



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Long-Term Care

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## Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
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4.0	Policies and procedures as of March 1, 2019 Published: July 25, 2019	Scheduled update: <ul style="list-style-type: none"> <li>• Reorganized and edited text as needed for clarity</li> <li>• Updated links to the new IHCP website</li> <li>• Indicated, in the <a href="#">Introduction</a> section, the applicable IHCP provider type/specialties of LTC facilities</li> <li>• Added about reference to MDS reviews in the <a href="#">Level-of-Care Assessments, Level I Screens, and Level II Evaluations for Long-Term Care</a> section</li> <li>• Removed reference to HCBS waiver participants from the <a href="#">Level-of-Care Assessment Requirements</a> section</li> <li>• Removed the table showing NF risk criteria and frequency in the <a href="#">Minimum Data Set Reviews – Case-Mix/LOC/PASRR Review Procedures</a> section</li> <li>• Added IAC references to the <a href="#">Level-of-Care Review Process</a> section</li> </ul>	FSSA, Myers and Stauffer, and DXC

Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"> <li>• Updated mailing address and added email address in the <a href="#">LOC Referral Process</a> section</li> <li>• Updated the <a href="#">Member LOC Appeals</a> section</li> <li>• Updated the <a href="#">Resident Review Process</a> section</li> <li>• Added the <a href="#">Level I Referral Process</a> section</li> <li>• Updated mailing address, and added email address in the <a href="#">Level II Referral Process</a> section, and removed information about follow-up if recommended services are not being provided</li> <li>• Added a note about required end-of-therapy date reporting in the <a href="#">Application of Recalculated Case-Mix Indices and IHCP Rates</a> section</li> <li>• Added information about the Validation Improvement Plan in the <a href="#">Application of Corrective Remedies</a> section</li> <li>• Added the <a href="#">IHCP Member Eligibility Considerations</a> section</li> <li>• Removed the <i>Short-Term Placement in an Institution for Mental Disease</i> section</li> <li>• Updated the <a href="#">Managed Care Considerations for LTC Facilities</a> section</li> <li>• Added the <a href="#">Preventing and Correcting Inappropriate Eligibility Changes</a> section and subsections</li> <li>• Updated information about Schedule X in the <a href="#">Case-Mix Reimbursement</a> section</li> <li>• Updated the <a href="#">Quality Assessment Fee</a> section with new SPA and IAC information</li> <li>• Updated the type-of-bill code in the <a href="#">ICF/IID Billing Procedures</a> section</li> <li>• Removed stop reason code information from the <a href="#">Autoclosure Process for Inpatient Crossover Claims</a> section</li> </ul>	

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*Note: For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).*

## Introduction

The Indiana Family and Social Services Administration (FSSA) and the Centers for Medicare & Medicaid Services (CMS) design and define the following for the Long-Term Care (LTC) program:

- Level of care (LOC)
- Preadmission Screening and Resident Review (PASRR)
- Case-mix reimbursement methodology

These safeguards are necessary to protect the health and welfare of institutionalized Indiana Health Coverage Programs (IHCP) members, as well as all individuals with mental illness (MI) or intellectual or developmental disability (ID/DD). This review system assists the FSSA in meeting its responsibilities under the law while effectively monitoring, processing, and ensuring appropriate payment of LTC facility claims.

LTC facilities include the following IHCP providers:

- Nursing facilities – Provider type 03, specialties 030 and 032
- Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) – Provider type 03, specialty 031

*Note: The IHCP offers the Program of All-Inclusive Care for the Elderly (PACE) in designated service areas within the state. For more information about PACE, see the [Member Eligibility and Benefit Coverage](#) module.*

## Level-of-Care Assessments, Level I Screens, and Level II Evaluations for Long-Term Care

All applicants to Medicaid-certified nursing facilities (NFs) in Indiana are entered in the State's web-based PASRR system, and a **Level I screen** is completed to initiate the PASRR process. When indicated, a **Level II evaluation** is performed to identify the specialized needs of individuals with MI, ID/DD, or MI/ID/DD. For individuals seeking Medicaid coverage of their NF stay, as well as for certain other populations, an **LOC** assessment is completed to determine whether the individual meets State LOC criteria.

LOC reviews and referrals for Level I screens and Level II evaluations can also take place as part of the minimum data set (MDS) reviews conducted periodically for all residents of Medicaid-certified NFs in Indiana. See the [Minimum Data Set Reviews – Case-Mix/LOC/PASRR Review Procedures](#) section for details.

Providers can request access to the web-based PASRR system via email at [dts-das@fssa.in.gov](mailto:dts-das@fssa.in.gov). Questions or issues regarding PASRR may be sent to [PASRR@fssa.in.gov](mailto:PASRR@fssa.in.gov). For additional information, see the see the Indiana PASRR provider manual and other resources available from the [Indiana PASRR User Tools](#) page at [ascendami.com](http://ascendami.com) and the [Preadmission Screening and Resident Review](#) page at [in.gov/fssa](http://in.gov/fssa).

## Level-of-Care Assessment

LOC assessments are submitted by hospital providers, NF providers, and Area Agencies on Aging (AAAs) via the State's web-based PASRR system. The primary objective of the LOC assessment is to determine whether an individual meets NF LOC criteria set forth in *Indiana Administrative Code 405 IAC 1-3-1* and *405 IAC 1-3-2*. The AAA performs on-site assessments for individuals who do not appear to meet NF criteria for a final determination prior to any denial.

The FSSA determines the appropriateness of the IHCP reimbursement for all placements of IHCP members in Medicaid-certified NFs. For NFs subject to case-mix reimbursement, there are no skilled or 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 a Medicaid-certified NF. The FSSA Division of Aging (DA), the AAAs, and Myers and Stauffer LTC review teams use these criteria.

## Level-of-Care Assessment Requirements

For NF **applicants**, an LOC determination is required for the following:

- IHCP members seeking admission to a Medicaid-certified NF with Medicaid as their pay source
- Level II candidates (indicated by Level I screen), regardless of pay source
- All PACE participants who *do not* have a valid/current LOC on record

For NF **residents**, an LOC assessment is required for the following:

- Residents who become Medicaid-active during their NF stay and will be using Medicaid as the pay source for NF services
- Residents who experience a significant change in medical condition (see the Indiana PASRR provider manual, which can be requested from the [Indiana PASRR User Tools](http://ascendami.com) page at ascendami.com)
- All PACE participants, annually
- Residents admitted with long-term care approval whose medical status has improved but do not wish to leave the facility
- Residents whose short-term approval is coming to an end and the resident has medical needs to support continued stay

## Level-of-Care Outcome

Possible outcomes for an LOC assessment include the following:

- NF applicants and residents:
  - Approved for short-term NF stay (30, 60, 90, or 120 calendar days)
  - Approved for long-term NF stay (more than 120 days)
  - Denied for NF stay

*Note: Denials are referred to the AAA, which will conduct an on-site LOC assessment prior to any denial being issued.*

- PACE participants:
  - Approved for long-term NF stay (more than 120 days)
  - Denied for NF stay (requires further review)

*Note: Denials are referred to the AAA, which will conduct an on-site LOC assessment.*

Providers have access to print outcome letters via the State's web-based PASRR system. Letters must be maintained in the resident's medical record or readily accessible.

The individual (or guardian) has the right to appeal all LOC decisions. All outcome letters include a notice of the individual's appeal rights.

## **Level I Screen**

A Level I screen is required for all individuals seeking admission to a Medicaid-certified NF, regardless of pay source. Level I screens are submitted by hospitals, AAAs, and NFs via the State's web-based PASRR system.

### **Level I Screen Requirements**

A Level I screen is required in the following cases:

- Before admission to a Medicaid-certified NF
- For NF residents who have a significant change in mental status indicating the need for an updated Level I screen, a subsequent Level I screen, or an updated Level II evaluation

*Note Information about significant change is located in the Indiana PASRR provider manual, which can be requested from the [Indiana PASRR User Tools](#) page at [ascendami.com](#). If the change meets the criteria of a significant change per the CMS 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.*

- Before the conclusion of an approved time-limited stay, for individuals with a diagnosis of MI, ID/DD, or MI/ID/DD requiring a Level II evaluation and who are expected to need to stay beyond the approved amount of time

### **Level I Outcomes**

Possible outcomes for a Level I screen include the following:

- No Level II Required
- Level II Negative, No Status Change
- Level II Positive, No Status Change
- Exempted Hospital Discharge
- Emergency Categorical
- Respite Categorical
- Refer for Level II Onsite
- Withdrawn
- Cancelled

Providers have access to print outcome letters via the State's web-based PASRR system. Letters must be maintained in the resident's medical record or readily accessible.

## PASRR Level II Evaluation

The PASRR Level II evaluation process identifies rehabilitative or specialized services that an individual may require. PASRR Level II evaluations are conducted by the following entities:

- The Division of Disability and Rehabilitative Services (DDRS) Level II contractor – For individuals with an ID/DD or MI/ID/DD diagnosis
- The Division of Mental Health and Addiction (DMHA) Level II contractors – For individuals with a diagnosis of MI only

Level II evaluations must be completed prior to admission (when indicated by the Level I screen) and whenever a resident experiences a significant change in condition.

NFs are responsible for planning and delivering (or arranging for) all required rehabilitative services identified through the PASRR Level II process. The NF is required to do the following:

- Determine the most appropriate setting for persons with MI, ID/DD, or MI/ID/DD.
- Address both mental and physical health needs of residents.

For information about Level II contractor billing and reimbursement, see the [Preadmission Screening and Resident Review Billing](#) section.

