Indiana Health Coverage Programs

PROVIDER BULLETIN

BT200204 JANUARY 30, 2002

To: All Nursing Facilities

Subject: Changes to Nursing Facility Rules and Clarification of Bed Hold and Crossover Information

Overview

This provider bulletin provides an update on several important ***Indiana Health Coverage Programs (IHCP) nursing facility reimbursement changes*** that the Office of Medicaid Policy and Planning (OMPP) ***recently implemented.*** The OMPP reported these initiatives to all nursing facilities certified to participate in the IHCP in a letter dated August 27, 2001. These initiatives include policy changes to the following:

- Payment of bed hold/leave days for nursing facilities
- Payment of nursing facility Medicare crossover claims
- Case mix rate setting methodology

Bed Hold Payment Policy Changes

For services rendered on or after October 1, 2001, the IHCP will only reimburse for bed hold days to nursing facilities that have occupancy rates of 90 percent or greater. This policy change is addressed at *405 IAC 5-31-8*.

In response to questions, the OMPP has prepared the following nursing facility guidelines to properly implement new IHCP payment policies for reservation of nursing facility beds, such as *bed hold*.

General Rule for Bed Hold Payments

To determine eligibility for IHCP payment for bed hold days, each nursing facility must determine the occupancy rate as of the date that an IHCP resident leaves the facility for hospital or therapeutic leave. Guidelines are provided below for determining this occupancy rate. If the facility's occupancy rate is equal to or greater

than 90 percent as of the date the IHCP resident leaves the facility for hospital or therapeutic leave, the facility is permitted to receive IHCP reimbursement for the bed hold days for the duration of that resident's leave of absence, subject to the limitations prescribed by *405 IAC 5-31-8.*[1] If the facility's occupancy rate is less than 90 percent, the facility is not permitted to receive IHCP reimbursement for any bed hold days for the duration of that resident's leave of absence.

Determination of Occupancy Rate

The occupancy rate used to determine eligibility for bed hold reimbursement shall be determined and documented by the facility as of the date an IHCP resident leaves the facility for therapeutic or hospital leave. For purposes of this rule, the occupancy rate shall be determined as follows:

$\frac{(a + b)}{c} = d$	The calculation to the left is used, where (a) is the total number of nursing facility residents present in the facility (excluding residents in residential beds) as of the midnight census, plus (b) the number of residents on a leave of absence – regardless of whether such leave of absence is approved for payment, **divided by** (c) the total number of licensed nursing facility beds (excluding residential beds) **equals** (d) the occupancy rate.

The eligibility for bed hold reimbursement shall be determined as of the first day of the IHCP resident's leave of absence from the facility. Once that resident's eligibility for bed hold reimbursement status is determined for a given leave of absence, their status shall not change as a result of subsequent changes in the facility's occupancy rate. For IHCP residents that began an approved leave of absence prior to September 30, 2001, and do not return to the facility prior to October 1, 2001, the prior IHCP payment policy for bed hold days applies until that resident returns to the facility. IHCP payment will be made for such leaves of absence, subject to limitations in effect prior to October 1, 2001.

Billing Guidelines for Bed Hold Days

The facility must ***code*** for leave days using the revenue codes as indicated below. For internal record keeping purposes, facilities ***must*** continue to submit claims for bed hold days ***regardless of whether those leave days are eligible for IHCP payment.*** Bed hold days not ***eligible for payment*** must be billed using *Revenue Code 180.* The bed hold days ***appear on the EOB as a*** payment denial ***but still allow OMPP to track those unpaid leave days***. Bed hold days ***eligible*** for IHCP payment

[1]Pursuant to 405 IAC 5-31-8(b), hospital leave is limited to fifteen (15) days per single hospital stay. Pursuant to 405 IAC 5-31-8(c), therapeutic leave is limited to thirty (30) days in any calendar year.

pursuant to *405 IAC 5-31-8* and this bulletin should be billed using either *Revenue Code 183* or *185*, as applicable.

