

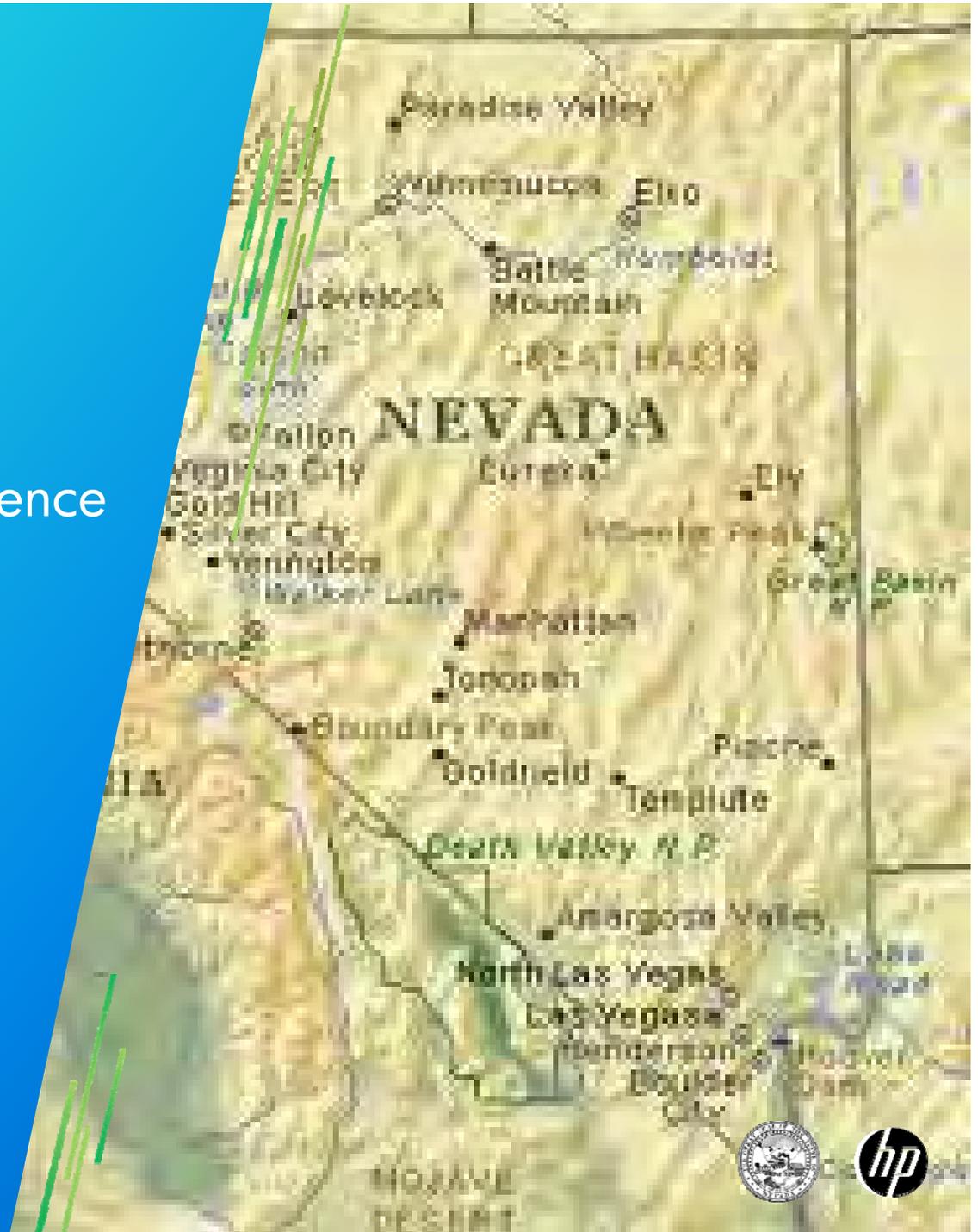
Nursing Facility

Provider Type 19

Annual Medicaid Conference
October 2012

Presented by
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What Will Be Covered

- Why and How to Verify Eligibility.
- Recipient Liability.
- Nursing Facility Tracking Form.
- Billing Authorization.
- Therapeutic Leave of Absence Policy.
- Level of Care Policy.
- PASRR Policy.
- Contacts and References.



