



INDIANA HEALTH COVERAGE
PROGRAMS PROVIDER MANUAL

Chapter 14: Long Term Care

Chapter 14: Revision History

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Chapter 14: Table of Contents

Chapter 14: Revision History	14-2
Chapter 14: Table of Contents.....	14-4
Section 1: Introduction to Long Term Care.....	14-6
General Information	14-6
Section 2: State Level of Care and Form 450B Reviews for Long Term	
Care Members.....	14-7
Level of Care Review.....	14-7
Review Objective.....	14-7
Indiana Pre-Admission Screening Procedures	14-7
Forms 450B and Form 450B State Authorization/Data Entry	14-7
Ordering Form 450B and OMPP Form 450B SA/DE.....	14-8
Completion and Certification of 450B	14-8
OMPP Form 450B Nursing Facility Level of Service – State	
Authorization and Data Entry	14-9
Use of OMPP Form 450B SA/DE Nursing Facility Level of Service	
State Authorization and Data Entry, Computer Generated by the State	14-9
Medicare to IHCP Forms 450B and 450B SA/DE.....	14-10
Readmission to a Nursing Facility from a Hospital	14-10
Resident Changes from Private-Pay to IHCP Member	14-10
Admissions from Other Nursing Facilities.....	14-11
Official Form 450B or Form 450B SA/DE Retained in Chart	14-13
Duplicate Forms 450B and 450B SA/DE	14-13
Nursing Facilities Not Reimbursed by Case Mix Methodology	14-14
Section 3: Updated Policies and Procedures.....	14-15
Bed-Hold Payment Policy	14-15
General Rule for Bed-Hold Payments.....	14-15
Determination of Occupancy Rate	14-15
Billing Guidelines for Bed-Hold Days.....	14-15
Monitoring of Bed-Hold Payments	14-16
Reporting of Bed-Hold Days on the Nursing Facility Financial Report	14-16
Medicare Crossover Claims Payment Policy Changes.....	14-16
Nursing Facility Room and Board	14-17
Medicare Part D and Long-Term Resident Enrollment.....	14-17
CMS Fax Procedures for Multiple LTC Resident PDP Enrollment	
Information	14-18
Hospice Provider Reimbursement Terms	14-18
Additional Information	14-20
Claims for Durable Medical Equipment.....	14-20
Section 4: Pre-Admission Screening and Resident Review Process	14-21
Overview	14-21
Significant Change Referral by Nursing Facility	14-21
PASRR Level II Exclusions and Categorical Determinations	14-21
Reimbursement Limitations for Pre-Admission Screening and	
Resident Review Placements	14-22
Pre-Admission Screening and Resident Review Forms	14-23
Ordering Pre-Admission Screening and Resident Review Forms.....	14-24
Pre-Admission Screening and Resident Review Requirements for	
Nursing Facility Transfers and Readmissions.....	14-24

Section 5: EDS Audit Procedures	14-26
Overview	14-26
Minimum Data Set Audit Process	14-27
Resident Review Process.....	14-27
Section 6: Member Level of Care Appeal Process	14-28
General Information	14-28
Notification Process	14-28
Appeal Process.....	14-29
Appeal Decision Notification.....	14-29
Agency Review Decision.....	14-29
Section 7: MDS Audit Findings and Rate Calculation Appeal Process	14-30
Overview	14-30
Application of Recalculated Case Mix Indices and IHCP Rates.....	14-30
Application of Corrective Remedies	14-31
Section 8: Billing Considerations	14-32
General Information	14-32
Nursing Facility Billing.....	14-32
Autoclosure of Member Level of Care	14-32
Retro-rate Adjustments	14-34
Edit 1024.....	14-35
Section 9: Managed Care Considerations	14-36
General Information	14-36
<i>Care Select</i>	14-36
Risk-Based Managed Care	14-36
Short-Term Nursing Facility Placement	14-36
Long-Term Nursing Facility Placement.....	14-37
Index	14-38

Section 1: Introduction to Long Term Care

General Information

Level of Care (LOC), Pre-Admission Screening and Resident Review (PASRR), and the case mix reimbursement methodology are designed and defined by the Indiana Family and Social Services Administration (IFSSA) and the Centers for Medicare & Medicaid Services (CMS). These are the safeguards necessary to protect the health and welfare of institutionalized Indiana Health Coverage Programs (IHCP) members, as well as all residents with mental illness or mental retardation (MI/MR). This review system assists the IFSSA in meeting its responsibilities under the law while effectively monitoring, processing, and ensuring appropriate payment of nursing facility (NF) claims. It also provides State management with the information necessary for planning. The long-range objective of the IFSSA is to provide for the effective and efficient administration of the IHCP.

The sections that follow summarize:

- LOC and case mix review processes and supportive documentation
- Updated policies and procedures
- PASRR process
- EDS audit procedures
- Member LOC appeal process
- Minimum data set (MDS) audit findings and rate calculation appeal process
- Billing considerations
- Managed care considerations for Long Term Care (LTC) members and providers

Section 2: State Level of Care and Form 450B Reviews for Long Term Care Members

Level of Care Review

The Indiana Family and Social Services Administration (IFSSA) determines the appropriateness of the Indiana Health Coverage Programs (IHCP) reimbursement for all placements of IHCP members in IHCP-certified nursing facilities (NFs). For facilities subject to case mix reimbursement, there are no longer skilled and intermediate levels of IHCP reimbursement. However, the criteria found in *405 IAC 1-3-1* and *405 IAC 1-3-2* continue to define the threshold of nursing care needs required for admission to or continued stay in an IHCP-certified NF. The Division of Aging (DA), the Indiana Pre-Admission Screening (IPAS) agencies, and EDS Long Term Care (LTC) auditing teams use these criteria.

Review Objective

The primary objective of the review is to determine whether a resident needs NF care in accordance with the State Level of Care (LOC) criteria set in *405 IAC 1-3-1* and *405 IAC 1-3-2*.

Indiana Pre-Admission Screening Procedures

All IHCP and non-IHCP applicants to IHCP-certified NFs are referred to the local IPAS agency to initiate the IPAS process. The DA continues to render medical decisions about the need for NF care under the criteria in *405 IAC 1-3-1* and *405 IAC 1-3-2* for NF applicants, non-Pre-Admission Screening and Resident Review (PASRR), who are IHCP members or are pending IHCP eligibility. The local IPAS agent continues to render determinations for NF admission for private-pay, non-IHCP applicants. The local Aging and Disability Resource Center (ADRC) that was formerly known as Area Agency on Aging (AAA) completes pre-admission screening (PAS) and PASRR.

When all required information is submitted, the ADRC renders final decisions on the IPAS cases pursuant to *460 IAC 1-1-12*. To expedite the IPAS determination process, it is critical that the provider completes in full the *Form 450B* Section I, *Resident Identification* and Section II, *Physician Certification for Long Term Care Services*. The provider must include all appropriate information on the *Form 450B*.

For the *Form 450B* to be processed, the provider must complete the *primary diagnosis* field with the diagnosis and must not mark it *see attached*. When the physician completes and signs Section II of the *Form 450B*, no one else can make any changes or additions to Section II. All updated or additional information must be provided as an attachment with an explanation of the new or changed information provided and a signature or notation of the name of the individual providing the additional information. Attachments should support, or more fully explain, the information documented on the *Form 450B*.

Under the case mix system of reimbursement, the physician must certify on the *Form 450B* the need for NF care, rather than a specific LOC.

Forms 450B and Form 450B State Authorization/Data Entry

This section outlines the *Form 450B, Physician Certification for Long Term Care Services*, for IHCP reimbursement in an NF or for Home and Community-Based Services (HCBS) waivers.

The *Form 450B* is required for the following:

- Admission to an NF
- Facility-to-facility transfers
- Placement on HCBS waivers
- Authorization for IHCP reimbursement for intermediate care facilities for the mentally retarded (ICFs/MR)
- Authorization for IHCP reimbursement to NFs for residents who subsequently become eligible for IHCP services

The section titled, [Use of OMPP Form 450B State Authorization/Data Entry \(SA/DE\) Nursing Facility Level of Service State Authorization and Data Entry, Computer Generated by the State](#), provides more information about the use of *OMPP Form 450B SA/DE*.

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

Form 450B and *OMPP Form 450B SA/DE* can be ordered from the following address or accessed online with the state of Indiana:

**Department of Administration
Forms Distribution Center
6400 East 30th Street
Indianapolis, IN 46219**

How to Access Online Forms with the State of Indiana

1. Go to the Indiana Commission on Public Records Web site, located at <http://www.in.gov/icpr/>.
2. Click **Forms Management**, located in the toolbar on the left side of the page.
3. Click **Forms Online Catalog**.
4. Scroll down until **Family and Social Services Administration** is displayed and click the link.
5. To find a State form, hit “Ctrl” and “F” at the same time and a small box will appear on the screen. Type the State form number in the **Find what** box and press **Find Next** or **Enter**. The State Form with the search information will be highlighted.
6. Print the State form. If it is more than one page, print the forms double-sided.

Note: The 450B is a two-sided form that needs to be printed double-sided.

Completion and Certification of 450B

For the DA to complete the LOC review, the provider must fully complete the *Form 450B* and sign and date the physician certification section. Forms received with omitted or altered dates are returned to the facility for correction.

Sections I and II – Sections I and II of each *Form 450B* must include the correct member identification number (RID) and all appropriate dates. If Section II of the form does not provide sufficient space for the medical information, documents must be attached containing additional information for the LOC review.

Provider Number – *Form 450B* requires the *facility provider number*. The IHCP number for the named facility must be documented on the form. Medicare numbers must not be used. After approval by the DA, the facility IHCP provider number listed on the *Form 450B* or *Form 450B SA/DE* is entered in the IndianaAIM member LOC window. The provider number recorded on the member LOC window must match the number of the provider filing the LTC claim for the member.