## Level II Outcomes

Possible outcomes for a Level II evaluation include the following:

- Long-term approval
  - Admit to or remain in an NF without an identified end-date
- Time-limited approval
  - Approved for a specific time frame
  - New Level I, LOC, and Level II required if stay required beyond initial time frame is approved
- Denial
  - NF placement does not appear to be appropriate

Providers should maintain all Level II evaluations and outcome letters in the resident's medical record or have them readily accessible.

The individual (or guardian) has the right to appeal all Level II decisions. All outcome letters include a notice of the individual's appeal rights.

## PASRR Level II Exemptions

Certain circumstances allow individuals who have MI or ID/DD diagnoses to be exempt from PASRR or to be admitted to an NF through an abbreviated Level II evaluation process.

An exemption allows for residents meeting criteria for Level II evaluation to be federally exempt from the full Level II evaluation process prior to NF admission. The following exemptions may be applied in Indiana:

- Exempted hospital discharge (EHD)
- Dementia exemption

Exemptions may be applied only to individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.

### ***Exempted Hospital Discharge (EHD)***

A short-term exemption from the PASRR process is allowed for individuals with known or suspected MI or MI/ID/DD who meet both of the following:

- Are being discharged from a medical hospital to an NF after receiving medical (nonpsychiatric) services
- Require short-term treatment of 30 calendar days or less in an NF for the same condition for which they were hospitalized

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 PASRR-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 ID/DD assessment must be completed *prior to* any NF admission.

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.

### ***Dementia Exemption***

Certain individuals are excluded from PASRR when a dementia condition is present. The dementia exclusion applies to the following:

- Individuals with a sole diagnosis of dementia
- Individuals with a primary diagnosis of dementia and a secondary MI diagnosis

The submitting provider must include sufficient evidence clearly confirming dementia as the primary diagnosis.

## **Level II PASRR Categorical Decisions**

Certain circumstances allow individuals who have MI or ID/DD diagnoses to be exempt from PASRR or to be admitted to an NF through an abbreviated Level II evaluation process. A categorical PASRR decision allows residents meeting criteria for Level II evaluation to be federally exempted from the full Level II evaluation process prior to NF admission.

Two types of categorical Level II decisions may be applied:

- Provisional emergency situations
- Respite stays

As with exemptions, categorical decisions may be applied only for individuals who do not pose a threat to themselves or others and whose behavioral symptoms are stable.

### ***Provisional Emergency Situations***

The provisional emergency categorical decision may be applied when an individual has a Level II condition (MI, ID/DD, or MI/ID/DD) and all of the following apply:

- There is a sudden unexpected and urgent need for placement (such as loss of a caregiver, loss of a residence, or suspicion of abuse/neglect).
- The individual meets Adult Protective Services (APS) or Child Protective Services (CPS) criteria.
- A lower level of care is not available or appropriate.

Provisional emergency situations allow for up to 7 calendar days in an NF. If additional days are required, a new Level I and LOC assessment, and new Level II when applicable, must be obtained prior to the approval end date through the State's web-based PASRR system.

An APS admission is designated as a *maximum stay of 7 days* in accordance with *Code of Federal Regulations 42 CFR 483.130(d)(5)*. An APS report must be made by the entity that completed the Level I screen.

### **Respite Stays**

Respite is available for individuals who reside with an in-home caregiver. The respite care must not exceed 30 calendar days per quarter. There must be 30 calendar days between respite stays of 15 calendar days or more. Both of the following criteria must be met:

- Individual resides in the community with an in-home caregiver.
- Individual is expected to return home from the NF.

*Note: This admission must be authorized through the State's web-based PASRR system.*

## **Screening Requirements for Reimbursement of Nursing Facility Services**

The following sections describe LOC and PASRR screening and evaluation requirements for IHCP reimbursement of NF services provided to members who are newly admitted, who become IHCP-eligible during their stay, or who transfer between facilities.

### **New PASRR 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* (for example, in the case of an appeal or an on-site assessment following an LOC denial) *may* be reimbursable if the resident is found to be eligible for NF services.

A person with MI or ID/DD who does not meet the previously listed requirements for a short-term admission is subject to the preadmission 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.

### **Residents Who Change from Private-Pay to IHCP Coverage**

If a resident becomes eligible for IHCP coverage during his or her stay, the NF is required to complete an LOC assessment via the State's web-based PASRR system after the resident is notified of his or her Medicaid eligibility.

### **Interfacility Transfers**

No additional screening is required for residents transferring to another NF, as long as the individual was not discharged to a lower level of care. This policy applies to individuals who have been approved through PASRR for NF admission and who transfer:

- From one Indiana NF to another Indiana NF
- From an Indiana NF to a hospital and back to the same or another Indiana NF

After the transfer is complete, additional screening is required in the following cases:

- A significant change in condition has occurred.
- The individual has been discharged to a lower level of care (such as community placement) and needs to return to the same or different NF.
- The approved length of stay is nearing expiration.

The two NFs must enter the discharge date and new admission date in the State's web-based PASRR system.

## Minimum Data Set Reviews – Case-Mix/LOC/PASRR Review Procedures

The FSSA contracts with Myers and Stauffer to complete periodic minimum data set (MDS) reviews for all residents of Medicaid-certified NFs in Indiana, regardless of payer source. Every Medicaid-certified NF in Indiana is reviewed a minimum of once every 3 years. (Year is defined as the State fiscal year – July 1 through June 30.)

The purpose of the review is to ensure that the IHCP is reimbursing for the appropriate Resource Utilization Group (RUG) classification as demonstrated by the MDS version 3.0 and supporting documentation.

The Myers and Stauffer Long Term Care review team (LTC review team) also performs reviews of LOC and PASRR documentation for NF residents. The objectives of the LTC team reviews 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*. (Request referral through the State's web-based PASRR system for residents who do not appear to meet NF LOC.)
- Ensure that Level I screens are completed and reflect the resident's current mental and physical condition.
- Ensure that Level II evaluations are completed as needed.
- Ensure all services recommended by the Level II evaluations are provided.
- Determine whether the IHCP is reimbursing the provider for the appropriate RUG-IV classification, reflective of resident needs.
- Verify that the MDS responses that impact the RUG score are accurate and supported with the appropriate documentation within the assessment reference period.

**NFs will be notified up to 72 hours prior to the scheduled MDS review.** The LTC review team conducts an entrance and exit conference to apprise the facility staff of the nature, purpose, and sequence of events of the review, as well as the review results. The review team is available to address facility questions and concerns. The review team consists of registered nurses.

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

Myers and Stauffer reviews MDS supportive documentation using review parameters established in the case-mix rules. At a minimum, Myers and Stauffer reviews a sample of the facility's MDS assessments. Myers and Stauffer determines whether any records in the sample are unsupported. If the percent of unsupported MDS records in the sample exceeds the 20% threshold set forth in *405 IAC 1-14.6-4(j)(2)*, Myers and Stauffer expands the scope of the review to include the greater of an additional 20% or 10 assessments.

## ***Level-of-Care Review Process***

The LOC review during the MDS process is used to determine whether residents continue to have needs requiring NF placement in accordance with State LOC criteria *405 IAC 1-3-1* and *405 IAC 1-3-2*.

### **LOC Referral Process**

When the LTC review team identifies a resident who does not appear to meet LOC criteria, the team will present the provider with a Level of Care referral form at the time of the exit conference. The provider should then complete the LOC assessment using the State's web-based PASRR system. After the LOC assessment has been completed and the NF provider has received the outcome letters, the LOC referral form should be completed. A copy of the completed LOC referral form should be mailed within 30 calendar days of the exit conference via U.S. Postal Service (recommended certified mail) to the following address:

**Vanessa Convard, PASRR Manager**  
**Division of Aging**  
**402 W. Washington St., Room W454**  
**Indianapolis, IN 46204**

An alternative option is for providers to send the form via **secure email** to [vanessa.convard@fssa.in.gov](mailto:vanessa.convard@fssa.in.gov).

### **Member LOC Appeals**

The individual or guardian has the right to appeal all LOC decisions. All outcome letters include a notice of the individual's appeal rights.

- If the agency review decision favors the appellant, or member, the administrative law judge will give further direction on next steps that must be taken by the State to ensure an appropriate assessment is completed.
- If the decision is favorable to the FSSA, the member LOC segment is not changed, and the *date of the original decision* of the LTC review team stands regarding reimbursement.

## ***Resident Review Process***

A resident review is a review of a previous Level I or Level II determination. Determining the need for a resident review assessment is based on the following:

- A finding of the prior Level II evaluation that a yearly review is required
- A finding that a Level II evaluation was required but was never completed, such as a missed referral
- A significant change in the individual's MI, ID/DD, or MI/ID/DD condition
- A determination made by the LTC review team that a Level II evaluation is required
- The person is in the NF with a time-limited approval and will need to remain in the NF longer than the approval period allows

### **Level I Referral Process**

When the LTC review team identifies a resident in need of Level I referral, the team will present the provider with a Level I referral form at the time of the exit conference. The NF provider should then contact the appropriate agency to conduct a comprehensive Level I screen:

- Residents identified as not having a Level I screen upon admission
- Residents identified as not having an updated Level I accurately reflecting the resident's current mental and/or physical condition at the time of the review

The date of Level I contractor notification should be recorded on the referral form in the “Date of Referral” column. After the Level I screen has been completed by the NF provider, the “Date Level I Received” column should be completed. The completed Level I referral form must be submitted within 30 calendar days of the exit conference, via U.S. Postal Service (recommended certified mail) to:

**Vanessa Convard, PASRR Manager**  
**Division of Aging**  
**402 W. Washington St., Room W454**  
**Indianapolis, IN 46204**

An alternative option is for providers to send the form via **secure email** to [vanessa.convard@fssa.in.gov](mailto:vanessa.convard@fssa.in.gov).