Disclaimer

- This presentation is intended to provide you with some of the key information related to payment.
- It is ***not*** intended to fully represent the Nevada Medicaid Services Manual requirements or requirements of the Federal regulations.



Why and How to Verify Eligibility

Why providers should check eligibility:

- Ensures recipient has active benefits.
- Allows you to check for other coverage (Third Party Liability).
- Helps you in determining the right place to send the claim the first time.

There are three ways to check eligibility:

- Electronically on the Provider Web Portal at www.medicaid.nv.gov
- ARS (800-942-6511).
- Swipe card system (This is a “pay for service” system to which providers may subscribe).



Recipient Liability

- Nevada Division of Welfare and Supportive Services (DWSS) determines recipient liability.
- DWSS sends the notice of decision.
- Recipient liability amount is interfaced from the DWSS NOMADS system to the Medicaid MMIS system.
- Claims are reduced by the recipient liability amount.



Nursing Facility Tracking Form

Medicaid Services Manual (MSM) 503.4

The Division of Health Care Financing and Policy (DHCFP) Nursing Facility Tracking Form (NMO 4958E) is used as a notification to begin and/or end payment dates for nursing facility stays. The information provided on this form is used to determine the dates authorized for reimbursement.

- Finding the form.
- Instructions to complete the Nursing Facility Tracking Form.



Finding the form

http://dhcfp.nv.gov

The screenshot shows the website for the Nevada Department of Health and Human Services, Division of Health Care Financing and Policy. The page is dated Wednesday, September 12th, 2012. The main navigation bar includes links for 'Nevada Department of Health and Human Services', 'DHCFP Home', 'Telephone Directory', 'Sitemap', and 'About Us'. The 'DHCFP INDEX' sidebar on the left contains a list of links, with 'Forms' circled in red. A sub-menu for 'Forms' is open, showing 'Nursing Facilities' circled in red. The main content area is titled 'Nursing Facility Information' and includes a search box, radio buttons for 'The Web' and 'DHCFP', and a 'Search' button. Below the search box, there is a link to 'The Centers for Medicare and Medicaid Services Nursing Home Compare Website' and a section for 'Health Division Health Care Quality and Compliance Inspection and Survey results:' with links for 'All facility list' and 'Search by name and/or location'. Other links in the sidebar include 'Adult Day Health Care Services', 'Form 3058', 'HPES', 'ICE/MR Tracking Form', 'Imbudsman Program', 'ity Resource Center', 'Facility Forms', '3430 Form Instructions', '3430 Serious Occurrence Report', 'Nevada Medicaid and Child Facility Rates', and 'MDS Guidelines'.



Instructions to Complete the Nursing Facility Tracking Form

- If the resident is not Medicaid eligible upon admission, do not submit this form until Medicaid eligibility has been determined. This form is only to be used when Medicaid is the primary payment source.
- Provide the name of the person completing the form, email address, and date form is submitted.
- Submit online at the DHCFP website <http://dhcfp.nv.gov> or the form may be printed and mailed to 1100 E. William Street, Suite 102, Carson City, NV 89701. The facility should retain a copy for their records.



Instructions to Complete the Nursing Facility Tracking Form, continued

- Submit the form within 72 hours of any admission, service level change, payment continuation (due to a previous time limitation), new or retro eligibility determination, Hospice disenrollment or Medicaid Managed Care disenrollment, OR within 72 hours in the event of a discharge, death, transfer or Hospice enrollment.
- If the resident has been discharged, complete Section III.



Section I – Admission Information

- a) Indicate the date the resident was admitted to the facility, regardless of payment source. This may differ from the payment beginning date.
- b) Indicate whether a PASRR Level I Identification screening and PASRR II evaluation (if applicable) has been completed. If yes, indicate the completion date. If the PASRR is time limited, indicate the limitation date.
- c) Indicate whether a Level of Care screening has been completed. If yes, indicate the completion date. If the screening is time limited, indicate the limitation date.