OMPP Form 450B Nursing Facility Level of Service – State Authorization and Data Entry

The *OMPP Form 450B SA/DE* can be used in place of the *Form 450B* for the following:

1. Admission from HCBS waiver
2. Admission from other NFs, not subject to IPAS or PASRR
3. Short-term PASRR exclusions with Respite Adult Protective Services (APS) – seven days only – exempted hospital discharge
4. Admission from other NF – no hospitalization
5. Medicare primary residents who had no existing effective Medicaid reimbursement date
6. Resident changes from private pay (non-IHCP) to IHCP member status, including changes in eligibility from a managed care organization (MCO) to Traditional Medicaid
7. Readmission to NFs from hospitals when resident was approved for NF care preceding the hospitalization

A complete minimum data set (MDS) with an A3a date, with RN signature, must be submitted within 90 days of the effective date requested is required for submission with the *OMPP Form 450B SA/DE* addressed in items 1 and 4 in this section.

Use of OMPP Form 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 implemented a statewide, automated IPAS/PASRR case processing database and tracking system. IPAS and PASRR cases subject to State review can be electronically transmitted to the State for determination of admission and continued care in an NF.

The ADRC generates the majority of IPAS determinations by computer for both the *Pre-Admission Screening Form 4B (PAS 4B)* and the *OMPP Form 450B SA/DE*. The computer-generated *OMPP Form 450B SA/DE* format looks different from the paper *OMPP Form 450B SA/DE* issued by the Forms Distribution Center. When the *OMPP Form 450B SA/DE* is computer generated, it shows a determination in Section II, *State Authorization*, and the form includes an Indiana Family and Social Services Administration (IFSSA)-authorized signature. Applicants and nursing facilities receive the IPAS Form 4B on white paper.

The computer-generated *OMPP Form 450B SA/DE* is the official 450B form maintained with the resident's medical records for the current institutionalization. The DA does not return a form signed by a physician when the *OMPP Form 450B SA/DE* is generated for State authorization.

The IPAS agency can forward the PASRR Level I form and the IPAS application to the NF. The computer-generated *OMPP Form 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 NF, the NF must maintain the official 450B form in the resident's records. The official 450B form contains a State-authorized signature.

Medicare to IHCP Forms 450B and 450B SA/DE

An approved Form 450B for the current LTC facility provider for Medicare dates of service is NOT required for a change from Medicare primary to an IHCP primary resident. The Medicare claim automatically crosses over from the Medicare reimbursement system to IndianaAIM for possible IHCP reimbursement of the coinsurance and deductible for dually eligible residents in NFs. **DO NOT HOLD the Form 450B** when waiting for the Medicare coverage period to stop. **SUBMIT the Form 450B immediately for LOC processing.**

If the resident does not have an approved *Form 450B* or *OMPP Form 450B SA/DE* for IHCP reimbursement for the current institutionalization, the facility can submit a completed MDS and the new *OMPP Form 450B SA/DE*, as described in the section, [Resident Changes from Private-Pay to IHCP Member](#).

Readmission to a Nursing Facility from a Hospital

Under the case mix reimbursement system, if the resident exhausted bed-hold days, it is no longer necessary for the nursing facility to submit a new *Form 450B* unless instructed to do so by the EDS LTC Unit. This applies to the following:

- Readmission of IHCP and dually eligible IHCP and Medicare residents

A new *Form 450B* is required under the following situation:

- Residents approved for NF care who change NFs immediately following the hospitalization, rather than returning to the original NF, regardless of the length of the intervening hospitalization

The term *approved for NF care* means that a valid *Form 450B* or new *Form 450B SA/DE*, approved by the State, has been entered in IndianaAIM authorizing the NF stay and IHCP reimbursement for the period immediately preceding the hospitalization. The following requirements must be met:

- The IHCP reimbursement date must be documented by the DA on the *Form 450B* in the *Effective Medicaid Reimbursement Date* block of the State Authorization section.
- If IndianaAIM does not show that the resident was authorized for IHCP reimbursement immediately preceding the hospitalization, the DA does not authorize the readmission to the NF. In this situation, the NF must submit a completed *Form 450B* and proof of IPAS, if the resident has been in the NF for less than one year prior to the requested start date for IHCP reimbursement. This applies for all NF care to be reimbursed by IHCP.

Table 14.1 provides more information.

Resident Changes from Private-Pay to IHCP Member

The DA continues to require the submission of a fully completed *Form 450B* or *Form 450B SA/DE* to authorize IHCP reimbursement when a resident's payment status changes from non-IHCP to IHCP. The requirement includes residents who are changing eligibility status from Medicare only, non-IHCP, to dually eligible Medicare and IHCP. Documentation that the resident's admission was originally approved through the IPAS/PASRR assessment process, such as a copy of the *PAS 4B, Notice of Assessment Determination*, must be submitted with the *Form 450B*.

The following expedites the Form 450B process at the DA for residents who have recently been approved for admission to the facility through IPAS. Residents, who change from private-pay to IHCP within 90 days of the date the State issued the signed *Form 450B* or *OMPP Form 450B SA/DE*, should have the *PAS 4B*, the state-issued *Form 450B*, or *OMPP Form 450B SA/DE* resubmitted to the DA. This form has already been coded for entry in *IndianaAIM*. Rather than complete a new *Form 450B*, the facility must complete the RID number and the date the resident became IHCP-eligible. This resubmitted *Form 450B* or *OMPP Form 450B SA/DE* must be immediately forwarded to the DA for entry in *IndianaAIM* and does not require another medical review.

NFs have another option for submitting a fully completed *Form 450B* for resident changes from private pay to IHCP reimbursement. The admitting facility can submit a hard copy of the fully completed MDS, version 2.0 or subsequent version as approved by the Centers for Medicare & Medicaid Services (CMS), **for the period under review**, along with a fully completed new *Form 450B SA/DE Nursing Facility Level of Service – State Authorization and Data Entry*, described in this chapter. If the A3a date, the last day of the MDS observation period, on the completed MDS is within 90 days of the IHCP effective or requested reimbursement start date, the DA considers the MDS current **for the period under review**.

Table 14.1 provides more information.

Admissions from Other Nursing Facilities

All admissions of IHCP members directly from other NFs continue to require the submission of a completed *Form 450B* or optional *Form 450B SA/DE* to the DA to show the continuing need for NF care. Documentation that the resident is not subject to IPAS and the one-year non-IHCP payment penalty, such as a copy of the *PAS 4B* for the previous NF, must be attached to the *Form 450B*. Dates of primary Medicare coverage also need to be documented on the *Form 450B*, as applicable.

As long as the resident is initially authorized to enter an NF and has received ongoing medical care in an NF or hospital, another IPAS application is not required for transfers between NFs.

NFs can submit a fully completed *Form 450B* for admissions from other NFs. The admitting facility can submit a hard copy of the fully completed MDS, version 2.0 or subsequent version as approved by the CMS, **for the period under review**, along with a fully completed new *Form 450B SA/DE Nursing Facility Level of Service – State Authorization and Data Entry* described in this chapter. If the A3a date on the completed MDS is within 90 days of the IHCP-effective or requested reimbursement start date, the DA considers the MDS current **for the period under review**.

Table 14.1 provides more information.

Table 14.1 – Use of Forms 450B and 450B SA/DE When IHCP Status Is Checked as IHCP Member

Scenario	Qualifier	Form Required	Accompanying Information	Official Form To Be Retained on Chart
Initial admission to nursing facility (IPAS and PASRR)	All IPAS/PASRR cases	Entire <i>Form 450B</i> (Sections I and II) completed	Complete IPAS/PASRR packet (no change)	Computer-generated <i>OMPP 450B SA/DE</i> ADRCs now generate these forms on all cases. The provider should receive the computer-generated <i>OMPP 450B SA/DE</i> in all cases. When this form comes from the ADRCs, it does not have an effective Medicaid reimbursement date. Because of the missing information, the NF is responsible for forwarding this form along with the <i>Form 4B</i> to the DA for an effective date. If the ADRCs have a Medicaid number, admission date, and an NF listed on the <i>Form 450B</i> , the computer-generated form will not be in the packet from the ADRC. It is sent to the provider from the LOC Unit at the DA (State Level) and has an effective Medicaid reimbursement date on this form when it is received in the mail.
From the HCBS waiver to an NF	All HCBS waiver cases coming into an NF	Long <i>Form 450B</i> (sections I and II) completed and/or <i>450B SA/DE</i> with a fully completed MDS**	Freedom of Choice Letter, Level I (Triggered Level II outside the short term exclusions PASRR certification) needed	Returned <i>Form 450B</i> or <i>450B SA/DE</i> with an effective Medicaid reimbursement date
Short-term PASRR exclusions	Respite APS (seven days only) exempted hospital discharge	Long <i>Form 450B</i> (Sections I and II) completed and/or <i>450B SA/DE</i> with a fully completed MDS***	Level I – Section 5, Part B1 Section 5, Part B2 Section 4, Part A	Returned <i>Form 450B</i> with an effective Medicaid reimbursement date
PAS not completed	Client discharged and so forth	Long <i>Form 450B</i> (Sections I and II) completed	<i>Form 4B</i> PAS application Level I	Returned <i>Form 450B</i> with an effective Medicaid reimbursement date

Scenario	Qualifier	Form Required	Accompanying Information	Official Form To Be Retained on Chart
NF to hospital and return to another NF (with an effective Medicaid reimbursement date)	Following any length of hospitalization	<i>Form 450B</i> (Section I only) or <i>450B SA/DE</i>	None	Returned <i>Form 450B</i> with an effective Medicaid reimbursement date
Transfer from NF to NF (no intervening hospitalization)	Transfer to another NF	Entire <i>Form 450B</i> (Sections I and II) completed or <i>Form 450B SA/DE</i> with fully completed MDS**	Copy of <i>PAS 4B</i> from previous NF (copy of MDS from admitting NF)	Returned <i>Form 450B</i> with effective Medicaid reimbursement date
Resident change from private pay (non-Medicaid) to Medicaid members	Including changes in eligibility status from Medicaid MCO to regular Medicaid	Entire <i>Form 450B</i> (Section I and II) completed or <i>Form 450B SA/DE</i> with fully completed MDS** or computer-generated <i>OMPP 450B SA/DE***</i>	Copy of <i>PAS 4B</i>	Returned <i>Form 450B</i> with an effective Medicaid reimbursement date or computer-generated <i>OMPP 450B SA/DE</i>

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

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

Note: Nursing facilities must contact the MCO immediately for IHCP members enrolled in risk-based managed care (RBMC) for determination of the initial admission.

