Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200002 APRIL 5, 2000

To: All Nursing Facilities and Area Agencies on Aging/IPAS Contact Persons

Subject: Use of Forms 450B and OMPP 450B SA/DE

Overview

The purpose of this bulletin is to clarify the use of the various 450B forms. There are currently three different forms in use:

- *Form 450B (State Form 38143)* is used for physician certification for long-term care services.
- *OMPP 450B SA/DE (State Form 49120)* is used for nursing facility level of service, state authorization, and data entry. Facilities can order this form from the Department of Administration, Forms Distribution Center.
- *OMPP 450B SA/DE* (computer-generated) is used for nursing facility level of service, state authorization, and data entry. This form is generated by the Office of Medicaid Policy and Planning (OMPP) for Indiana Pre-admission Screening (IPAS) determinations.

A copy of each form is attached to this bulletin as a reference.

The use of three variations of the 450B has led to confusion as to which form is the official State 450B nursing facility determination form to be maintained in a resident's chart. As a result of this confusion, some nursing facilities have not recognized the official form and have requested that the OMPP reissue 450B forms. This results in additional and unnecessary work for nursing facilities and OMPP staff.

Please refer to provider bulletin, *E98-40,* issued November 16, 1998, for general instructions on *Form 450B* nursing facility level of service procedures.

Use of *Form 450B (State Form 38143) Physician Certification for Long Term Care Services*

As described in bulletin *E98-40*, *Form 450B* provides initial medical information and must be submitted for all nursing facility admissions under the IPAS and Pre-Admission Screening and Resident Review (PASRR) screening requirements. It may also be submitted to the OMPP to provide medical information for other State determinations, such as admissions from other nursing facilities and changes in payment from private pay to Medicaid reimbursement.

If a *Form 450B* is **signed by the State in Section III-State Department Authorization**, this becomes the official form that should be retained in a resident's medical record for the admission or action addressed by the *Form 450B.*

IPAS agencies may include unsigned *Form 450Bs* with the IPAS packet forwarded to the admitting nursing facility, however, these *Form 450Bs* **are not the official forms** to be used by the facility.

A copy of this form is provided in Figure 1.1.

Use of *OMPP 450B SA/DE (State Form 49120) Nursing Facility Level of Service State Authorization and Data Entry*, Distributed by the Forms Distribution Center

Bulletin *E98-40* provided a copy of the *OMPP 450B SA/DE* form distributed by the Forms Distribution Center. The bulletin also describes how nursing facilities use this form. The *OMPP 450B SA/DE* may be used by facilities to submit medical information to the OMPP with a signed minimum data set (MDS) assessment record that is **current** with the requested effective date, as an alternative to submission of the *Form 450B* signed by the physician.

> *Note: The* OMPP 450B SA/DE *cannot be used for service dates prior to the October 1, 1998, implementation of case mix reimbursement.*

A copy of this form is provided in Figure 1.2.

Use of *OMPP 450B SA/DE Nursing Facility Level of Service State Authorization and Data Entry,* Computer Generated by the State

To enhance and expedite case processing, the State has implemented a statewide, automated IPAS/PASRR case processing, database, and tracking system. IPAS and PASRR cases may be electronically transmitted to the State for determination of admission and continued care in a nursing facility.

The OMPP is now generating the majority of the IPAS determinations for both the *PAS 4B* and the *OMPP 450B SA/DE* by computer. The computer-generated *OMPP 450B SA/DE* format looks somewhat different than the *OMPP 450B SA/DE* issued by the Forms Distribution Center. When the *OMPP 450B SA/DE* is computer generated, it shows a determination in **Section II, State Authorization**, and the form includes an Indiana Family Social Services Administration (IFSSA)-authorized signature.

Please note that this computer-generated *OMPP 450B SA/DE* is the official 450B form to be maintained with the resident's medical records for the current institutionalization. The OMPP will not return a form signed by a physician when the *OMPP 450B SA/DE* is generated for State authorization.

The IPAS agency may forward the original *Form 450B* with the IPAS packet to the nursing facility, however, the computer-generated *OMPP 450B SA/DE* is the only official *Form 450B* for use by the facility.