Section II – Payment Information

- a) Indicate the date you are requesting Medicaid payment to begin. This date should correspond with the reason for the payment request.
- b) Complete the Reason for Payment Request. Indicate one choice as described below:
 - **Admission:** An admission to the facility and Medicaid is the primary payment source.
 - **Service Level change:** Any service level change between NF Standard and Ventilator Dependent or Pediatric Specialty Care I and II (a new LOC screening is required).
 - **Payment Continuation:** Requesting payment continuation due to a time limited PASRR or LOC screening (an updated PASRR or LOC screening is required).



Section II – Payment Information, continued

- **Retro-Eligible:** Service dates that become eligible prior to the existing billing authorization.
 - **Eligibility Reinstated:** The resident has lost Medicaid eligibility for more than 6 months and the resident's eligibility has now been reinstated (the facility must submit the tracking form to obtain a new billing authorization).
 - **Hospice Disenrollment:** The resident elects to disenroll from the Hospice program.
 - **Medicaid Managed Care Disenrollment:** The resident is disenrolled from the Medicaid Managed Care program.
- c) Indicate the Service Level Category for this resident. If your choice is LOC prior to 1/1/02, indicate the appropriate level of care code (SNL-1, 2, 3 or ICL-1, 2, 3).



Section III – Discharge Information

Upon discharge, complete Section III of the tracking form and submit within 72 hours on any occurrence listed below:

- a) Home or Community Based Living: Home or any other community based, independent or group living situation.
- b) Hospital: Admitted as an inpatient to a hospital; this does not include admission to an emergency room or observation bed.
- c) Death: Resident deceased.