Official Form 450B or Form 450B SA/DE Retained in Chart

The facility must retain the specific *Form 450B* or *Form 450B SA/DE* approved by the State, or the State representative, authorizing the current admission. A *Form 450B SA/DE* that has been computer-generated and approved by the State replaces the original *Form 450B* or *Form 450B SA/DE* that was submitted to the State for the medical review. The State returns only the signed *Form 450B* or *Form 450B SA/DE* with State authorization regarding the admission or continued care.

Duplicate Forms 450B and 450B SA/DE

Submission of duplicate *Form 450B* or *Form 450B SA/DE* is unnecessary and adds to the paperwork processed by the provider and the DA. Duplicates delay the review process of the initial *Form 450B* or *Form 450B SA/DE*.

To streamline the process of determining whether a duplicate *Form 450B* is necessary, the DA requests that the provider contact the *Division of Aging LTC Unit* at (317) 232-4359 to verify the dates of the *Form 450B* or *Form 450B SA/DE* that have been processed by the DA.

If the original *Form 450B* or *Form 450B SA/DE* was *not* mailed from the NF before the date of the forms currently being processed by the DA, *the NF must not submit a duplicate form*. For instance, the original *Form 450B* or *450B SA/DE* was mailed from the NF March 3, 2009; however, the DA is reviewing forms received the week of February 24, 2009. The duplicate submission of paperwork delays the LOC determination process.

Nursing Facilities Not Reimbursed by Case Mix Methodology

NFs not subject to the case mix reimbursement methodology have no changes in *Form 450B* procedures. These facilities continue to be subject to intermediate and skilled LOC determinations for all IHCP reimbursements.

Section 3: Updated Policies and Procedures

Bed-Hold Payment Policy

The Indiana Health Coverage Programs (IHCP) reimburses for bed-hold days only to nursing facilities that have occupancy rates of 90 percent or greater. This policy change is addressed at *405 IAC 5-31-8*.

General Rule for Bed-Hold Payments

To determine eligibility for IHCP payment for bed-hold days, each nursing facility must determine the occupancy percentage as of the date that an IHCP resident leaves the facility for hospital or therapeutic leave. Guidelines are provided below for determining this occupancy percentage. If a facility’s occupancy percentage 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 percentage 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 percentage 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 percentage shall be determined as follows:

$\frac{(a + b)}{c} = d$	This calculation 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 percentage.
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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 status for bed-hold reimbursement is determined for a given leave of absence, that resident’s status shall not change as a result of subsequent changes in the facility’s occupancy percentage.

Billing Guidelines for Bed-Hold Days

The facility must *code* for leave days using the revenue codes as indicated below. For internal recordkeeping 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 explanation of benefits (EOB) as a payment denial, but still allow the DA to track those unpaid leave days**. Bed-hold

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

days **eligible** for IHCP payment pursuant to 405 IAC 5-31-8 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**

*Note: LTC providers are no longer required to discharge IHCP members using the patient status code “02” for hospitalizations exceeding 15 days; however, there is no reimbursement for hospital leave days in excess of 15 days per stay. Providers should **not** submit a new Form 450B when a resident returns to the LTC facility following a hospital stay of greater than 15 days.*

Monitoring of Bed-Hold Payments

The Office of Medicaid Policy and Planning (OMPP) and its contractors routinely monitor all nursing facility (NF) claims for payment of bed-hold days. Monitoring may result in a need for facilities to provide documentation that their occupancy percentage conforms to the requirements of 405 IAC 5-31-8. If the OMPP determines that any IHCP payments for bed-hold days were made inappropriately, recoupment for such payments is immediately initiated.

All providers are reminded, if it is determined that leave day claims were submitted with a revenue code other than the 180-185 series, the claims must be adjusted. All adjustment requests must be forwarded on the appropriate adjustment claim form and sent to the following address:

EDS Adjustments
P.O. Box 7265
Indianapolis, IN 46207-7265

Reporting of Bed-Hold Days on the Nursing Facility Financial Report

NFs 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 184 and 185 of *Schedule I*, and included on lines 144 and 148 of *Schedule A* at 50 percent of the nursing facility’s case mix reimbursement rate per bed-hold day. See *Chapter 8* for more information on billing instructions.

Medicare Crossover Claims Payment Policy Changes

Medicare crossover claims are addressed in 405 IAC 1-18-2.

Medicare payment policy permits coinsurance and deductible amounts that an NF cannot collect must be treated as a *Medicare bad debt*, and are generally eligible for reimbursement by Medicare to ensure that any adverse financial impact on the NF is minimal. Refer to *Chapter 8* for additional claim billing information.

The OMPP has received inquiries from providers about what claims can be submitted to Medicare as bad debt when Explanation of Benefit (EOB) 9004 – *No payment made, personal resource amount is more than the Indiana Health Coverage allowed amount* has posted to an adjudicated claim on the provider's Remittance Advice (RA). Until IndianaAIM is modified, providers must send bad debt information to Medicare for review. Providers must submit a copy of the IHCP RA to reflect that the claim was adjudicated by the IHCP and paid at zero. The RA reflects patient liability deductions included in the adjudicated claim by indicating the specific dollar amount in the *Patient Responsibility* field locator on the RA, which is located between the *TPL* and the *Paid* field locators. If an amount is indicated in this field locator, this is the amount of patient liability that was deducted from the claim. EOB 9004 should **not** be used as the basis for determining whether a patient liability amount was deducted from the claim.

In addition, some Long Term Care (LTC) providers have misused resident personal resource account funds to satisfy a coinsurance or deductible cost.

Note: The IHCP does not allow an LTC facility to use any portion of a member's personal resource account to cover any portion of the coinsurance or deductible amount that is not paid by the IHCP program.

For example, if the Medicare payment is *greater than* the IHCP-allowed amount and the claim is paid at zero, the coinsurance or deductible cannot be collected by the LTC facility from the member's personal resource account. Similarly, if the Medicare paid amount is *less than* the IHCP amount, allowing a portion of the coinsurance or deductible to be paid, the difference between the payment amount and the difference in the coinsurance amount or deductible cannot be collected from the member's personal resource account. Providers that have not been following the correct policy must begin doing so immediately.

Nursing Facility Room and Board

When an NF resident elects Medicare benefits for room and board at the beginning of the month, liability is collected at the beginning of the month, as if the resident were not using Medicare days. If the resident uses Medicare room and board benefits for the entire month, the liability collected at the beginning of the month is placed into the resident's personal needs allowance account. If the resident is using Medicare benefits for room and board for several months, this could put the resident over personal resources. In this case, the caseworker must be notified. The resident could be taken off Medicaid until personal resources are exhausted. The resident could then reapply for Medicaid, and a new Form 450B would have to be completed. If the resident uses only a portion of the month for Medicare room and board benefits, the liability collected by the nursing facility is only for the days that Medicaid paid the nursing facility room and board. The remaining liability is placed in the resident's personal needs allowance account. If the dollar amount in the personal needs allowance account exceeds the limit allowed, the caseworker must be notified.

Medicare Part D and Long-Term Resident Enrollment

Many LTC facility residents have cognitive conditions such as dementia. The LTC facility or pharmacy cannot require residents to join a particular prescription drug program (PDP). Only the member or the person who holds the power of attorney for the member can enroll the member in a PDP. The Centers for Medicare & Medicaid Services (CMS) recognizes state laws that authorize certain people under specific circumstances to enroll and disenroll Medicare members in PDPs.

CMS Fax Procedures for Multiple LTC Resident PDP Enrollment Information

LTC facilities may need PDP enrollment information for members residing in their facilities who are both IHCP and Medicare members. Nursing homes without Internet access or that need Medicare PDP enrollment information for multiple residents can use a special CMS fax-based procedure. Nursing home representatives must provide the required authentication information for each of their Medicare members using the appropriate authentication form. Nursing homes are required to fax the completed form to Medicare at (785) 830-2593, along with the appropriate cover sheet including the name and telephone number of a voice contact. Providers must use these forms to expedite fax requests for PDP information to CMS. Failure to follow these procedures results in delayed response time. Medicare customer service representatives process the requests and fax them back to the nursing home. To request these forms, cover sheets, and instructions, call 1-800-MEDICARE.

Hospice Provider Reimbursement Terms

It is not mandatory for NF providers to reserve beds; however, the OMPP continues to reimburse hospice providers at one-half the NF case mix reimbursement rate for reserving NF beds for hospice members, when the occupancy criteria are met as set forth in *405 IAC 5-34-12*.

It is the hospice agency's responsibility to confirm the NF occupancy percentage on the date that the leave of absence begins. Hospice providers can bill the IHCP for leave days only when the NF occupancy percentage is at 90 percent or greater on the day the leave begins. If the NF occupancy percentage falls below 90 percent following the date the leave began, the hospice provider can continue to bill the 50 percent of the NF's case mix reimbursement rate for the entire hospital or therapeutic leave.