Any leave day, whether eligible for payment or not, must be coded on the claim using one of the three codes listed below:

- 180 – Bed hold days ***not*** *eligible for payment*
- 183 –Therapeutic bed hold days *eligible for payment*
- 185 –Hospital bed hold days *eligible for payment*

Monitoring of Bed Hold Payments

Beginning October 1, 2001, the OMPP and its contractors routinely monitor all nursing facility claims for payment of bed hold days. Monitoring may result in a need for facilities to provide documentation that their occupancy rate conforms to the requirements of *405 IAC 5-31-8* and this bulletin. If the OMPP determines that any IHCP payments for bed hold days were made inappropriately, recoupment adjustments for such payments will be immediately initiated.

Reporting of Bed Hold Days on the Nursing Facility Financial Report

For dates of service on and after October 1, 2001, nursing facilities must report IHCP resident bed hold days that are ***eligible*** for IHCP payment on the *Nursing Facility Financial Report*. Bed hold days not ***eligible*** for IHCP payment must not be reported on the *Nursing Facility Financial Report*. Bed hold days that are ***eligible*** for IHCP payment must continue to be reported on line 186 of *Schedule I,* and included on lines 144 and 148 of *Schedule A* at the rate of one-half per bed hold day.

Impact on the Existing 450B Process

Effective for dates of service on or after October 1, 2001, there are **no changes** to the established *Form 450B* procedures. Providers should follow the guidelines detailed in bulletin *BT200002*, published April 5, 2000.

The changes to the bed hold policy merely reflect a change in the criteria for which nursing facilities can receive reimbursement for bed hold days. Regardless of whether or not the nursing facility can receive reimbursement for bed hold days as a result of occupancy, the following policy applies:

- As long as an IHCP member intends to return to the nursing facility and does so within the designated bed hold time frames (15 consecutive days for hospitalization or 30 calendar days for therapeutic leave), the resident should not be discharged from the nursing facility for purposes of IHCP reimbursement (see below for MDS guidelines).

- The nursing facility is not required to submit a new *Form 450B* or to process a new Indiana Pre-Admission Screening (IPAS) application for re-admission following a hospitalization or authorized therapeutic leave that does not exceed the allotted time frame.
  - When a resident exceeds the allotted bed hold time frame, the nursing facility must initiate the *Form 450B SA/DE* as outlined in bulletin *BT200002*. This process has not changed.
  - If the nursing facility **does not** anticipate the return of an IHCP resident, regardless of occupancy, bed hold **cannot** be billed to the IHCP. The resident must be discharged from the nursing facility and all applicable new admission criteria must be followed should the resident be re-admitted to the nursing facility.
- **The changes to the bed hold reimbursement policy have no impact on the MDS process.** The nursing facility must continue to assess whether or not return is anticipated and follow the appropriate MDS coding protocol detailed in the RAI manual.

Medicare Cross-Over Claims Payment Policy Changes

Beginning with services rendered on October 1, 2001, IHCP ***has*** changed its payment policy for Medicare crossover claims such that IHCP payment is only made ***when*** the ICHP payment amount is less than the IHCP rate on file at the time the crossover claim is processed by EDS. Please note that Medicare crossover claims are not reprocessed retroactively as a result of retroactive changes in IHCP rates. This change in payment policy for Medicare crossover claims is addressed at *405 IAC 1-18-2*.

It is expected that this payment policy change will result in a number of Medicare crossover claims with dates of service on or after October 1, 2001, to be processed with a zero IHCP paid amount. Medicare crossover claims for dates of service prior to October 1, 2001, are not impacted by this policy change, and the deductible and coinsurance amounts for these claims as determined by Medicare continue to be paid by the IHCP.

OMPP has confirmed that Medicare payment policy permits coinsurance and deductible amounts that a nursing facility cannot collect be treated as a "Medicare bad debt," and are generally eligible for reimbursement by Medicare, so any adverse financial impact on the nursing facility should be minimal.

