INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Long-Term Care

LIBRARY REFERENCE NUMBER: PROMOD00037
PUBLISHED: JULY 18, 2024
POLICIES AND PROCEDURES AS OF JULY 1, 2024
VERSION: 7.0

Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of Oct. 1, 2015 Published: Feb. 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: Oct. 13, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of Feb. 13, 2017) Published: April 11, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of April 1, 2017 Published: Sept. 28, 2017	Scheduled update	FSSA, Myers and Stauffer, and DXC
3.0	Policies and procedures as of Feb. 1, 2018 Published: July 10, 2018	Scheduled update	FSSA, Myers and Stauffer, and DXC
4.0	Policies and procedures as of March 1, 2019 Published: July 25, 2019	Scheduled update	FSSA, Myers and Stauffer, and DXC
5.0	Policies and procedures as of June 1, 2020 Published: Jan. 28, 2021	Scheduled update	FSSA, Myers and Stauffer, and Gainwell
6.0	Policies and procedures as of Jan. 1, 2023 Published: Feb. 16, 2023	Scheduled update	FSSA, Myers and Stauffer, and Gainwell
7.0	Policies and procedures as of July 1, 2024 Published: July 18, 2024	Scheduled update: • Reorganized and edited text as needed for clarity, including dividing the module into numbered sections • Added heading and a note with cross-references in the *Long-Term Care Facility Providers* section • Updated the *Member Eligibility Considerations* section and subsections • Added heading and updated information in the *Verifying Member Eligibility* section • Added heading and introductory text for *Section 2: Nursing Facilities*	FSSA, Myers and Stauffer, and Gainwell

Version	Date	Reason for Revisions	Completed By
		• Added Terminal Illness and Convalescent categorical outcomes in the *Level I Outcomes* section • Added Terminal Illness and Convalescent categorical decisions in the *Level II PASRR Categorical Decisions* section • Updated the *Minimum Data Set Reviews – Processing and Oversight Review Procedures* section • Removed the *Resident Review Process* section and subsections • Removed the *MDS Review Findings and Rate Calculation Appeal Process* section and subsections • Added the *Nursing Facility Policies for Indiana PathWays for Aging* section • Added heading and updated the *Nursing Facility Policies for Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise* section and subsections • Updated the *Nursing Facility Reimbursement Methodology* section and removed the *Case-Mix Reimbursement* subsection • Added heading and updated the *Nursing Facility Claim Completion and Submission* section • Added *Additional Billing and Reimbursement Information for Nursing Facility Providers* heading and introductory text • Consolidated the *Leave Days for NF Billing* section into the *Leave Days in a Nursing Facility* section • Added the *Transportation for NF Residents* section	

Version	Date	Reason for Revisions	Completed By
		• Replaced the *Submitting Cost Reports and Schedules* section with separate, updated sections: – *Submitting NF Cost Reports and Schedules* – *Submitting ICF/IID Cost Reports and Schedules* • Updated the *Quality Assessment Fee* section • Replaced the *Retro-Rate Adjustments* section with separate, updated sections: – *Retro-Rate Adjustments for Nursing Facilities* – *Retro-Rate Adjustments for ICFs/IID* • Added heading and introductory text in the *Nursing Facility Considerations for Managed Care Members* section • Updated the *Nursing Facility Reimbursement for Managed Care Members* section • Added heading and introductory text for *Section 3: Intermediate Care Facilities for Individuals With Intellectual Disabilities* • Updated the *ICF/IID Claim Completion and Submission* section • Added *Additional Billing and Reimbursement Information for ICF/IID Providers* heading and introductory text • Consolidated the *Leave Days for ICF/IID Billing* section into the *Leave Days in an ICF/IID* section • Added instructions for providers if the LOC is ended incorrectly in the *Correcting an Erroneous Autoclosure* section	

Table of Contents

Section 1: Introduction

Note: For updates to information in this module, see IHCP Bulletins at in.gov/medicaid/providers.

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.

Long-Term Care Facility Providers

As used in this module, the term *LTC facilities* refers to the following IHCP provider specialties, enrolled under provider type 03 – *Extended Care Facility*:

- Nursing facilities (NFs)
  - Specialty 030 – *Nursing Facility*
  - Specialty 032 – *Pediatric Nursing Facility*
- Intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)
  - Specialty 031 – *ICF/IID*

The information in this module does not pertain to any other type of facility.

Note: For information about psychiatric residential treatment facilities (PRTFs), see the Behavioral Health Services module. For information for long-term acute care (LTAC) facilities, see the Inpatient Hospital Services module. For information about state-operated 590 Program facilities, see the 590 Program module. For information about traumatic brain injury (TBI) facilities, see the Therapy Services module.

Member Eligibility Considerations

The IHCP Traditional Medicaid fee-for-service (FFS) program includes coverage for LTC services in an NF or ICF/IID, for members with a qualifying LOC determination.

Effective July 1, 2024, the Indiana PathWays for Aging (PathWays) managed care program also provides coverage for LTC services in an NF. For members enrolled in any *other* managed care program – Healthy Indiana Plan (HIP), Hoosier Care Connect or Hoosier Healthwise – **short-term** care in a nursing facility may be covered, but for coverage of long-term NF services, the member must qualify for and be transitioned to FFS Traditional Medicaid or PathWays. For more information, see the *Nursing Facility Considerations for Managed Care Members* section.