When the NF occupancy is below 90 percent on the date that the leave of absence begins, the hospice agency should use revenue code 180 to bill the IHCP for leave days. Revenue code 180 is a nonpaid revenue code used to generate an IHCP denial, and it can be used when charging a resident or legal guardian for nonreimbursed bed-hold days.

The explanation of benefits (EOB) detail for revenue code 180 lists the claim as denied, with *EOB 4215 – Leave days not a covered service for this bill type – nursing facility occupancy less than 90 percent*.

When a member who receives hospice services and resides in a nursing facility has dual eligibility, the hospice provider must bill claims to the IHCP using revenue code *659 – Hospice services/other/dual eligibility NF recipients only*. A member is considered dually eligible if he or she is enrolled in both Medicare and Medicaid. The member may also have other commercial insurance. When verifying member eligibility, members who are dually eligible will be listed as being qualified Medicare beneficiaries (QMB-Also).

When a member who receives hospice services and resides in a nursing facility is not dually eligible (not a QMB), the hospice provider must bill claims to the IHCP using revenue code *653 – Hospice services/routine home care delivered in a nursing facility* or *654 – Hospice services/continuous home care delivered in a nursing facility*. The provider must use revenue code 653 or 654 even if the member has other commercial insurance and Medicaid.

If other insurance pays for the hospice care services in full, the hospice provider shall only receive payment from the IHCP for room and board services. If other insurance and the IHCP reimbursed the provider for hospice care services, the provider was overpaid and must refund the overpayment to the IHCP.

To refund the overpayment, the provider must complete a *Hospice Accounts Receivable Refund Adjustment* form. The form is located on the following page of the IHCP Web site:
<http://www.indianamedicaid.com/ihcp/Hospice/content/forms.asp>.

Mail the completed form and a check for the overpayment amount to:

EDS Refunds
P.O. Box 2303 Dept. 130
Indianapolis, IN 46206-2303

The following example shows how to calculate the amount of an overpayment for revenue code 653 or 654.

Table 14.2 – Nursing Home Room and Board Calculation

Nursing Home Room and Board Level of Care		
Letter Represented	Description	Amount
A	Nursing Home's Room and Board Rate	\$136.98
B	Payment Percentage of the Room and Board Rate	95
C	Medicaid Reimbursement Per Day (A*B=C)	\$130.13
D	Number of Days in the Month	31
E	Total Reimbursement Amount for the Month (C*D=E)	\$4,034.03
F	Patient Liability for the Month	\$1,019.00
G	Total Medicaid Reimbursement for Room and Board (E-F=G)	\$3,015.03

Table 14.3 – Hospice Routine Healthcare Calculation

Hospice Routine Healthcare		
Letter Represented	Description	Amount
A	Routine Home Care Rate for the County of the Provider	\$126.92
B	Number of Days in the Month	31
C	Medicaid Hospice Reimbursement for the Month (A*B=C)	\$3,934.52
D	Amount Paid by Third-party Liability	\$3,410.00
E	Total Medicaid Reimbursed for Hospice (C-D=E)	\$524.52

In this example, the provider received the full hospice reimbursement (Table 14.3, line C) of \$3,934.52 and no reimbursement for Room and Board (Table 14.2, line G.)

The IHCP should have reimbursed the provider \$3,539.55 (Total Medicaid Reimbursement for Room and Board, \$3,015.03, plus the Total Medicaid Reimbursement for Hospice, \$524.52).

The provider was overpaid and must refund the IHCP \$394.97 (\$3,934.52 minus \$3,539.55).

Note: An individual form must be completed for each claim that is being refunded.

Additional Information

For more information about the billing process for bed-hold claims, contact the EDS Long Term Care help desk at (317) 488-5094. The help desk is not manned daily. An LTC field auditor returns calls during the third full week of every month. Inquiries are handled in a first-come, first-serve order. The LTC help desk is beneficial to LTC providers who have LOC questions regarding their members or claims.

Claims for Durable Medical Equipment

Medical supplies, nonmedical supplies, and routine durable medical equipment (DME) items billed to the IHCP for members residing in LTC facilities will deny. LTC facilities include NF, intermediate care facilities for the mentally retarded (ICFs/MR), and community residential facilities for the developmentally disabled (CRFs/DD). The IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies, or routine DME items provided to an IHCP member residing in an LTC facility. The costs for these services are included in the facility per-diem rate, and the medical supplier or DME company should bill the LTC facility directly for such services. For further information, refer to *405 IAC 5-13-3* and *405 IAC 5-31-4*.

Healthcare Common Procedure Coding System (HCPCS) codes for medical supplies, nonmedical supplies, or routine DME items billed to the IHCP for members residing in LTC facilities will deny with explanation of benefit (EOB) code 2034 – *Medical and nonmedical supplies and routine DME items are covered in the per diem rate paid to the Long Term Care facility and may not be billed separately to the IHCP.*

Note: The LTC Durable Medical Equipment (DME) Per Diem Table is available on the Indiana Medicaid Web site at www.indianamedicaid.com.

Section 4: Pre-Admission Screening and Resident Review Process

Overview

The Pre-Admission Screening and Resident Review (PASRR) process remains a requirement in all Indiana Health Coverage Programs (IHCP)-certified nursing facilities (NFs). Residents, regardless of known diagnoses or methods of payment, IHCP or non-IHCP, who reside in an IHCP-certified NF are subject to the PASRR process. The Level I Identification Screen, *Form 450B*, Section IV, must be completed for each applicant or resident by the NF prior to or at the time of pre-admission screening. The form is completed to identify residents who may have a mental illness (MI), mental retardation/developmental disability (MR/DD), or mental illness/mental retardation/developmental disability (MI/MR/DD), or related condition.

Significant Change Referral by Nursing Facility

If a significant change occurs in the resident's MI/MR/DD condition, the NF is responsible for referring the resident to the appropriate agency, such as the community mental health center (CMHC) or Diagnostic and Evaluation (D&E) team, within at least 21 days. The full resident review (RR) assessment and determination must be completed within an annual average of seven to nine days. If this change meets the criteria of *significant change* per the Resident Assessment Instrument (RAI) Manual, the NF is also responsible for completing a Significant Change minimum data set (MDS) within 14 days of the change in condition.

PASRR Level II Exclusions and Categorical Determinations

The Indiana PASRR program for NF admission of members identified as possibly having an MI or MR/DD diagnosis is detailed in this section. Categories of PASRR Level II exclusions and categorical determination criteria of *Form 450B* Section V are located in *42 CFR 483 Subpart C* and *E (483.100 through 483.206)*.

Exempted Hospital Discharge

This exemption is limited to stays of up to 30 days. It is allowed only when all of the following circumstances exist:

- The resident has been hospitalized for acute inpatient care.
- The resident requires NF services for the condition for which care was received in the hospital.
- The attending physician certifies **before admission to the facility** that the resident is expected to require fewer than 30 days of NF services.

The physician certification must be in writing on Section V, Part A, of the Level I. Following the admission, if a change in condition causes the resident to require more than 30 days of NF services, the required Level II assessment and final determination must be completed within 40 calendar days from the date of the initial admission. The additional 10 days are for completion of the Level II only. If the Level II evaluation determines the resident is inappropriate for NF placement, only 40 days are reimbursable.

The IHCP does not reimburse for more than 40 days unless the individual is appropriately placed in the NF. However, the IHCP does not reimburse for inappropriate use of *Exempted Hospital Discharge* placements. This category is not allowed for the admission of any member whose stay is *anticipated to exceed 30 days at the time of the request* for the NF admission. In the final PASRR regulations, the CMS noted that, "...not all convalescent care admissions from hospitals will be able to fit the prerequisites for a PAS-exempt hospital discharge. For instance, convalescence from a broken hip would normally be expected to require longer than 30 days." In such a case, the PASRR Level II MI or MR/DD assessment must be completed *prior to* any NF admission.

As part of the required Level II process, when a member requires a stay exceeding the 30-day limit under the *Exempted Hospital Discharge*, the NF must provide written documentation, signed and dated, to the local pre-admission screening (PAS) agency that explains the following:

- Reason the continued stay is needed
- Anticipated length of the additional stay, such as 30 days, 60 days, or long-term placement

This request must be clearly documented in writing in the case record with the Level I.

Under no circumstances is this category allowed for admission of residents whose stay in any NF is anticipated to exceed 30 days at the time of the admission request.

Respite Short-Term 30-Day

Admission to an NF from *home* for short-term respite care must not exceed 30 calendar days per quarter. There must be a break of at least 30 days between stays of 15 or more consecutive days of respite care. To qualify for *respite* care, on admission there must be an *expressed intention of leaving the NF* by the expiration of the approved respite time period.

These admissions are allowed solely for respite care, not for the previously allowed *acute recuperative care*, for residents who are *expected to return home* following the NF stay. *Respite care* is defined as a temporary or periodic service provided to a functionally impaired individual for the purpose of *relieving* the regular caregiver. This short-term stay applies solely to residents who have a caregiver and who originate from a noninstitutional, community-based setting, including foster care homes. Respite care is not allowed for a person coming from an institution such as a hospital, NF, large ICF/MR, or a group home.

Note: This admission must be authorized by the local PAS agency prior to the admission on Form 450B/PASRR 2A-Section V, Part B.

Adult Protective Services

An Adult Protective Services (APS) admission is designated as a *maximum stay of seven days* in accordance with *42 CFR 483.130(d)(5)*. This admission must be authorized jointly by an APS investigator and the PAS agency **prior to** the admission, and must be the placement of last resort. The individual must be in need of intensive emergency intervention or in imminent danger.