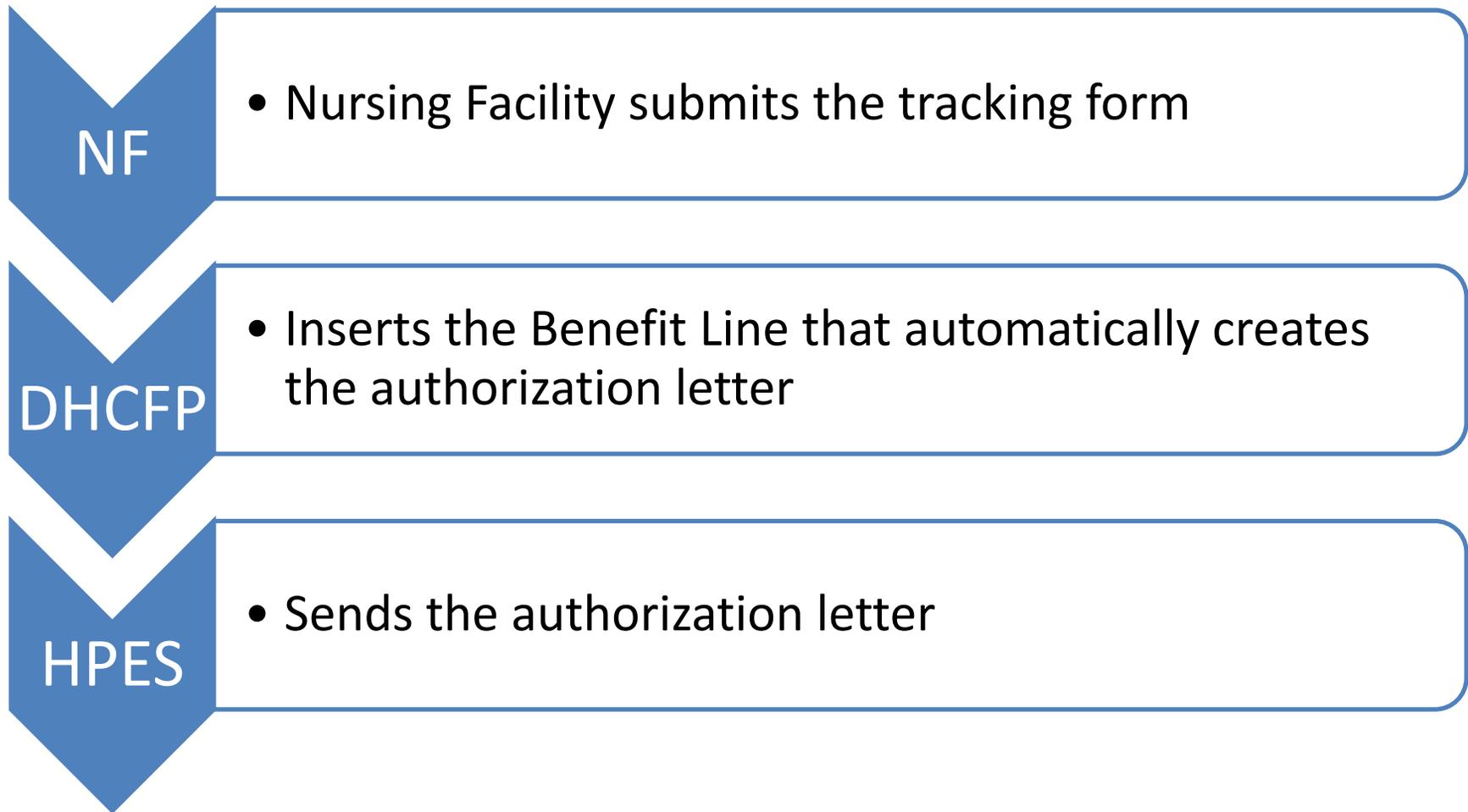


Section III – Discharge Information, continued

- d) Transfer: Transfer to another nursing facility. Indicate the name of the facility to which the resident is transferred.
- e) Hospice Enrollment: The resident elects to enroll in the Hospice program while in the nursing facility. Indicate the name of the Hospice.
- f) PASRR II Determination: Any discharge, regardless of pay source, directly related to a PASRR II recommendation. Indicate to where the resident was discharged.



Billing Authorization Process Flow



Therapeutic Leave of Absence (LOA) Policy – MSM 503.7

Therapeutic leave (TL) includes therapeutic or rehabilitative home and community visits and also includes leave used in preparation for discharge to community living overnight stays. TL does not apply when a recipient is out on pass for short periods of time or while in hospital emergency rooms or for hospital inpatient stays.

- Reimbursement.
- Provider Responsibility.



Reimbursement

- The per diem rate is reimbursed for reserving beds for TL up to an annual maximum of 24 days (January 1 - December 31). No carry over into the next calendar year.
- Keep accurate leave day records in the recipient's chart. A record of leave days must be part of receiving facility transfer documents so that the receiving facility may determine the number of therapeutic leave days that have been exhausted by the sending facility within the same calendar year.
- Medicaid reimbursement is not available for dates beyond those specified in the physician's order should a recipient fail to return to the facility within the specified time frame.
- Revenue code 183 is used on the billing claim.



Provider Responsibility

- TL must be authorized in writing by the recipient's attending physician to ensure the recipient is medically stable and capable of safely tolerating the absence. A physician's order such as "may go out on pass" is not acceptable for this purpose.
- Must be included in the recipient's plan of care.
- Must provide care instructions for the responsible person who will be accompanying the recipient during their therapeutic leave of absence.
- Must reserve and hold the same room and bed for the Medicaid recipient on TL.



Level of Care (LOC) – MSM 503.3

LOC is a screening assessment conducted prior to admission to a nursing facility for Medicaid eligible recipients and is used to determine if a recipient's condition requires the level of services offered in a nursing facility, or whether the recipient would qualify for less restrictive services which may be community based.

- What is it and why is it important.
- Where to find the MSM.
- Requirements.
- Reminders.
- Retrospective.
- Categories.



Level of Care – What is it and why is it important?

- A level of care assessment is a screening tool used to evaluate the medical necessity of a nursing facility admission for Medicaid eligible individuals.
- Federal regulation requires “medical necessity” to be determined.
- LOC is required for Medicaid reimbursement.
- Identifies possibility of less restrictive services and leads to Facility Outreach and Community Integration Services (FOCIS) referrals.



Level of Care – Where is the LOC form located?

- www.medicaid.nv.gov
 - From the “Providers” tab.
 - Select “Forms”.
 - Click on form number FA-19 “Level of Care Assessment for Nursing Facilities”.