ICF/IID services remain covered only under FFS Traditional Medicaid. Any managed care member who requires placement in an ICF/IID must qualify for and be transitioned to Traditional Medicaid for coverage.

> *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.*

Verifying Member Eligibility

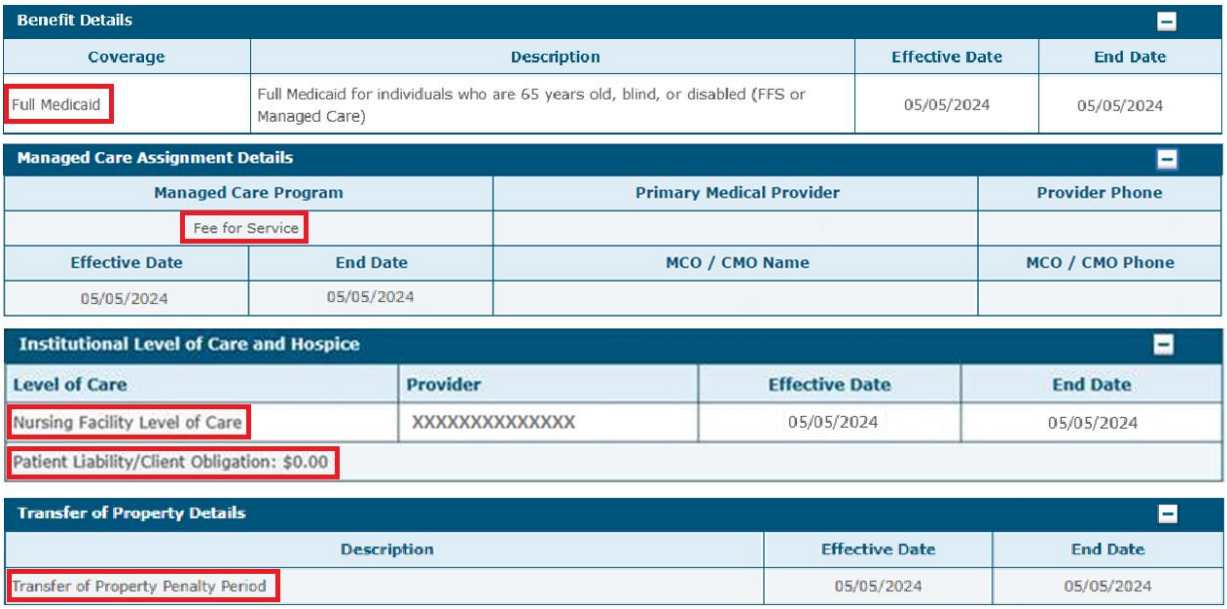
LTC facility providers are responsible for verification of the IHCP member's active eligibility and coverage status at the time of admission as well as on an ongoing basis. At a minimum, facility providers should verify this information monthly. Because most changes to eligibility or coverage status 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 (IHCP Portal), phone-based virtual assistant (GABBY) or 270/271 Eligibility Benefit Inquiry and Response electronic transactions – to determine active eligibility and coverage status. For details about these EVS options, see the *Member Eligibility and Benefit Coverage* module.

LTC facility providers must look for the following key pieces of information when verifying member eligibility in the EVS:

- **Coverage type** – "Full Medicaid" and "Package A – Standard Plan" are the only two benefit plans that allow for coverage of LTC in an NF or ICF/IID, for members with an applicable LOC.
- **Managed care information** – Only members identified as either "Fee-for-Service" or "Indiana PathWays for Aging Managed Care" may be eligible for coverage of LTC services in an NF. Only members identified as "Fee-for-Service" may be eligible for coverage of LTC services in an ICF/IID.
- **Level-of-care assignment** – Eligibility for LTC facility services is indicated in the EVS by the following institutional LOC responses:
  - **Nursing Facility Level of Care** – Indicates coverage for LTC services in an NF
  - **ID/DD Nursing Facility Level of Care** – Indicates coverage for LTC services in an ICF/IID
- **Patient liability** – If the EVS indicates a patient liability/client obligation for the institutionalized member, the IHCP will deduct the monthly liability amount indicated from the facility's claim payments for that member. See the *Patient Liability* section for details.
- **Transfer-of-property penalty** – If the EVS indicates a transfer-of-property penalty period for the member, LTC facility services are not covered for that date of service. See the *Transfer-of-Property Penalty Period* section.