Reimbursement Limitations for Pre-Admission Screening and Resident Review Placements

In accordance with *42 CFR 483.122(b)*, IHCP reimbursement for new admissions is available only for the NF services furnished *after* any required screening or review has been performed and the placement is determined to be appropriate for the resident.

Services provided *prior to* final determination *may* be reimbursable if the resident is found to be eligible for NF services. A person with MI or MR/DD who does not meet the above requirements for a short-term admission is subject to the pre-admission screening assessments prior to admission. IHCP reimbursement does not begin until the required assessments are completed *and* it is determined that the individual is *appropriately* placed in an NF.

Refer to the section [Pre-admission Screening and Resident Review Requirements for Nursing Facility Transfers and Readmissions](#) in this chapter for information about members subject to RR requirements, rather than to the PAS assessments.

Pre-Admission Screening and Resident Review Forms

Current PASRR forms are listed below:

- *PASRR Level I, Identification Evaluation Criteria (State Form 45277 [Revised 5/93] Form 450B/PASRR 2A – Sections IV and V, Part A)*

NFs, hospitals, physicians, and PAS agencies use this form. The Level I is now required for the PAS process only. Completion is no longer required annually:

- **Section IV:** Additional instructions are provided on the back of the form. This section is used for PAS screening assessment.
 - **Section V, Part A:** Part A includes only the Exempted Hospital Discharge Level II exemption. The physician, prior to the placement in an NF, must certify this exemption. However, to qualify for IHCP reimbursement for the NF placement, the placement must meet the specific requirements of the Exempted Hospital Discharge as defined in Section V, Part A, and in the instructions on the back of the form. Note that Section V is applicable only for exempted hospital discharges.
- *PASRR Categorical Determination for Short-Term Nursing Facility Care [State Form 45932 (R/6-93) Form 450B/PASRR 2A – Section V, Part B]*

This form can be used only by the local PAS agencies and APS investigators authorizing the short-term NF placements.

- **Section V, Part B:** Part B includes the signed authorization for Respite Short-Term (30-day) and Adult Protective Services (seven-day) short-term placements. Respite care is an exclusion from PAS, but APS is not. APS allows temporary admission while PAS is being completed for residents applying for continued stay in the facility, rather than moving to an alternative placement.

IPAS Assessment Determination State Form 707/Form 4B is no longer required to be blue or beige.

Providers should submit PASRR claims to EDS using the paper CMS-1500 claim form, the HIPAA-compliant electronic 837 Professional Claims and Encounters (837P) Transaction format, or Web interChange.

The provider must submit these claims for the member using the PASRR member identification number that begins with **800** and the member's Social Security number. If an applicant does not have or refuses to provide a Social Security number, providers may contact the Customer Assistance Unit at (317) 655-3240 in the Indianapolis local area or at 1-800-577-1278 to obtain a PASRR identification number.

Providers can obtain information about how to submit claims using the CMS-1500 paper claim, the electronic 837P transaction, or Web interChange by visiting the IHCP Web site at <http://www.indianamedicaid.com>. This Web site includes Web interChange instructions, Companion Guides for Electronic Data Interchange (EDI) Solutions Transactions, the current *Indiana Health Coverage Programs (IHCP) Provider Manual*, a provider field representative telephone listing, and

additional IHCP information. For answers to specific questions, providers may also call EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or at 1-800-577-1278.

Ordering Pre-Admission Screening and Resident Review Forms

When placing an order for PASRR forms, the full title name, State form number, and the revision date should be specified, as shown in Table 14.4.

Table 14.4 – PASRR Form Orders

Title	PASRR Level I – Identification Evaluation Criteria
Form	State Form 45277 (R/5-93)/Form 450B/ PASRR2A-Sections IV and V, Part A
Specify	May 1993 Revision

The *PASRR Level I – Identification Evaluation Criteria* contains both the evaluation criteria and the *Exempted Hospital Discharge* admission category, as shown in Table 14.5. The IPAS agencies, NFs, hospitals, and physicians use this form.

Table 14.5 – PASRR Level I Identification Evaluation Criteria

Title	PASRR Categorical Determination for Short-Term Nursing Facility Care
Form	State Form 45932 (R/6-93) Form 450B/ PASRR 2A – Section V, Part B

This form is ordered only by the IPAS agencies. NFs, hospitals, and physicians are not authorized to use this form.

Order forms from the Forms Distribution Center by writing to the following address:

**Department of Administration
Forms Distribution Center
6400 East 30th Street
Indianapolis, IN 46219**

Pre-Admission Screening and Resident Review Requirements for Nursing Facility Transfers and Readmissions

- PASRR Requirements for Transfers between NFs, 42 CFR 483.106(b)(4), specify that an interfacility transfer occurs when an individual is transferred from one NF to another, with or without an intervening hospital stay. Interfacility transfers may be subject to RR unless IPAS has not yet been completed.

Note: Each NF is responsible for ensuring that RRs are timely and that transfers are accepted only for residents whose needs the NF can meet. Prior to the admission, the NF must obtain the current status of the resident, including the following:

- * *The most recent PASRR Level II form*
- * *Current medical information, including nursing notes, to ensure that the transfer placement is appropriate*
- * *The PAS 4B form for residents with an NF admission less than one year*
- * *The RR letter determination form*

*These copies **must** accompany the transferring resident to the new facility. The current Level II from the transferring facility must be a part of the record. The NF is responsible for meeting any recommendations listed on the Level II.*

- Refer to *Table 14.1* in *Section 2* of this chapter for use of forms *450B* and *450B SA/DE* to update IndianaAIM for transfer between NFs.
- PASRR Requirements for Readmission to an NF following Hospitalization, *42 CFR 483.106(b)(3)*
 - A resident is a readmission if readmitted to a facility from a hospital to which he or she was transferred to receive care. Readmissions are subject to RR rather than PAS. This procedure places no limit on the length of the hospitalization when the readmission to the NF is directly from the hospital. The NF readmission is also not limited by the type of care received in the hospital, as long as the prior NF admission was approved under PASRR requirements.
 - Readmissions following care in a psychiatric unit of an acute care hospital or in a psychiatric hospital for MI are equally exempt from PAS, as are readmissions following acute medical care in an acute care hospital bed. For residents who have received inpatient psychiatric services, the NF is responsible for obtaining the following at readmission to an NF:
 - Written assurances from the hospital that the patient is stable and not a danger to the patient or others
 - Information about the mental health services the individual requires

This information must be retained in the resident's active record at the NF in addition to the PASRR-MI Level II.

- The resident remains subject to the RR if the following exist:
 - RR is due during the hospital stay
 - RR must be performed within the quarter following the readmission to the NF
- *RR for Significant Change in the Resident's Mental Health Condition* – If the RR is not due and there has been a significant change in the mental health condition of the resident, an immediate RR is required to determine whether the continued stay is appropriate. If the assessment indicates a substantial change in the condition of the resident that would have a bearing on the resident's mental health or overall functioning needs, the NF must immediately refer the resident for an RR as follows:
 - The NF submits a written referral to the local CMHC for MI residents or to the D&E team for MR/DD or MI/MR/DD residents, as appropriate.
 - The written referral must contain the rationale for requesting the RR, specifying the areas of change.

This expedited RR policy applies to residents who are being readmitted or transferred to an NF, as well as to residents in an NF who have undergone a substantial change in mental health condition, regardless of interfacility transfer or readmission.

- Requirements for IHCP *Reimbursements for NF Transfers and Readmissions Not Requiring PASRR Level II Assessments* – To receive IHCP reimbursement for NF services for IHCP members being transferred between NFs or readmitted to NFs following discharges for hospitalizations that do not require PASRR Level II assessments, the admitting NF must submit new paperwork for review and approval by the Division of Aging (DA). These routine transfers and readmissions require the submission of the following:
 - A new *Form 450B*, Sections I and II or an *OMPP Form 450B SA/DE* with a completed MDS
 - The most current PAS 4B and the PAS application verifying compliance with the State PAS Program, if the transfer or readmission occurs within the first year of IHCP-reimbursed NF placement
- This paperwork applies regardless of whether there has been a change in the LOC at the time of the transfer or readmission to the NF.

Section 5: EDS Audit Procedures

Overview

A periodic Level of Care (LOC)/case mix review is completed for all Indiana Health Coverage Programs (IHCP) and IHCP-pending residents, and also includes all residents in IHCP-certified nursing facilities (NFs), as appropriate under state and federal regulations.

The case mix review is conducted for the following:

- A minimum of 40 percent of residents or 25 residents, whichever is greater and regardless of payer source, are initially selected for the review sample from the roster.
- A sample of those residents in each of the Resource Utilization Group (RUG)-III classification groups

The purpose of the review is to ensure that the IHCP is reimbursing for the appropriate RUG classification, as demonstrated by the minimum data set (MDS), version 2.0 and supporting documentation.

The EDS Long Term Care (LTC) auditing team performs LOC, Pre-Admission Screening and Resident Review (PASRR), and case mix reviews in all IHCP-certified NFs at least once every 15 months. The objectives of the EDS LTC audits are as follows:

- Determine whether residents continue to have needs requiring NF placement in accordance with State LOC criteria defined by *405 IAC 1-3-1* and *405 IAC 1-3-2*.
- Ensure all services recommended by the Level II assessments are provided.
- Determine whether IHCP is reimbursing the provider for the appropriate RUG-III classification, reflective of resident needs.
- Verify that the MDS responses are accurate and supported with the appropriate documentation within the assessment reference period.

NFs may be notified up to 72 hours prior to the scheduled case mix/LOC/PASRR audit. The LTC auditing team conducts an entrance and exit conference to apprise the facility staff of the nature, purpose, and sequence of events of the audit, as well as the audit results. The auditing teams make themselves available to address facility questions and concerns. These auditing teams consist of qualified professionals, including registered nurses and licensed social workers may also be qualified mental retardation professionals (QMRP), or designees as appropriate, and are required by federal and state regulations.

