ADMINISTRATIVE DIRECTIVE

TRANSMITTAL: 96 ADM-6

DIVISION: Health and Long Term Care

TO: Commissioners of Social Services

DATE: March 6, 1996

SUBJECT: Medicare Maximization for Nursing Facility Care

SUGGESTED DISTRIBUTION: Medical Assistance Staff
Staff Development Coordinators
Data Entry Staff

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ATTACHMENTS: Attachment I: Use of Exception Codes
(Available on-line)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
90 INF-42		505.9 540.5	367-a		90 LCM-02

I. PURPOSE

The purpose of this administrative directive (ADM) is to inform districts of policy changes which revise nursing facility (NF) Medicare Maximization requirements.

II. BACKGROUND

Since first introduced in 1976, all Medicare Maximization efforts have required NF staff to document their efforts to obtain Medicare reimbursement for individuals identified as having a reasonable likelihood of being covered.

The 1990 Medicare Maximization effort selected five Resource Utilization Groupings (RUGS) II as its standard for identifying individuals with a reasonable chance of being covered by Medicare. The five RUGS II groupings are: Rehabilitation A and B; Special Care A and B; and, Clinically Complex D. A complete discussion of the 1990 Medicare Maximization effort and delineation of the five designated RUGS II groupings can be found in 90 LCM-02, "Medicare Optimization" and 90 INF-42, "Medicare Optimization for Care Provided in Skilled Nursing Facilities."

Due to the initiation of the Health Care Financing Administration (HCFA) demonstration project entitled the "Multistate Skilled Nursing Facility (SNF) Case Mix Payment Demonstration", Medicare Maximization policy and procedures have been revised. New York State, with the New York State Department of Health (DOH) as lead agency, is a participant in this demonstration. This project establishes a Medicare payment system for long term care services which matches available resources to resident need. The patient assessment system for this project is termed RUGS III.

Although NF participation in the demonstration project is voluntary, it is anticipated that most Medicare certified NFs will participate, as an increase in the Medicare per diem rate is expected for these facilities. In addition, the current budget bill calculates a Medicare target methodology and expected level of Medicare revenue for NFs. Failure to achieve this Medicare target could result in a loss of Medicaid funds to facilities.

III. PROGRAM IMPLICATIONS

The State's current Medicare Maximization policy states that all NF residents identified as having a reasonable likelihood of being covered by Medicare shall have Medicare applications and, if necessary, requests for redetermination of denials, made on their behalf before Medicaid assumes payment responsibility.

Participating and Non-participating Facilities. For the purposes of this ADM, a participating facility shall mean a NF which is

participating in the "Multistate Skilled Nursing Facility (SNF) Case Mix Payment Demonstration." A non-participating facility, for the purposes of this ADM, means a NF, enrolled as a provider in the Medicaid program but not participating in the "Multistate Skilled Nursing Facility (SNF) Case Mix Payment Demonstration."

The Medicare Maximization process is revised for participating facilities in the demonstration project.

A. SUBMISSION OF MEDICARE APPLICATIONS. With the initiation of the demonstration project, criteria for submission of Medicare applications differ between participating facilities and non-participating facilities.

1. Participating facilities: These facilities are exempt from Medicare Maximization procedures.

   Participating facilities are not required to submit Medicare documentation for ANY Medicaid recipient. Medicaid reimbursement must not be inhibited for any resident of a participating facility for the purpose of Medicare Maximization. Social services districts must exempt participating facilities from any enhanced Medicare Maximization procedures established in that district.

   Although participating facilities are exempt from current Medicare Maximization procedures, it is required that a nursing facility will continue to make Medicare application for any resident, regardless of RUGS category, whose diagnoses or combination of services appear to meet Medicare guidelines for coverage. The decision to submit a Medicare application for a recipient who is outside the automatically covered categories is the responsibility of the participating facility. Social services districts must not request submission of specific Medicare applications or reconsiderations.

2. Non-participating facilities: Non-participating facilities must continue to maximize Medicare reimbursement according to current Department policy. The maximization effort for a non-participating facility includes any enhanced procedures required by the social services district fiscally responsible for each resident.

B. TARGET POPULATION.

There is no change in current policy regarding individuals included in this target population. Individuals included in the Medicare Maximization target population must exhibit the following characteristics:

1. Medicare Enrollment. Individuals must be enrolled in Medicare, either by virtue of age or established disability.

2. Technical Eligibility. Since Medicare requires a three day hospital stay prior to granting NF coverage, the Medicare

Maximization effort targets only those technically eligible individuals who have been admitted or readmitted to a NF within 30 days of an acute hospital stay.

C. ASSESSMENT PROCESS.

Participating and non-participating facilities are required to utilize the Minimum Data Set, Plus (MDS+) and the Patient Review Instrument (PRI) as resident assessment instruments. The PRI must continue to be submitted to the social services district as part of the placement process.

Participating and non-participating facilities must continue to utilize the RUGS II assessment system for Medicaid covered patients. Medicaid reimbursement cannot be made without the establishment of the RUGS II category.

D. DOCUMENTATION OF MEDICARE MAXIMIZATION ACTIVITIES.

1. Participating facilities are exempt from Medicare Maximization documentation requirements. Facilities participating in the demonstration project utilize the RUGS III assessment system to establish a patient's Medicare category. Patients residing in participating NFs who fall into one of the top four RUGS III categories receive automatic Medicare coverage. These categories are: Rehabilitation; Extensive Care; Special Care; and, Clinically Complex. Participating facilities must continue to utilize the RUGS II assessment system to establish a patient's Medicaid payment category.