Figure 1 – Coverage Details in the IHCP Portal for a Traditional Medicaid (FFS) Member With a Nursing Facility Level of Care, No Patient Liability and a Transfer of Property Penalty Period



Benefit Details

Coverage	Description	Effective Date	End Date
Full Medicaid	Full Medicaid for individuals who are 65 years old, blind, or disabled (FFS or Managed Care)	05/05/2024	05/05/2024

Managed Care Assignment Details

Managed Care Program	Primary Medical Provider	Provider Phone
Fee for Service		

Effective Date	End Date	MCO / CMO Name	MCO / CMO Phone
05/05/2024	05/05/2024		

Institutional Level of Care and Hospice

Level of Care	Provider	Effective Date	End Date
Nursing Facility Level of Care	XXXXXXXXXXXXX	05/05/2024	05/05/2024
Patient Liability/Client Obligation: $0.00			

Transfer of Property Details

Description	Effective Date	End Date
Transfer of Property Penalty Period	05/05/2024	05/05/2024

Patient Liability

Patient liability is the term applied to the monetary amount that IHCP residents must contribute toward their 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 Division of Family Resources (DFR) calculates and assigns the patient liability amount. Member information, including patient liability/client obligation amount, is updated daily from the information relayed by the Indiana Eligibility Determination and Services System (IEDSS) at the county offices. Providers are not required to send the *C-519* form.

For FFS members, information about the patient liability amount is available through the EVS, as described in the *Verifying Member Eligibility* section. For PathWays members, the EVS will indicate if a patient liability applies, but the provider will need to contact the member's MCE for the liability amount.

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 the IHCP. Therefore, the facilities involved in the transfer must coordinate any liability deductions.

Transfer-of-Property Penalty Period

Some members incur a transfer-of-property penalty while they are transferring assets. During this period, claims for LTC services will be denied.

Providers enrolled as extended care facilities (type 03) will see the *Transfer of Property Details* panel during eligibility verification in the IHCP Portal (see Figure 1) if the member is ineligible for coverage of these services on the dates searched due to a transfer-of-property penalty period.

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 that does not include LTC coverage, 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.

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.

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 *Find My Local DFR Office* page at 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.

The Indiana Health Coverage Programs (IHCP) covers long-term care (LTC) in a nursing facility (NF) for members who meet NF level-of-care (LOC) criteria and who are enrolled in the Traditional Medicaid fee-for-service (FFS) program or the Indiana PathWays for Aging (PathWays) managed care program.

For information about NF coverage policies and procedures for members enrolled in another managed care program, see the *Nursing Facility Policies for Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise Members* subsection.

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 NF 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 – Processing and Oversight Review Procedures* section for details.

Providers can request access to the state's web-based PASRR system via email at dts-das@fssa.in.gov. Questions or issues regarding PASRR may be sent to PASRR@fssa.in.gov. For additional information, see the Indiana PASRR provider manual and other resources available from the *Indiana PASRR Tools and Resources* page at maximusclinicalservices.com and the *Preadmission Screening and Resident Review* page at in.gov/fssa/da.

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*. Prior to any denial, individuals who do not appear to meet NF criteria receive an on-site assessment from the AAA for a final determination.

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, the AAAs and Myers and Stauffer LTC review teams use these criteria.

Circumstances Requiring a Level-of-Care Assessment

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 NF 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 Tools and Resources* page at maximusclinicalservices.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 Outcomes

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 Tools and Resources page at maximusclinicalservices.com. If the change meets the criteria of a significant change per the Centers for Medicare & Medicaid Services (CMS) Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual, the NF is also responsible for completing a Significant Change 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
- Terminal Illness Categorical
- Convalescent Categorical
- Refer for Level II On-site
- 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.

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.

Four types of categorical Level II decisions may be applied:

- Provisional Emergency
- Respite
- Terminal Illness
- Convalescent

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 Categorical

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 seven calendar days in an NF. If additional days are required, a new Level I and LOC assessment, and a new Level II when applicable, must be obtained through the state's web-based PASRR system prior to the approval end date.

An APS admission is designated as a **maximum stay of seven 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 Categorical

Respite stays are 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:

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

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

Terminal Illness Categorical

The Terminal Illness categorical decision is available when a person has a medical condition that, when running its normal course, would have a life expectancy of six months or less.

Convalescent Categorical

The Convalescent categorical decision is a short-term exemption from the PASRR process for individuals with a known or suspected mental illness, intellectual disability or related condition who meet the following criteria:

- Received acute inpatient treatment in a medical hospital and are being discharged from the hospital to an NF after receiving medical (nonpsychiatric) services
- Need short-term treatment (between 31–60 calendar days) in an NF for the same condition for which they were hospitalized
- Are psychiatrically stable and does not present a risk of harm to self or others

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 the NF stay, the NF is required to complete an LOC assessment via the state's web-based PASRR system after the resident is notified of 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 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 – Processing and Oversight Review Procedures

All Medicare and Medicaid certified NFs are required to conduct and transmit to CMS an assessment of individual NF residents' needs on a periodic basis, in accordance with state and federal requirements. The minimum data set (MDS) resident assessment instrument (RAI) is required for use for those periodic assessments. The FSSA leverages the MDS RAI as the basis for determining resident acuity and nursing resource needs for the Medicaid NF reimbursement system. The MDS resident assessment information is collected and processed for use in the NF reimbursement system by an independent state contractor, Myers and Stauffer.

The FSSA uses a case-mix reimbursement methodology based on the Resource Utilization Group Version 4 (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.

Beginning Oct. 1, 2023, the Optional State Assessment (OSA) is the only RUG classification. The Office of Medicaid Policy and Planning (OMPP) requires Medicaid-certified nursing facilities to complete the OSA with the same assessment reference date (ARD) as each federally required MDS assessment submitted. This will allow for a RUG-based case mix score to be calculated and the current RUG-based reimbursement methodology to continue.