Level of Care Requirements

- The level of care assessment is completed by a licensed health care professional.
- When a recipient's condition improves and it appears that the resident may no longer meet a nursing facility standard level of care, the nursing facility must complete and submit a new level of care assessment form.
- When a resident no longer meets a nursing facility level of care, the provider is responsible for the recipient's safe discharge.
- If the provider needs further assistance, a referral to the Facility Outreach and Community Integration Services program can be made by contacting one of the DHCFP District Offices.



Level of Care Requirements, continued

- The provider must request an updated level of care when a recipient's condition changes significantly (can be an improvement or a decline), such as:
 - Recipient who has a ventilator dependent level of care and is no longer on a ventilator.
 - Recipient who has a nursing facility standard level of care and requires ventilator support.
 - Recipient who has improved and may no longer meet the level of care criteria for nursing home placement.



Level of Care Reminders

- Medicaid reimbursement is not available when:
 - A recipient is not currently eligible.
 - A facility admits a recipient who does not have a completed level of care.
 - A facility chooses to admit a recipient who does not meet a nursing facility level of care.
 - A resident no longer meets a nursing facility level of care.
- Mark correct boxes on level of care screening form.



Level of Care Reminders, continued

- Monitor the recipient's eligibility closely – eligibility can be updated daily.
- Level of care determinations may be time limited.
- These determinations may be limited to 90 days.



Retrospective Level of Care

- Nursing facility residents who become Medicaid eligible after admission (retro-eligibility) must have a LOC determination prior to the provider obtaining a billing authorization for Medicaid reimbursement.
- If an individual becomes Medicaid eligible after death or discharge from a nursing facility, the level of care screening may be requested and determined retroactively.



Pre-Admission Screening and Resident Review (PASRR) – MSM 503.2

The purpose of the PASRR screening is to identify any indicators of Mental Illness (MI), Mental Retardation (MR) or a Related Condition (RC) and to make referrals for PASRR Level II screenings. It must be completed on ALL admissions regardless of payment source.

- Medicaid Services Manual.
- HP Enterprise Serviced (HPES) roles and responsibilities.
- Level I.
- Level II.
- Payment authorization.
- Non-reimbursement bottom line.



Medicaid Services Manual – dhcfp.nv.gov

Nevada Department of Health and Human Services
Division of Health Care Financing and Policy

Nevada Department of Health and Human Services | DHCFP Home | Telephone Directory | Sitemap | About Us

DHCFP INDEX

- DHCFP Home
- Audit Information
- Behavioral Health Services
- Boards & Committees
- Care Management Organization & 1115 Waiver
- Civil Rights and Advance Directives
- Dental Health Services
- Employment Opportunities
- EPSDT/Healthy Kids Program
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- HPES
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- Indian Health Programs
- Managed Care Organizations
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- Public Notices
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- Subscriptions

Division of Health Care Financing and Policy (DHCFP)

The Division of Health Care Financing and Policy (DHCFP) works in partnership with the **Centers for Medicare & Medicaid Services** to assist in providing quality medical care for eligible individuals and families with low incomes and limited resources. The medical programs are known as Medicaid and Nevada Check Up.

Medicaid

Provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid but whose family income is at or below 200% of the Federal Poverty Level. To apply for or obtain additional information regarding the Nevada Check Up program use the following link www.nevadacheckup.nv.gov or call toll free 1-877-543-7669.

Nevada Check Up

Provides health care benefits to uninsured children from low-income families who are not eligible for Medicaid but whose family income is at or below 200% of the Federal Poverty Level. Information regarding the Nevada Check Up program is available at www.nevadacheckup.nv.gov or by calling toll free at 1-877-543-7669.

Nevada Check Up Manual
NV Medicaid Operations Manual
NV Medicaid Services Manual

Report Provider Identified Overpayment

Apply for Medical Assistance Programs

Report Medicaid Fraud!

