 800999999999), or the applicant's PASRR identification number. If an applicant does not have or refuses to provide a Social Security number, providers may contact the Customer Assistance Unit at 1-800-457-4584to obtain a PASRR identification number. At no time should a member bear financial responsibility for a PASRR Level II assessment.

PASRR claims must be submitted via a *CMS-1500* paper claim form, Portal professional claim, or 837P electronic transaction within one year of the date of service. The provider must properly identify and itemize all services rendered. See the *Claim Submission and Processing* module for general billing instructions.

Providers submitting claims using the Portal must meet the technical requirements for Portal access and have a valid Portal account and password. Providers that currently have a Portal account and password do not need an additional account and password to submit PASRR claims.

New providers wanting to use the 837P transaction for PASRR claims must complete, submit, and obtain prior approval of their vendor's software, trading partner ID, logon ID, and password. Providers should allow one week to process vendor and account information. Providers may obtain instructions for account setup by obtaining a copy of the *Companion Guide – 837 Professional Claims and Encounters Transaction* on the *IHCP Companion Guides* page at indianamedicaid.com. Providers who currently send claims using the 837P transaction are not required to make a second application.

Providers must submit a claim for each service instance. Services cannot be combined with other non-PASRR service types, even if the services are rendered on the same day or same visit. For example, a claim for PASRR services cannot be combined with a claim for Medicaid services.

PASRR claims are subject to all edits and audits not excluded by PASRR program requirements. If a claim encounters an edit or audit for missing or invalid information, the claim suspends or denies.

Provider reimbursement for rendered services is determined by the procedure codes, modifiers, and associated maximum (max) fee rate. Procedure codes, modifiers, and max fee rates must accompany all PASRR claim submissions. Providers are responsible for entering billable charges per the published procedure code and max fee rate.

Procedure codes and modifiers must accompany all claim submissions. *Core*MMIS captures as many as four modifiers for all PASRR claims. If the procedure code or applicable modifier is missing or invalid, edits deny or suspend claims.

Providers may void or replace PASRR claims. PASRR financial information is available on the 835 RA transaction. PASRR claims processing information is reflected on the 276/277 Claim Status Request Response transactions. Providers can inquire on the claim's status using the Portal.

The procedure codes and modifiers for PASRR are listed in the *Long-Term Care Codes* on the *Code Sets* page at indianamedicaid.com.