The FSSA also utilizes the independent state contractor, Myers and Stauffer, to complete periodic MDS reviews for all residents of Medicaid-certified NFs in Indiana, regardless of payor source. The purpose of the review is to provide oversight of MDS submissions and ensure that the IHCP is reimbursing for the appropriate classification of submitted MDS resident assessment in accordance with the following manuals:

- *MDS and Case Mix Index Supportive Documentation Manual*, available from the *Case Mix and Related Services* page of the Myers and Stauffer website at myersandstauffer.com
- *Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual*, available from the *Resident Assessment Instrument* page of the CMS website at cms.gov

The MDS review process may result in a reimbursement rate reduction if certain review thresholds are exceeded. Any reimbursement impact will be addressed with reconsideration rights. The MDS review process is further detailed in the *MDS and Case Mix Index Supportive Documentation Manual*.

The Myers and Stauffer Long Term Care review team (LTC review team) may also perform 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. *(Review may be optional.)*
- Ensure that Level I screens are completed and reflect the resident's current mental and physical condition, on an as-needed basis. *(Review may be optional.)*
- Ensure that Level II evaluations are completed as needed. *(Review is required.)*
- Ensure all services recommended by the Level II evaluations are provided.

Level-of-Care Review Process

The LOC review during the MDS process may be 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 Referrals

When the LTC review team identifies an NF resident who does not appear to meet NF LOC criteria, the team notifies the NF provider during the exit conference and presents the provider with a *Myers and Stauffer Level of Care Referral* form.

The provider should then complete an LOC assessment of the individual using the web-based PASRR system within 30 calendar days of the exit conference.

After the LOC assessment has been completed and the NF provider has received the outcome letters, the *Myers and Stauffer Level of Care Referral* form should be completed and retained for the provider's records.

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 of Indiana 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.

Nursing Facility Reimbursement Methodology

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.

The IHCP reimburses Indiana NFs at a facility-specific daily rate (or per diem) for members who meet NF level of care.

Effective for July 1, 2023, the IHCP will reimburse qualifying NF providers with a resident-specific add-on in addition to their daily per diem. NF providers who meet the qualifications and attest to being able to meet the needs of members can qualify for the member add-on. To be reimbursed for the specialized services, NF providers will use the *Nursing Facility Schedule of Special Facility Qualifications* (Schedule Z) to obtain qualification as a facility providing these specialized services. The Schedule Z form and instructions are available on the Long Term Care page of the Myers and Stauffer website, under Nursing Facility > Forms > Schedule of Special Facility Qualifications (Schedule Z).

Nursing Facility Claim Completion and Submission

NFs bill using the institutional claim (*UB-04* claim form or electronic equivalent).

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.
- NFs that qualify for the SCU add-on bill using revenue code 193 and still bill for room-and-board charges using the applicable room-and-board revenue code.
- NFs that qualify for the ventilator add-on bill using revenue code 199 and still bill for room-and-board charges using the applicable room-and-board revenue code.
- 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.

Fee-for-service NF claims may be submitted to Gainwell Technologies using the 837I electronic transaction or IHCP Portal institutional claim, or by mailing the *UB-04* claim form to the following address:

Gainwell –UB-04 Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Note: Gainwell P.O. boxes will be changing, effective Aug. 1, 2024. The new address for FFS institutional claims will be:

Gainwell – UB-04 Claims
P.O. Box 50448
Indianapolis, IN 46250-0418

For members enrolled in a managed care program, covered NF services should be billed to the member's MCE. See the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers, for contact information.

For general billing information, see the *Claim Submission and Processing* module (for FFS claims) or refer to information provided by the applicable MCE (for managed care claims).

Additional Billing and Reimbursement Information for Nursing Facility Providers

The following sections provide additional billing and reimbursement information specific to NF providers. For LTC facility billing and reimbursement information that is applicable to both NFs and ICFs/IID, see *Section 4: Additional Information for Long-Term Care Facilities*.

Leave Days in a Nursing Facility

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, the individual 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*.

Transportation for NF Residents

Effective for dates of service on or after July 1, 2023, nursing facilities are responsible for coordinating and reimbursing transportation providers for non-advanced life support (ALS)/ basic life support (BLS) nonemergency transportation (NEMT) services for their IHCP residents. Additionally, with the exception of ALS and BLS transports, IHCP reimbursement for NEMT services provided to NF residents will be considered included in the NF per diem rate and cannot be billed separately to the IHCP.

For nonemergency ambulance transports that meet medical necessity for ALS or BLS services, the nursing facilities must coordinate the ALS or BLS transportation directly with an IHCP-enrolled ambulance

provider, and the ambulance provider will submit claims to Gainwell for the appropriate procedure codes based on the types of services provided during the transport.

When an IHCP member is transported from home to an admitting NF, from an NF to a hospital for an inpatient or observation stay, or from a hospital back to the NF where they had previously been admitted, the NF is responsible for arranging and reimbursing the transportation.

When IHCP members are transferred between NFs, the admitting/receiving facility is responsible for transportation. Discharging and admitting facilities will need to communicate with each other to understand the responsibility of each and to ensure a smooth transfer. The responsible NF will claim the expense on their cost report, and the expense will be reimbursed via that facility's future per diem.

