



# INDIANA HEALTH COVERAGE PROGRAMS

## PROVIDER REFERENCE MODULE

# Long-Term Care Facility Services

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Version	Date	Reason for Revisions	Completed By
		<ul style="list-style-type: none"><li>• Added the <a href="#">Outpatient Drug Reimbursement for LTC Members</a> section</li><li>• Updated the <a href="#">Autoclosure of LOC for Discharged Residents</a> section and subsections as needed, including removing the <a href="#">Autoclosure Process for Inpatient Crossover Claims</a> subsection</li></ul>	



# Table of Contents

<b>Section 1: Introduction .....</b>	<b>1</b>
Long-Term Care Facility Providers .....	1
Member Eligibility Considerations .....	2
Verifying Member Eligibility .....	2
Patient Liability.....	3
Transfer-of-Property Penalty Period.....	4
Preventing and Correcting Inappropriate Eligibility Changes .....	4
<b>Section 2: Nursing Facilities .....</b>	<b>7</b>
PASRR and Level-of-Care Assessments .....	7
Level-of-Care Assessment .....	8
PASRR Level I Screen.....	10
PASRR Level II Evaluation.....	11
Screening Requirements for Reimbursement of Nursing Facility Services .....	14
Minimum Data Set Reviews – Processing and Oversight Review Procedures .....	14
Nursing Facility Reimbursement Methodology .....	15
Nursing Facility Claim Completion and Submission.....	16
Additional Billing and Reimbursement Information for Nursing Facility Providers .....	17
Leave Days in a Nursing Facility.....	17
Transportation for NF Residents.....	17
Submitting NF Cost Reports and Schedules .....	18
Quality Assessment Fee.....	18
Physician Visits to Members in a Nursing Facility.....	19
Rate Adjustments for Nursing Facilities .....	19
Medicare Crossover Payment Policy .....	19
Nursing Facilities Not Medicare-Certified.....	20
Certificate of Need Program .....	20
Nursing Facility Considerations for Managed Care Members.....	21
Nursing Facility Policies for Indiana PathWays for Aging.....	21
Nursing Facility Policies for Healthy Indiana Plan, Hoosier Care Connect and Hoosier Healthwise .....	21
Nursing Facility Reimbursement for Managed Care Members .....	24
Outpatient Drug Reimbursement for Managed Care in an LTC Facility .....	24
<b>Section 3: Intermediate Care Facilities for Individuals With Intellectual Disabilities.....</b>	<b>25</b>
ICF/IID Reimbursement Methodology .....	25
ICF/IID Claim Completion and Submission.....	26
Additional Billing and Reimbursement Information for ICF/IID Providers .....	27
Leave Days in an ICF/IID.....	27
Tax Assessment .....	28
Submitting ICF/IID Cost Reports and Schedules .....	28
Retro-Rate Adjustments for ICFs/IID.....	29
<b>Section 4: Additional Information for LTC Facilities.....</b>	<b>31</b>
Correcting LTC Claim Denials Related to LOC Provider Information .....	31
Durable Medical Equipment and Supply Reimbursement for LTC Members .....	31
Outpatient Drug Reimbursement for LTC Members .....	32
Autoclosure of LOC for Discharged Residents.....	32
LTC Facility Residents Who Elect Hospice Benefits .....	32
LTC Facility Residents Admitted to a Hospital.....	32
Correcting an Erroneous Autoclosure.....	33
Medicaid Recovery Audit Contractor for Long-Term Care Facilities .....	33



## Section 1: Introduction

*Note: For updates to information in this module, see [IHCP Bulletins](https://www.in.gov/medicaid/providers) at [in.gov/medicaid/providers](https://www.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

All NF admissions require a PASRR and a qualifying LOC determination to receive Medicaid reimbursement; see the [PASRR and Level-of-Care Assessments](#) section for details. Coverage for long-term services in an NF is available to eligible IHCP members enrolled in the Traditional Medicaid fee-for-service (FFS) program or the Indiana PathWays for Aging (PathWays) managed care program. For members enrolled in any **other** managed care program (such as Healthy Indiana Plan [HIP], Hoosier Care Connect or Hoosier Healthwise), **short-term** care in an NF 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, as described in the [Nursing Facility Considerations for Managed Care Members](#) section.