The facility is responsible for ensuring that all resident medical records are complete, up-to-date, and available to the auditing teams and for assisting with resident observations. Each resident's medical record documentation must support all notations made on the MDS form.

For nursing facility follow-up audits, the LTC auditing team is not required to contact the facility prior to the audit. An unannounced LTC audit occurs when the initial audit Validation Rate is below 80 percent. The purpose of the unannounced follow-up audit is to return and review for improvements cited on the Validation Improvement Plan.

Minimum Data Set Audit Process

EDS periodically conducts audits of MDS supportive documentation using audit parameters established in the case mix rules. At a minimum, EDS audits a sample of the facility's most recently transmitted MDS records from each of the seven RUG-III categories in which the facility has residents. EDS determines whether any records in the sample are unsupported. If the percent of unsupported MDS records in the sample exceeds the 20 percent threshold set forth in 405 IAC 1-14.6-4(k)(2), EDS expands the scope of the audit to include the latest MDS assessment of all facility residents.

Resident Review Process

Determining the need for a resident review (RR) assessment is based on the following:

- A finding of the prior Level II that a yearly review is required.
- A finding that a Level II was required but was never completed, such as a missed referral.
- A significant change in the resident's mental illness (MI), mental retardation/ developmental disability (MR/DD), or mental illness/mental retardation/developmental disability (MI/MR/DD) condition.
- A determination made by the EDS LTC auditing team that a Level II assessment is required.

Note: The EDS LTC auditing team is responsible for reviewing a sample of 25 percent, or a minimum of five residents, of the entire resident population with MI/MR/DD diagnoses.

Residents identified as possibly having an MI diagnosis are referred to State-contracted community mental health centers (CMHCs). Residents identified with a possible MR/DD or dual diagnoses as MI and MR/DD are referred to the Diagnostic and Evaluation (D&E) team. A comprehensive Level II assessment of the resident's mental and physical needs is completed by the appropriate agency.

Regardless of payment source, names of any resident identified as having an MI, MR/DD, or MI/MR/DD diagnosis, verified by Level II, must be presented to the EDS auditing team in the form of a requested list at the time of the EDS IHCP on-site review. The following resolutions can occur:

- If the prior Level II recommendations include mental health services and the resident is being followed by the CMHC for the delivery of those services, the team does not refer this resident for a yearly RR.
- The most current Level II states geriatric or medical needs take precedence over programming or treatment needs. The resident is not referred for a yearly RR.

Note: If the condition of the resident changes such that programming or treatment needs should take precedence, the NF is responsible for making a referral to the proper agency in a timely manner.

The EDS LTC auditing team refers cases to the Indiana State Department of Health (ISDH) and the appropriate agency, CMHC, or D&E team, for follow-up if the services recommended by the current Level II are not being provided to the resident. Such services must be evidenced in the medical documentation for the resident. Delivery of recommended Level II services is a condition of IHCP certification.

Section 6: Member Level of Care Appeal Process

General Information

This section addresses the nursing facility (NF) Level of Care (LOC) discharge appeal process for the member. The member can appeal the LOC transfer or discharge decision to the Indiana Family and Social Services Administration (IFSSA) Hearing and Appeals Section, pursuant to *470 IAC 1-4-3*.

Notification Process

After completion of the Indiana Health Coverage Programs (IHCP) on-site review conducted by the EDS Long Term Care (LTC) auditing team, the following actions are taken:

- A letter containing the results of the audit is generated from EDS within 10 business days.
- The letter is forwarded to the NF. The letter contains the name of any IHCP member who does not meet the NF criteria found in *405 IAC 1-3-1* and *405-IAC 1-3-2*. The member name, member identification number, and effective date of discharge from IHCP reimbursement are included.
- A letter addressed to the member, outlining the proposed discharge and appeal information, is enclosed in the NF letter packet. The NF is responsible for forwarding the letter to the member, legal guardian, or power of attorney, as appropriate, for notification.
- If the member recommended for discharge by EDS has a diagnosis of MI, MR/DD, or MI/DD as confirmed by a Level II assessment, a final determination is made by the DA. Pursuant to *42 CFR 483.130*, the Division of Disability, Aging, and Rehabilitative Services (DDARS) issues the final determination about the member's need for NF services.
- Included with the EDS audit letter packet are two forms for use with the discharge decision – Form 1703 and Form 1702.
 - *Form 1703, Notification of Discharge/Transfer of Member to Approved Level of Care* is completed if there is agreement with the recommendation and the resident does not appeal. The form must be returned to the address below prior to the effective date of the NF LOC discharge:

**EDS Long Term Care Review Unit
950 N. Meridian St., Suite 1150
Indianapolis, IN 46204-4288**

- *Form 1702 – Request for Reconsideration of Level of Care Change/Discharge Recommendation* is completed if the member's physician documents specific medical rationale based on *405 IAC 1-3-1* and *405 IAC 1-3-2* for retaining the resident at the NF LOC. Reconsideration can be requested on *Form 1702*. The *Form 1702* must be accompanied by appropriate supporting medical documentation as noted on the form and must be received at the EDS LTC Unit address noted above prior to the effective date of discharge. In addition, the member appeal must be forwarded prior to the effective date of the discharge to the following office:

**ATTN: Hearing and Appeals Section
MS04
FSSA Division of Aging
402 W. Washington Street, Room E 034
Indianapolis, IN 46204**

Note: Reconsideration must be requested and the appeal must be filed when there is disagreement with the recommendation.

It is important that either Form 1702 (appeal request) or Form 1703 be submitted before the effective date of discharge. The LOC ends on the effective date of the discharge if an appeal is not filed or Form 1703 is not submitted.

Appeal Process

After Form 1702 and the supporting medical documentation is received, the EDS LTC auditing staff reviews the information and determines whether the discharge decision should be rescinded. If EDS rescinds the decision to discharge, no change is made to the member LOC for reimbursement. The IFSSA Hearing and Appeals Division notifies the member of the EDS LTC decision.

If the member appeals the NF discharge, but EDS does not rescind the discharge decision, reimbursement continues through the appeal process until receipt of the hearing decision by the administrative law judge (ALJ). If the ALJ decision favors the member, the reimbursement continues following the ALJ decision. If the ALJ decision favors the Office of Medicaid Policy and Planning (OMPP), the reimbursement terminates after receipt of the hearing decision.

Note: Pursuant to 405 IAC 1-1-5.1, the OMPP can instruct the fiscal contractor, EDS, to recover payment made during the appeal process if the hearing decision is favorable to the OMPP.

Appeal Decision Notification

All parties – the member, the NF, the OMPP, and EDS – are notified of the ALJ decision by letter. If the decision favors the appellant, or member, there is no break in reimbursement to the facility.

If the decision favors the OMPP, the reimbursement ends three days after the date of the decision. The date of the hearing decision is found at the end of the decision letter.

If the member chooses to request IFSSA Hearing and Appeals Division review of this hearing decision, reimbursement does *not* continue during the pending agency review.

Agency Review Decision

If the agency review decision favors the appellant, or member, the member LOC window is reopened so the NF can again bill for the NF stay and be reimbursed at the appropriate case mix rate.

If the decision is favorable to the OMPP, the member LOC segment is not changed, and the initial decision of the ALJ stands regarding the reimbursement.

For any questions related to the member appeal process, call the following number:

**EDS Long Term Care Review Unit
(317) 488-5062**

Section 7: MDS Audit Findings and Rate Calculation Appeal Process

Overview

At the end of the minimum data set (MDS) field audit, EDS Long Term Care (LTC) auditors conduct an exit conference with appropriate nursing facility (NF) staff and review the preliminary results of the audit and other comments and recommendations about the NF's clinical documentation systems. Following the exit conference, the LTC Unit issues preliminary MDS audit findings, including discharges and referrals. The LTC Unit documents these findings in writing and forwards them to the NF within 10 business days. The NF then has an opportunity to review the written preliminary audit findings. If the NF disagrees with the findings, the NF can submit an informal, written reconsideration request to EDS within 15 business days. The informal, written reconsideration request must include specific audit issues the NF believes were misinterpreted or misapplied during the audit. MDS supporting documentation provided after the audit exit conference must not be considered in the reconsideration process per *405 IAC 1-15-5(c)*. EDS LTC then reviews the NF request and within 10 business days communicates the final MDS audit findings to the NF in writing, along with a response to the issues raised. The MDS audit concludes after EDS communicates the final MDS audit findings to the NF.

An NF with more than 20 percent of unsupported records is required to submit a Validation Improvement Plan (VIP) to EDS LTC for review. The VIP must be submitted within 15 business days following the EDS LTC request, and must outline the NF remedy, completion date, and party responsible for implementing the plan to ensure future compliance with the supportive documentation guidelines. The VIP is required when the scope of the MDS audit is expanded to all residents, and the unsupported or untimely threshold for all residents is still exceeded per *405 IAC 1-14.6-4(k)*.

After the informal reconsideration process, EDS communicates the final MDS audit findings to the facility, the Division of Aging (DA), and Myers and Stauffer to use in the case mix rate-setting process. The information includes unsupported MDS worksheets that were previously transmitted to the State.

Application of Recalculated Case Mix Indices and IHCP Rates

Myers and Stauffer incorporates the final MDS audit findings from the EDS LTC Unit into the calculation of the facility's time-weighted case mix index (CMI) used for Indiana Health Coverage Programs (IHCP) rate-setting purposes. There is usually a one-quarter lag time between the MDS A3a assessment-reference date and the impacted IHCP rate-effective date. The MDS audit may be concluded for some MDS records in sufficient time for the audit findings to be incorporated into the facility's initial quarterly case mix rate setting affected by the audit. However, depending on the relationship between the assessment key dates and audit completion date, application of MDS audit findings for some MDS records could result in retroactive rate adjustments.