## Level II Referral Process

When the LTC review team identifies a resident in need of Level II MI or ID/DD referral, the team will present the provider with a Level II referral form at the time of the exit conference. The NF provider should then contact the appropriate agency to conduct a comprehensive Level II evaluation of the resident’s mental and physical needs:

- Residents identified as possibly having an MI diagnosis should be referred to the DMHA Level II contractor.
- Residents identified with a possible ID/DD or dual diagnoses as MI and ID/DD should be referred to the DDRS Level II contractor.

The date of Level II contractor notification should be recorded on the referral form in the “Date of Referral” column. After the Level II evaluation has been completed and certification received by the NF provider, the “Date Level II Received” column should be completed. The completed Level II referral form must be submitted within 30 calendar days of the exit conference, via U.S. Postal Service (recommended certified mail) to:

**Vanessa Convard, PASRR Manager**  
**Division of Aging**  
**402 W. Washington St., Room W454**  
**Indianapolis, IN 46204**

An alternative option is for providers to send the form via secure email to [vanessa.convard@fssa.in.gov](mailto:vanessa.convard@fssa.in.gov).

At the time of the on-site review, the NF must present the LTC review team with a list of all residents, regardless of payment source, who were verified by the Level II evaluation as having an MI, ID/DD, or MI/ID/DD diagnosis. The following resolutions can occur:

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

*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.*

## ***MDS Review Findings and Rate Calculation Appeal Process***

At the end of the MDS field review, Myers and Stauffer LTC reviewers conduct an exit conference with appropriate NF staff and review the preliminary results of the review and other comments and recommendations about the NF's clinical documentation systems.

Following the exit conference, Myers and Stauffer issues preliminary MDS review findings, including recommending LOC reassessment on residents that may not meet NF level of care. Myers and Stauffer documents these findings in writing and provides them to the NF. The NF then has an opportunity to review the written preliminary review findings. If the NF disagrees with the findings, the NF can submit an informal, written reconsideration request to Myers and Stauffer within 15 business days. The informal, written reconsideration request must include specific review issues the NF believes were misinterpreted or misapplied during the review. MDS supporting documentation provided after the review exit conference will not be considered in the reconsideration process per *405 IAC 1-15-5(c)*. Myers and Stauffer then reviews the NF request and, within 10 business days, communicates the final MDS review findings to the NF in writing, along with a response to the issues raised.

After the informal reconsideration process, Myers and Stauffer communicates the final MDS review findings to the following:

- Nursing facility
- FSSA Office of Medicaid Policy and Planning (OMPP)
- Rate-setting contractor to use in the case mix rate-setting process

The MDS review concludes after Myers and Stauffer communicates the final MDS review findings to the NF.

### **Application of Recalculated Case-Mix Indices and IHCP Rates**

The rate-setting contractor incorporates the final MDS review findings into the calculation of the facility's case mix index (CMI) used for IHCP rate-setting purposes on a quarterly basis. (See the [Case-Mix Reimbursement](#) section for more information about the case-mix reimbursement method.) There is at least a one calendar quarter lag time between the MDS assessment reference date (ARD) and the impacted IHCP rate-effective date. Depending on the relationship between the assessment key dates and review completion date, application of the MDS review findings for some MDS records could result in retroactive rate adjustments.

The MDS ARD generally determines the calendar quarters 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 FSSA publishes the time-weighted user guide and updates the guide as needed.

A reviewed MDS record is considered supported unless the reviewed MDS values result in a different RUG-IV classification group for that MDS assessment record, according to *405 IAC 1-14.6-2(nn)*.

When a case-mix rate is established that includes the MDS review findings, in addition to questioning rate-setting issues, the NF can request a formal rate reconsideration, including raising MDS review issues with which they disagree, pursuant to *405 IAC 1-14.6-22(c)*. The formal reconsideration request for rate setting and MDS review issues should be sent to the rate-setting contractor within 45 days after release of the IHCP rate by the rate-setting contractor.

The rate-setting contractor coordinates the MDS review issue with the LTC review team and issues a written response to all rate-setting issues raised along with the LTC review team response to all MDS review 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 review or rate-setting issues, the rate-setting contractor reissues the IHCP rate following the completion of the reconsideration process. If the NF disagrees with any determination resulting from the formal reconsideration process, the facility can appeal the determination pursuant to *Indiana Code IC 4-21.5-3-7* and *405 IAC 1-1.5*.

*Note: Effective **July 1, 2019**, the IHCP requires nursing facility providers to submit end-of-therapy dates through the MDS web portal for use in the Time-Weighted CMI Resident Roster Reports. This reporting requirement will be enforced for establishing Medicaid rates effective **July 1, 2020**.*

*The MDS web portal, on the [Myers and Stauffer website](http://mslc.com/Indiana) at [mslc.com/Indiana](http://mslc.com/Indiana), accepts end dates for therapy segments if end dates are not reported on the MDS assessments. Important information, including data cutoffs and report posting dates for the new end-of-therapy time-weighted report process, can be found under End of Therapy Roster Resources on the [Case-Mix and Related Services > Review Resources](#) page at [mslc.com/Indiana](http://mslc.com/Indiana).*

## Application of Corrective Remedies

As provided in the FSSA case-mix rules, after the review, the percent of reviewed MDS records that are determined to be unsupported is computed.

Pursuant to 405 IAC 1-14.6-4(j), for facility MDS reviews, a corrective remedy applies if the number of unsupported MDS records exceeds 20%. When an NF achieves an unsupported Error Threshold percentage of more than 20% (such as 20.45%), this number is not rounded up or down, but instead is reported as exceeding the Error Threshold due to being more than 20%. NFs that score greater than 20% unsupported, as outlined in the *Indiana Administrative Code (IAC)*, receive at a minimum a 15% Administrative Component Corrective Remedy penalty applied for one quarter.

The NF is required to develop and complete a Validation Improvement Plan (VIP). This improvement plan must include the following:

- Areas identified as lacking sufficient documentation
- Facility plan for documentation improvements specific to those items identified
- Implementation date for each improvement plan

The administrator or designee must sign and date the VIP. The VIP must be mailed via United States Postal Service (USPS) and received by Myers and Stauffer LC, at the following address within 30 calendar days:

**Cynthia Smith, RN, RAC-CT**  
**Myers and Stauffer LC**  
**9265 Counselors Row, Suite 100**  
**Indianapolis, IN 46240**

All unsupported MDS records are reclassified, and the NF is subject to a case-mix review within 4–12 months. Additional consecutive unsupported MDS reviews will result in increased Corrective Remedy penalties as delineated in Table 2.

Pursuant to 405 IAC 1-14.6-4(j), the corrective remedy is applied when the scope of the MDS review is expanded to include the greater of an additional 20% or 10 assessments and the number of unsupported MDS records exceeds 20%.

The corrective remedy is applied as a percent of the administrative component of the IHCP case-mix rate using the percentage in Table 2. The corrective remedy takes effect beginning in the calendar quarter *following* the completion of the MDS review and remains in effect for one quarter.

Table 2 – Corrective Remedy Percentage

MDS Field Review for Which Corrective Remedy Is Applied	Administrative Component Corrective Remedy Percent
First MDS field review	15%
Second consecutive MDS field review	20%
Third consecutive MDS field review	30%
Fourth or more consecutive MDS field review	50%

*Example:* An MDS review begins November 3, 2018, is finalized on December 29, 2018, and the findings indicate that more than 20% of the reviewed MDS records are unsupported; a corrective remedy is applied beginning January 1, 2019. The corrective remedy remains in effect for one calendar quarter. The facility may not recover any reimbursement lost due to the corrective remedy.

## IHCP Member Eligibility Considerations

LTC facility providers are responsible for verification of the IHCP member’s active eligibility and coverage status at the onset of service delivery as well as on an ongoing basis. At a minimum, facility providers should verify this information monthly. Because most changes to eligibility or coverage status occur at the beginning of calendar months, it is recommended that eligibility verifications be timed accordingly. Providers can use any of the IHCP Eligibility Verification System (EVS) options – the IHCP Provider Healthcare Portal (Portal), the Interactive Voice Response (IVR) system, or 270/271 electronic transactions – to determine active eligibility and coverage status.

Verifying eligibility enables a provider to determine whether the member is enrolled as fee-for-service or through a managed care program. Additionally, the system indicates the member’s LOC assignment and any patient liability monthly amount (see the [Patient Liability](#) section). See the [Member Eligibility and Benefit Coverage](#) module for information about verifying eligibility.

### ***Managed Care Considerations for LTC***

Long-term care services are not included in the scope of benefits provided to members in the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise managed care programs. However, MCEs may provide coverage for services in a nursing facility on a **short-term basis** if this setting is more cost-effective than other options and if the member can obtain the care and services needed.

If longer-term care is needed, the services are covered under the IHCP fee-for-service (FFS) Traditional Medicaid program, if applicable income and asset requirements are met. Managed care members must be **disenrolled** from their health plans before the LOC status can be entered in *CoreMMIS*. Upon disenrollment from managed care, members’ IHCP coverage continues under the Traditional Medicaid program.

Effective January 1, 2019, Hoosier Care Connect members receiving hospice benefits while residing in an NF will remain enrolled with their MCE for the duration of their hospice period, even if their NF stay exceeds the limit for a short-term stay.