ICF/IID services are 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 following IHCP Eligibility Verification System (EVS) options to determine active eligibility and coverage status:

- IHCP Provider Healthcare Portal (IHCP Portal)
- Phone-based virtual assistant (GABBY)
- 270/271 Eligibility Benefit Inquiry and Response electronic transactions

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	XXXXXXXXXXXXXXXX	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 members must contribute toward their monthly care in an LTC facility. The terms *client obligation*, *member liability* and *personal resource contribution* also indicate patient liability.

## Patient Liability Amount Information

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.

Information about the patient liability amount is available through the EVS, as described in the [Verifying Member Eligibility](#) section.

## Deviation Requests for Medical Expenses

A deviation allows medical expenses that are not covered by Medicaid to be entered as a countable expense to lower the liability amount a member is responsible to pay. Members approved for a MED 1 category that reside in a Medicaid-certified facility or are approved for a Home- and Community-Based Services (HCBS) waiver may receive a deviation request. Providers should email [dfpdeviationrequests@fssa.in.gov](mailto:dfpdeviationrequests@fssa.in.gov) to notify the DFR that a deviation has been requested. Please do not send documentation to this email mailbox. Verification documents for the deviation request must be mailed with the deviation request to the document center at:

**FSSA Document Center**  
**PO Box 1810**  
**Marion, IN 46952**

The DFR reminds providers that documentation (such as an explanation of benefits [EOB]) of the medical expense must include a provider-generated bill or a copy of such a bill, which includes the date of service and type of service, and clearly shows the amount that the member owes after any third-party payment.

After the DFR receives and verifies the deviation request, the member and their authorized representative will receive notification of the deviation.

## **IHCP Billing and Reimbursement for Members With Patient Liability**

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.

## **Provider Requirements for Collecting Patient Liability**

When collecting the patient liability amount for a resident, LTC facility 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.*

## ***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 for their facility type, the eligibility/coverage resolution **cannot be made retroactive**. Therefore, LTC services rendered during the affected time period cannot be reimbursed by the IHCP.

*Note: Regularly verifying member eligibility could prevent claim denials and possible loss of revenue for providers.*

## 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](http://in.gov/fssa/dfr) webpage at [in.gov/fssa/dfr](http://in.gov/fssa/dfr).

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

## Follow Up With the DFR

If a provider identifies an eligibility or coverage change for a member, or believes the incorrect eligibility or coverage has been assigned for a member, the provider should immediately contact the DFR at 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](https://www.in.gov/fssa/dfr) webpage at [in.gov/fssa/dfr](https://www.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.

## Section 2: Nursing Facilities

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.

### PASRR and Level-of-Care Assessments

As part of the federally mandated Preadmission Screening and Resident Review (PASRR) process, all applicants to Medicaid-certified nursing facilities in Indiana are entered in the state's web-based PASRR system, [AssessmentPro](#), and must undergo a **Level I screen** to determine whether they might have serious mental illness (SMI) or an intellectual or developmental disability (ID/DD). When indicated, a **Level II evaluation** is performed to identify the specialized needs of individuals with MI, ID/DD or MI/ID/DD.

Additionally, for individuals seeking Medicaid coverage of their NF stay, as well as for certain other populations, an **LOC assessment** must be completed to determine whether the individual meets state NF LOC criteria.

*Note: 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.*

On July 1, 2025, the Indiana Family and Social Services Administration (FSSA) launched the Indiana Level of Care Assessment Representative (LCAR), through which a designated contractor, Maximus, administers the state's NF LOC and PASSR procedures. For more information, see the [Indiana LCAR website](#) at [inlcar.com](http://inlcar.com) or contact the Indiana LCAR – Maximus Help Desk as follows:

- **833-597-2777** – For phone-based support, available weekdays from 8 a.m. to 6 p.m. Eastern Time
- [INLCAR@maximus.com](mailto:INLCAR@maximus.com) – To send questions about NF LOC assessments
- [PASRR@fssa.in.gov](mailto:PASRR@fssa.in.gov) – To send questions about the PASRR process or to request access to AssessmentPro

Additional resources, including the Indiana PASRR provider manual, are available from the following webpages:

- [Provider Resources](#) on the Indiana LCAR website ([inlcar.com](http://inlcar.com))
- [Preadmission Screening and Resident Review](#) on the Bureau of Better Aging (BBA) website ([in.gov/fssa/ddars/bba](http://in.gov/fssa/ddars/bba))
- [IN Level of Care Assessment Representative](#) on the Division of Disability, Aging and Rehabilitative Services (DDARS) website ([in.gov/fssa/ddars](http://in.gov/fssa/ddars))

## Level-of-Care Assessment

Indiana LCAR conducts LOC assessments and provides determinations for individuals seeking nursing facility placement. Requests to schedule an LOC assessment may be submitted to the Indiana LCAR – Maximus Help Desk at 833-597-2777 or by using the Assessment Request form on the AssessmentPro system.