Provider Incentive Program for Electronic Health Records (EHRs)

Hours of operation:

Tuesday May 29th 2012

The Web DHCFP

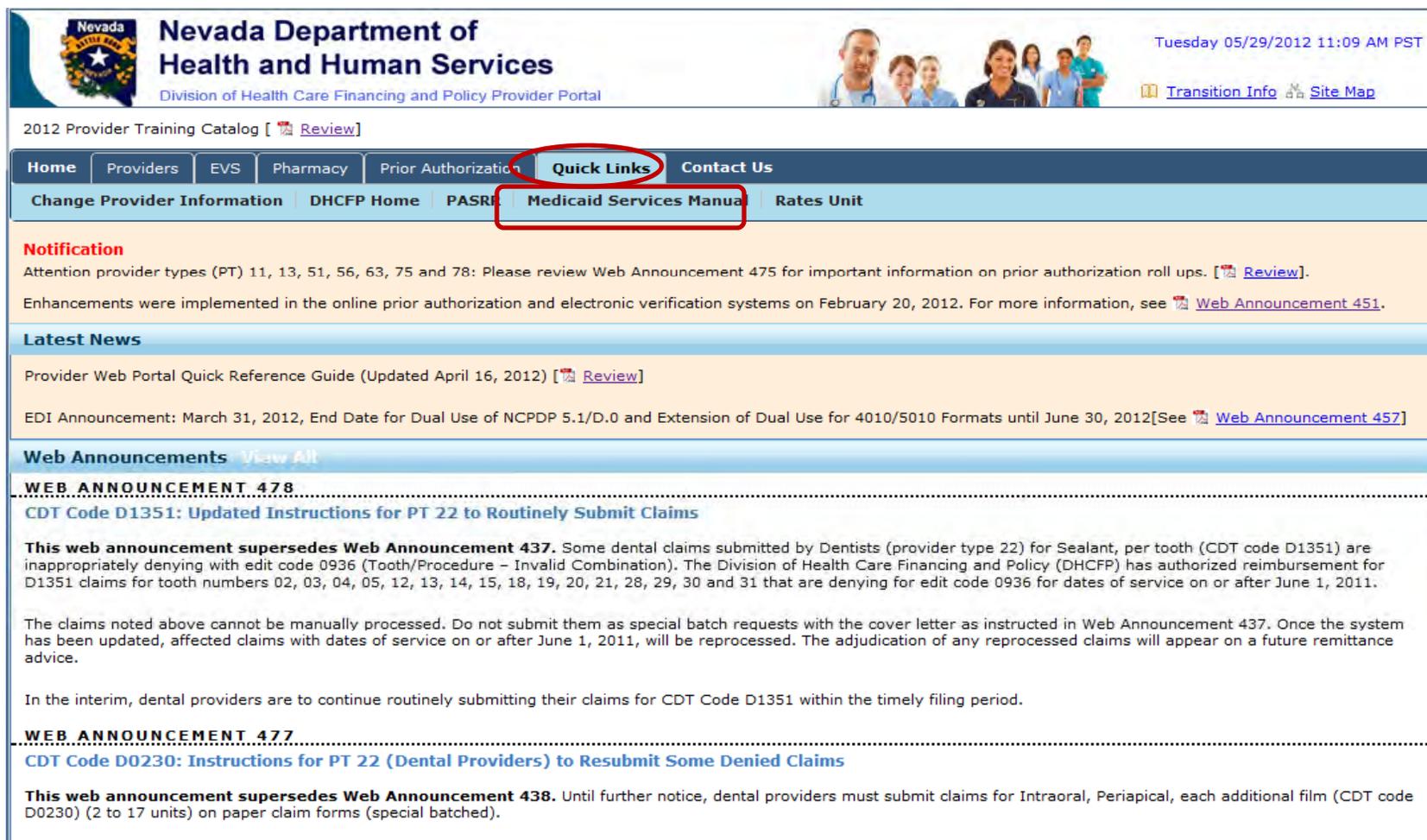
WHAT'S NEW

IMPORTANT!