> *Note: Regardless of the 450B form used by the physician or nursing facility, the nursing facility must maintain the official 450B form in the resident's records. The official 450B form contains a State-authorized signature.*

A copy of this form is provided in Figure 1.3.

Resubmission of the Computer-Generated 450B SA/DE When Resident Becomes Medicaid Eligible, to Expedite the Data Entry of Nursing Facility Care in Indiana*AIM*

If a resident was not on the Medicaid program at the time the computer-generated *OMPP 450B SA/DE* form was issued, but **has since become Medicaid eligible** and the requested effective date for Medicaid reimbursement does not exceed 90 days following the date of the

State-authorized signature on the *OMPP 450B SA/DE*, the nursing facility should:

1. Change the **Medicaid Status** box to **Medicaid Recipient**; complete and update the resident's Medicaid Recipient Identification (RID) number, new Medicaid eligibility date, and nursing facility provider number; and add any missing information in **Section I** of the computer-generated *OMPP 450B SA/DE*
2. **Resubmit** the computer-generated *OMPP 450B SA/DE* (that the OMPP has already computer coded) to the OMPP to expedite data entry into Indiana*AIM*. This will allow Medicaid to begin reimbursement for the nursing facility care. **Do not resubmit a new *Form 450B* or the unsigned *Form 450B*** in the IPAS packet from the IPAS agency.

If a resident becomes eligible for Medicaid subsequent to the admission and the effective date of Medicaid eligibility is **more than 90 days following the date of the State-authorized signature** on the computer-generated *OMPP 450B SA/DE*, the nursing facility will have to submit a new *Form 450B.* Or the facility may submit the new *OMPP 450B SA/DE* **and** signed MDS assessment record that is current for the effective date of the requested Medicaid reimbursement. This new *Form 450B* must document a medical need for continued stay in a nursing facility and must also include the information described in the first step under resubmission of the computer-generated *OMPP 450B SA/DE*.

Process for Ordering Form 450B and OMPP 450B SA/DE

Form 450B (State Form 38143 (R5/6-93)) and OMPP 450B SA/DE (State Form 49120 (11-98)) can be ordered from the State. Orders should be submitted on facility letterhead. Please specify the full name of the form and State form number and submit the order to:

Department of Administration
Forms Distribution Center
6400 E. 30th Street
Indianapolis, IN 46219

Additional Information

If you have any questions regarding the information contained in this bulletin, please contact the EDS Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

PHYSICIAN CERTIFICATION FOR LONG-TERM CARE SERVICES
State Form 38143 (R5 / 6-93) Form 450B / PASARR2A
Indiana Family and Social Services Administration (IFSSA)

CONFIDENTIAL

ASSESSMENT TYPE	MEDICAID STATUS
☐ Initial Assessment	☐ Medicaid Pending
☐ Re-Screening	☐ Medicaid Recipient
☐ ARR	☐ Non-Medicaid

Name of contact | Upon completion return to: ☐ Area PAS agency ☐ IFSSA ☐ Integrated Field Services Case Manager ☐ Other _____

I - RECIPIENT IDENTIFICATION

Name of applicant *(last, first, middle)*	Date of birth *(mo., day, yr.)*	Sex	Name of county
Name of nursing facility or ICF / MR	Facility admission date *(mo., day, yr.)*		Medicaid number
Address of facility *(street and number)*	Re-admission date from hospital		Level of care transfer date
City, state and ZIP code	Requested length of care ☐ Short-term ☐ Long-term		Facility provider number(s) "I". "S".

Admitted from:
☐ a. Acute Hospital ☐ b. Psychiatric Bed ☐ c.Home ☐ d. Nursing Facility _____ ☐ e. ICF/MR ☐ f. Out-of-state _____ ☐ g. Other _____

II - PHYSICIAN'S MEDICAL EVALUATION

Federal and state regulations require a physician's medical evaluation, plan of treatment and explicit recommendation for care prior to admission or continued care in a nursing facility, the C.H.O.I.C.E. program, or the Medicaid Home and Community-Based Waiver program.