Case Mix Rate Setting Policy Changes

Effective October 1, 2001, the OMPP implemented the following revisions to the IHCP case mix reimbursement system:

- Moving repairs and maintenance costs from the capital component to the indirect care component
- Correcting a long-standing problem in equitably reimbursing for therapy costs
- Changing from the RUG-III version 5.01 to version 5.12 resident classification system
- Applying a *cap* on the amount of future inflation included in prospective per diem rates
- Reducing the profit add-on share percentage for the direct care and indirect care rate components from 60 percent to 52 percent
- Adding on a rate for facilities that care for eight or more ventilator-dependent residents to ensure appropriate access to services
- Re-establishing a phase-in for the MDS audit program

The above changes in rate setting methodology resulted in all nursing facility providers receiving a new IHCP rate effective October 1, 2001. The updated IHCP rates were issued to all providers in October 2001.

Additional Information

Questions about the information in this bulletin should be directed to EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278.

Appendix A: Frequently Asked Questions About Changes to Rules and Regulations Effective October 1, 2001

The following questions were received from nursing facility providers, consultants and nursing facility associations.

Bed Hold Occupancy Calculation

1) How will rounding be determined for purposes of the 90 percent rule?

Conventional rounding standards apply – for example 89.5 percent is rounded to 90 percent.

2) A facility has 84 licensed beds. On December 10, 2001, the facility has 75 in-house residents, not including one who just went to the hospital. The facility calculated 90 percent of 84 to be 75.6 residents. Will the only method of calculating the percentage be residents in-house divided by licensed beds?

The calculation of the bed hold occupancy percentage will be determined by dividing the number of residents in-house plus the number of residents on a bed hold (excluding all residents in residential beds), regardless of payer source or reimbursement, by the number of licensed beds (excluding residential beds). Unpaid bed holds are included, regardless of payer source or reimbursement.

3) Are *licensed beds* that count toward occupancy, the number of beds listed on our State Board of Health license that must be displayed in the facility?

The number of *licensed beds* counted toward occupancy refers to the number of licensed beds recorded on the *Certification and Transmittal* issued by the Indiana State Department of Health.

4) How is the occupancy percentage calculated when a private pay resident in a two-bed room pays a higher rate in order to have a *private room* when there are two licensed beds in the room?

If a room is licensed for two beds, the occupancy is determined by the actual number of licensed beds, not the number of residents in the room.

Bed Hold Payment

5) If we use *Revenue Code 180,* do we show all the days as covered? Has EDS tried this in Indiana*AIM*?

When nursing facilities are below 90 percent occupancy and not eligible for leave day reimbursement, the leave days must be billed using *Revenue Code 180* on the UB-92 claim form. The nursing facility must bill one-half the per diem rate for leave days, using standard billing procedures. For example, a nursing facility bills for dates of service November 1 – 30, 2001. The resident was in-house for 25 days and on a bed hold for 5 days. The nursing facility per diem rate is $100.00. The nursing facility was below 90 percent on the first day of the bed hold. The claim reflects the following:

- Covered days = 30
- FDOS 11/01/01 TDOS 11/30/01
- Rev Code 120 = 25 units Billed amount $2,500.00
- Rev Code 180 = 5 units Billed amount $250.00

Testing confirms the claim pays the rate on file for *Revenue Code 120*. The detail line for *Revenue Code 180* denies, showing EOB *4215 – Leave days not a covered service for this bill type – nursing facility occupancy less than 90 percent.*

6) Is the nursing facility still entitled to payment for the entire leave if the resident left the facility prior to October 1, 2001, and the nursing facility is below 90 percent?

Yes. Eligibility for reimbursement is determined by the occupancy level on the day the leave begins. Therapeutic or hospital leaves, that began prior to October 1, 2001, are not subject to the occupancy percentage calculation.

Nursing facilities are reimbursed for leave days at one-half of the per diem rate when a resident who qualified for a paid leave before October 1, 2001 returns to the facility after October 1, 2001.

7) Is the nursing facility still entitled to payment if the nursing facility was at 90 percent when the resident leaves, but then drops to 89 percent?