*Note: Reimbursement of LTC facility services is not available for Hoosier Healthwise Package C members.*

NFs and AAAs must notify the managed care entity (MCE) when a managed care member is admitted to an NF or undergoes the PASRR. The MCE is financially responsible for all care provided to its members until enrollment termination is effective. IHCP FFS is financially responsible for LTC reimbursement after the member is approved for NF LOC per *405 IAC 1-3-1* and *405 IAC 1-3-2*, and the member is disenrolled from the MCE. The MCE is financially responsible for short-term placement fees made to the nursing facility at the IHCP FFS rate or at a rate negotiated with the facility. For HIP, member reimbursement is at Medicare rates, or 130% of Medicaid rates if the service does not have a Medicare reimbursement rate.

Although LTC services are not covered in the managed care delivery system, an MCE can place its enrollees in an NF 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 one of the long-term care LOC categories is approved and entered into the Core Medicaid Management Information System (*CoreMMIS*).

The responsibility for verifying patient healthcare coverage lies with the NF that has direct access to the patient and the patient's IHCP Member ID (Medicaid number also known as RID). If the NF determines, upon checking eligibility on the date of admission, that the patient is enrolled in a managed care program, the NF must notify the MCE within 72 hours after admission:

- If the NF notifies the MCE within 72 hours of admission, the MCE is liable for charges for a set number of days **from the date of admission**, dependent upon the managed care program in which the member is enrolled:
  - Up to 30 days from the date of admission for Hoosier Care Connect
  - Up to 60 days from the date of admission for Hoosier Healthwise
  - Up to 100 days from the date of admission for HIP
- If the NF fails to verify a patient's coverage in managed care, or fails to contact the MCE within 72 hours of admission, the NF may be at risk for charges incurred until the NF has notified the MCE of the patient's status. In the case of notification after the 72 hour deadline, the MCE will be liable for charges for a set number of days **from the date of notification**, as follows:
  - Up to 30 days from the date of admission for Hoosier Care Connect
  - Up to 60 days from the date of notification for Hoosier Healthwise
  - Up to 100 days from the date of admission for HIP
  - The MCE must have a process that documents NF notification to the MCE.

If the member is still in the NF after the allotted time (per managed care program), and the member is still enrolled in a managed care program, the NF becomes liable for any costs associated with the patient until the LOC has been implemented.

The length of coverage required for the MCE 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 extended period in these cases is to allow sufficient time for the notification, preadmission screening, LOC determination, and disenrollment from managed care to take place and to ensure appropriate reimbursement to the facility for services rendered.

During the period in which the member is assigned to the MCE, NFs must coordinate with the MCE to allow members to use appropriate in-network services. Information about the specific MCE network in which a member is enrolled is available through the EVS.

*Note: Member enrollment in managed care is effective on the 1st and 15th calendar days of the month. LTC facility providers should use any of the EVS options (Portal, IVR system, or 270/271 electronic transaction) upon admission and screening of a new patient, and must recheck again on the 1st and 15th of every month for existing patients, to confirm IHCP eligibility and to verify in which IHCP program the patient is enrolled, for the purposes of care coordination and reimbursement. If a resident's coverage changes to managed care during his or her stay, the facility must notify the MCE immediately of the member's status in the facility.*

## Nursing Facility Requirements for HIP Members

NF providers must report any admission or discharge of an IHCP member enrolled in HIP to both the Division of Aging (DA) and the Division of Family Resources (DFR) within 10 days of the event:

- Providers should report the event to the DA through the PASRR nursing facility census tracking tool.
- Reports should be made to the DFR via the online [Benefits Portal](#), by fax or mail, or by calling 1-800-403-0864.

Reporting that a HIP member has been admitted to the NF does not automatically change the member's coverage category and benefit plan. A HIP member can be admitted to an NF and remain enrolled in the HIP program; however, coverage of skilled nursing care for most HIP members is limited to 100 days. Stays beyond this limit will require the member's enrollment to be transitioned from HIP to a fee-for-service benefit plan to continue Medicaid coverage.

To transition, HIP members must qualify under the income and resource limits associated with FFS benefits. The NF must take specific steps within the first 60 days of admission to facilitate the member's transition:

- All NF stays for HIP members require PA. If a member's stay is expected to extend beyond the original PA time frame, the provider should request an extension of the PA from the enrolling MCE before the original PA expires to allow time for assessment and possible transition to FFS coverage.
- The NF must complete the PASRR process and report the member's LOC to the DA using the PASRR nursing facility census tracking tool. If appropriate, the NF must notify the enrolling MCE of the intent to extend a member's stay and the need to transition the member to FFS coverage.
- The NF must notify DFR of the need to move the member to FFS coverage.

When completing this process, NFs are reminded that coverage category changes are **prospective**; therefore, changes are effective on the 1st of the month following the date the request is made. NFs must work with the MCE on the submission of PA requests and claims for the dates of service during the transition period. If the facility has met the required notice and assessment obligations but a request for PA or a claim is denied by the MCE, the provider must exhaust all grievances and appeals processes with the MCE to resolve the issue.

If the NF cannot resolve the issue with the MCE, the facility may contact the DFR to request a retroactive transition date for the member's disenrollment from managed care and enrollment in FFS. Requests must include the following:

- Documentation that clearly shows the claim or PA request was denied by the MCE
- Verification that all grievances with the MCE have been exhausted
- An explanation of the situation

All requests are reviewed on a case-by-case basis; approval of a retroactive transition date is not guaranteed.

## ***Preventing and Correcting Inappropriate Eligibility Changes***

If a provider discovers that a member's IHCP eligibility or coverage status has changed inappropriately, the provider must immediately contact the DFR. There may be instances where the provider first becomes aware of a member's eligibility or coverage change when claims for the member begin to deny. Although the DFR cannot correct or address *reimbursement* issues, if the reimbursement issue is eligibility-related, the latter must be resolved first.

Providers should be aware that if a member's eligibility and coverage status changes to a managed care category, in some instances the eligibility/coverage resolution **cannot be made retroactive**, which means LTC services rendered during the affected time period cannot be reimbursed by the IHCP.

## **Reasons for Eligibility and Coverage Changes**

There are a number of situations that might cause a member's eligibility or coverage to change. Common situations such as those outlined in the following sections require attention or action by the facility provider as noted.

### ***Changes at Age 19***

Members served in a State-certified facility (ICF or group home) should apply for adult disability benefits with the Social Security Administration (SSA) before the member's 18th birthday. If a member residing in such a facility turns 19 years of age, and there is no SSA disability determination on file, the member's eligibility will automatically be reconsidered and the member likely will be systematically reassigned to HIP, which serves qualifying *nondisabled* adults.

HIP does not cover institutional services such as those provided in an ICF setting. After a member is enrolled in HIP, changes to restore their FFS Traditional Medicaid coverage cannot be made retroactive. ICF providers should anticipate the aging of members to ensure proactive steps are taken to maintain the members' eligibility for ICF services. If a provider discovers that a member's IHCP eligibility or coverage status has been changed to HIP, the provider must immediately contact the DFR and request that the member's eligibility be reconsidered for the "Disabled" aid category.

### ***Changes Due to Social Security Status***

If there is a change in the member's status with the SSA, this change may also affect a member's IHCP eligibility and coverage status. Notices of such changes and requests for information or follow-up action from the SSA must be addressed in a timely manner by a member's authorized representative (AR) to prevent changes to or termination of IHCP coverage. See the [Authorized Representative Considerations](#) section for additional information regarding ARs.

### ***Changes Due to Issues Originating at the DFR***

Similar to changes with the SSA, any notifications or requests of action by the DFR must be addressed in a timely manner. Notification that a member's eligibility or coverage is changing or ending, or that additional information is needed by the DFR to prevent termination of benefits, signals the need for a timely response from the member's designated AR.

## **Authorized Representative Considerations**

If the provider is the designated AR for the member, the provider has additional responsibility to ensure that the member's eligibility and coverage status remain current and accurate. The provider must have familiarity with the member to the extent the provider can correctly and accurately respond to specific, detailed questions and requests for information.

Providers that serve as ARs should be aware of the following:

- A person can have more than one AR.
- For individuals 18 years of age and older, no information can be released to a third party (including parents, case managers, providers, and so on) unless an AR form for that party is on file with the DFR.
- ARs must have working knowledge of the member's information including income, resources, residency, and so on.
- It is necessary to keep the DFR updated of AR changes, such as address and telephone number changes. Failure to do so could result in DFR notices not being sent to the AR and consequently in loss of IHCP coverage. AR forms are available on the [DFR Forms](#) page at [in.gov/fssa/dfr](http://in.gov/fssa/dfr).

A provider designated as the AR must follow up immediately and directly with the DFR on any notifications, requests for information, or updates related to an individual.

### Follow Up with the DFR

If a provider identifies an eligibility or coverage change for a member, or believes the incorrect eligibility or coverage has been assigned for a member, the provider should immediately contact the DFR at 1-800-403-0864 to request a review of the issue. If the submitting provider is not on file as an AR, the DFR will review the case, but the DFR cannot release any findings back to the provider directly. Additional contact information can be found on the [DFR website](#) at [in.gov/fssa/dfr](http://in.gov/fssa/dfr). Please note that the DFR is unable to resolve claim-related issues or answer questions about specific claim submission requirements. The entity responsible for the member's care can assist with these inquiries.

## Long-Term Care Reimbursement Methodologies

There are two reimbursement methodologies for LTC facilities based on the type of facility rendering the service: NFs (IHCP provider specialties 030 and 032) and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) (IHCP provider specialty 031).

The following sections outline the reimbursement methodologies for NFs and ICFs/IID. For reimbursement and billing information for long-term acute care (LTAC) facilities, see the [Inpatient Hospital Services](#) module.