Patient Evaluation *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Ambulatory	☐ Contractures	☐ Colostomy / Ileostomy	☐ Self Fed
☐ Wheelchair	☐ Incontinent *(bladder)*	☐ Other Ostomy	☐ I.V. Fluids / Nutrition *
☐ Cane or Walker	☐ Incontinent *(bowel)*	☐ Aphasic	☐ Tube Fed - Type _____
☐ Bedfast	☐ Catheter _____	☐ Agitated / Combative	☐ Decubiti *(size, stage, treatment)* *
☐ Ventilator Dependent	☐ Tracheotomy	☐ Confused / Disoriented	☐ Other *_____

Primary diagnosis ***(include dates)*** | Secondary / tertiary diagnosis ***(include dates)***

Patient's overall prognosis

Plan and Treatment *(check all applicable boxes below. "*" requires explanation in "Clinical Summary")*

☐ Medications *(describe below)*	☐ Regular Diet	☐ Minimum Nursing Intervention	☐ Independent with ADLs
☐ *Restorative Services* *	☐ Other (specify _____	☐ Moderate Nursing Intervention *	☐ Assisted with ADLs
☐ *Sterile Dressing* *	☐ _____	☐ Intensive Nursing Intervention *	☐ Dependent for all ADLs

Medications *(dosage and frequency)*

Clinical summary *(attach additional information as necessary)*

LEVEL OF CARE PHYSICIAN CERTIFICATION

Complete for all Applications	Complete for Home Care *(if applicable)*
Level of care recommended ☐ Skilled ☐ Intermediate	☐ Medicaid Home and Community Based Waiver service
☐ ICF/MR - Large/Small ☐ Other *(specify)* _____	☐ C.H.O.I.C.E.

I certify that community supported in-home care is ☐ safe and feasible ☐ not safe or feasible in regard to health and safety of this patient. If not safe or feasible, explain.

Signature of physician *(stamps are NOT acceptable)*	Date signed *(month, day, year)*	Typed or printed name of physician

III - STATE DEPARTMENT AUTHORIZATION

This certification is for: ☐ Admission ☐ Transfer ☐ Continued Care
☐ Approved ☐ Disapproved
Effective Medicaid reimbursement date
Comments

Authorized signature ☐ IFSSA ☐ Area PAS agency | Date signed *(month, day, year)*

Figure 1.1 – Form 450B (State Form 38143) Physician Certification for Long Term Care Services

NURSING FACILITY LEVEL OF SERVICE STATE AUTHORIZATION AND DATA ENTRY
State Form 49120 (11-98) / OMPP 450B SA/DE
Indiana Family and Social Services Administration (FSSA)

CONFIDENTIAL

MEDICAID STATUS
☐ Medicaid Pending
☐ Medicaid Recipient
☐ Non-Medicaid

Disclosure of information requested is MANDATORY and CONFIDENTIAL pursuant to IC 12-15-2, IC 12-21 and 470 IAC 1-3-1.

INSTRUCTIONS:

NOTE: This form may be utilized in place of the Form 450B "Physician Certification for Long Term Care Services" for persons already in a nursing facility (NF) and only in the following situations:

1. PAS/PASRR, onset of NEW MEDICAID (*private pay to Medicaid recipient*), and NURSING FACILITY to NURSING FACILITY TRANSFERS when a fully completed MDS (*Initial, Quarterly , or Significant Change* ***for the period under review***) is available. A copy of the applicable MDS must be submitted with this form in place of the Form 450B. NOTE: The Physician Orders for the NF care must be in the resident's records and available for audit.
2. READMISSION to any NF after the 15-day bed-hold from a hospital stay, to reinstate Medicaid reimbursement for persons who have a State authorization for Medicaid reimbursement for NF care prior to the hospitalization (***No MDS is required***). Please specify the "from and through" dates of the hospitalization in Section I below.

Evidence of PAS (4B) must be attached if the request for Medicaid reimbursement is for a time period less than one year from the initial admission.