- [1115 Waiver Application](#)
- [Care Management Organization & 1115 Waiver](#)
- [Letter from the Director RE: Behavioral Health](#)
- [Provider Incentive Program for EHRs](#)
- [DHHS - Office of Health Information Technology \(HIT\)](#)



Medicaid Services Manual – www.medicaid.nv.gov



Nevada Department of Health and Human Services
Division of Health Care Financing and Policy Provider Portal

Tuesday 05/29/2012 11:09 AM PST

2012 Provider Training Catalog [[Review](#)]

Home Providers EVS Pharmacy Prior Authorization **Quick Links** Contact Us

Change Provider Information DHCFP Home PASRP **Medicaid Services Manual** Rates Unit

Notification
Attention provider types (PT) 11, 13, 51, 56, 63, 75 and 78: Please review Web Announcement 475 for important information on prior authorization roll ups. [[Review](#)].
Enhancements were implemented in the online prior authorization and electronic verification systems on February 20, 2012. For more information, see [Web Announcement 451](#).

Latest News

Provider Web Portal Quick Reference Guide (Updated April 16, 2012) [[Review](#)]
EDI Announcement: March 31, 2012, End Date for Dual Use of NCPDP 5.1/D.0 and Extension of Dual Use for 4010/5010 Formats until June 30, 2012[See [Web Announcement 457](#)]

Web Announcements [View All](#)

WEB ANNOUNCEMENT 478
CDT Code D1351: Updated Instructions for PT 22 to Routinely Submit Claims

This web announcement supersedes Web Announcement 437. Some dental claims submitted by Dentists (provider type 22) for Sealant, per tooth (CDT code D1351) are inappropriately denying with edit code 0936 (Tooth/Procedure – Invalid Combination). The Division of Health Care Financing and Policy (DHCFP) has authorized reimbursement for D1351 claims for tooth numbers 02, 03, 04, 05, 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30 and 31 that are denying for edit code 0936 for dates of service on or after June 1, 2011.

The claims noted above cannot be manually processed. Do not submit them as special batch requests with the cover letter as instructed in Web Announcement 437. Once the system has been updated, affected claims with dates of service on or after June 1, 2011, will be reprocessed. The adjudication of any reprocessed claims will appear on a future remittance advice.

In the interim, dental providers are to continue routinely submitting their claims for CDT Code D1351 within the timely filing period.

WEB ANNOUNCEMENT 477
CDT Code D0230: Instructions for PT 22 (Dental Providers) to Resubmit Some Denied Claims

This web announcement supersedes Web Announcement 438. Until further notice, dental providers must submit claims for Intraoral, Periapical, each additional film (CDT code D0230) (2 to 17 units) on paper claim forms (special batched).



HPES Roles and Responsibilities

- Conducts all Level I Identification Screening Determinations.
- Conducts all Level II PASRR Evaluations and Screening Determinations.
- Maintains database for all Level I and Level II Screenings.
- Issues copies of Determination Letters and Summary of Findings.
- Final review and sign-off authority for all PASRR Level II Determinations.
- Provides statistical reports to the Division of Mental Health and Developmental Services (MHDS).



PASRR Level I – What is it and who needs it?

- A screening tool used to identify if the individual has indicators of:
 - mental illness (MI) or
 - mental retardation (MR) or
 - a related condition (RC)
- All potential nursing facility residents...
regardless of payment source or anticipated length of nursing facility placement



PASRR Level I – When does it need to be done?

- When placement in a Medicaid-certified nursing facility is “imminent”.
- Prior to admission to any Medicaid-certified nursing facility.
- Within 14 days of a significant change in condition (either mental or physical), as indicated by a Significant Change in Status Assessment (SCSA) Minimum Data Set (MDS).
- Prior to the expiration of any time-limited PASRR screening determination.



What happens if a PASRR Level II is needed?

- HPES notifies the requestor that a Level II is needed. The Level I Determination Letter indicates a determination of “IA” (Level I – A code).
- The individual may not be admitted to a nursing facility until the Level II is completed.
- HPES makes all arrangements for the completion of the Level II.
- HPES notifies the requestor of the completion of the Level II by issuing the PASRR Level II determination letter.



PASRR Level I Requirements

- Discharging facility must:
 - Complete and submit Level I form.
 - Allow 1-3 business days for Level I determinations (acute = 1 day, all others = 3 days).
 - Obtain the Level I determination prior to admission to a nursing facility.
 - Forward copies of the determination letter to the receiving facility (preferably in the “pre-admission” paperwork).