### ***Nursing Facility Reimbursement***

Effective for dates of service from January 1, 2014, through June 30, 2019, the IHCP implemented a 3% reduction in reimbursement paid to NFs. This reduction applies to NF providers reimbursed under *405 IAC 1-14.6*. The reduction is to the Medicaid *per diem* rate before the reduction of any patient liability or third-party liability (TPL) on the claim. This reduction applies to all IHCP NF claims, including Medicare crossover claims.

### **Case-Mix Reimbursement**

The IHCP uses a case-mix methodology system to reimburse NFs. This system is based on the principle that payment for NF services should take into account a resident's clinical condition and the resources needed to provide appropriate care for that condition. Therefore, the case-mix system of reimbursement is based on one IHCP rate, adjusted each quarter for changes in a patient's acuity level, for all IHCP residents in a Medicaid-certified or dually licensed Indiana NF.

The case-mix system of reimbursement allocates greater IHCP payment to direct patient care, while continually responding to cost changes that occur with respect to the resources used in providing that care.

Under the case-mix reimbursement system, the IHCP rate is the sum of the following separate rate components:

- *Direct care* – Direct care includes the following:
  - All allowable nursing and nursing aide services
  - Medical supplies
  - Medical director services
  - Medical record costs
  - Nurse aide training
  - Nurse consulting services directly related to the provision of hands-on resident care
  - Oxygen
  - Pharmacy consultants
  - Rental costs for low-air-loss mattresses, pressure-support surfaces, and oxygen concentrators – subject to an overall \$1.50 per resident day limit
  - Support and license fees for software used exclusively in hands-on resident care support, such as MDS assessment software and medical records software
  - Replacement dentures for Medicaid residents provided by the facility that exceed State Medicaid plan limitations for dentures
  - Legend and nonlegend sterile water used for any purpose
  - Educational seminars for direct care staff
- *Indirect care* – Indirect care includes the following:
  - Activity services and supplies
  - Allowable dietary services and supplies
  - Patient housekeeping services and supplies
  - Patient laundry services and supplies
  - Plant operations services and supplies
  - Raw food
  - Social services
  - Utilities
  - Repairs and maintenance
  - Recreational services and supplies
  - Cable or satellite television throughout the NF, including residents' rooms
  - Pets, pet supplies and maintenance, and veterinary expenses
  - Educational seminars for indirect care staff
  - Nonambulance travel and transportation of residents
  - Nursing consulting services – whether provided by internal facility personnel, central office personnel, or contracted – that are not directly related to the provision of hands-on resident care (Such nursing consulting services include but are not limited to: health survey, quality assurance processes, and MDS consultation – excluding data input and coding.)
  - Behavioral and psychological consulting services
- *Administrative* – Administrative includes the following:
  - Allowable advertising
  - Allowable administrator and co-administrator services
  - Allowable home office services and supplies that are patient-related and appropriately allocated to the NF
  - Legal and accounting fees
  - Liability insurance
  - License dues and subscriptions
  - Management

- Office and clerical staff
- Office supplies used for any purpose, including repairs and maintenance, and service agreements for copiers and other office equipment
- Other consultant fees
- Owners' compensation (including director's fees) for patient-related services
- State gross receipts taxes
- Telephone
- Travel
- Utilization review costs
- Working capital interest
- Qualified intellectual disabilities professional (QIDP)
- Educational seminars for administrative staff
- Support and troubleshooting, maintenance, and license fee for all general and administrative computer software and hardware, such as accounting or other data processing activities
- Court-appointed guardian, financial institution, or third-party trust costs not covered by resident personal funds
- Pre-employment related costs such as background checks, drug testing, and employment-contingent physicals

*Note: The administrative component reimbursement is adjusted to 100% of the average allowable median patient day cost.*

- **Capital** – Allowable capital-related items include the following:
  - Fair rental value allowance
  - Property insurance
  - Property taxes
  - Noncapitalized costs associated with minor equipment purchases that are not directly attributed to a specific department
- **Therapy** – Direct cost for allowable therapy services.
- **Nursing Facility Quality Add-On** – Based on the NF's report card score using the latest published data as of the end of each state fiscal year and other quality measures defined by 405 IAC 1-14.6-7(m):
  - Facilities that are a new operation and do not have the required information to calculate their facility specific add-on will receive the statewide average.
  - The maximum amount of the Nursing Facility Quality Add-On is \$14.30 per patient day.
  - NFs need to submit the *Schedule of Staff Retention (Schedule X) – Part 1* and *Schedule for Advance Care Planning Training (Schedule X) – Part 2* on a calendar-year basis. *Schedule X – Part 1* is required to be submitted by March 31 of the year following the calendar year report period. All nursing facility employees should be included on *Schedule X – Part 1* regardless of which personnel line the costs are reported. *Schedule X – Part 2* is required to be submitted for employees completing the advance care planning training through the Relias system by June 30 and is due by July 31 of the same year (beginning in 2019). A minimum of one employee must have completed, on or before June 30, a level one advance care planning training program. These reports are submitted to Myers and Stauffer for use in determining the Total Quality Score. The *Schedule X – Part 1* and *Schedule X – Part 2* forms and instructions are available on the [Long-Term Care](#) page of the Myers and Stauffer website at [mslc.com/Indiana](http://mslc.com/Indiana) (under **Nursing Facility > Forms**).

- *Special Care Unit Add-On* – NFs with special care units (SCUs) that provide specialized care to residents with Alzheimer’s disease or dementia, as defined by *405 IAC 1-14.6-2(hh)*, are eligible for increased reimbursement in the form of an SCU add-on. The SCU add-on is calculated using the facility’s *Nursing Facility Schedule of Special Care Unit Qualifications* form (Schedule Z) and MDS 3.0 information. This schedule should be completed on a calendar-year basis and is due to Myers and Stauffer by March 31 of the year following the report period. The Schedule Z form and instructions are available on the [Long-Term Care](#) page of the Myers and Stauffer website at [mslc.com/Indiana](http://mslc.com/Indiana) (under **Nursing Facility > Forms**).
- *Ventilator Unit Add-On* – NFs that provide inpatient services to more than eight ventilator-dependent residents, as determined by MDS data, may receive additional reimbursement at a rate of \$11.50 per Medicaid resident day.
- *Quality Assessment Fee Add-On* – This add-on is determined by dividing the product of the assessment rate times total non-Medicare patient days by total patient days from the most recently completed desk-reviewed annual financial report.

The FSSA retains a contractor that establishes the applicable rate.

## Quality Assessment Fee

NFs are required to pay a quality assessment fee (QAF) in the following amounts per non-Medicare (for example, private pay or Medicaid) patient day, pursuant to *SPA 17-018* for NFs specified at *405 IAC 1-14.6*:

- \$16.37 per non-Medicare patient day if the NF’s total census is **fewer than** 62,000 patient days per year and the NF is privately owned or operated, or is a nonstate-government owned or operated facility that became nonstate-government owned or operated on or after July 1, 2003.
- \$4.09 per non-Medicare patient day if the NF’s total census is **at least** 62,000 patient days per year and the NF is privately owned or operated or nonstate-government owned or operated, or if the NF is a nonstate government owned or operated facility that became nonstate government owned or operated before July 1, 2003.
- The following facilities are exempt from the QAF:
  - Hospital-based NFs licensed under *IC 16-21*
  - Continuing care retirement communities (CCRC) that meet the statutory requirements at *Section 486 of HEA 1001(ss)-2009*
  - The Indiana Veterans’ Home

A portion of the QAF is used to increase NF Medicaid reimbursement for initiatives that promote and enhance improvements in quality of care to NF residents.

## Leave Days in an NF

The IHCP does not cover “bed-hold” days in a NF as a member benefit unless the member is under hospice care. As described in the [Leave Days for NF Billing](#) section, providers must make members aware of their bed-hold policies and cannot charge members for services that the members do not request.

## ***Intermediate Care Facilities for Individuals with Intellectual Disability Reimbursement***

ICFs/IID are divided into two distinct categories:

- Large private ICF/IID – More than eight beds
- Small ICF/IID – Four to eight beds and are commonly referred to as community residential facilities for the developmentally disabled (CRF/DD), or group homes
  - Basic developmental
  - Child rearing
  - Child-rearing residences with specialized programs
  - Developmental training
  - Intensive training
  - Sheltered living
  - Small behavioral management residences for children
  - Small extensive medical needs residences for adults
  - Extensive support needs residences for adults

### **Proprietary Large Private and Small ICFs/IID**

The all-inclusive *per diem* rate for these facilities includes the following services:

- Durable medical equipment (DME) – All DME, except customized items and associated repair costs, **including but not limited to the following:**
  - Bed rails
  - Canes
  - Crutches
  - Ice bags
  - Traction equipment
  - Walkers
  - Wheelchairs, standard
- Customized equipment includes any piece of equipment designed for a particular member that cannot be used by other members. The equipment contains parts that are specially made and not readily available from a DME provider.
- Medical and nonmedical supplies – All medical and nonmedical supplies and equipment including those items generally required to ensure adequate medical care and personal hygiene of residents
  - The facility, pharmacy, or other provider may not bill these items to the IHCP separately.
- Mental health services – Including behavior management services and consulting, psychiatric services, and psychological services
- Nursing care – Nursing services and supervision of health services
- Room and board – Room accommodations, all dietary services (including routine and special dietary services and school lunches), and personal laundry services
- Therapy services – Physical and occupational therapy, speech pathology, and audiology services provided by a licensed, registered, or certified therapist, as applicable, employed by the facility or under contract with the facility are included in the all-inclusive rate
  - Therapy services provided away from the facility must meet the criteria outlined in *405 IAC 5-22*. All therapies must be specific and effective treatment for the improvement of function. Reimbursement is not available for services for remediation of learning disabilities.