PASRR: Note, there are no changes in the PASRR program requirements or procedures other than the State allowing the MDS to be used in place of the Form 450B for individuals who are already in the NF. The Form 450B may continue to be used.

A fully completed Form 450B, including the physician's signature, must continue to be submitted in any situation where the NF does not have a completed MDS for the resident or chooses not to submit the MDS in place of a Form 450B. Submit either a complete, physician signed Form 450B or this form with a copy of the applicable complete MDS. **PLEASE DO NOT SUBMIT BOTH Form 450B and the MDS.**

SECTION I - RECIPIENT IDENTIFICATION

Name of applicant (*last, first, middle*)	Date of birth (*month, day, year*)	Sex	Name of county
Name of NF (*stamp or label accepted*)	NF admission date (*mo., day, yr.*)	Medicaid number (RID)	
Address of NF (*number and street*)	Re-admission date from hospital	Social Security number	
City, state, ZIP code	Discharge date (*if applicable*)	New Medicaid eligibility date	

Resident admitted from:
☐ a. Home ☐ d. Acute Care Hospital - From _____ Through _____
☐ b. ICF/MR ☐ e. NF Facility _____ ☐ g. Out-of-State ___
☐ c. Psychiatric Bed ☐ f. ARCH / RBA / Residential ☐ h. Other _____

Request length of care ☐ Short-term ☐ Long-term
NF provider number
Medicare from/through dates

SECTION II - STATE AUTHORIZATION

This certification is for: ☐ Admission ☐ Readmission ☐ Continued Care
Date data entered
Comments:
☐ Approved ☐ Disapproved
Effective Medicaid reimbursement date
Authorized signature: ☐ IFSSA ☐ Area PAS agency
Date signed (*month, day, year*)

MEDICAID only:	Rvwr ID	LOC code	Start Rsn	Start date	Stop Rsn	Stop date	Prior Res	Empty Bed

■ **RESIDENT COPY** **Resident Appeal Rights / How to Request an Appeal**

If you are not satisfied with this decision, you may request an appeal within 30 days of the date of receipt of this decision. Sign and return this form or send a letter with your signature to: MS04, Indiana Family and Social Services Administration, Hearings and Appeals, 402 W. Washington St., Rm. W392, Indianapolis, Indiana 46204. (IC 12-15-28 and 405 IAC 1.1-1) Be sure that the letter contains your address and a telephone number where you can be reached. It is also helpful if you describe the nature of the action you are appealing, if you are not using this form to request the appeal. If you are unable to write this letter yourself, you may have someone assist you in requesting this appeal.

You will be notified in writing by IFSSA Hearings and Appeals of the date, time and place for the hearing. Prior to, or at the hearing, you will have the right to examine the entire contents of your case record. You may represent yourself at the hearing or authorize a representative such as an attorney or other spokesperson to do so. At the hearing you will have full opportunity to bring witnesses, establish all pertinent facts and circumstances , advance any arguments without interference and question or refute any testimony or evidence presented.

☐ **I wish to appeal the above decision.** Signature of resident / guardian

Figure 1.2 – OMPP 450B SA/DE (State Form 49120) Nursing Facility Level of Service State Authorization and Data Entry

NURSING FACILITY LEVEL OF SERVICE
STATE AUTHORIZATION & DATA ENTRY
State Form 49210 (11-98) / OMPP 450B SA/DE
Indiana Family and Social Services Administration (IFSSA)

Medicaid Status
☐ Medicaid Pending
☐ Medicaid Recipient
☐ Will Apply ☐ MCO
☐ Private Pay

I - RECIPIENT INFORMATION

Name of applicant (last, first, middle)	Date of birth (mm/dd/yyyy) / Sex	Name of County
Name of nursing facility (Stamp or label accepted)	Facility Admission Date / /	Medicaid number
Address of facility (street and number)	Readmission date from hospital / /	Social Security Number --
City, State, and ZIP code	Discharge date (if applicable) / /	New Medicaid eligibility date / /
Admitted from: ☐ a. Home ☐ b. ICF/MR ☐ c. Psychiatric Bed ☐ d. Acute Hospital from through ☐ e. Nursing Facility ☐ f. ARCH RBA Residential ☐ g. Out-of-state ☐ h. Other		Requested length of care ☐ Short ☐ Long Facility Provider Number Medicare from/through dates

