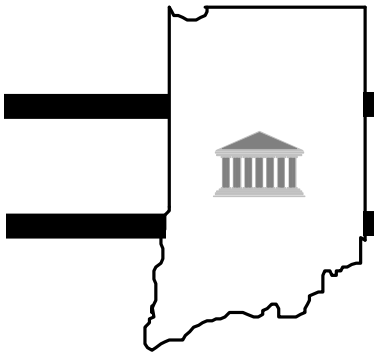

# INDIANA MEDICAID UPDATE

**August 14, 1998**

**TO: Indiana Medicaid Nursing Facility Providers**

**RE: Case Mix Reimbursement**

This is to remind all nursing facilities that the final rule 405 IAC 1-14.6, which establishes a case mix system of reimbursement, will become effective on October 1, 1998. Pursuant to the rule, payment under this methodology will be based upon one Medicaid rate, determined each quarter, for all Medicaid recipients in Medicaid-certified and dually-licensed nursing facilities.

The purpose of this bulletin is to cover a range of issues that are important for providers to be aware of as we transition to the case mix reimbursement system.

## Provider Information on the Indiana*AIM* System

Under the case mix reimbursement system, each nursing facility will have only one nursing facility level of care designation on Indiana*AIM* and one per diem rate that is calculated by taking into account resource usage for each resident within the facility. This single per diem rate per facility will be paid effective 10/1/98. The per diem rate will change quarterly, as described in the final rule, and will be electronically transmitted from Myers and Stauffer, OMPP's rate-setting contractor, to EDS on a routine basis. Myers and Stauffer will simultaneously notify each facility of its updated Medicaid rate. All intermediate, skilled, and skilled-ventilator rates with effective dates prior to October 1, 1998 will be end-dated for dates of service after September 30, 1998.

## Criteria for Nursing Facility Level of Services

With the implementation of the case mix reimbursement system, there will no longer be skilled and intermediate levels of Medicaid reimbursement. However, the criteria found at 405 IAC 1-3-1 and 1-3-2 **will continue** to define the threshold of nursing care needs required for admission to or continued stay in a Medicaid-certified nursing facility and will continue to be used by the OMPP, the Pre-Admission Screening (PAS) agencies, and EDS review teams.

It should be noted that, as is true under the current reimbursement system, the criteria found at 405 IAC 1-3-2 (intermediate criteria) generally are not applicable to individuals who are developmentally unable to perform the activities described in that rule. These individuals must meet the criteria set forth in 405 IAC 1-3-1 (skilled criteria) for admission or continued stay in a nursing facility. For example, children must have medical needs requiring nursing care that are beyond the scope of customary parental care, and developmentally disabled individuals must usually have medical needs that take precedence over their developmental disability specialized services needs.

## IPAS/PASRR

The implementation of case mix **does not** change any requirements for the Indiana Pre-Admission Screening program (IPAS) or the federal PASRR program, with the exception that levels of care will no longer be determined.

## Form 450B/Nursing Facility Level of Care

The "Form 450B," "Physician Certification for Long Term Care Services," has been the vehicle through which State authorization for admissions, transfers between levels of care, re-admissions, Medicare-to-Medicaid transfers, and new Medicaid eligibility has been communicated between the Office of Medicaid Policy and Planning and the nursing facility provider. Form 450B's for service dates prior to Medicaid case mix implementation October 1, 1998 will continue to be processed for skilled and intermediate level of care determinations by the OMPP Level of Care Unit.

Please note that if a resident is currently approved for a Medicaid level of care, the Indiana*AIM* System will automatically convert his/her intermediate, skilled or skilled-ventilator level of care to case mix NF at the time of implementation. **As a result, the nursing facility should not submit a Form 450B for the sole purpose of conversion from a level of care already approved by the OMPP under the current (Rule 14.1) system (i.e. skilled or intermediate) to case mix (Rule 14.6).**

For dates of service on or after October 1,1998, **the Form 450B will no longer be used for level of care changes, since the case mix system of reimbursement is automatically updated to reflect significant changes in condition that are identified on MDS forms.** Additionally, the Form 450B will no longer be required for any **readmission** following a hospitalization exceeding the bed-hold policy as long as the resident was approved for nursing facility care preceding the hospitalization. This applies to readmissions from a hospital to the same or another nursing facility; as long as there has been no break in medical care. Note: nursing facilities will be required to submit a "450B Data Entry/Authorization Sheet" (currently being developed) to OMPP in place of the Form 450B, for purposes of data entry of the resident's readmission date and the appropriate facility provider number in Indiana*AIM* to reinstate nursing facility reimbursement.

The Office of Medicaid Policy and Planning will continue to conduct nursing facility level of services reviews for the IPAS/PASRR programs, new Medicaid eligibility, and nursing-facility-to-nursing-facility transfers (with no intervening hospitalization), as it is currently done through the Form 450B process. Please note that if the "Level of Care Transfer Date" box on the Form 450B is completed for any change effective on or after October 1, 1998, the OMPP will not process the Form 450B and it will be returned to the facility. If the facility is intending to reflect other changes, such as new Medicaid eligibility, readmission, or a transfer from another nursing facility, this information should not be entered in the "Level of Care Transfer Date" box.

