INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Long-Term Care

LIBRARY REFERENCE NUMBER: PROMOD00037
PUBLISHED: SEPTEMBER 28, 2017
POLICIES AND PROCEDURES AS OF APRIL 1, 2017
VERSION: 2.0

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	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: April 11, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: September 28, 2017	Semiannual update: • Edited and reorganized text as needed for clarity • Made extensive revisions to update the Preadmission Screening and Resident Review (PASRR) process • Updated RUG-III to RUG-IV • Changed Hewlett Packard Enterprise references to DXC Technology • Added the *Short-Term Placement in an Institution for Mental Disease* section • Updated the rate reduction information in the *Proprietary Large Private and Small ICFs/IID* section • Added that LOC information must match billing provider information in the *Autoclosure Process for Inpatient Crossover Claims* section • Updated the *EOB 1024* section • Updated PASRR information in the *Preadmission Screening and Resident Review Billing* section	FSSA, Myers and Stauffer, and DXC

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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 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 (MI), intellectual or developmental disability (ID/DD), or both (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 LTC facility claims.

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

State Level-of-Care Reviews for Long-Term Care Members

The FSSA determines the appropriateness of the IHCP reimbursement for all placements of IHCP members in IHCP-certified nursing facilities (NFs). For NFs subject to case-mix reimbursement, there are no skilled or 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 Area Agencies on Aging (AAAs), 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 entered in the State's web-based PASRR system, and a Level I screening is completed to initiate the PASRR process. For individuals seeking Medicaid coverage of their NF stay (whether they currently reside in an NF or are seeking NF placement), or for any individual triggering a Level II assessment, a level-of-care assessment is completed to determine whether the individual meets LOC criteria as outlined in *405 IAC 1-3-1* or *405 IAC 1-3-2*. The AAA performs on-site assessments for individuals who do not appear to meet NF criteria for a final determination prior to any denial.

For additional information, see the *Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual*.

Level-of-Care Screen

For NF **applicants**, an LOC screen is required for the following, except as noted:

- Medicaid recipients seeking admission to a Medicaid-certified NF with Medicaid as their pay source
- Level II candidates (indicated by Level I screen), regardless of pay source:
  - Exempted Hospital Discharge – LOC screen is not required **unless** the stay is longer than the approved 30 calendar days
  - Provisional Emergency Situations – LOC screen is not required **unless** the stay is longer than the approved seven days
  - Respite Admission – LOC screen is not required **unless** the stay is longer than the approved 30 calendar days
  - Dementia Exemption Admission
- All PACE participants who *do not* have a valid/current LOC on record
- All Home and Community-Based Services (HCBS) waiver participants who *do not* have a valid/current LOC on record

For NF **residents**, an LOC assessment is required for the following:

- Residents who become Medicaid-active during their NF stay
- Residents who experience a significant change in medical condition (see the *Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual*)
- All PACE participants annually, and more often as needed as medical needs change
- Residents admitted with long-term care approval whose medical status has improved but do not wish to leave the facility
- Residents whose short-term approval is coming to an end and the resident has medical needs to support continued stay

Level of Care Outcome

Providers have access to print outcome letters via the State's web-based PASRR system. Letters must be maintained in the resident's medical record or readily accessible.

Possible outcomes for an LOC screen include the following:

- NF applicants/residents:
  - Approved for short-term skilled NF stay (30, 60, 90, or 120 calendar days)
  - Approved for short-term intermediate NF stay (30, 60, 90, or 120 calendar days)
  - Approved for long-term skilled NF (more than 120 days)
  - Approved for long-term intermediate stay (more than 120 days)
  - Denied for NF stay

> *Note: Denials are referred to the AAA, which will conduct an on-site LOC assessment prior to any denial being issued.*

- PACE participants:
  - Approved for long-term skilled NF stay (more than 120 days)
  - Approved for long-term intermediate NF stay (more than 120 days)
  - Denied for NF stay (requires further review)

> *Note: Denials are referred to the AAA, which will conduct an on-site LOC assessment.*

Level I Screen

A Level I screen is required for all individuals seeking admission to a Medicaid-certified nursing facility, regardless of pay source. Level I screens are submitted by hospitals, AAA, and NF providers via the State's web-based PASRR system.