In the following cases, *other* entities may conduct the assessment and submit it to the LCAR contractor, Maximus, for review and determination:

- **Hospitals** use AssessmentPro to conduct and submit LOC assessments for inpatients seeking nursing facility placement.
- **Nursing facilities** will continue to use AssessmentPro to conduct and submit LOC assessments and reassessments for prospective and existing residents through the end of 2025. Beginning **Jan. 1, 2026**; the LCAR contractor will take over this function for the NFs.
- **Program of All-Inclusive Care for the Elderly (PACE) providers** will continue to conduct annual LOC reassessments on AssessmentPro for PACE members residing in NF facilities
- **Area Agencies on Aging (AAAs)/Aging Disability Resource Centers (ADRCs) and independent case managers (ICMs)** may submit interRAI data elements to the LCAR contractor for individuals they currently support in nonwaiver programs, when the individuals' needs change and they begin to seek NF care.
- **PathWays managed care entities (MCEs)** will submit interRAI data elements to the LCAR contractor for their members seeking admission to or continued residence in an NF, using the member's full Comprehensive Health Assessment Tool (CHAT).

*Note: AssessmentPro users must ensure patient information is accurate before submitting an assessment to the LCAR contractor. The healthcare professional submitting the assessment is required to attest that the information is accurate to the best of their knowledge. The submitter accepts full responsibility for submitted content. It is important that the submitter only use a patient's IHCP Member ID (IHCP Medicaid number also known as RID) when submitting their request. Submitters should never use any other patient ID except the Member ID. Failing to do so can jeopardize timely turnaround for LOC and PASRR decisions.*

*The FSSA allows retroactively dating the LOC assessment reference date (ARD) up to 90 days prior to the date the LOC is submitted with the following guidelines:*

- *The ARD cannot predate the day Medicaid benefits became active.*
- *The ARD cannot predate the PASRR Level I assessment date.*
- *This applies only to LOC assessments completed for nursing facility admissions.*

*For more information, contact the Indiana LCAR – Maximus Help Desk at [INLCAR@maximus.com](mailto:INLCAR@maximus.com).*

In all the preceding cases, the assessment information must continue to be submitted to the LCAR contractor for review and determination. Indiana uses the interRAI (Resident Assessment Instrument) suite of assessment tools for nursing facility LOC determinations, as follows:

- interRAI Home Care (HC) – Age 18 and older
- interRAI Pediatric Home Care (PEDS) – Age 4 through 17
- interRAI Early Years (EY) – Age 0 through 3

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 a review by the FSSA prior to 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 be the criteria that the FSSA Bureau of Better Aging (BBA), Maximus, and Myers and Stauffer LTC review teams use to define the threshold of nursing care needs required for admission to, or continued stay in, a Medicaid-certified NF.

## 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 is available on the [Provider Resources](#) webpage at inlcar.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 (up to 90 days)
  - Approved for long-term NF stay (more than 90 days)
  - Denied for NF stay (requires further review)
- PACE participants:
  - Approved for long-term NF stay (more than 120 days)
  - Denied for NF stay (requires further review)

*Note: Potential denials for NF applicants and residents and PACE participants will receive a review by the FSSA prior to final determination.*

Providers have access to print outcome letters via the AssessmentPro 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.

## PASRR Level I Screen

A Level I screen is required for all individuals seeking admission to a Medicaid-certified NF, regardless of pay source.

PASRR Level I screens are performed by Indiana LCAR, except in the following cases, where another entity completes the screen and submits it to the LCAR contractor, Maximus, for review and determination:

- **Hospitals** use AssessmentPro to conduct and submit Level I screens for inpatients seeking nursing facility admission.
- **Nursing facilities** will continue to use AssessmentPro to conduct and submit Level I screens for prospective and existing residents through the end of 2025. Beginning **Jan. 1, 2026**; the LCAR contractor will take over this function for the NFs.
- **AAAs** may use AssessmentPro to conduct and submit Level I screens for individuals they currently support in nonwaiver programs and that are newly in need of NF services.