PASRR Level I Requirements, continued

- Nursing facility must:
 - Obtain the determination letter as proof of the screening completion – recommend doing this before admission.
- Note:** Determination letters can be obtained from:
- HPES online PASRR system.
 - Discharging facility.
 - Not admit if the determination is “IA” – must wait until the Level II Individual Evaluation is complete.
 - Not admit if the determination is “IIA”.



Level II – PASRR Screenings

- There are two types of Level II PASRR screenings:
 - A “Categorical Determination”
 - OR
 - An “Individual Evaluation”



PASRR Level II – “Categorical Determinations”

- EHD – may be admitted for less than 30 days.
- IIE – 45 days: meets criteria and does not require specialized services for the period of time indicated.
- IIF – terminally ill and has physician’s certification of life expectancy of 6 months or less.
- IIG – has a **severe** physical illness/condition and is not expected to benefit from specialized services.



PASRR Level II – “Categorical Determinations”, continued

- One of the previous determination codes will be indicated on the Level I determination letter.
- Any of these codes are acceptable for placement in the NF.
- If EHD or IIE – these are time-limited and payment authorizations for these will be stopped effective on the “limitation/update due” date (this date is provided in the determination letter).
- If the facility admits on an expired determination, no payment will be issued until the Level II (Individual Evaluation performed by a psychiatrist, psychologist or both if dual diagnosis) is completed.



PASRR Level II – “Individual Evaluations”

- Possible determination codes are:
 - IIA - Do not admit.
 - IIB - OK to admit.
 - IIC - OK to admit.
 - Halted IB (has a diagnosis of Dementia or other Organic Brain Syndrome) - OK to admit.
 - Halted IC (does not meet the federal definition of serious MI, MR or RC) – OK to admit.



Payment Authorizations and PASRR

- As part of the Medicaid payment authorization process, screening completion dates and determination codes are monitored for compliance.
- No payment authorization will be granted when the receiving facility has not complied with the requirements of the PASRR program.



Non-Reimbursement Bottom Line

- Failure of the nursing facility to verify prior to admission completion of a PASRR determination that clears the individual for admission will result in a non-reimbursement from Medicaid, until the Level I (and if Level I = IA, until the Level II) is complete.
- Failure to update time-limited screenings prior to the expiration date; no reimbursement from expiration date to new completion date.
- Determinations of Level I = IA and/or a Level II = IIA mean the individual was not cleared for nursing facility placement and no payment authorization will be issued for those stays.



Contact information

HPES Points of Contact	
Sarah Ramirez	(775) 335-8557
Thea Fraga	(775) 335-8556
Provider Web Portal (password resets)	(877) 638-3472, option 2, then option 7
Fax (PASRR and LOC)	(855) 709-6847 (effective Nov. 12, 2012)
Claim Status Information	(877) 638-3472, option 2, then option 3
DHCFP Points of Contact	
Connie Anderson Chief, Continuum of Care	canderson@dhcfp.nv.gov
Londa Moore PASRR Coordinator	(775) 684-3757
Patricia (Trish) O'Flinn Administrative Support	(775) 684-3669
Medicaid District Offices	Carson City 775-684-3676 Elko 775-753-1191 Las Vegas 702-668-4200 Reno 775-687-1900



Reference List

Reference	Location
Medicaid Services Manual Chapter 500 - Nursing Facility Services	503.2 – PASRR 503.3 – LOC 503.4 – Nursing Facility Tracking 503.5 – Billing Authorizations 503.6 – Patient Liability 503.7 – Therapeutic Leave of Absence 503.13C – Hearings
Medicaid Services Manual Chapter 3100 – Hearings	3104 (Recipients) 3105 (Providers)
DHCFP website	http://dhcfp.nv.gov
HPES web portal	http://www.medicaid.nv.gov
PASRR Level I Form	FA-18
Level of Care Form	FA-19
PASRR/LOC Request Form	FA-20
Nevada Provider Training Team	nevadaprovidertraining@hp.com