Yes. Eligibility for reimbursement is determined by the occupancy level on the day the leave begins.

8) Is the facility entitled to payment if the facility has 100 licensed beds, and census is 91, if one person leaves in the morning, and the other leaves in the evening?

Yes, please refer to the response to question 2. Occupancy rate is calculated as of the midnight census on the day the leave begins. In this example, the census remains at 91 percent because all residents, both in-house and on leave of absence are included in the calculation. Leave days for both of these residents is eligible for reimbursement.

For IHCP reimbursement, all bed holds, regardless of payment, are used to determine the occupancy of the nursing facility.

It is the responsibility of each nursing facility to determine its policy for whether beds will or will not be held if IHCP does not reimburse.

9) If *hold beds* count toward the census, is that for all payer types? For example, a nursing facility is holding a bed for a Medicare resident who is not IHCP backup. Counting this resident, the nursing facility's census is at 90 percent. If someone else leaves, is the nursing facility entitled to payment?

Yes. See response to question 2.

10) If *hold beds* count into the nursing facility's census percentage, how will the State know if the nursing facility is receiving payment for these days? What if a nursing facility *holds* the bed, such as leaving clothing and personal things in the room, but doesn't charge for this period; is that bed hold counted?

See response to question 2. Per the IHCP provider agreement, "the provider is individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the provider, the provider's employees, or the provider's agents. The provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law."

The OMPP reviews claims data to determine whether a provider has billed inappropriately for bed hold days. Indiana*AIM* will not be changed to review this type of billing situation. The OMPP does not require the nursing facility to notify them when a provider charges the patient or family when the facility is below 90 percent.

11) If a nursing facility holds a bed and charges the private-pay resident, but they refuse to pay, and the nursing facility adjusts the amount off the books, if this affected the 90 percent, should the nursing facility adjust the bill to IHCP for affected residents, or is this required, since the nursing facility held the bed in good faith thinking they would get paid?

The nursing facility counts bed holds in the occupancy percentage regardless of the patient's payer source or reimbursement. Therefore, if the private-pay patient refuses to pay, that patient is still counted toward the calculation of the 90 percent occupancy rate. If the nursing facility's policy is that a patient needs to be discharged if a patient does not pay his or her bill, then, the patient cannot be counted towards the calculation of the 90 percent occupancy rate.

12) Thirty therapeutic leave days are allowed per member per calendar year. What if a resident uses the bulk of these days in the first half of the year, when the facility is under 90 percent occupancy, then later uses additional days when the facility has reached 90 percent or higher occupancy. How is the State going to know the resident has reached his or her limit? Some facilities will not be able to use *Revenue Code 180* with software limitations. Will all leave days be under *Revenue Code 180*, not just therapeutic days?

Indiana*AIM* tracks the number of leave days per resident, per year. As stated above, eligibility for IHCP payment for leave days is determined on the day the leave begins, regardless of when the leave days are taken during the year. If a resident uses more than 30 therapeutic leave days per calendar year (reimbursed or non-reimbursed), the nursing facility is only required to submit a new *Form 450B* if subsequent therapeutic leave days exceed 15 days consecutive days in duration. A new *Form 450B* is required for the OMPP to review and determine whether the member continues to meet the minimum level of care for nursing facility placement.

If a provider's software cannot accommodate *Revenue Code 180* billing, the provider has two options: (1) Bill the claim using Provider Electronic Solutions; (2) Bill the claim on paper using *Revenue Code 180* to indicate the bed hold days, until provider software modifications are completed. *Revenue Code 180* is used to bill both therapeutic and hospital leave days.

13) If beds are not held, due to less than 90 percent occupancy, is 30 days of therapeutic leave still applicable per facility? Or, 30 days for a resident regardless of the facility?

Per *405 IAC 5-31-8 (c)* "A leave of absence must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member's plan of care. The total length of time allotted for therapeutic leaves in any calendar year is thirty (30) days. The leave days need not be consecutive." If the facility discharges a resident rather than holding the bed, the 30 days does not apply.