In all other cases, a request should be submitted to Indiana LCAR – Maximus Help Desk to have an LCAR assessor be assigned to schedule and conduct the Level I screen.

## 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 is available on the [Provider Resources](#) webpage at [inlcar.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 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 AssessmentPro 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. All PASRR Level II evaluations are conducted by Indiana LCAR, in collaboration with the Division of Disability, Aging and Rehabilitative Services (DDARS) Bureau of Disabilities Services (BDS) for individuals with ID/DD, and with input from the Division of Mental Health and Addiction (DMHA), as necessary, for individuals with MI.

Level II evaluations must be completed prior to NF 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 LOC assessment, Level I screen and a new Level II evaluation must be performed and completed in AssessmentPro 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 AssessmentPro.*

### ***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 a review by FSSA 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 and submit an LOC assessment via AssessmentPro (or, beginning Jan. 1, 2026, to submit a request for the LCAR contractor, Maximus, to complete an LOC assessment) 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 AssessmentPro.

## **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.

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](#) webpage of the Myers and Stauffer website at [myersandstauffer.com](http://myersandstauffer.com)
- *Minimum Data Set (MDS) Resident Assessment Instrument (RAI) Manual*, available from the [Resident Assessment Instrument](#) webpage of the CMS website at [cms.gov](http://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 under *405 IAC 1-14.7*. Reconsideration rights are communicated through the provider summary letter issued following completion of the MDS review. Responses are required within 15 calendar days of notification. 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 AssessmentPro 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.

## 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.

The IHCP reimburses 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 – *Subacute Care - Subacute Care - Level III* 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 – *Subacute Care - Other Subacute Care* 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 stays of less than 30 days upon discharge of the patient. Providers can bill stays of 30 days or more monthly, or more frequently if desired.
- An attending provider must be included on the claim. A valid attending provider must be enrolled in the IHCP with a Type 1 NPI. In some instances, the attending provider may be the member's certifying physician.

*Note: Currently, the IHCP FFS claim-processing system requires the attending provider on the claim to be enrolled under either the **Rendering** classification or the **Ordering, Prescribing, Referring (OPR)** classification. The IHCP is in the process of making system changes that will also allow providers that are enrolled under the **Billing** classification, **with a Type 1 NPI**, to act as the attending provider on institutional claims. Until these system changes are complete, providers may seek an administrative review or dispute of a claim that denied inappropriately due to this issue. Providers should include documentation from the National Plan and Provider Enumeration System (NPPES) NPI Registry tool showing that the individual has an active Type 1 NPI on the date of a claim. Providers should also include a copy of IHCP Bulletin [BT2025142](#) as documentation for their administrative review or dispute.*

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**  
**PO 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](http://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 LTC 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.

### ***Transportation for NF Residents***

Nursing facilities (provider specialties 030 and 032) are responsible for coordinating and reimbursing transportation providers for all non-advanced-life-support (ALS)/non-basic-life-support (BLS) nonemergency medical transportation (NEMT) services – including both ambulatory and wheelchair van transports – for their Medicaid residents. Additionally, with the exception of ALS and BLS transports, IHCP reimbursement for NEMT services provided to NF residents is 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***

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 determined to be a change of ownership or structure, the cost report is due no later than the due date identified on the Change of Ownership Letter.

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

- Myers and Stauffer Indiana LTC web portal at [inltcdepxchange.mslc.com](http://inltcdepxchange.mslc.com) (preferred)
- Standard mail (USPS, UPS or FedEx)
- Hand delivery to Myers and Stauffer office during normal nonholiday business hours
- 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 *405 IAC 1-14.7*:

- \$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. Documentation must be kept on file for postpayment review.

### ***Rate Adjustments for Nursing Facilities***

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*.

### ***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.
- 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 NF is minimal.

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

## 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](mailto: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](https://in.gov/health) webpage 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***

Eligible Hoosiers age 60 and older receive Medicaid coverage through the Indiana PathWays for Aging (PathWays) managed care program.