When an FFS IHCP member is discharged from a hospital and admitted to an NF as a new admission, the hospital will be responsible for arranging the transport of the member with the FFS transportation broker. The discharging hospital will be responsible for communicating and verifying the new admission status of the member with the transportation broker.

Submitting NF Cost Reports and Schedules

After March 31, 2023, the OMPP requires all Medicaid-participating NF providers to maintain a calendar year (Jan. 1 – Dec. 31) fiscal period for Medicaid cost-reporting purposes. The due date for these cost-reporting filings will be the last day of the fifth month after the fiscal period end date (May 31). For transactions beginning July 1, 2023, determined to be a change of ownership or structure, the cost report is due no later than the last day of the fifth calendar month after the fiscal period, or 30 days following notification by the OMPP that the cost report must be filed.

Acceptable submission methods for the cost reports and schedules that are required from NFs are as follows:

- Meyers and Stauffer Indiana LTC web portal at inltcdeptexchange.mslc.com (preferred)
- Standard mail (USPS, UPS or FedEx)
- Hand delivery to Myers and Stauffer office during normal nonholiday business hour

Failure to submit a cost report by the required deadlines could result in a rate reduction to the provider's daily per diem currently being paid.

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 non-state-government owned or operated facility that became non-state-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 is a non-state-government owned or operated facility that became non-state-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

Prior to July 1 of each year, the OMPP will determine the portion of the monthly QAF liability that is expected to exceed the estimated FFS monthly claim-payment volume for each NF provider. The rate-setting contractor will generate and distribute letters to NF providers detailing the estimated additional monthly assessment fee liability that will not be covered by FFS claim volume. Providers will send a check or electronic funds transfer (EFT) to Gainwell for the amount noted in the letter.

Gainwell will establish the full monthly assessment liability as accounts receivable and monitor for any underpayment in accordance with the IHCP *Financial Transactions and Remittance Advice* module. A reconciliation will be performed as needed to determine any over or under payment.

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.

Physician Visits to Members in a Nursing Facility

Physician visits to members residing in an NF are separately reimbursable when billed by the physician on a professional claim, limited to one visit per 27 days unless sufficient documentation is provided to justify additional visits.

Retro-Rate Adjustments for Nursing Facilities

Effective July 1, 2024, Medicaid NF reimbursement rates are set in a fully prospective manner. As such, any changes to an established Medicaid NF reimbursement rate or the imposition of any rate reductions or corrective remedies will be addressed through a reduction of the Medicaid per diem rate or the NF settlement process, as detailed in *405 IAC 1-14.7*. Retro-rate adjustments will no longer occur.

Medicare Crossover Payment Policy

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

When an NF resident elects Medicare benefits for room and board, the NF 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 NF 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 the resident's personal resources limit. In this case, the NF 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 web-based PASRR system.
- If the resident uses only a portion of the month for Medicare room-and-board benefits, the liability collected by the NF is only for the days that Medicaid paid the NF room and board. The NF 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 NF must notify the county caseworker.

Medicare payment policy permits coinsurance or copayment and deductible amounts that cannot be collected by the NF 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 NFis minimal.

The FSSA has received inquiries from providers about what claims can be submitted to Medicare as bad debt when EOB code 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 code 9004 should **not** be used as the basis for determining whether a member liability amount was deducted from the claim.

In addition, some NF providers have misused resident personal resource account funds to satisfy a coinsurance, copayment or deductible cost.

> *Note: The IHCP does not allow an NF 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 NF 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 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.

Certificate of Need Program

The Certificate of Need program for Indiana comprehensive care facilities (nursing facilities) is the result of *Senate Enrolled Act 190* from the 2018 session of the Indiana General Assembly.

With certain exceptions, a Certificate of Need is required to:

- Build, develop or establish a new healthcare facility (nonreplacement facility)
- Move an existing healthcare facility to another county
- Relocate beds from one facility to another
- Change the comprehensive bed capacity of a healthcare facility
- Change the type or scope of any healthcare service offered by a healthcare facility

Exceptions that do not require a Certificate of Need can be found at *IC 16-29-7-1* and *IC 16-29-7-16*. If providers believe they meet one of the exceptions, they can email their exception request to the Indiana Department of Health (IDOH) at providers@isdh.in.gov for review.

Certificate of Need applications will be accepted July 1 through July 31 each year. Applications submitted after July 31 will be reviewed the following year. All Certificate of Need applications must include all information required in the application and be submitted with a nonrefundable $5,000 application fee.

Applications for a Certificate of Need will be evaluated according to all relevant State Health Plan standards, policies and criteria.

For more information, see the *Certificate of Need Program* page at in.gov/health.

Nursing Facility Considerations for Managed Care Members

The following sections describe IHCP policies and procedures for members enrolled in a managed care program who require NF services.

Nursing Facility Policies for Indiana PathWays for Aging

On July 1, 2024, eligible Hoosiers age 60 and older began receiving Medicaid coverage through the Indiana PathWays for Aging (PathWays) managed care program. For general information about the program, including eligibility criteria and managed care entity (MCE) selection, see the *Member Eligibility and Benefit Coverage* module (this information will be included in the next update).