A Level I screen is required in the following cases:

- Before admission to a Medicaid-certified nursing facility
- For residents who have a significant change in mental status indicating the need for an updated Level I screen, a subsequent Level I screen, or an updated Level II evaluation

> *Note* *Significant change information is located in the Indiana PASRR Level I & Level of Care Screening Procedures for Long Term Care Services Provider Manual. If the change meets the criteria of a 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.*

- Before the conclusion of a short stay approval, for individuals with a diagnosis of MI, ID/DD, or MI/ID/DD requiring a Level II evaluation and who are expected to need to stay beyond the approved amount of time

Level I Outcomes

Providers have access to print outcome letters via the State's web-based PASRR system. Letters must be maintained in the resident's medical record or readily accessible.

Possible outcomes for a Level I screen:

- No Level II Required
- Level II Negative, No Status Change
- Level II Positive, No Status Change
- Exempted Hospital Discharge
- Emergency Categorical
- Respite Categorical
- Refer for Level II Onsite
- Withdrawn
- Cancelled

PASRR Level II Evaluation

The Level II PASRR Evaluation process identifies rehabilitative or specialized services that an individual may require. The Division of Disability & Rehabilitative Services (DDRS) Level II contractor conducts these evaluations for residents with an ID/DD or MI/ID/DD diagnosis. The Division of Mental Health and Addiction (DMHA) Level II contractors conduct these evaluations for residents with a diagnosis of MI only.

Level II evaluations must be completed prior to admission and whenever a resident experiences a significant change in condition.

Level II evaluations require nursing facilities to be responsible for planning and delivering (or arranging for) all required rehabilitative services identified through the PASRR Level II process:

- Determine the most appropriate setting for persons with MI/ID/DD.
- Address both mental and physical health needs of residents.

Level II Outcomes

Providers should maintain all Level II evaluations and summary letters in the resident's medical record or have them readily accessible:

- Long-term approval
  - Admit to or remain in an NF without an identified end-date
- Time-limited approval
  - Approved for a specific time frame
  - New Level I, LOC, and Level II required if stay required beyond initial time frame approved
- Denial
  - NF placement does not appear to be appropriate

PASRR Level II Exemptions

Certain circumstances allow individuals who have MI or ID/DD diagnoses to be exempt from PASRR or to be admitted to an NF through an abbreviated Level II evaluation process.

An exemption allows for residents meeting criteria for Level II evaluation to be federally exempt from the full Level II evaluation process prior to NF admission. The following exemptions may be applied in Indiana:

- Exempted hospital discharge (EHD)
- Dementia exemption

Exemptions may be applied only to individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.

Exempted Hospital Discharge (EHD)

A short-term exemption from the PASRR process is allowed for individuals with known or suspected MI or MI/ID/DD who meet both of the following:

- Are being discharged from a medical hospital to a nursing facility after receiving medical (nonpsychiatric) services
- Require short-term treatment of 30 calendar days or less in an NF for the same condition for which they were hospitalized

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 PASRR-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.

Dementia Exemption

Certain individuals with dementia are excluded from PASRR when a dementia condition is present. The dementia exclusion applies to the following:

- Individuals with a sole diagnosis of dementia
- Individuals with a primary diagnosis of dementia and a secondary MI diagnosis

The submitting provider must include sufficient evidence clearly confirming dementia as the primary diagnosis.

Level II PASRR Categorical Decisions

Certain circumstances allow individuals who have MI or ID/DD diagnoses to be exempt from PASRR or to be admitted to an NF through an abbreviated Level II evaluation process. A categorical PASRR decision allows residents meeting criteria for Level II evaluation to be federally exempted from the full Level II evaluation process prior to NF admission.

Two types of categorical Level II decisions may be applied:

- Provisional emergency situations
- Respite stays

As with exemptions, categorical decisions may be applied only for individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.

Provisional Emergency Situations

The provisional emergency categorical decision may be applied when an individual has a Level II condition (MI, ID/DD, or MI/ID/DD) and all of the following apply:

- There is a sudden unexpected and urgent need for placement (such as loss of a caregiver, loss of a residence, or suspicion of abuse/neglect).
- The individual meets Adult Protective Services (APS) or Child Protective Services (CPS) criteria.
- A lower level of care is not available or appropriate.