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

If a PathWays member seeks admission to an NF, the facility should contact the member's MCE to ensure that the LOC assessment is submitted to Indiana LCAR for review and determination, as described in the [Level-of-Care Assessment](#) section. The LCAR contractor, Maximus, will perform any necessary PASRR Level I and II services for these members. For MCE contact information, see the [IHCP Quick Reference Guide](#), available at in.gov/medicaid/providers.

*Note: PathWays does not include coverage for LTC services in an 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 (*CoreMMIS*). 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 and HIP 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. Hoosier Healthwise members are transitioned to FFS for hospice services.

## 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 the LCAR contractor 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 60 days from the date of admission for Hoosier Care Connect
  - Up to 60 days from the date of admission for Hoosier Healthwise
  - Up to 100 days from the date of admission for HIP
- **If the NF fails to verify a patient's coverage in managed care, or fails to contact the MCE within 72 hours of admission**, the NF may be at risk for charges incurred until the NF has notified the MCE of the patient's status. In the case of notification **after the 72-hour deadline**, the MCE will be liable for charges for a set number of days **from the date of notification**, as follows:
  - Up to 60 days from the date of notification for Hoosier Care Connect
  - Up to 60 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.

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 Bureau of Better Aging (BBA) and the Division of Family Resources (DFR) within 10 days of the event, as follows:

- To the BBA using the PathTracker tool on [AssessmentPro](https://assessmentpro.com) at assessmentpro.com.
- To the DFR via the online [FSSA Benefits Portal](https://fssabenefits.in.gov) at fssabenefits.in.gov, by faxing 888-436-9199 or by mail to the local DFR office. To find your DFR office contact information, visit the [Find My Local DFR Office](https://in.gov/fssa/dfr) webpage 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 per benefit year. 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 LCAR contractor, 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 BBA and the DFR within 10 days, the FFS start date cannot be backdated.*

NFs must work with the HIP 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 HIP MCE, the provider must exhaust all grievances and appeals processes with the HIP MCE to resolve the issue.

If the NF cannot resolve the issue with the HIP MCE, the facility may contact the DFR to request a retroactive transition date for the member's disenrollment from HIP and enrollment in an aged, blind or disability Medicaid category (as appropriate). 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 BBA 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](mailto:OMPPProviderRelations@fssa.in.gov).

### ***Nursing Facility Reimbursement for Managed Care Members***

The rates for NF services covered under a managed care program are equal to the reimbursement rates established for FFS Medicaid.

### ***Outpatient Drug Reimbursement for Managed Care in an LTC Facility***

The MCE reimbursement processes for covered outpatient drugs, dispensed by LTC pharmacy providers, must align with existing FFS processes.

MCEs must not consider drug coverage to be included in per diem rates and must provide reimbursement for all covered outpatient drugs (including those typically requiring administration by a licensed healthcare provider) and covered over-the-counter (OTC) drugs to all IHCP-enrolled pharmacy providers servicing members admitted to LTC facilities, until the member is transitioned to FFS, if applicable. Additionally, the Indiana Medicaid Drug Utilization Review (DUR) Board approves prior authorization criteria for drugs on the Statewide Uniform Preferred Drug List (SUPDL); neutral drugs are reviewed by the OMPP.

LTC pharmacy providers should submit point-of-sale (POS) claims to MCE pharmacy benefit managers (PBMs) prior to dispensing, as MCEs may continue to apply utilization edits and prior authorization criteria approved by the DUR Board. Coverage of OTC drugs may be limited to those included on the OTC Drug Formulary. MCEs may deny reimbursement for drugs administered to members not meeting approved PA criteria and for drugs not included on the OTC Drug Formulary.

## Section 3: Intermediate Care Facilities for Individuals With Intellectual Disabilities

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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 of 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 a Family and Social Services Administration (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 [Durable Medical Equipment and Supply Reimbursement for LTC Members](#) 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.
- An attending provider must be included on the claim. A valid attending provider must be enrolled in the IHCP with a Type 1 NPI.