The PathWays program provides coverage for NF services, including long-term care (LTC), for eligible members with an NF LOC. To qualify for reimbursement, the NFs must be licensed by the Indiana Department of Health, enrolled with the Indiana Health Coverage Programs (IHCP) and contracted with the PathWays member's MCE.

For more information, contact the PathWays MCEs. See the *IHCP Quick Reference Guide*, available at in.gov/medicaid/providers.

> *Note: PathWays does not include coverage for LTC services in intermediate care facility for individuals with intellectual disabilities (ICF/IID). If a PathWays member requires placement in an ICF/IID, the member must be disenrolled from PathWays and transitioned to FFS coverage under Traditional Medicaid.*

Nursing Facility Policies for Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise

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 an NF 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 NF care is needed, the member must be disenrolled from managed care and, if applicable income and asset requirements are met, transitioned to the FFS Traditional Medicaid program. HIP, Hoosier Care Connect and Hoosier Healthwise members must be **disenrolled** from their managed care entity (MCE) before the LOC status can be entered in Core Medicaid Management Information System (*Core*MMIS). Upon disenrollment from managed care, members' IHCP coverage continues under the Traditional Medicaid program.

> *Note: Reimbursement of LTC facility services is not available for Hoosier Healthwise Package C – Children's Health Insurance Program (CHIP) members.*

Hospice Exception

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.

MCE Notification and Coverage Requirements

When a HIP, Hoosier Care Connect or Hoosier Healthwise member is admitted to an NF or undergoes the PASRR, the NF and AAA are required to notify the member's MCE. The MCE is financially responsible for all care provided to its members until enrollment termination is effective – including for short-term placement fees made to the NF. IHCP FFS is financially responsible for reimbursement of LTC facility services provided after the member has been approved for NF LOC (per *405 IAC 1-3-1* and *405 IAC 1-3-2*) **and** disenrolled from the MCE.

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 the HIP, Hoosier Care Connect or Hoosier Healthwise managed care program, the NF must notify the MCE within 72 hours after admission. The MCE is responsible for coverage of the patient's NF charges as follows:

- 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 90 days from the date of admission for Hoosier Care Connect
  - Up to 90 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 90 days from the date of notification for Hoosier Care Connect
  - Up to 90 days from the date of notification for Hoosier Healthwise
  - Up to 100 days from the date of notification for HIP

If the member is still in the NF after the allotted time (per managed care program), and the member is still enrolled in HIP, Hoosier Care Connect or Hoosier Healthwise, 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 (MCE or FFS) that receives the member to honor authorizations of the previous health plan for the first 90 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. In the case of NF services, this period 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 managed care program and 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 must use the IHCP eligibility verification system (EVS) upon admission and screening of a new patient – and again, for existing patients, on the 1st and 15th of every month – to confirm IHCP eligibility and to verify in which IHCP program the patient is enrolled, for the purposes of care coordination and reimbursement. If the EVS indicates managed care enrollment under the HIP, Hoosier Care Connect or Hoosier Healthwise program upon admission or at any time during the LTC facility stay, the facility must notify the MCE immediately of the member's status in the facility. For more information about the EVS, see the Verifying Member Eligibility section.*

Additional 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 and the Division of Family Resources (DFR) within 10 days of the event, as follows:

- To the Division of Aging through the Path Tracker tool at assessmentpro.com.
- To the DFR via the online FSSA Benefits Portal at fssabenefits.in.gov, by faxing 800-403-0864 or by mail to the local DFR office. To find your DFR office contact information, visit the *Find My Local DFR Office* page at in.gov/fssa/dfr.

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.

The IHCP recommends that the member or authorized representative contact the DFR to request an eligibility interview at the same time that the provider reports the admission to an NF. The eligibility interview is necessary to determine whether the member can be transitioned from HIP to the FFS benefit coverage category.

To be transitioned to FFS Traditional Medicaid, HIP members must be determined as disabled per the definition used by the Social Security Administration and must qualify under the income and resource limits associated with FFS benefits. After the Social Security Administration or Medical Review Team (MRT) completes a disability determination, the member's coverage can be transitioned from the managed care delivery system to the FFS delivery system, effective on the first day of the month following the reported change.

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 Division of Aging 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 the transition to the FFS benefit coverage category is completed, the member and authorized representatives may receive a benefit award letter indicating that FFS coverage will begin the month following the **disability determination**. If this occurs, and an earlier start date is required for coverage of prior dates, the NF provider must contact the DFR to request the FFS coverage start date be backdated to the month following the **reported change**. After the start date has been backdated, the DFR will send a second benefit award letter indicating the new FFS coverage start date.

> *Note: If a member's admission to an NF was not reported to the Division of Aging and the DFR within 10 days, the FFS start date cannot be backdated.*

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.

