



PROVIDER BULLETIN

BT 200347

JULY 8, 2003

**To: All Nursing Facilities and Intermediate Care Facilities  
for the Mentally Retarded ICF/MR (Large and Small)**

**Subject: Long Term Care Appropriate Billing Practice**

## Overview

This bulletin reminds all Long Term Care (LTC) providers of the appropriate billing practice for Indiana Health Coverage Programs (IHCP) residents discharged from a LTC facility. Although providers were notified of this requirement in multiple publications, including Chapter 14 of the *IHCP Provider Manual*, the volume of calls received by the Office of Medicaid Policy and Planning (OMPP) and EDS indicates that a reminder is necessary.

To ensure IHCP members receive all entitled benefits, it is the responsibility of each LTC provider to properly document the discharge of these residents. Since January 1998, IndianaAIM uses the patient status code from the UB-92 claim form, which is locator box 22 STAT, to close the member level of care segment. This process was automated allowing providers to show the discharge of IHCP residents by using the appropriate patient status code on the UB-92 claim form. This eliminates the need for written discharge information to be submitted to the OMPP.

During a recent review of claims, the IHCP noted that many LTC facilities are incorrectly coding claims for members leaving the LTC facility. Incorrect status coding of a claim not only leads to overpayment to the facility, but also prevents members from receiving services such as supplies when discharged from the LTC facility. Providers should be aware that overpayments made to facilities are subject to recoupment.

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

- 01 – Discharged to home or self-care, routine discharge
- 02 – Discharged or transferred to another short-term hospital for inpatient care
- 05 – Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution
- 06 – Discharged or transferred to home under care of organized home health service organization
- 07 – Left against medical advice or discontinued care
- 08 – Discharged or transferred to home care under intravenous provider
- 20 – Expired

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

It is **imperative** that LTC providers carefully complete the UB-92 claim form to ensure the **To Dates of Service (TDOS)** line on the claim form accurately reflects the actual date of discharge for the member, even though LTC providers do not receive reimbursement for the date of discharge. The following situations result from billing practices that do not accurately reflect the TDOS and/or the **Patient Status Code**, causing difficulty for the provider or the member:

- Primarily, when a member is discharged, but the LTC claim indicates a status code of 30, the provider is stating the member is still a patient. Consequently, neither EDS nor the OMPP is aware of the member's discharge from the LTC facility and the level of care (LOC) segment continues to show residence in a LTC facility. As a result, IHCP members are unable to obtain medications, durable medical equipment (DME), and other items while in the community, and this could endanger the member's health and safety. Additionally, the LTC facility could be overpaid. These overpayments are subject to recoupment.
- When the provider bills using the incorrect patient status code indicating the member was discharged, even though the member remains a resident of the facility, the member's level of care segment in IndianaAIM is closed showing the TDOS on the claim form as the stop date. Subsequent claims submitted for this member will deny with EOB 2008 – *Recipient not eligible for this LOC for DOS*. This situation impacts not only current claims, but the auto-closure function reads the patient status code on each claim during retro rate adjustments and will close the segment again, even if it was restored by the LTC staff. As a result of previous inappropriate billing of claims, providers could be faced with large accounts receivable balances.

Providers aware of paid claims listing an incorrect patient status code are instructed to submit adjustments to correct the patient status code. This ensures the correct information is reflected in IndianaAIM and alleviates any future denial of claims during retro rate adjustments.

Denied claims cannot be adjusted. If providers have experienced a recent denial of claims due to an incorrectly billed patient status code, they should contact the Long Term Care Unit at (317) 488-5099 and leave all pertinent information, including the member identification (RID) number, provider name, provider number and telephone number, as well as the dates of service for the denied claims on voice mail. The third week of each month, a LTC analyst will review the denials. If the claims indicate that an incorrect patient status code was billed, the level of care stop date can be manually removed. To receive reimbursement the provider will need to re-bill denied claims after the level of care changes are made.

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