The MDS A3a assessment reference date generally determines the calendar quarter during which each MDS assessment applies for case mix rate-setting purposes. The time-weighted guidelines are followed to calculate the number of calendar days each MDS record remains effective. The OMPP published the time-weighted guidelines and updates the guidelines as needed.

An audited MDS record is considered supported unless the audited MDS values result in a different RUG-III classification group for that MDS assessment record, according to *405 IAC 1-14.6-2(hh)*.

When a case mix rate is established that includes the MDS audit findings, in addition to questioning rate-setting issues, the NF can request a formal rate reconsideration, raising MDS audit issues with which they disagree, pursuant to *405 IAC 14.6-22(c)*. The formal reconsideration request for rate setting and MDS audit issues should be sent to Myers and Stauffer within 45 days after release of the IHCP rate by Myers and Stauffer. Myers and Stauffer coordinates the MDS audit issue review with EDS and issues a written response to all rate-setting issues raised along with the EDS response to all MDS audit issues raised within 45 days after receipt of the formal rate reconsideration request. If the formal reconsideration results in a recalculation of the previously established IHCP rate due to MDS audit or rate-setting issues, Myers and Stauffer reissues the IHCP rate following the completion of the reconsideration process. Revised MDS worksheets are provided to document any changes in MDS audit findings that result from the reconsideration process. If the NF disagrees with any determination resulting from the formal reconsideration process, the facility can appeal the determination pursuant to *IC 4-21.5-3-7* and *405 IAC 1-1.5*.

Application of Corrective Remedies

As provided in the OMPP case mix rules, after the audit, the percent of audited MDS records that are determined to be either unsupported or untimely is computed.

Pursuant to *405 IAC 1-14.6-4(k)*, for facility MDS audits started by EDS, a corrected remedy applies if the number of unsupported MDS records exceed 20 percent. When an LTC facility achieves an unsupported Error Threshold percentage of more than 20 percent – such as 20.45 percent – this number is not rounded up or down but instead is reported as exceeding the Error Threshold due to being more than 20 percent. This is only when the Error Threshold percentage exceeds the allowed amount of 20 percent.

The Validation Rate, which is stated in the LTC provider correspondence and findings letters, refers to the percentage of supported records. The Validation Rate represents the percentage of supported records, and the Error Threshold represents the percentage of unsupported records. These two percentage measurements are conversely related.

Pursuant to *405 IAC 1-14.6-4(k)*, the corrective remedy is applied when the scope of the MDS audit was expanded to include all residents.

The corrective remedy is 15 percent of the administrative component of the IHCP rate. The corrective remedy takes effect beginning in the calendar quarter *following* the completion of the MDS audit and remains in effect for one quarter.

Example: An MDS audit begins November 4, 2008, is finalized on December 30, 2008, and finds that 21 percent of the audited MDS records are unsupported; a corrective remedy is applied beginning January 1, 2009. The corrective remedy remains in effect for one calendar quarter. The facility may not recover any reimbursement lost due to the corrective remedy.

Section 8: Billing Considerations

General Information

Member patient liability is the term applied to the monetary amount that an Indiana Health Coverage Programs (IHCP) resident must contribute toward his or her monthly care in the facility. **Personal resource contribution** is a term that is also used for this amount.

Calculating and assigning the member patient liability amount is a function of the local county office of the Division of Family Resources (DFR). Member information, including liability or personal resource contribution, reflected in *IndianaAIM* is updated daily from the information relayed by the Indiana Client Eligibility System (ICES) at the county offices. Providers are not required to send the *C-519* form.

Current income must be applied to current needs. As an example, a Social Security benefit check received in October must be applied to the October charges. The only exception is the direct deposit benefit check sometimes recorded by the bank at the end of one month instead of early in the next month when it would normally be received. Because most resources are available on a calendar month basis, all accounts involving resource deductions must be billed on a calendar month basis, such as June 1 through June 30.

The patient's liability amount is automatically deducted from the total reimbursement of the claim. The provider must not indicate the resource contribution anywhere on the claim form. When a member transfers between facilities during a billing period, the liability is deducted from the first claim received and processed by *IndianaAIM*. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

Nursing Facility Billing

Autoclosure of Member Level of Care

IndianaAIM uses the STAT code field 17 of the *UB-04* claim form to close out the member Level of Care (LOC) segment for selected discharge status codes. Automation of this process eliminates the need for providers to notify the Division of Aging (DA) of all residents discharged from an NF or ICF/MR during a given month. The DA requests that facilities not submit monthly discharge information for residents whose discharge information is noted on the *UB-04* claim form.

It is imperative that the nursing facility (NF) or intermediate care facility for the mentally retarded (ICF/MR) provider submits the patient status code applicable to the *through date of service* indicated on the claim form. *IndianaAIM* closes out the member LOC segment for a member whose claim has one of the patient status codes listed in Table 14.6.

Table 14.6 – Patient Status Codes

Patient Status Code	Definition
01	Discharged to home or self care (routine discharge)
02	Discharged or transferred to another short-term general hospital for inpatient care
05	Discharged or transferred to another type of institution for inpatient care or referred for outpatient services to another institution
07	Left against medical advice or discontinued care
08	Discharged or transferred to home under care of a home IV provider
20	Expired

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 closes the member LOC segment and all future claims are denied for edit 2008 – *Member ineligible for level of care billed*. Providers should use the status code 30 when billing a hospital or therapeutic bed hold.

Note: *When the 15-day bed-hold period has expired, the resident should not be discharged with the appropriate status code unless he does not return to the facility. The hospital bed-hold days must be billed using Revenue Code 185 or Revenue Code 180 as appropriate to facility occupancy percentage, and the claim must reflect the actual date of discharge as the “to” date of service when the resident does not return to the facility.*

The requirement for a new 450B following a hospital stay in excess of 15 days has been eliminated by the Division of Aging.

It is important to bear in mind that the limitations for hospital leave prescribed by 405 IAC 5-31-8 remain in effect and prohibit reimbursement for greater than 15 days per single hospital stay.

Examples:

- A resident was in a Long Term Care facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the NF or ICF/MR on July 2. Occupancy was 92 percent on the day the resident went to the hospital. The Long Term Care facility should bill for June service dates as follows: 23 days of per diem for the appropriate LOC and seven days of hospital bed hold per Revenue code 185. The status code would be 30, because the member is still a resident of the NF or ICF/MR during the bed-hold days.
- A resident was in a Long Term Care facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the NF or ICF/MR on July 10 and remained in the facility the remainder of the month. The Long Term Care facility should bill for June service dates as indicated above. The July claim should reflect dates of service July 1 through July 31, a patient status code of “30,” 9 units of Revenue code 185, and 22 units of per diem for the appropriate LOC.
- If the same resident was discharged to home or to another facility from the hospital and did not return to the Long Term Care facility on the anticipated date of July 2, the July bill should reflect one day of bed hold and 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.
- Bed hold cannot be billed when the resident’s return is not anticipated.

- Providers that have previously received payment for a particular resident but have recently received claim denials for Edit 2008 should contact the **EDS Long Term Care Unit help desk** at **(317) 488-5094**. **Providers must not contact the DA directly or send in a new Form 450B**. An EDS LTC analyst can review the denial reasons specific to the claim. If the member's LOC was discontinued as a result of the discharge status code, the analyst reviews the claims to determine which claim caused the autoclosure. If an incorrect status code was used, the analyst advises the provider of any action that should be taken and, in many cases, manually reopens the LOC. To have claims considered for payment, two steps must occur:
 - First, the provider must adjust or replace paid claims that indicated an incorrect discharge status code.
 - Second, the provider must call the Long Term Care help desk to have the LOC updated.
- After the LOC changes are made, the denied claims can be rebilled and considered for payment. If the denied claims are resubmitted prior to the LOC being updated, the claims will deny again with edit 2008 – *No LOC on File*.

Providers should not submit a new *Form 450B* unless instructed to do so by the EDS LTC Unit.

Note: Nursing facility providers must not discharge residents via the patient status code on the UB-04 claim when the resident elects the Hospice Benefit while remaining in the nursing facility. The provider should use a "30" patient status code and reflect the date the resident began Hospice coverage as the To Date of Service on the claim. This will eliminate autoclosure of the LOC segment and provide continuity of reimbursement.

Retro-rate Adjustments

If a provider experiences claim denial in conjunction with a retro-rate adjustment, and the EDS LTC Unit has reviewed and manually reopened an LOC segment, the provider can rebill denied claims on paper. If the denied claim is past the filing limit, the provider should attach a letter stating that the claim was denied due to an autoclosure of the LOC during a retro-rate adjustment. The letter should also indicate that the provider has spoken with the EDS LTC help desk, and that the LOC segment for the member has been reinstated. The letter is sufficient to waive the filing limit and allow the claims to be processed.

Providers that previously received payment for claims with an incorrect status code should initiate adjustments that reflect the correct status codes. This ensures that the correct information is reflected in *IndianaAIM* and alleviates any future denial of claims during retro-rate adjustments.

EDS deactivates the autoclosure process for retro-rate adjustments. This prevents claim denial and the creation of unnecessary accounts receivable for LOC segments that have previously been manually restored by EDS following notification that the provider billed the incorrect patient status code.