The following steps outline the process providers, members and authorized representatives should complete to transition a member from HIP to FFS coverage:

1. The NF provider submits written notice of the NF admission within 10 days of the admission to both the Division of Aging and the DFR, as described previously.
2. The member or authorized representative contacts the DFR to request an eligibility interview to determine whether they can be transitioned to FFS coverage. (This step should occur at the same time as the provider performs step 1.)
3. After the transition process has been completed and the member has been awarded FFS coverage for the month following the disability determination, the provider may need to call the DFR to request the FFS coverage start date to be backdated.
4. If backdating of the coverage (in step 3) is not completed within three weeks, the provider should email the appropriate DFR regional mailbox to escalate the issue.
5. If the coverage is not appropriately backdated after an additional three weeks, the provider can contact the OMPP Provider Relations team at OMPPProviderRelations@fssa.in.gov.

Nursing Facility Reimbursement for Managed Care Members

For dates of service on and after Jan. 1, 2024, the rates for NF services covered under a managed care program will be equal to the reimbursement rates established for FFS Medicaid.

> *Note: For dates of service from Nov. 1, 2022, through Dec. 31, 2023, only HIP MCEs were required to use the Medicare reimbursement methodology and associated rates for payment of NF claims.*

Section 3: Intermediate Care Facilities for Individuals With Intellectual Disabilities

The information in this section applies to long-term care (LTC) services provided to eligible Indiana Health Coverage Programs (IHCP) members residing in an intermediate care facilities for individuals with intellectual disabilities (ICFs/IID).

ICFs/IID are divided into two distinct categories:

- Large private ICF/IID – More than eight beds
  - Comprehensive rehabilitative management needs facility
- 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

For coverage LTC services in a large or small ICF/IID, the member must be enrolled under the Traditional Medicaid fee-for-service (FFS) program, and must have an applicable level-of-care (LOC) assignment.

ICF/IID Reimbursement Methodology

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

- *Room and board* – Room accommodations, all dietary services (including routine and special dietary services and school lunches), and personal laundry services
- *Nursing care* – Nursing services and supervision of health services
- *Medical and nonmedical supplies* – All medical and nonmedical supplies and equipment furnished by the facility for the usual care and treatment of residents
- *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

> **Note: 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. The IHCP follows the definition of customized item in 42 CFR Section 414.224. To be considered a customized item, a covered item (including a wheelchair) must be "uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of a physician, and be so different from another item used for the same purpose that the two items cannot be grouped together for pricing purposes."*

- *Mental health services* – Including behavior management services and consulting, psychiatric services and psychological 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
  - 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, 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.*

The services described in the preceding list are covered in the per diem rate and may not be billed to Medicaid by the facility, a pharmacy or any other provider. For billing information about **nonstandard** DME, see the *Claims for Durable Medical Equipment and Supplies* section.

For information about submitting cost reports and schedules, see the *Submitting ICF/IID Cost Reports and Schedules* section.

ICF/IID Claim Completion and Submission

ICFs/IID bill using the institutional claim (*UB-04* claim form or electronic equivalent). Since ICF/IID services are covered only under Traditional Medicaid, all ICF/IID claims are billed as FFS. 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 67X series.

ICF/IID claims may be submitted to Gainwell Technologies using the 837I electronic transaction or IHCP Provider Healthcare Portal (IHCP Portal) institutional claim, or by mailing the paper claim to the following address:

Gainwell –UB-04 Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Note: Gainwell P.O. boxes will be changing, effective Aug. 1, 2024. The new address for FFS institutional claims will be:

Gainwell – UB-04 Claims
P.O. Box 50448
Indianapolis, IN 46250-0418

See the *Claim Submission and Processing* module for general billing information.

Additional Billing and Reimbursement Information for ICF/IID Providers

The following sections provide additional billing and reimbursement information specific to ICF/IID providers. For LTC facility billing and reimbursement information that is applicable to both NFs and ICFs/IID, see *Section 4: Additional Information for Long-Term Care Facilities*.

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. 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 for ICFs/IID 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 1 for the bed-hold revenue codes that are used for ICF/IID billing.

Table 1 – 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

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.

Submitting ICF/IID Cost Reports and Schedules

Acceptable submission methods for the cost reports and schedules that are required from ICFs/IID are as follows:

- Myers and Stauffer Indiana LTC web portal at inltcdeptexchange.mslc.com (preferred)
- Standard mail (USPS, UPS or FedEx)
- Hand delivery to Myers and Stauffer office during normal nonholiday business hours

Providers must file a nine-month historical cost report 60 days following the end of the provider's first nine months of operation. The due date for an annual cost report is 90 days after the close of the provider's reporting year. Failure to submit a cost report by the required deadlines could result in a penalty that reduces the rate then currently being paid by 10%.

Retro-Rate Adjustments for ICFs/IID

Changes to Medicaid ICF/IID reimbursement rates are generally made in a retroactive manner. As part of this process, Gainwell deactivates the autoclosure process for retro-rate adjustments. This deactivation prevents claim denials and the creation of unnecessary accounts receivable for LOC segments that have previously been manually restored by Gainwell following notification that the provider billed the incorrect patient status code, as described in the *Correcting an Erroneous Autoclosure* section.

Section 4: Additional Information for LTC Facilities

The following sections provide long-term care (LTC) billing and reimbursement information that may be applicable to both nursing facility (NF) and intermediate care facility for individuals with intellectual disabilities (ICF/IID) providers for the Indiana Health Coverage Programs (IHCP).