The therapeutic leave day allotment equals 30 days per calendar year per member, regardless of whether reimbursement is received due to the occupancy percentage calculation. For example, a resident goes on a 15 day therapeutic leave and the nursing facility is below the 90 percent occupancy requirement: The nursing facility does not receive IHCP reimbursement for these leave days. Within the same calendar year, the resident goes on another 15 day therapeutic leave and the facility is at or above 90 percent occupancy: The nursing facility receives IHCP reimbursement for these leave days. If the resident should use additional therapeutic leave days in this same calendar year and the facility is at or above 90 percent occupancy, the nursing facility does not receive IHCP reimbursement for the leave days because the resident has exhausted the 30 day therapeutic leave day allotment for the calendar year.

Therapeutic leave days are per resident *regardless of the facility in which the resident resides*. Therefore, a resident who changes facilities three times in one calendar year would only be allowed 30 days of therapeutic leave, not 90 days, regardless of the occupancy of the facility.

Audit of Bed Hold Payment And Nursing Facility Occupancy Percentage

14) How will the nursing facility be audited for occupancy and leave days?

Each nursing facility is expected to produce, upon request by the OMPP or it contractors, sufficient documentation that the facility occupancy level was equal to or greater than 90 percent on the first day of a leave of absence for a resident when IHCP payment is claimed. Sufficient documentation could include, but is not limited to, items such as daily census logs, revenue and billing records, facility policies on bed hold matters, and so forth.

15) When will recoupment take place for any incorrectly submitted leave day paid claims (during the time IHCP is developing rules)?

Recoupment takes place as soon as possible after any incorrectly paid claims are identified.

Billing for Bed Hold Days

16) Why would a nursing facility need to bill The IHCP for bed hold days if they are not at the 90 percent occupancy? Can the nursing facility bill two separate *still patient* claims?

At the direction of the OMPP, the nursing facility bills the IHCP using *Revenue Code 180*. *Revenue Code 180* is a non-paid revenue code, that provides the facility with an IHCP denial, used to charge a resident or legal guardian for non-reimbursed bed hold days.

Legal

17) Do we legally have to hold the bed 15 days?

Facilities are not legally obligated to hold beds for residents on leave.

Bed Hold Policy

18) Please clarify the correct process for the following scenario: The bed hold policy under the State's Medicaid Plan is: Medicaid will pay the nursing facility to reserve a bed at half the per diem for up to 15 days for each hospitalization and for 30 days per year for therapeutic leave of absence when occupancy is at 90 percent or greater.

Nursing facility policy states that beds will be reserved as follows:

If a nursing facility occupancy is 90 percent or higher, the bed is reserved for 15 days for each hospitalization and for 30 days of therapeutic leave in a calendar year. This is the correct process consistent with IHCP rules governing leaves of absence at *405 IAC 5-31-8*.

19) Is the following statement true?: If a nursing facility is below 90 percent occupancy, the bed will be reserved if paid for by the resident or other payer at the per day rate determined by the nursing facility. Therapeutic leave days cannot exceed 30 days per calendar year. If the resident exceeds 30 days of therapeutic leave, he or she must be discharged from the nursing facility.

No, the patient does not have to be discharged from the nursing facility if the nursing facility patient exceeds 30 days of therapeutic leave. Should a resident use more than 30 therapeutic leave days per calendar year (reimbursed or non-reimbursed), the nursing facility is only required to submit a new 450B if subsequent therapeutic leave days exceed 15 consecutive days in duration per incident.

20) If resident or other payer does not choose to reserve beds, the resident is readmitted on first available bed in semi-private room if the resident required the services provided by the nursing facility and is eligible for Medicaid services.

This is acceptable. However, if the resident has truly been discharged from the nursing facility – all applicable Indiana Pre-Admission Screening(IPAS), Pre-Admission Screening Resident Review (PASRR), and 450B requirements must be followed.

21) Are the above policies acceptable to the State?