II - STATE AUTHORIZATION

This certification is for:		Effective Medicaid reimbursement dates
☐ Admission ☐ Readmission ☐ Continued Care	☐ Approved ☐ Denied	
☐ Admission ☐ Readmission ☐ Continued Care	☐ Approved ☐ Denied	Date signed (month, day, year) / /
Authorized signature ☐ IFSSA ☐ Area PAS agency		

Comments

MEDICAID Only:	Rvwr ID	LOC Code	Start Rsn	Start Date	Stop Rsn	Stop Date	Prior Res	Bed

☐ Resident Copy

Resident Appeal Rights / How to Request an Appeal

☐ I wish to appeal the above decision	Signature of resident / guardian

Figure 1.3 – OMPP 450B SA/DE Nursing Facility Level of Service State Authorization and Data Entry (Computer Generated)

Table 1.1 - Use of Forms 450B and 450B SA/DE When Medicaid Status is Checked Medicaid Recipient (Requirements for Dates of Service on or After October 1, 1998*)

Scenario	Qualifier	Form Required*	Accompanying Information	Official Form to be retained on chart
Initial admission to NF (IPAS and PASRR)	All IPAS/PASRR cases	Entire 450B (Sections I and II) completed	Complete IPAS/PASRR packet - (no change)	Computer generated *OMPP 450B SA/DE* or *Form 450B* with **Section III** completed
NF to hospital and return same NF (with existing effective Medicaid reimbursement date)	Not exceeding bed hold policy	None	None	Existing 450B with effective Medicaid reimbursement date
NF to hospital and return same NF (with existing effective Medicaid reimbursement date)	Exceeding bed hold policy	450B (Section I only) *or* 450B SA/DE	None	Returned 450B with effective Medicaid reimbursement date
NF to hospital and return to another NF (with effective Medicaid reimbursement date)	Following any length of hospitalization	450B (Section I only) *or* 450B SA/DE	None	Returned 450B with effective Medicaid reimbursement date
Transfer from NF to NF (no intervening hospitalization)		Entire 450B (Section I and II) completed *or* 450B SA/DE with fully completed MDS**	Copy of PAS 4B from previous NF	Returned 450B with effective Medicaid reimbursement date
Resident change from private pay (non-Medicaid) to Medicaid recipient	Including changes in eligibility status from Medicaid MCO to regular Medicaid	Entire 450B (Section I and II) completed *or* 450B SA/DE with fully completed MDS** or computer-generated OMPP 450B SA/DE***	Copy of PAS 4B	Returned 450B with effective Medicaid reimbursement date or computer-generated *OMPP 450B SA/DE*
Change from Medicare primary payer to Medicaid primary payer (without existing effective Medicaid reimbursement date)	When Medicare coverage ends	Entire 450B (Section I and II) completed *or* 450B SA/DE with fully completed MDS**	Copy of PAS 4B	Returned 450B with effective Medicaid reimbursement date or computer-generated *OMPP 450B SA/DE*
Change from Medicare primary payer to Medicaid primary payer (with existing effective Medicaid reimbursement date)	When Medicare coverage ends	450B (Section I only) or 450B SA/DE	None	Returned 450B with effective Medicaid reimbursement date or computer-generated *OMPP 450B SA/DE*

* *For dates of service **prior to** October 1, 1998 – Submit a fully completed* Form 450B *for the level of care (skilled or intermediate) requested.*

** *The fully completed MDS for the period under review should be submitted with the* Form 450B SA/DE *only. A3a date (last day of the MDS observation period) must be within 90 days of Medicaid effective date or requested start date.*

*** *Resubmit an updated (RID, dates, provider number) State-generated* OMPP 450B SA/DE *if a resident became Medicaid eligible and the requested effective date for Medicaid reimbursement is within 90 days of the state-authorized signature on the* OMPP 450B SA/DE.