EOB 1024

If a fee-for-service (FFS) NF or ICF/IID claim denies for EOB code 1024 – *Billing provider is not member's listed Long Term Care provider. Please verify provider number and resubmit*, the provider should verify that the member's level-of-care (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 *Core*MMIS 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. 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 Division of Aging or BDDS.

Claims for Durable Medical Equipment and Supplies

IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies or routine DME items (and associated repair costs) provided to IHCP members residing in LTC facilities (NFs and ICFs/IID, including CRFs/DD). 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*.

FFS claims with procedure 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 code 2034 – *Medical and nonmedical supplies and routine DME items are covered in the per diem rate paid to the Long Term Care facility and may not be billed separately to the IHCP*.

> *Note: The LTC DME Per Diem Table is accessible from the Long-Term Care DME Per Diem Table page at in.gov/medicaid/providers.*

Nonstandard items of DME and associated repair costs that have received prior authorization must be billed to the IHCP directly by the DME provider. Facilities may not require members to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the OMPP. The OMPP must be notified when the member no longer needs the equipment. For more information about DME and supplies, see the *Durable and Home Medical Equipment and Supplies* module.

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 by submitting the appropriate patient status code on the institutional claim (field 17, STAT, on the *UB-04* claim form) in a timely manner. *Core*MMIS uses the patient status code to close the member's LOC segment. If the LOC is not updated, it prevents members from receiving services, supplies and pharmacy prescription fulfillment upon discharge from the LTC facility.

The process of autoclosing LOC segments based on patient status code eliminates the need for LTC providers to submit written discharge information to the FSSA Division of Aging of all residents discharged from an NF or ICF/IID during a given month. The Division of Aging 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*, accessible from the *Code Sets* page at in.gov/medicaid/providers. If a claim includes one of these patient status codes, *Core*MMIS automatically closes out the LOC segment for that member.

> *Note: In addition to the patient status code, LTC providers must also include the appropriate occurrence code and date (in fields 31a–34b of the UB-04 claim form or equivalent electronic claim fields) for discharges of IHCP members: occurrence code **42 – Date of discharge** (for live discharges) or occurrence code **55 – Date of death**. For more information about occurrence codes, see the Claim Submission and Processing module.*

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 IHCP 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. Providers should be aware that overpayments to facilities are subject to recoupment.

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 – *Still a patient* and reflect the date the resident began hospice coverage as the "through" date for the period covered on the claim.

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) code 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, with 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.

Autoclosure Process for Inpatient Crossover Claims

*Core*MMIS 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.

When all the following occur for an inpatient crossover claim, *Core*MMIS will close the member LOC segment using the *through* date of service from the claim as the LOC end date:

- An accommodation (room and board) 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.
- The patient status code indicates discharge as listed in *Autoclosure Patient Status Codes for Inpatient Crossover Claims* table on *Long-Term Care Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

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 Gainwell or the Division of Aging so the LOC can be manually end-dated.*

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 **Gainwell LTC help desk** at **317-488-5094** or inxix_ltc@gainwelltechnologies.com. **Providers must not contact the Division of Aging.**

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, when deemed appropriate, the LOC can be *manually restored* in *Core*MMIS. If the LOC was ended incorrectly, the provider will need to submit a request to the FSSA to have the LOC reestablished.

To have claims considered for payment after an autoclosure caused by an erroneous patient status code, the following steps must occur:

1. The provider must adjust or replace any paid claims that had an incorrect discharge patient status code.
1. The provider must call or email the LTC help desk and provide the internal control number (ICN)/Claim ID of the adjusted claim to have the LOC manually updated.
2. After the LOC changes are made, claims that previously denied with EOB code 2008 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 code 2008.

   If the denied claim is past the filing limit, the provider must do the following when resubmitting the claim:
   - *For electronic claims:* Include a claim note indicating "**Retro LOC.**" The claim note is sufficient to bypass the filing limit and allow the claim to be processed.
   - *For paper claims:* Attach a letter stating that the claim was denied due to an erroneous autoclosure of the LOC, that the provider has contacted the LTC help desk, and that the LOC segment for the member has been reinstated. Gainwell provider representatives will then seek

approval from the FSSA OMPP to have the filing limit waived so that the claim can be special batched.

Medicaid Recovery Audit Contractor for Long-Term Care Facilities

The CMS established the Recovery Audit Contractor (RAC) program to promote the integrity of the Medicaid program. Under the federally required RAC program, states must contract with one or more Medicaid RACs to identify inappropriate payments (both overpayments and underpayments) and to recover overpayments from Medicaid providers.

As the Indiana Medicaid RAC, Indiana FSSA Audit Services conducts LTC financial audits of all IHCP-enrolled extended care facilities (provider type 03), including nursing facilities, ICF/IIDs, pediatric nursing facilities, residential care facilities and psychiatric residential treatment facilities (PRTFs).

The RAC audits focus on, but are not limited to:

- Payments made for dates of service after date of discharge
- Duplicate Medicaid payments
- Appropriateness of reporting Medicare or other third-party payments
- Errors related to patient liability application or collection

For more information, see the *Provider and Member Utilization Review* module and the *Medicaid Recovery Audit Contractor (RAC) Overview* page at in.gov/medicaid/providers. For questions about the Medicaid RAC program, call 800-457-4515.