See comments under each individual question above.

Crossover Claim and Co-Insurance Questions

22) Will DMERC Co-insurance (from the carrier) continue to cross over, but pay as $0.00?

All Medicare Part B claims billed by the nursing facility are paid at $0.00. The claims continue to cross over to Indiana*AIM* from Medicare; however, the claims are adjudicated as paid claims at a zero amount.

23) Is the nursing facility required to have the Medicaid $0.00 remits for the bad debt log to Medicare?

Please refer this question to the Medicare fiscal intermediary.

24) If a resident has private insurance that covers 80 percent of the deductible, in the past a provider would bill Medicaid the full amount of co-insurance, show 80 percent was paid by private insurance, show the 20 percent as a balance due and

Medicaid would pay the 20 percent. Will nursing facility providers now get a denial for the 20 percent Medicaid will not pay or a denial for the first billing that shows the full amount due?

In this scenario, there is no change in the billing procedure for the crossover claim; however, the claim is paid at a $0.00 amount due to the changes in the IHCP reimbursement methodology for crossover claims.

25) Can a provider still use one commercial insurance rejection for 12 months to get Medicaid to process a zero payment?

Yes. When a service that is to be repeatedly furnished to a member and repeatedly billed to the IHCP and is not covered by the third-party commercial insurance policy, a provider can submit photo copies of the original insurer's denial for up to one year from the date of the original denial for each claim billed to the IHCP.

Co-Insurance

26) Will liability still be deducted from the co-insurance claim? This may have the State pay more than necessary. Example: A resident is Medicare the first 20 days of a month (all co-insurance days), then the patient reverts to Medicaid the remainder of the month. The nursing facility does not bill Medicaid for the room and board yet, as the nursing facility doesn't have a 450B. Co-insurance crosses and pays at $0.00, but the nursing facility liability is applied to the co-insurance, when the nursing facility bills for the room and board liability, it should be deducted as $0.00 and the RBN claim paid in full. Should the nursing facility cancel the patient's co-insurance claim and then adjust this claim, or leave as is?

EDS testing confirms that patient liability is deducted only from crossover claims paid at an amount greater than $0.00. Any remaining patient liability is deducted from the IHCP long-term care claim.

Crossover claims paid at $0.00 do not impact patient liability.

27) Will the rule of being able to bill Medicaid after 90 days of no response from a TPL still apply? Can the nursing facility bill EDS and get the co-insurance rejection without hearing from the commercial insurance first?

The rule changes in effect for long-term care facilities do not impact any established TPL policies. Please refer to Chapter 5 of the *Indiana Health Coverage Programs Provider Manual* for Third Party Liability requirements.

28) Is co-insurance still considered a *covered service*?

Co-insurance remains a covered service; however, in many instances co-insurance claims are paid at a zero amount because the amount paid by Medicare exceeds the IHCP allowed amount.

29) If Part B services are provided by a vendor (therapy, PEN, and such), will the vendor still receive payment for co-insurance?

Yes. Per *405 IAC 1-18-3*:

(a) Notwithstanding *405 IAC 1-1-3(f)(2)*, crossover claims filed by providers other than nursing facilities are reimbursed as set out in this section.

(b) IHCP reimbursement is equal to the Medicare co-insurance and deductible, if any, for the claim.

30) Medicaid is not paying a per diem rate for assisted living residents on Medicaid. Why would co-insurance billed by a nursing home not be paid?

The reimbursement methodology used for all Medicare crossover claims filed by nursing facilities is governed by *405 IAC 1-18-2*. Reimbursement is based upon the type and specialty of the billing provider as listed in Indiana*AIM*, not upon the residence of the member.

31) Will EDS process co-insurance as TPL or as a zero payment when a resident has commercial insurance? What if commercial insurance will not pay in a skilled nursing facility setting? Since EDS will never pay co-insurance, will the edit be deleted from the EDS system?

As previously stated, the rule changes in effect for long term care facilities do not impact any established TPL policies.