Provisional emergency situations allow for up to seven calendar days in an NF. If additional days are required, a new Level I and LOC screen, and new Level II when applicable, must be obtained prior to the approval end date through the State's web-based PASRR system.

An APS admission is designated as a *maximum stay of seven days* in accordance with *Code of Federal Regulations 42 CFR 483.130(d)(5)*. This admission must be authorized jointly by an APS investigator and the AAA **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.

Respite Stays

Respite is available for individuals who reside with an in-home caregiver. The respite care must not exceed 30 calendar days per quarter. There must be 30 calendar days between respite stays of 15 calendar days or more. Both of the following criteria must be met:

- Individual resides in the community with an in-home caregiver.
- Individual is expected to return home from the NF.

Note: This admission must be authorized through the State's web-based PASRR system.

Resident Changes from Private-Pay to IHCP Member

After the member has been notified of his or her Medicaid eligibility, the NF is required to complete an LOC screen via the State's web-based PASRR system.

Interfacility Transfers

No additional screening is required for residents transferring to another NF, as long as the individual was not discharged to a lower level of care. This policy applies to individuals who have been approved through PASRR for NF admission and who transfer:

- From one Indiana NF to another Indiana NF
- From an Indiana NF to a hospital and back to the same or another Indiana NF

Additional screening is required in the following cases:

- A significant change in condition has occurred.
- The individual has been discharged to a lower level of care (such as community placement) and needs to return to the same or different NF.
- The approved length of stay is nearing expiration.

The two nursing facilities must enter the discharge date and new admission date in the State's web-based PASRR system.

Reimbursement Limitations for PASRR 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.

Case-Mix/LOC/PASRR 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 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.* (Request referral through the State's web-based PASRR system for residents who do not appear to meet NF LOC.)

> *Note: When the LTC review team identifies a resident who does not appear to meet LOC, the team will complete a Level of Care referral form and present the form to the provider at the time of exit. The provider should then make the referral utilizing the State's web-based PASRR system. After the LOC referral has been completed and outcome letters received by the LTC provider, the LOC referral form should be completed. A copy of the completed LOC referral form in addition to a copy of the outcome letter(s) should be mailed to:*
>
> **Lynn Snider, BSN, RN, RAC-Ct**
> **Senior Healthcare Consultant**
> **Myers and Stauffer LC**
> **9265 Counselors Row, Suite 100**
> **Indianapolis, IN 46240**

- Ensure Level I assessments are completed and reflect the resident's current mental and physical condition
- Ensure all services recommended by the Level II assessments are provided.
- Determine whether the IHCP is reimbursing the provider for the appropriate RUG-IV 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 team is available to address facility questions and concerns. The review team consists of registered nurses.

The facility is responsible for ensuring that all resident medical records are complete, up-to-date, and available to the review team 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 MI, ID/DD, or 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 the DMHA Level II contractor. Residents identified with a possible ID/DD or dual diagnoses as MI and ID/DD are referred to the DDRS Level II contractor. 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 identifies 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 referral form, along with copies of the completed Level II and certification, must be completed and submitted within 45 business 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 appropriate agency for the delivery of those services, the team does not refer this resident for a yearly review.
- 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 review.

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 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

The individual or guardian has the right to appeal all LOC decisions. All outcome letters include a notice of the individual's appeal rights.

If the agency review decision favors the appellant, or member, the member LOC segment is 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.

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 recommending LOC screen on residents that may not meet NF level of care. Myers and Stauffer documents these findings in writing and provides 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 calendar 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 quarters 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-IV 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 1-14.6-22(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 NF 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%. Nursing facilities that score greater than 20% unsupported, as outlined in the *Indiana Administrative Code (IAC),* receive at a minimum 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 MDS records are reclassified, and the NF is subject to a case-mix review within 4–12 months. Additional consecutive unsupported MDS reviews will result in increased Corrective Remedy penalties as delineated in Table 4.

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, 2016, is finalized on December 30, 2016, and the findings indicate that more than 20% of the reviewed MDS records are unsupported; a corrective remedy is applied beginning January 1, 2017. 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

LTC services are not included in the scope of benefits provided to members in the IHCP managed care programs: Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise. These services are covered under the IHCP fee-for-service (FFS) Traditional Medicaid program, which the Eligibility Verification System (EVS) identifies as either *Full Medicaid* or *Package A – Standard Plan* 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 1st and 15th calendar days of the month. LTC providers should use any of the EVS options described in the *Electronic Data Interchange*, *Interactive Voice Response System*, and *Provider Healthcare Portal* modules upon admission of a new patient, and on the 1st 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.

