INDIANA MEDICAID UPDATE

November 2, 1998

TO: **All Indiana Medicaid-Certified Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded (Large and Small)**

SUBJECT: **Auto-Closure of the Recipient Level of Care Segment by the Indiana*AIM* System**

Attention: **Business Office Managers**

In January, 1998, the Indiana*AIM* system was modified to utilize the STAT code field (field 22) of the UB-92 claim form to close out the recipient level of care segment for selected discharge status codes. Automation of this process alleviates the need for providers to notify the Office of Medicaid Policy and Planning (OMPP) of all residents discharged from a nursing facility or intermediate care facility for the mentally retarded (ICF/MR) during a given month. Effective August 31, 1998, OMPP has requested that facilities no longer submit monthly discharge information.

Although this modification to the Indiana*AIM* system was previously announced to providers in remittance advice articles issued January 13, 1998 through February 24, 1998, OMPP and EDS have continued to receive a high volume of provider questions. This bulletin is intended to clarify the process.

It is **imperative** that the nursing facility or ICF/MR provider submit the patient status code applicable to the through date of service indicated on the claim form. Indiana*AIM* will close out the recipient level of care segment for a recipient whose claim has one of the following Patient Status Codes:

01	07
02	08
05	20

Caution: When filing a claim for a hospital or therapeutic bed hold, DO NOT use a discharge code on the claim form. The discharge status code will close the recipient Level of Care segment and all future claims will deny for edit 2008, "Recipient ineligible for level of care billed". Providers should use the status code of 30 when billing a hospital or therapeutic bedhold.

Please note that once the 15-day bedhold period has expired, the resident must be discharged with the appropriate status code. The hospital bedhold days must be billed using Revenue Code 185, and the claim must reflect the actual date of discharge as the "to" date of service. Upon readmission from the hospital to the facility, the individual can be readmitted with a new Form 450B. (For dates of service on or after October 1, 1998, complete Section 1 only.)

Examples:

1. A resident was in a long term care facility from June 1 through June 23. He/she was hospitalized on June 24 and returned to the nursing facility or ICF/MR on July 2. The long term care facility should bill for June service dates as follows: twenty-three (23) days of per diem for the appropriate level of care and seven (7) days of hospital bedhold (Revenue code 185). The patient status code would be "30" because the recipient is still a resident of the nursing facility or ICF/MR during the bedhold days.

2. If the same recipient did not return to the long term care facility on the anticipated date of July 2 (i.e.: was discharged to his/her home or to another facility from the hospital), the July bill should reflect one day of bedhold and then discharge on July 2 with a status code of "02". Although the date of discharge is not reimbursed, the claim **must** reflect this date with the appropriate status code reflecting true disposition of the resident.

3. Bedhold **may not** be billed when the resident's return is not anticipated.

It is important to remember that EDS cannot adjust denied claims. If you have experienced recent denial of claims that you believe is related to an incorrectly billed discharge code, please contact the **EDS Long Term Care Unit at (317) 488-5099.**

If you have previously received payment for a particular resident but have experienced recent claim denials for edit 2008, please contact the **EDS Long Term Care Unit at (317) 488-5099. DO NOT contact OMPP directly or send in a new Form 450B.** An EDS Long Term Care analyst will review the denial reasons specific to your claim. If the recipient's level of care was discontinued as a result of the discharge status code, the analyst will review the claims for the recipient and determine which claim caused the auto-closure. If it is determined that an incorrect status code was used, the analyst will advise the provider of any action that should be

taken and will, in many cases, be able to manually re-open the level of care. If the resident exhausted bedhold days, it may be necessary to submit a new Form 450B. Providers should not submit a new Form 450B until instructed to do so by the EDS Long Term Care Unit.

Many of the calls received by the EDS Long Term Care Unit have been related to processing of retro-rate adjustments. If you have experienced claim denial in conjunction with a retro-rate adjustment and the EDS Long Term Care Unit has reviewed and manually re-opened a level of care segment, you may re-bill denied claims on paper. If the denied claim is past the filing limit, please include an attached letter which states that the claim was denied due to an auto-closure of the level of care during a retro-rate adjustment. Indicate in the letter that you have spoken with the EDS Long Term Care Unit and that the level of care segment for the recipient has been reinstated. Submit paper claims with attachments to the appropriate address indicated in the Indiana Medical Assistance Programs Provider Manual. The letter will be sufficient to waive the filing limit and allow the claims to be processed.

Providers who have previously received payment for claims with an incorrect status code should initiate adjustments that reflect the correct status codes. This will insure that the correct information is reflected in the Indiana*AIM* system and alleviate any future denial of claims during retro-rate adjustments.

If you have any questions regarding the content of this bulletin, please contact the **EDS Long Term Care Unit at (317) 488-5099**.