Although the instances when EDS can pay crossover claims at an amount greater than zero are greatly reduced, it is conceivable that co-insurance can be paid on occasion. The edit will not be deleted from Indiana*AIM*.

32) A resident is on Medicare Part A the first 20 days of the month with no co-insurance and the next nine days with co-insurance of $891. The resident then goes to Medicaid for two days with a liability of $100. How should the liability be applied?

Please refer to the response to question 26. Patient liability is deducted from any crossover claim paid at an amount greater than $0.00 and from long-term care claims only.

Family Payment to Reserve Beds

33) Can a nursing facility charge privately for the Medicaid bed holds? Does the State have any say in how much a facility can charge to reserve a bed? Can a nursing facility deviate liability for reserving beds? Can bed hold expenses be deducted from patient trust?

If the facility is below 90 percent occupancy, then the bed hold is not considered a IHCP covered service; therefore, the resident, family, or legal guardian can be billed by the nursing facility to hold the bed for the IHCP member.

Each nursing facility must have a detailed written description for bed hold policy in the admissions package. The State does not stipulate a dollar amount that a nursing facility can charge the family for non-IHCP covered services.

A nursing facility cannot deviate liability for reserving a bed while the IHCP member is on therapeutic or hospitalization leave.

Bed hold expenses can be deducted from the patient's trust account or personal needs allowance per facility policy and agreement from the resident, family, or resident's power of attorney or guardian.

34) Can a family be billed privately for holding a bed after 15 days of hospitalization if the nursing facility is not at 90 percent occupancy?

Yes, see response to question 33. Residents whose hospital leave exceeds the maximum number of consecutive days (15 days) allowed by regulation, must be discharged, and upon return to the nursing facility, a *Form 450B* or *450B SA/DE* must be submitted to the OMPP. The facility policy about bed hold must be clearly documented and made available to all residents.

35) A resident discharges December 3, 2001. The resident has one in-house day and one bed hold day charge. The nursing facility is at 86 percent occupancy on December 2, 2001, and the resident's liability is $800. Can the resident pay for the bed hold?

The facility cannot deviate liability.

There is no change in the operating policy about application of the patient's liability, therefore, the facility must transfer the patient liability with the patient under the following circumstances:

- If the patient expires while on hospital or therapeutic leave, the excess in patient liability must be returned to the local Division of Family and Children (DFC). If the nursing facility has difficulty returning the money to the local DFC, the money is forwarded to the OMPP.
- If the patient transfers to another nursing facility after hospitalization, the patient liability must be forwarded to the receiving long-term care facility.
- If the nursing facility has less than 90 percent occupancy, the nursing facility can bill the resident, family, or legal guardian for the hospital or therapeutic leave days per the nursing facility's bed hold policy.
- If the patient is discharged to the community, the excess patient liability must be refunded to the patient or the patient's legal guardian.

36) If a resident wishes to hold a specific bed instead of any bed in the nursing facility can the resident be charged for it if Medicaid would pay for a bed hold? What if the nursing facility doesn't meet the 90 percent occupancy?

The nursing facility is not required to hold a specific bed. If the bed hold is an IHCP covered service due to 90 percent or greater occupancy, then the only requirement is that the bed being held must be an IHCP-certified bed. The IHCP does not pay to hold a specific bed. If the nursing facility does not meet the 90 percent occupancy level for billing leave days, the nursing facility can bill the resident, family or the resident's legal guardian according to the nursing facility's bed hold policy.

Spenddown

37) What if the resident is on a spenddown budget? Can the *bed hold* be used to meet the spenddown even if the nursing facility is not at 90 percent occupancy?

Yes. Bed hold can be used toward the resident's spenddown since it would be an incurred cost of the resident regardless of the occupancy level of the nursing facility. A spenddown member is considered a private pay resident until spenddown has been met for the month.

38) If a resident is on a spenddown budget can the co-insurance and deductibles count toward meeting spenddown?

Yes. Co-insurance and deductibles are counted toward an IHCP member's spenddown.