- Transportation – Reasonable cost of necessary transportation for the member, which is included in the *per diem* rate, including transportation to vocational/habilitation services, except for transportation that is provided to accommodate the delivery of emergency services
  - Emergency transportation services must be billed to Medicaid directly by the transportation provider.
- Habilitation – Habilitation services provided in an FSSA-approved setting that are required by the resident’s program plan of active treatment developed in accordance with *42 CFR 483.440*, including, but not limited to, the following:
  - Training in activities of daily living
  - Training in the development of self-help and social skills
  - Development of program and evaluation plans
  - Development and execution of activity schedules
  - Vocational/habilitation services

*Note: The all-inclusive per diem rate for small ICFs/IID also includes day habilitation services.*

## Leave Days in an ICF/IID

Reimbursement is available for reserving beds for members in a private ICF/IID, provided that the criteria set out in *405 IAC 5-13-6* are met.

The two types of reimbursed leave days for ICF/IIDs are as follows:

- Hospitalization – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/IID. If the member is discharged from the ICF/IID following a hospitalization in excess of 15 consecutive days, the ICF/IID is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/IID does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/IID level-of-care services. The facility must maintain a physician’s order for hospitalization in the member’s file at the facility.
- Therapeutic leave of absence – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member’s habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician’s order for the therapeutic leave in the member’s file at the facility.

Providers must use the appropriate room and board revenue code for the days the member was a patient in the ICF/IID and the applicable leave of absence revenue code for the days the member was out of the ICF/IID, as described in the [Leave Days for ICF/IID Billing](#) section.

## Tax Assessment

Large and small private ICFs/IID are assessed a 6% tax on the total annual revenue of the facility for the facility’s preceding fiscal year. The assessment on provider total annual revenue is an allowable cost for cost reporting and audit purposes. Total annual revenue is determined from the provider’s previous annual financial reporting period.

## Billing Instructions for Long-Term Care Services

Instructions for billing LTC facility services are separated into two subsections, based on the type of facility rendering the service: NFs and ICFs/IID.

Both NFs and ICFs/IID bill using the institutional claim (*UB-04* claim form, 837I electronic transaction, or Portal institutional claim). Providers should mail LTC paper claims to the following address for processing:

**DXC – Institutional Claims  
P.O. Box 7271  
Indianapolis, IN 46207-7271**

See the [Claim Submission and Processing](#) module for general billing information.

### ***Nursing Facility Billing***

LTC services are available to IHCP members who meet the threshold of nursing care needs required for admission to, or continued stay in, a Medicaid-certified NF.

### **NF Billing Procedures**

NFs must follow the general instructions for completing the institutional claim, as well as the specific instructions that follow:

- NFs bill for room-and-board charges using the applicable room-and-board revenue code. Acceptable room-and-board revenue codes include 110, 120, and 130. Revenue codes 180, 183, and 185 for leave-of-absence days are not reimbursable to the NF.
- The FSSA uses a case-mix reimbursement methodology based on the RUG-IV Classification of that member. The facility must maintain documentation in the medical record that substantiates the physical or behavior needs of the member as identified on the MDS. The RUG-IV Classification is based on the MDS.
- NFs cannot bill separately for medical and nonmedical supply items, personal care items, or therapies. Providers can bill parenteral or enteral services and therapies received by dually eligible (Medicare and Traditional Medicaid) members to Medicare and, subsequently, the IHCP as crossover claims on the appropriate claim type for these services.
- Inpatient care crossover services must be billed on the institutional claim (*UB-04* claim form or electronic equivalent). Any inappropriate billing and reimbursement is subject to recoupment by FSSA Program Integrity.
- Providers can bill short-term stays of less than 30 days upon discharge of the patient. Providers can bill long-term stays of 30 days or more monthly, or more frequently if desired.

### **Leave Days for NF Billing**

The IHCP does not reimburse for bed-hold days in an NF as a member benefit unless the member is under the care of hospice. All IHCP members residing in an NF are directed to talk with their individual provider regarding any type of “bed-hold” or leave-day policy that may exist in that facility. Providers must make members aware of their policies and that a member cannot be charged for services the member does not request. There is no requirement that NFs hold beds.

The facility must inform a resident in writing prior to a hospital transfer or departure for therapeutic leave that Medicaid does not pay for bed holds; the facility must also communicate its policies regarding bed-hold periods. An NF is required to follow a written policy under which a resident, whose hospital or therapeutic leave exceeds Medicaid coverage limitations, is readmitted to the facility upon the first availability of a bed in a semiprivate room, if the resident requires NF-level services and is eligible for

Medicaid NF services. (See *42 CFR 483.12(b)(3)* and *410 IAC 16.2-3.1-12(a)(27)*.) Regardless of the length of leave, if the individual remains eligible for NF level of care and Medicaid, he or she must be readmitted to the facility to the first available bed.

Because Medicaid does not pay to hold beds in NFs except for hospice care, all bed holds for days of absence are considered noncovered services for which the resident may elect to pay. If the facility offers this option, the facility must include this information in its written policy, as well as on the written information provided to the resident prior to hospital transfer or departure for therapeutic leave.

Facilities cannot establish a minimum bed-hold charge, such as a certain number of days, because this could overlap with covered services if the resident returns before the minimum period lapses. The facility must also follow the requirements for billing members for noncovered services set forth in the *Charging Members for Noncovered Services* section of the [Provider Enrollment](#) module. Further, it is the resident's choice to elect to pay for this service. Facilities can charge residents only for items and services requested by the resident. See *42 CFR 483.10(c)(8)*.

NFs are also obligated to inform residents upon admission of services for which the resident may be charged and the amounts of those charges. Residents must also be informed of any changes to available services and any charges. See *42 CFR 483.10(b)(5)–(6)*. Facilities must provide 30 days' advance written notice to residents of any changes in rates or services the rates cover. See *410 IAC 16.2-3.1-4(i)*.

Bed-hold revenue codes 180, 183, and 185 are noncovered for NFs. It is not necessary for NFs to submit claims for bed-hold days under any circumstances, including for revenue code 180 – *Bed-hold days not eligible for payment*.

## ***Intermediate Care Facilities for Individuals with Intellectual Disability Billing***

LTC services are available to IHCP members with an applicable LOC who reside in a large or small ICF/IID.

### **ICF/IID Billing Procedures**

ICF/IIDs must follow the general instructions for completing the institutional claim, as well as the following specific instructions:

- ICFs/IID bill for room-and-board charges using the applicable room-and-board revenue code. Acceptable room-and-board revenue codes include 100, 110, 120, and 130.
- The ICF/IID reimbursement rate is an inclusive rate. Therefore, ICFs/IID cannot bill separately for medical and nonmedical supply items, personal care items, or therapies. The reimbursement rate for small ICFs/IID also includes day services as part of the inclusive rate. However, ICFs/IID can bill separately when billing crossover claims. Any inappropriate billing or reimbursement is subject to recoupment by FSSA Program Integrity.
- ICF/IID providers use a type-of-bill code from the 66X series.

*Note: For dates of service before January 1, 2019, the IHCP allowed small ICFs/IID (also known as CRFs/DD or group homes) to submit claims with a type-of-bill code in the 67X series. However, effective for dates of service on or after January 1, 2019, both large and small ICFs/IID must use the HIPAA-compliant 66X series for the type-of-bill code.*

### **Leave Days for ICF/IID Billing**

Reimbursement is available for reserving beds for members in a private ICF/IID, provided that the criteria set out in *405 IAC 5-13-6* is met. Providers must use the appropriate room-and-board revenue code for the

days the member was a patient in the ICF/IID and use the applicable leave of absence revenue code for the days the member was out of the ICF/IID.

The two types of reimbursed leave days are as follows:

- **Hospitalization** – Must be ordered by the physician for treatment of an acute condition that cannot be treated in the facility. The total time allowed for payment of a reserved bed for a single hospital stay is 15 consecutive days. If the member requires hospitalization longer than 15 consecutive days, the member must be discharged from the ICF/IID. If the member is discharged from the ICF/IID following a hospitalization in excess of 15 consecutive days, the ICF/IID is still responsible for appropriate discharge planning. Discharge planning is required if the ICF/IID does not intend to provide ongoing services following the hospitalization for those members who continue to require ICF/IID level-of-care services. The facility must maintain a physician’s order for hospitalization in the member’s file at the facility. *Providers must use **revenue code 185** to denote a leave of absence for hospitalization.*
- **Therapeutic Leave of Absence** – Must be for therapeutic reasons, as prescribed by the attending physician and as indicated in the member’s habilitation plan. The maximum total length of time allotted for therapeutic leaves in any calendar year is 60 days per member residing in an ICF/IID. The leave days need not be consecutive. If the member is absent for more than 60 days per year, no further reimbursement is available to reserve a bed for that member in that year. The facility must maintain a physician’s order for the therapeutic leave in the member’s file at the facility. *Providers must use **revenue code 183** to denote a therapeutic leave of absence.*

Providers should use **revenue code 180** when the hold days are not eligible for payment. See Table 3 for the bed-hold revenue codes that are used for ICF/IID billing.

Table 3 – Bed-Hold Revenue Codes for ICF/IID Billing

Revenue Code	Description
180	Bed-hold days not eligible for payment
183	Therapeutic bed-hold days eligible for payment
185	Hospital bed-hold days eligible for payment

## ***Patient Liability***

*Patient liability* is the term applied to the monetary amount that an IHCP resident must contribute toward his or her monthly care in the facility. The terms *client obligation*, *member liability*, and *personal resource contribution* also indicate patient liability.