> *Note: Reimbursement of LTC facility services is not available for Hoosier Healthwise Package C members.*

Short-Term Placement in a Nursing or LTC Facility

While LTC 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 long-term care, or whose short-term placement becomes a long-term placement, will be disenrolled from managed care when LTC LOC is approved and entered into the Core Medicaid Management Information System (*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.

Short-Term Placement in an Institution for Mental Disease

For dates of services on or after July 5, 2016, MCEs may authorize coverage for short-term stays for members aged 21–64 in an institution for mental disease (IMD) in lieu of services or settings covered under Indiana's Medicaid State Plan.

For IHCP members enrolled in HIP, Hoosier Care Connect, or Hoosier Healthwise managed care programs, MCEs can authorize stays in an IMD for inpatient services related to mental health, behavioral health, and substance use disorder. The IHCP will establish eligible IMD providers following the definition in *42 CFR 435.1010*. This definition may include hospitals providing inpatient care for psychiatric or substance use disorder, or subacute facilities providing crisis residential services for psychiatric or substance use disorder.

If the member's IMD stay exceeds 15 days in a calendar month and the member is awaiting placement in a state hospital, the member will be disenrolled from the MCE and enrolled in Traditional Medicaid. The *590 Program* provider reference module provides additional information regarding this process. The MCE is responsible for ensuring that the member is properly transitioned with no gap in coverage. For all other stays greater than 15 days in a calendar month, the member will remain enrolled with the MCE and continue to receive care coordination services.

Placement in a Long-Term Care Facility

NFs and AAAs must notify the MCE immediately when an MCE member is admitted to an LTC facility or undergoes the 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: NFs and ICFs/IID. 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 Reimbursement

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

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

- *Capital* – Allowable capital-related items include the following:
  - Fair rental value allowance
  - Property insurance
  - Property taxes
- *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.
  - 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.
- *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).
- *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, 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 unless the member is under hospice care. 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 Reimbursement

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

Effective July 1, 2016, in accordance with Section 10 of *Public Law 12-2016*, the rate reduction at *405 IAC 1-12-27* is void. 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: NFs and ICFs/IID.

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

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

Nursing Facility Billing

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-IV 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-IV Classification is based on the MDS.
- 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:	*Providers must 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 end-date 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 an 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.** 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 DXC.*

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.

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. LOC information must match billing provider information.

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 DXC 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.

DXC 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 DXC following notification that the provider billed the incorrect patient status code.

Note:	*Hospice providers are not required to submit individual claim adjustment forms to DXC for retro-rate adjustments for room-and-board payments under the IHCP hospice benefit. DXC 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

If an LTC claim denies for EOB 1024 – *Billing provider is not member's listed Long Term Care provider. Please verify provider number and resubmit*, the provider should verify that the LOC information reflects the correct IHCP Provider ID for the billing facility for the dates of service billed. 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 Division of Aging using their dedicated email address: DA.NFinforequest@fssa.in.gov.

If the LTC facility does not have a State-approved LOC with the correct IHCP Provider ID for the dates of service billed, the facility must follow the established procedures for obtaining LOC approval from the DA. ICFs/IID should direct LOC eligibility questions to the local Bureau of Developmental Disabilities (BDDS) field office.

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 DXC 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 PASRR through the State's PASRR web-based system. 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 PASRR 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 Facilities for Individuals with Intellectual Disability Billing

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

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.

The PASRR Level II contractors are approved only to conduct PASRR Level II assessments through contractual arrangements with the DDRS and the 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.

When submitting a claim for PASRR for an individual who doesn't have an existing IHCP Member ID, the provider must use a specially assigned PASRR Member ID, which begins with the digit 4. Providers can use the EVS options (Provider Healthcare Portal at indianamedicaid.com, IVR system at 1-800-457-4584, or 270/271 electronic transaction) to obtain the IHCP Member ID or PASRR Member ID assigned to an eligible individual. 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.

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

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.