450B Procedure

39) If a bed is not held and a patient is discharged, is a new *Form 450B* required?

Yes, there is no change to this requirement. A new 450B is required if the bed is not held per the nursing facility's bed hold policy. If the resident is discharged from the nursing facility, a new 450B is required for readmission to any long-term care facility along with PAS and PASRR requirements when the readmission is from the community.

40) A nursing facility is not required to submit a *Form 450B* or *450B SA/DE* unless the resident exceeds the 15-day hospitalization, regardless of whether the nursing facility receives reimbursement. If the nursing facility's policy is that unless payment is made for the bed to be held, either by Medicaid or another payer, the nursing facility will discharge the resident. Does the State expect a new *450B* for that resident?

If the bed is not held and the patient is discharged, the nursing facility bills the claim using the appropriate discharge status code. This automatically closes the

level of care segment in Indiana*AIM*. The OMPP requires a new *450B* for the new resident in the following circumstances:

- Hospital leave: The nursing facility must submit a *450B* for the readmission once any Medicare covered days in the nursing facility have expired to restart the nursing facility IHCP coverage in Indiana*AIM*.
- Therapeutic leave: When a person is in the community, the nursing facility must comply with all federal PASRR and State PAS regulations that require the person be rescreened as a new admission to a nursing facility from the community.

41) Is a nursing facility required to give a notice of discharge if the resident is discharged for therapeutic leave?

The discharge requirements for a nursing facility are regulated by the Omnibus Reconciliation Act (*OBRA '87)*, which does not exempt therapeutic leave days. Per the Indiana State Department of Health (ISDH), all discharge requirements apply regardless of whether a nursing facility discharges a patient due to the IHCP reimbursement bed hold changes.

To clarify, facilities are not required to give a notice of transfer or discharge to a resident who is going on therapeutic leave. They are only required to provide the bed hold notice. Since therapeutic leave is resident-initiated (as opposed to a facility-initiated involuntary discharge), notice of transfer or discharge is not required. However, this is complicated by the fact that if a facility has a policy that does not hold the bed unless it is paid for, a discharge notice is required. The nursing facility is required by *CFR 483.12 (b)(3)* to readmit the resident unless the person no longer has any nursing facility level of care or the level of care is such that the nursing facility cannot meet the resident's needs. For further clarification of discharge requirements, please contact the ISHD Division of Long Term Care.

Minimum Data Set

42) What are minimum data set (MDS) reporting requirements? Does the nursing facility discharge-return? Is this required or optional?

The changes to the IHCP bed hold reimbursement policy have no impact on the MDS assessment completion requirements. MDS completion requirements are located in federal OBRA regulations.

Cost Report

43) It appears that there is an attempt to never use the most recent annual report to establish a new nursing facility's rate. This will almost always be detrimental to the provider. Please explain.

For cost reporting and rate setting purposes, *405 IAC 1-14.6-4(b)* and *7(b),* as added at *22 IR 2240 (April 1, 1999),* defines the first annual cost report for a facility that has undergone a change in ownership or control to be that cost report period that contains a minimum of six months. Prior to the new owner having six months of financial report data the previous provider's most recently completed annual financial report is used to calculate the new provider's first annual rate review. This requirement allows a methodology for a new owner to receive an inflation adjustment to his/her rate without waiting for the new owner to have six months of financial data. Additionally, this addresses concerns about the use of extremely short period cost reports for rate setting purposes, and to ensure that financial data used for rate setting was subject to verification to the maximum extent possible.

44) How will the non-reimbursed bed hold be treated for cost reports?

Cost report Schedules I and A must include bed hold days for leave days eligible for IHCP payment. Bed hold days not eligible for reimbursement are not reported on the cost report.

45) If the therapy cost report calculation has changed, do we still need to do the Part B disclosure form? This was completed if a resident's Medicaid only resource utilization group (RUG) was in the rehab category but did not have Medicare Part B.

Effective October 1, 2001, the *Medicare Part B Disclosure Form* is no longer required.