The local county office of the DFR calculates and assigns the patient liability amount. Member information, including patient liability/client obligation reflected in *CoreMMIS*, 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.

Providers must apply current income to current needs. As an example, a Social Security benefit check received in October must be applied to October charges. The only exception is the direct deposit benefit check that is 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 that involve resource deductions must be billed on a calendar month basis, for example, June 1 through June 30, or July 1 through July 31.

*Note: Providers must deduct patient resources from the payment in the month that the resources are received.*

*Veterans' pensions will not prevent a member from receiving the monthly personal needs allowance typically allotted for Medicaid members.*

The IHCP automatically deducts the member's liability amount 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 member liability is deducted from the first claim received and processed by CoreMMIS. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

## ***Autoclosure of LOC for Discharged Residents***

To ensure that IHCP members receive all benefits to which they are entitled, it is the responsibility of each LTC provider to properly document the discharge of residents in a timely manner. If the LOC is not updated, it prevents members from receiving services, such as supplies and pharmacy prescription fulfillment, upon discharge from LTC facilities. Providers should be aware that overpayments to facilities are subject to recoupment.

CoreMMIS uses the patient status code from the institutional claim (field 17, STAT, on the *UB-04* claim form) to close the member's LOC segment. This process eliminates the need for LTC providers to submit written discharge information to the FSSA Division of Aging (DA) of all residents discharged from an NF or ICF/IID during a given month. The DA requests that facilities not submit monthly discharge information for residents whose discharge information is noted on the claim.

For a list of the only patient status codes that are valid codes for members who are discharged from LTC facilities, see the *Autoclosure Patient Status Codes for Member Level of Care* table in *Long-Term Care Codes* on the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

If a claim includes one of these patient status codes, CoreMMIS closes out the LOC segment for that member.

LTC providers do not receive reimbursement for the date of discharge. Therefore, it is imperative that LTC providers carefully complete the claim to ensure that the *through* date for the period covered (the second date in the Covered Dates field in the Portal claim header or the second date in field 6 on the *UB-04* claim form) accurately reflects the actual date of discharge for the member.

### ***LTC Facility Residents Admitted to a Hospital***

When filing a claim for a resident who has been admitted to the hospital, LTC providers **should not** use a discharge code on the claim. The discharge patient status code closes the member LOC segment and all future LTC claims are denied for explanation of benefits (EOB) 2008 – *Member is not eligible for this level of care for dates of service*. To eliminate autoclosure of the LOC segment while the resident is hospitalized, the LTC provider should use a patient status code of 30 – *Still a patient*. The claim should include the dates the resident was hospitalized, but should not bill per diem units for those dates.

Examples:

- A resident was in an LTC facility from June 1 through June 23. The resident was hospitalized on June 24 and returned to the LTC facility on July 10, and remained in the facility the rest of the month.
  - The LTC facility claim for June should reflect service dates of June 1 through June 30, with 23 units of *per diem* for the LOC. The status code would be 30 – *Still a patient*, because the member is still a resident of the LTC facility while in the hospital.
  - The July claim should reflect July 1 through July 31 dates of service, a patient status code of 30, and 22 units of *per diem* for the LOC.
- If the same resident was discharged to home or to another facility from the hospital and did not return to the LTC facility on the anticipated date of July 10, the July bill should reflect discharge on

July 10 with a status code of 02 – *Discharged or transferred to another short-term general hospital for inpatient care*. 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.

### *LTC Facility Residents Who Elect Hospice Benefits*

When a resident elects the hospice benefit while remaining in the LTC facility, the LTC facility provider must not use a discharge code on the claim. To eliminate autoclosure of the LOC segment and provide continuity of reimbursement, the provider should use a patient status code of 30 and reflect the date the resident began hospice coverage as the “through” date for the period covered on the claim.

### *Correcting an Erroneous Autoclosure*

Providers that have previously received payment for a particular resident but have recently received claim denials for EOB 2008 should contact the **LTC help desk** at **(317) 488-5094**. **Providers must not contact the DA**. If the member’s LOC was discontinued as a result of the discharge status code, Provider Relations will review the claims to determine which claim caused the autoclosure. If an incorrect status code was used, Provider Relations will advise the provider of any action that should be taken so that the LOC, when deemed appropriate, *can be manually restored* in CoreMMIS.

To have claims considered for payment, two steps must occur:

1. The provider must adjust or replace paid claims that indicated an incorrect discharge patient status code.
2. The provider must call the LTC 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 EOB 2008.

### *Autoclosure Process for Inpatient Crossover Claims*

CoreMMIS uses the patient status code (field 17, STAT, of the *UB-04* claim form) of inpatient crossover claims to close the member LOC segment. LOC information must match billing provider information.

If an accommodation code is billed on the crossover claim, the *through* date of service is less than or equal to the end date of the member LOC segment, and the patient status code indicates discharge as listed in *Long-Term Care Codes* on the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). CoreMMIS will close the member LOC segment using the *through* date of service from the claim as the LOC end date.

This autoclosure process enables dually eligible members who are discharged from an LTC facility while on a Medicare Part A stay to readily receive services in the community that are not available to members with an active NF LOC.

*Note: Inpatient crossover claims indicating the patient status code 02 – “Discharged or transferred to another short-term general hospital for inpatient care” will not be included in the autoclosure process for members on a Medicare Part A stay. In the event the member does not return to the LTC facility from the hospital stay, the LTC facility must notify either DXC or the DA so the LOC can be manually end-dated.*

### ***Retro-Rate Adjustments***

If a provider experiences claim denial in conjunction with a retro-rate adjustment, and the LTC help desk has reviewed and manually reopened an LOC segment, the provider may rebill the denied claim 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 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 process ensures that the correct information is reflected in *CoreMMIS* and alleviates any future denial of claims during retro-rate adjustments.

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

*Note: Hospice providers are not required to submit individual claim adjustment forms to DXC for retro-rate adjustments for room-and-board payments under the IHCP hospice benefit. DXC implemented changes to the claim-billing system to allow mass adjustments for NF room-and-board rate of hospice claims billed under type-of-bill code 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 NF retro-rates are mass adjusted. This change expedites hospice claims payments to contracted NFs. Hospice and NF providers are reminded that mass adjustments to the room-and-board rate under the IHCP hospice benefit for members residing in NFs are reflected on the hospice provider's Remittance Advice (RA). Hospice and NF providers are encouraged to develop coordination and payment procedures to address this retro-rate adjustment issue in their contracts.*

### ***EOB 1024***

If an LTC claim denies for EOB 1024 – *Billing provider is not member's listed Long Term Care provider. Please verify provider number and resubmit*, the provider should verify that the LOC information reflects the correct IHCP Provider ID for the billing facility for the dates of service billed. A cover letter requesting that the information is entered in *CoreMMIS* due to claim denial for EOB 1024 should be submitted via secure email to the Division of Aging using their dedicated email address: [DA.NFinforequest@fssa.in.gov](mailto:DA.NFinforequest@fssa.in.gov). ICFs/IID should direct LOC eligibility questions to the local Bureau of Developmental Disabilities (BDDS) field office.

If the member does not have a State-approved LOC with the correct IHCP Provider ID for the dates of service billed, the facility must follow the established procedures for obtaining LOC approval from the DA or BDDS.

## ***Medicare Crossover Payment Policy***

In accordance with 405 IAC 1-18-2, the IHCP makes a payment only when the Medicare payment amount is less than the IHCP rate on file at the time DXC processes the crossover claim. A paid claim can have an amount of \$0.

When an LTC facility resident elects Medicare benefits for room and board, the LTC facility collects liability at the beginning of the month, as if the resident was not using Medicare days:

- If the resident uses Medicare room-and-board benefits for the entire month, the LTC facility places the liability collected at the beginning of the month in the resident's personal needs allowance account. If the resident uses Medicare benefits for room and board for several months, the resident could exceed his or her personal resources limit. In this case, the LTC facility must notify the county caseworker, who redetermines the financial eligibility of the resident and may end-date the resident's IHCP eligibility until personal resources are again exhausted. The resident may then reapply for Medicaid and must complete a new PASRR through the State's PASRR web-based system.
- If the resident uses only a portion of the month for Medicare room-and-board benefits, the liability collected by the LTC facility is only for the days that Medicaid paid the LTC facility room and board. The LTC facility places the remaining liability in the resident's personal needs allowance account. If the dollar amount in the personal needs account exceeds the limit allowed, the nursing facility must notify the county caseworker.

Medicare payment policy permits coinsurance or copayment and deductible amounts that cannot be collected by the LTC facility to be treated as a *Medicare bad debt* and are generally eligible for reimbursement by Medicare to ensure that any adverse financial impact on the LTC facility is minimal.

The FSSA has received inquiries from providers about what claims can be submitted to Medicare as bad debt when EOB 9004 – *Pricing adjustment – amount paid is zero* has posted to an adjudicated claim on the provider's RA. 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 member liability deductions included in the adjudicated claim by indicating the specific dollar amount in the patient liability field (PATIENT LIAB) on the RA, which is located between the other insurance amount field (OTH INS AMOUNT) and the PAID AMOUNT field. If an amount is indicated in this field, this amount of member liability was deducted from the claim. EOB 9004 should **not** be used as the basis for determining whether a member liability amount was deducted from the claim.