*Note: Currently, the IHCP FFS claim-processing system requires the attending provider on the claim to be enrolled under either the **Rendering** classification or the **Ordering, Prescribing, Referring (OPR)** classification. The IHCP is in the process of making system changes that will also allow providers that are enrolled under the **Billing** classification, **with a Type 1 NPI**, to act as the attending provider on institutional claims. Until these system changes are complete, providers may seek an administrative review or dispute of a claim that denied inappropriately due to this issue. Providers should include documentation from the National Plan and Provider Enumeration System (NPES) NPI Registry tool showing that the individual has an active Type 1 NPI on the date of a claim. Providers should also include a copy of IHCP Bulletin [BT2025142](#) as documentation for their administrative review or dispute.*

For ICFs/IID, qualified intellectual disability professionals (QIDPs) may enroll as an OPR provider if they are not already enrolled with the IHCP. The IHCP allows for the following QIDPs to enroll as an OPR provider:

- Psychologists
- Licensed doctor of medicine or osteopathy
- Social workers
- Occupational therapists
- Speech-language pathologists or audiologists
- Physical therapists

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**  
**PO 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 LTC 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](http://inltcdeptexchange.mslc.com) 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).

### Correcting LTC Claim Denials Related to LOC Provider Information

If a fee-for-service (FFS) NF or ICF/IID claim denies for explanation of benefits (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.

- For **nursing facilities**, a cover letter requesting that the information be entered in CoreMMIS due to claim denial for EOB 1024 should be submitted via secure email to the Family and Social Services Administration (FSSA) Bureau of Better Aging (BBA), using their email address: [bds.help@fssa.in.gov](mailto:bds.help@fssa.in.gov).
- **ICFs/IID** should direct LOC eligibility questions to the local FSSA Bureau of Disabilities Services (BDS) 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 FSSA, as described in Sections 1 and 2 of this module.

### Durable Medical Equipment and Supply Reimbursement for LTC Members

IHCP policy stipulates that providers cannot bill the IHCP directly for medical supplies, nonmedical supplies or *routine* durable medical equipment (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](https://www.in.gov/medicaid/providers) webpage at [in.gov/medicaid/providers](https://www.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 IHCP members to purchase or rent such equipment with their personal funds. DME purchased with Medicaid funds becomes the property of the Office of Medicaid Policy and Planning (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.

## Outpatient Drug Reimbursement for LTC Members

Drug coverage is not included in per diem rates for LTC facilities. IHCP-enrolled pharmacy providers may bill the IHCP directly for all covered outpatient drugs (including those typically requiring administration by a licensed healthcare provider) and covered over-the-counter (OTC) drugs provided to IHCP members residing in an LTC facility.

Facilities may not require IHCP members to purchase these items.

## Autoclosure of LOC for Discharged Residents

*Note: The LOC autoclosure process described in this section applies to **fee-for-service (FFS)** LTC claims only. For managed care members, the NF LOC is closed after the provider reports the discharge using the [AssessmentPro](#) PathTracker tool. All NF discharges must be reported using the PathTracker tool, regardless of whether the LOC was closed through the autoclosure process described in this section.*

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. CoreMMIS 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.

For a list of the only patient status codes that are valid codes for members who are discharged from LTC facilities, see the *Patient Status Codes for Autoclosure of Member Level of Care* table in *Long-Term Care Codes*, accessible from the [Code Sets](#) webpage at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). If a claim includes one of these patient status codes, CoreMMIS automatically closes out the LOC segment for that member.

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 use one of the following patient status codes, as appropriate:

- 02 – *Discharged or transferred to another short-term general hospital for inpatient care*
- 05 – *Discharged or transferred to a designated cancer center or children's hospital*

Patient status codes 02 and 05 are not included in the autoclosure process. In the event the member does not return to the LTC facility from the hospital stay, the member's LOC will be closed in CoreMMIS when the LTC facility reports the discharge in the AssessmentPro PathTracker tool.

## ***Correcting an Erroneous Autoclosure***

Providers that have previously received payment for a particular resident but have recently received claim denials for explanation of benefits (EOB) 2008 – *Member is not eligible for this level of care for dates of service* should contact the **Gainwell LTC help desk** at 317-488-5094 or [inxix\\_ltc@gainwelltechnologies.com](mailto:inxix_ltc@gainwelltechnologies.com). **Providers must not contact the BBA.**

If the member's LOC was discontinued as a result of the discharge patient status code, Provider Relations will review the claims to determine which claim caused the autoclosure. If an incorrect patient 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 CoreMMIS. 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.
2. 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.
3. 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 Centers for Medicare & Medicaid Services (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](#) webpage at [in.gov/medicaid/providers](http://in.gov/medicaid/providers). For questions about the Medicaid RAC program, call the IHCP Provider and Member Concerns Line at 800-457-4515, option 8 for Audit Services.