Note: Hospice providers are not required to submit individual claim adjustment forms to EDS for retro-rate adjustments for room and board payments under the IHCP hospice benefit. EDS has completed system changes to allow mass adjustments for nursing facility room and board rate of hospice claims billed under bill type 822 and for hospice revenue codes 653, 654, 659, 183, and 185. The system change permits hospice claims under these revenue codes to be mass adjusted on the same date that the nursing facility retro-rates are mass adjusted. This change expedites hospice claims payments to contracted nursing facilities. Hospice and nursing facility providers are reminded that mass adjustments to the room and board rate under the IHCP hospice benefit for members residing in nursing facilities are reflected on the hospice provider's Remittance Advice (RA). Hospice and nursing facility providers are encouraged to develop coordination and payment procedures to address this retro-rate adjustment issue in their contracts.

Edit 1024

All LTC providers must have a State-approved *Form 450B* or *Form 450B SA/DE* on file in IndianaAIM for their provider numbers before billing for services provided to members. The billing provider's National Provider Identifier (NPI) number on the LTC claim must cross walk to the provider's number from the State-approved *Form 450B* or *Form 450B SA/DE* listed on the recipient *Level of Care* window in IndianaAIM for the dates of service being billed. If an LTC claim is billed before information from the approved *Form 450B* or *450B SA/DE* has been entered in IndianaAIM, the claim is denied for edit 1024 – *Billing provider is not member's listed LTC provider, verify provider number and resubmit.*

When an LTC claim denies for edit 1024, the provider should verify the status of the *Form 450B* or *Form 450B SA/DE*. If the facility has a State-approved *Form 450B* or *Form 450B SA/DE* with the correct provider number for the billing facility for the dates of service billed, the approved *Form 450B* or *450B SA/DE* should be resubmitted to the DA. A cover letter requesting that the information is entered in IndianaAIM due to claim denial for edit 1024 should be submitted to the following address:

**Nancy Hopkins
FSSA Division of Aging
MS21
402 W. Washington St. Room W454, P.O. Box 7083
Indianapolis, IN 46207-7083**

If the LTC facility does not have a State-approved *Form 450B* or *Form 450B SA/DE* with the correct provider number for the dates of service billed, the facility must follow the established procedures for obtaining *Form 450B* LOC approval from the DA. The *Form 450B* or *Form 450B SA/DE* process for NFs is outlined in [Table 14.1](#). ICFs/MR should direct *Form 450B* eligibility questions to the local Bureau of Developmental Disabilities Services (BDDS) field office.

*Note: If the LTC provider has already submitted a *Form 450B* or *Form 450B SA/DE* to the DA, the provider must wait until the *Form 450B* or *Form 450B SA/DE* has been processed by the OMPP and returned before resubmitting the claim.*

Section 9: Managed Care Considerations

General Information

Indiana Health Coverage Programs (IHCP)-covered Long Term Care (LTC)/Level of Care (LOC) services are not included in the Hoosier Healthwise or *Care Select* programs. LTC/LOC services are not included in the scope of benefits provided to members in the managed care program. These services are covered under the IHCP fee-for-service (FFS) Traditional Medicaid program. Managed care members must be **disenrolled** from their health plans before they become eligible for LTC/LOC. Upon disenrollment from managed care, **members' IHCP coverage continues under the FFS Traditional Medicaid program.**

Member enrollment in managed care is effective on the 1st and 15th calendar days of the month. LTC providers should use any of the eligibility verification systems (EVS) described in *Chapter 3* upon admission of a new patient, and on the 1st and 15th of every month for existing patients, to confirm IHCP eligibility and to confirm in which IHCP program the patient may be enrolled, for the purposes of care coordination and reimbursement.

Care Select

Members who are assigned to a primary medical provider (PMP) in the *Care Select* delivery system will be disenrolled from the managed care program when LTC/LOC is approved and entered into IndianaAIM. The PMP is not responsible for certification of nursing facility (NF) services.

Risk-Based Managed Care

The following narratives describe the managed care organization's (MCO's) responsibilities for enrolled members in the risk-based managed care (RBMC) delivery system of Hoosier Healthwise when LTC services are necessary.

Short-Term Nursing Facility Placement

While LTC/LOC services are not covered in the RBMC delivery system, an MCO can place its enrollees in a nursing facility setting on a short-term basis. Members who require Long Term Care or whose short-term placement becomes a long-term placement will be disenrolled from managed care when LTC/LOC is approved and entered into IndianaAIM.

- The responsibility for verifying patient healthcare coverage lies with the NF or LTC facility that has direct access to the patient and the patient's member identification number (RID).
- If the NF or LTC facility determines, upon checking eligibility on date of admission on the 1st or 15th of each month, that the patient is enrolled in a Hoosier Healthwise MCO, the nursing facility or LTC facility must notify the MCO within 72 hours after admission.
 - If the NF or LTC facility notifies the MCO within 72 hours, the MCO shall be liable for charges for up to 60 calendar days from the date of admission.
 - If the NF or LTC facility fails to verify a patient's coverage in RBMC or fails to contact the MCO within 72 hours of admission, the NF or LTC facility may be at risk for charges incurred until the NF or LTC facility has notified the MCO of the patient's status.

- In the case of notification past the 72-hour deadline, the MCO shall only be liable for charges from the date of notification for up to 60 calendar days, beginning on the date of notification.
- The MCO shall have a process that documents the NF or LTC facility notification to the MCO.
- If, after 60 calendar days, the member is still in the NF or LTC facility, the long-term Level of Care determination has not been implemented, and the member is still enrolled in an MCO, the NF or LTC facility becomes liable for any costs associated with the patient until LOC has been implemented.

The 60-calendar-day coverage requirement for the MCO is an extension of the current managed care continuity of care policy that requires the health plan that receives the member to honor authorizations of the previous health plan for the first 30 days. This period is intended to allow for the proper notifications and reviews to take place without interrupting the care being delivered to the member. The initial period of 60 calendar days in these cases is to allow sufficient time for the notification, pre-admission screening, LOC determination, and disenrollment from managed care to take place and to ensure appropriate reimbursement to the facility for services rendered.

Long-Term Nursing Facility Placement

NF and Aging and Disability Resource Centers (ADRCs) must notify the MCO immediately when an MCO member is admitted to an LTC facility or undergoes the Indiana Pre-Admission Screening (IPAS)/ Pre-Admission Screening and Resident Review (PASRR). The MCO is financially responsible for all care provided to its members until enrollment termination is effective. IHCP FFS is financially responsible for LTC reimbursement once the member is approved for intermediate LOC, skilled LOC, or general case mix per *405 IAC 1-3-1* and *405 IAC 1-3-2*, and the member is disenrolled from the MCO.

LTC facilities shall coordinate with the MCO to allow members to use appropriate in-network services during the period in which the member is assigned to the MCO. Information about the specific MCO network in which a member is enrolled is available through the EVS.

Index**4**

450B and 450B SA/DE 14-8

A

Access online forms 14-8
 admissions from other nursing facilities.. 14-11
 ADRC..... 14-7, 14-37
 Adult Protective Services 14-22
 agency decision notification 14-29
 agency review decision 14-29
 Aging and Disability Resource Center 14-7,
 14-37
 appeal process 14-29
 application of corrective remedies 14-31
 audit procedures
 case mix review 14-26
 minimum data set audit process 14-27
 Autoclosure of Member Level of Care.... 14-32

B

Bed Hold Payments 14-15
 Monitoring 14-16
 billing considerations 14-32
 Billing Guidelines for Bed Hold Days 14-15

C

case mix index 14-30
 case mix reimbursement 14-14
 case mix review 14-26

E

edit 1024..... 14-35
 EDS audit procedures
 case mix review 14-26
 minimum data set audit process 14-27
 EDS Long Term Care Review Unit 14-28
 Exempted Hospital Discharge ... 14-21

F

Form 450B 14-7
 Form 450B State Authorization/Data Entry 14-
 7
 forms 14-8
 Forms Distribution Center..... 14-8

H

Hoosier Healthwise 14-36
 Hospice Provider Reimbursement 14-18

I

Indiana Pre-Admission Screening Procedures
 14-7

L

Level of Care review 14-7
 Long Term Care 14-6
 450B and 450B SA/DE
 completion and certification 14-8
 admissions from other nursing facilities. 14-
 11
 agency decision notification. 14-29
 agency review decision 14-29
 appeal process 14-29
 application of corrective remedies 14-31
 billing considerations 14-32
 case mix index 14-30
 case mix reimbursement 14-14
 edit 1024..... 14-35
 Form 450B 14-7
 Hoosier Healthwise 14-36
 Indiana pre-admission screening procedures
 14-7
 Level of Care review 14-7
 MDS field audit 14-30
 member Level of Care appeal process 14-28
 member patient liability 14-32
 PASRR Level II exclusions and categorical
 determinations 14-21
 personal resource contribution 14-32
 PMP 14-36
 pre-admission screening and resident
 review 14-21
 RBMC 14-36
 readmission to a nursing facility from a
 hospital 14-10
 resident changes from private-pay to IHCP
 member 14-10
 respite short-term 30-day 14-22
 retro-rate adjustments 14-34
 review objective 14-7
 short-term nursing 14-36
 long-term nursing facility placement 14-37

M

MDS field audit..... 14-30
 Medicare Crossover Claims Payment Policy
 Changes 14-16
 member Level of Care appeal process 14-28
 member patient liability 14-32
 minimum data set audit process 14-27

N

Nursing Facility Billing.....14-32
Nursing Facility Room and Board14-17

O

Occupancy Rate.....14-15
online forms14-8

P

personal resource contribution ..14-32
PMP.....14-36
pre-admission screening and resident review
.....14-21
Pre-Admission Screening and Resident
Review Forms.....14-23
primary medical provider14-36

R

RBMC.....14-36
readmission to a nursing facility from a
hospital14-10
resident changes from private-pay to IHCP
member.....14-10
Resident Review Process14-27
Respite Short-Term 30-Day14-22
retaining forms in records14-13
retro-rate adjustments.....14-34
risk-based managed care14-36

S

short-term nursing14-36
Submission of duplicate form 450Bs14-13