In addition, some LTC providers have misused resident personal resource account funds to satisfy a coinsurance, copayment, 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, copayment, 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, copayment, 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, copayment, or deductible to be paid, the difference between the payment amount and the difference in the coinsurance or copayment 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 Facilities Not Medicare-Certified***

IHCP-enrolled nursing facilities that are not Medicare-certified must comply with the following:

- The NF must use the Certification Statement available on the [Forms](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers) to certify to the FSSA that it will not request payment from the IHCP for services rendered to dually eligible IHCP members who are eligible to receive Medicare Part A nursing facility benefits. For as long as an NF elects not to become Medicare-certified, the NF must submit this certification annually to the FSSA's rate-setting contractor, Myers and Stauffer. NFs must send the Certification Statement with the facility's regularly scheduled cost report submission.
- The NF must maintain clinical, payment, and benefit records in sufficient detail to substantiate to the FSSA that a member for whom IHCP payment was requested is not also entitled to or eligible for Medicare Part A nursing facility benefits. The facility must contact the Medicare fiscal intermediary to determine the availability of Medicare.

## ***Comprehensive Care Beds***

Senate Enrolled Act 460, Section 155 prohibits the State Department of Health from approving: (1) the licensure of comprehensive care health facilities, (2) new or converted comprehensive care beds, or (3) the certification of new or converted comprehensive care beds for participation in the state Medicaid program.

*Note: There is no restriction on the addition of newly licensed comprehensive care beds if they will be certified **only for Medicare** or **not certified at all**. Applications for licensure or certification for Medicare of these beds are to be submitted to the ISDH as usual.*

## **Exceptions**

Exceptions are made for certain facilities that are:

- Under development
- Small house health facilities
- Replacement facilities
- Continuing care retirement communities
- Facilities located in counties whose comprehensive care bed occupancy rate exceeds 90%

*Note: Small house facilities are defined as having 10 to 12 private resident rooms in a residential dwelling of 8,000 square feet or less with specific requirements for private bathrooms for each resident, as well as a common living room, kitchen, and dining room. Applicants seeking Medicaid certification of small house health facility beds are limited to 50 comprehensive care beds per year; the state department may not approve Medicaid certification of more than 100 comprehensive care beds per year as small house health facility beds.*

This restriction does not apply to circumstances described in the following sections.

### *Acute Care Beds and Specialized Service Beds*

The restriction does not apply to acute care beds (usually found in hospitals) being converted to comprehensive care beds, except as restricted by current regulations, nor does it apply to comprehensive care beds that are providing “specialized services” and are therefore subject to *IC 16-29*. Specialized services beds are used solely for patients who have been diagnosed with one of the following conditions:

- Ventilator dependent
- Brain and high spinal cord trauma or a major, progressive neuromuscular disease
- Infected by the human immunodeficiency virus (HIV)

Applications under these exceptions are to be submitted to the ISDH as usual.

### *Replacement of Existing Beds*

The restriction does not apply to beds that are meant to replace existing Medicaid-certified beds if the facilities comply with the following requirements. The facilities must:

- Submit an application to the DA following the procedures outlined in this section.
- Meet the licensure, survey, and certification requirements of the ISDH (*IC 16-28*).

Beds may be replaced within a facility and between facilities. The beds must be certified at the time of the application, except in the case of an emergency or disaster.

All bed count changes must be in accordance with *Chapter 3* of the *State Operations Manual (3202 – Change in Size or Location of Participating SNF and/or NF)*, which can be found on the [Centers for Medicare & Medicaid Services \(CMS\) website](#) at cms.gov [**Regulations & Guidance > Guidance > Manuals > Internet-Only Manuals (IOMs)**]. Changes must also be in compliance with ISDH requirements.

Submit applications for the replacement of existing beds to the FSSA DA. When submitting a request, provide the following items:

- A letter from the licensee that owns the Medicaid-certified beds that are being replaced or transferred to another licensee. The letter should state that the transferor agrees to transfer the beds to the receiving facility and should include:
  - The licensee’s name and address (including county)
  - The licensee’s IHCP Provider ID
  - The licensee’s CMS Certification Number (CCN)
  - A contact person for each facility involved
  - The number of beds to be replaced or transferred
- A letter from the licensee that will receive the beds verifying the number of Medicaid-certified beds agreed to in the transaction described previously
- A completed *State Form (SF) 4332 – Bed Inventory*, reflecting bed inventory as it is prior to the requested replacement or transfer of beds for each facility involved (State forms are available online at [State Forms Online Catalog](#) at in.gov.)
- A completed *State Form (SF) 4332 – Bed Inventory*, reflecting bed inventory as it will be after the requested replacement or transfer of beds for each facility involved
- If the beds are being transferred to different ownership, a copy of the complete agreement about the bed transfer between the health facility transferring the beds and the health facility receiving the beds

Applicants requesting replacement of existing beds will be notified of the DA’s decision. Upon DA’s initial approval, the application packet is forwarded to the ISDH for its determination of compliance with licensure, survey, and certification requirements.

## Medicaid Certification of Comprehensive Care Beds in a New Comprehensive Facility – Construction Begun after June 30, 2011

Comprehensive care beds in a new comprehensive care facility for which construction began after June 30, 2011, may not be certified for participation in the Medicaid program before July 1, 2016. This restriction does not pertain if one of the following applies:

- The comprehensive care bed for which the health facility seeks certification is a replacement bed for an existing certified comprehensive care bed. Follow the application procedures for the replacement of existing beds outlined in the [Replacement of Existing Beds](#) section.
- The comprehensive care bed for which the health facility seeks certification is being converted from an acute care bed or is providing special services (as described in the [Acute Care Beds and Specialized Service Beds](#) section)
- The facility meets the requirements of a small house health facility.
- The facility is a continuing care retirement community that seeks to add licensed beds to an existing facility.
- The facility is a continuing care retirement community that has executed at least 50% of the facility's continuing care agreements with individuals before December 31, 2011.
- The facility is located in a county whose comprehensive care bed occupancy rate exceeds 90%.

On approval of the exception by the DA, the application packet is forwarded to the ISDH, Division of Long Term Care, for its determination of compliance with licensure, survey, and certification requirements.

All information should be submitted to:

**Sarah Renner, Director**  
**FSSA Division of Aging**  
**402 W. Washington St., Room W454**  
**Indianapolis, IN 46204**  
**Telephone: (317) 232-7123**  
**Email: [Yonda.Snyder@fssa.IN.gov](mailto:Yonda.Snyder@fssa.IN.gov)**

## ***Claims for Durable Medical Equipment***

Medical supplies, nonmedical supplies, and routine DME items billed to the IHCP for members residing in LTC facilities will deny. LTC facilities include NFs and ICFs/IID (including 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 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 the EOB 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.*

For more information about DME and supplies, see the [Durable and Home Medical Equipment and Supplies](#) module.

Note: The [LTC DME Per Diem Table](#) is available at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

## Preadmission Screening and Resident Review Billing

This section provides billing and claim-processing guidelines for PASRR providers. PASRR claims follow normal claim-processing procedures and payment logic, although there may be minor differences.

PASRR providers are entities that are approved to conduct PASRR Level II evaluations through contractual arrangements with the DDRS and the DMHA. The FSSA refers the names of new contracted entities to the Provider Enrollment Unit for further enrollment processing. If the entity is already enrolled as an IHCP provider, it does not need to reenroll; the existing IHCP Provider ID can be used for PASRR claims. If a current Provider ID does not exist, the provider must enroll as a PASRR provider to obtain a valid Provider ID for submitting PASRR claims. See the [Provider Enrollment](#) module for more information.

When submitting a PASRR claim for an individual who doesn't have an existing IHCP Member ID, the provider must use a specially assigned PASRR Member ID, which begins with the digit 4. Providers can use the EVS options ([Provider Healthcare Portal](#) accessible from the home page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers), IVR system at 1-800-457-4584, or 270/271 electronic transaction) to obtain the IHCP Member ID or PASRR Member ID assigned to an eligible individual. At no time should a member bear financial responsibility for a PASRR Level II evaluation.

PASRR claims must be submitted via a professional claim (*CMS-1500* paper claim form, Portal professional claim, or 837P electronic transaction) within 1 year of the date of service. The provider must properly identify and itemize all services rendered. See the [Claim Submission and Processing](#) module for general billing instructions:

- Providers submitting claims using the Portal must meet the technical requirements for Portal access and have a valid Portal account and password. See the [Provider Healthcare Portal](#) module for details. Providers that currently have a Portal account and password do not need an additional account and password to submit PASRR claims.
- New providers wanting to use the 837P transaction for PASRR claims must complete, submit, and obtain prior approval of their vendor's software, trading partner ID, logon ID, and password. Providers should allow 1 week to process vendor and account information. The [Electronic Data Interchange](#) module contains Instructions for account setup. Providers that currently send claims using the 837P transaction are not required to make a second application.

Providers must submit a claim for each service instance. Services cannot be combined with other non-PASRR service types, even if the services are rendered on the same day or same visit. For example, a claim for PASRR services cannot be combined with a claim for Medicaid services.

PASRR claims are subject to all edits and audits not excluded by PASRR program requirements. If a claim encounters an edit or audit for missing or invalid information, the claim suspends or denies.

Provider reimbursement for rendered services is determined by the procedure codes, modifiers, and associated maximum (max) fee rate. Procedure codes, modifiers, and max fee rates must accompany all PASRR claim submissions. Providers are responsible for entering billable charges per the published procedure code and max fee rate.

CoreMMIS captures as many as four modifiers for all PASRR claims. If the procedure code or applicable modifier is missing or invalid, edits deny or suspend claims. The procedure codes and modifiers for PASRR are listed in the *Long-Term Care Codes* on the [Code Sets](#) page at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

Providers may void or replace PASRR claims. PASRR financial information is available on the 835 RA transaction. PASRR claims processing information is reflected on the 276/277 Claim Status Request Response transactions. Providers can inquire on the claim's status using the Portal.