The OMPP is committed to streamlining the administrative processes as much as possible; therefore, it will continue to seek opportunities to further reduce Form 450B and other paperwork requirements in the future.

**Recipient Level of Care Information on the Indiana*AIM* System**

Currently, each level of care (i.e. intermediate, skilled, skilled-ventilator) has a specific level of care indicator on the Indiana*AIM* recipient level of care window to denote the level of care for which the recipient has been approved, and that indicator is then utilized in determining the correct reimbursement amount. Upon the transition to case mix, the level of care indicators noted above, for Medicaid residents currently in nursing facilities, will be systematically updated to reflect the new 'N' (Nursing Facility) level of care indicator for dates of service beginning October 1, 1998. Under case mix, the reimbursement rate is based on the information submitted on the MDS 2.0 form for each resident, which will then be used to compute a facility-average case mix index and rate. Since the provider will have only one rate, there will no longer be a need to separate residents into different levels of care. Therefore, these residents certified for nursing facility placement by the Office of Medicaid Policy and Planning (OMPP) will be denoted with the 'N' level of care indicator.

**Claim Submission**

***Bill Type*** - Claims filed under the current level of care (skilled and intermediate) system of reimbursement require a bill type specific to the level of care for the recipient. For example, a claim filed for a Medicaid resident with skilled level of care utilizes the 21X bill type in data element "4" on the UB92 claim form, and a claim filed for a Medicaid resident with intermediate level of care utilizes the 65X bill type in data element "4" on the UB92 claim form.

For dates of services on or after October 1, 1998, claims using either bill type 21X or 65X will continue to be accepted for any Medicaid resident within the nursing facility that is reimbursed under the case mix system.

***Revenue Code*** - Claims filed under the current level of care system of reimbursement require the specific revenue code on the claim form to correlate to the room accommodation provided to the resident. For example, a claim filed for a Medicaid resident in a private

room utilizes the revenue code 110, and a claim filed for a resident in a two-bed room utilizes the revenue code 120. For dates of service on or after October 1, 1998, the specific revenue code used will no longer be relevant. As a result, any of revenue codes 100, 110, 120 and 130 will be accepted for all Medicaid residents reimbursed by the case mix methodology in the nursing facility.

***Billed Rate vs. Rate on File*** – The Indiana*AIM* system will pay the per diem rate on file for all nursing facility claims with a date of service on or after October 1, 1998. This logic will provide for the payment of the most current rate received by EDS from Myers and Stauffer, in cases where the provider's notification is delayed. The current payment logic pays the provider the lesser of the billed amount or the per diem rate on file. This revised mechanism should also assist in the decrease of retroactive rate adjustments.

***EOB Messages*** - For dates of service on or after October 1, 1998, Explanation of Benefit (EOB) message 1017, "No case mix rate segment on file" will be activated. If the nursing facility bills a long-term care claim for a Medicaid recipient without a certified 'N' level of care, the claim will be denied. All other edits pertaining to nursing facility claims will remain active for dates of service before and after October 1, 1998.

***Therapeutic Leave Days/Hospital Leave Days –***Effective for dates of service on and after October 1, 1998 the Indiana*AIM* system will no longer accept the revenue code 180 for nursing facility claims. The revenue code specific to the leave must be utilized for billing purposes. Revenue code 183 must be used for a therapeutic leave of absence, and revenue code 185 must be used for the hospitalization bed hold. All leave of absences must have a supporting physician order in the resident's medical record.

***Ancillary Charges*** - The implementation of case mix will have no effect on the reimbursement of ancillary charges. Pursuant to 405 IAC 1-14.6-19, the approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supplies and equipment. The provider may not bill the Medicaid program for such items in addition to the established rate.

***Therapy Services*** - The implementation of case mix will have no effect on the reimbursement of therapy services. Pursuant to 405 IAC 14.6-20, therapy services provided to Medicaid residents by nursing facilities are included in the established rate. The provider may not bill the Medicaid program for therapies in addition to the established rate.

***Patient Liability*** - The implementation of case mix will have no effect on the application of patient liability through Indiana*AIM*.

***Adjustments*** - The implementation of case mix will have no effect on the processing of adjustments through Indiana*AIM*.

**EDS Nursing Facility Audits**

EDS will continue to conduct on-site audits in nursing facilities to review the continuing need for Medicaid reimbursement and to ensure that PASRR requirements are met. The on-site audit process will include a verification of the MDS 2.0 responses transmitted to Myers and Stauffer, through a review of the resident's medical documentation. A sample of all residents in the nursing facility will be reviewed, including those residents whose care is not directly funded by the Indiana Medicaid program.

With the implementation of the case mix reimbursement system, the OMPP and EDS have strived to make conversion from the current reimbursement methodology to the case mix system of reimbursement as seamless as possible. Therefore, the modifications made to the Indiana*AIM* System, as described in the 'Bill Type' and 'Revenue Code' sections above, will allow providers to continue the same billing procedures that were accepted under the current reimbursement methodology. **No change to long-term care providers' claim submissions will be necessary under the case mix reimbursement system**.

If you have any questions regarding the information contained in this bulletin, please contact the EDS Provider Assistance Unit at 1-800-577-1278, or for local providers and out-of-state providers not in a contiguous state, at (317) 655-3240.