2. For non-participating facilities, the face sheet of the PRI used for notification of admission and readmission initiates the process by identifying the RUGS II grouping assigned to the patient. The process of documentation includes three steps: a) documentation that the client falls into a RUGS II group which must be maximized; b) documentation that the client is technically eligible for Medicare coverage; and, c) documentation that the NF has either received Medicare payment for the patient, or has taken all the steps required to obtain Medicare coverage. There is no change in procedure for non-participating facilities.

E. MISCELLANEOUS.

1. Payment Of Co-Insurance. Even when covered by Medicare, a point is reached (after 20 days of full Medicare coverage) where Medicaid is obligated to pay the co-insurance. NFs are permitted to bill for co-insurance on the twenty-first day following an admission or readmission despite a "1" having been initially entered in the Principal Provider system. In order for the NF to receive MA payment for co-insurance days, the social services district must change the exception code of "1" to a "2". When submitting the claim, the NF must bill co-insurance on a separate claiming line to avoid being linked to the "1" governing the first 20 days of care.

2. Participating Nursing Facilities. A list of facilities participating in the demonstration project will be distributed to social services districts by this Department each month. Newly enrolled facilities will be flagged for easy identification. This list will be electronically mailed to a contact person designated by each district.

3. Third Party Health Insurance. Both participating and non-participating facilities are required to maximize any available third party health insurance (TPHI). Participating and non-participating facilities must document for the social services district that payments have been denied, maximized or exhausted. Social services districts can withhold Medicaid payment from facilities until documentation of third party health insurance disposition is received.

4. Out-Of-State Providers. Medicare Maximization policies apply to out-of-state facilities. The major difference is in the use of the PRI or RUGS groupings, which the Department cannot mandate for out-of-state facilities. The notification requirements, to the extent it is possible to identify individuals falling within the targeted RUGS groupings, are identical. Receipt of the facilities' admission notification triggers entry of Payment Exception Type "1". Receipt of copies of either an explanation of coverage or a copy of the reconsideration request to the fiscal intermediary should notify the social services district that a change in the Principal Provider Payment Exception Type to a "2" is required.

5. Control Group. St. Lawrence County has been designated the control group for this demonstration project by the Department and the NYSDOH. Medicare coverage for MA recipients who are the fiscal responsibility of St. Lawrence County must continue to be maximized according to standards established by the St. Lawrence County Department of Social Services. Both participating and non-participating facilities must continue submission of required documentation to the social services district for any recipient whose RUGS II or RUGS III assessment places him/her in a category deemed Medicare coverable according to St. Lawrence County maximization procedures.

IV. REQUIRED ACTION

Social Services districts must revise Medicare maximization policies as described in this directive for participating and non-participating facilities.

V. SYSTEMS IMPLICATIONS

Entry Into The Principal Provider System. Upon admission or readmission to a NF, all Medicaid clients must be entered into the Principal Provider System as having entered a specific NF on a specific date. Through the addition of two exception codes in

1990, the need to be able to prevent Medicaid payment for certain individuals within the Medicare Maximization target population has been accommodated.

The exception codes and their purposes are:

Exception Code 1 - Exception code 1, following the entry of facility provider identification number and effective date in the Principal Provider system, establishes that the client was appropriately admitted to that facility on that date, but that Medicaid payment is prohibited until documentation of appropriate Medicare Maximization and/or Third Party Health Insurance efforts has been received.

Exception Code 2 - Exception code 2, following the entry of facility provider identification number and effective date in the Principal Provider system, establishes that the client was appropriately admitted to that facility on that date, and that Medicaid payment is permitted because documentation of appropriate Medicare Maximization and/or TPHI efforts has been received.

The exception codes (1 and 2) are used for all admissions and readmissions to NFs. More specifically:

For both participating and non-participating facilities, enter exception code 2 for any individual who is not enrolled in Medicare.

For both participating and non-participating facilities, enter exception code 2 for all admissions and readmissions from any setting other than an acute care hospital. These admissions are not preceded by the required three day hospital stay, and are not technically eligible for Medicare.

For participating facilities, enter exception code 2 for all individuals upon admission. Appropriate Medicaid payment should not be inhibited for the purposes of Medicare Maximization. See Section III E, Miscellaneous, for a discussion of TPHI maximization in participating facilities.

For non-participating facilities, enter exception code 1 for all technically eligible individuals admitted or readmitted to a NF from an acute care hospital and for whom documentation of the completion of all required Medicare Maximization/TPHI activities has not been received.

For non-participating facilities, enter exception code 2 for any individual for whom an exception code 1 had initially been entered immediately upon receipt of documentation that all applicable Medicare Maximization/TPHI requirements have been met.

Note:

The exception code change from a "1", inhibiting Medicaid payment to a "2", allowing MA reimbursement should be done by the district

as soon as possible after proper documentation has been received from the NF. If this change is not entered in a timely manner, appropriate and necessary payment to the NF is blocked.

VI. EFFECTIVE DATE

This directive is effective March 15, 1996 retroactive to July 1, 1995.

Richard T. Cody
Deputy Commissioner
Division of Health and Long Term Care

ATTACHMENT I

USE OF EXCEPTION CODES

	CODE 1	CODE 2
PARTICIPATING FACILITIES		
Individual not enrolled in Medicare.		XXXXXX
Individual admitted from other than acute hospital setting.		XXXXXX
All individuals upon admission with no TPHI.		XXXXXX
Individuals with TPHI not exhausted.	XXXXXX	

For participating facilities, the "1" Exception Code should not be used for the purpose of maximizing Medicare.

NON-PARTICIPATING FACILITIES		
Individuals admitted from other than acute hospital setting.		XXXXXX
Individuals admitted from acute hospital setting with incomplete Medicare Maximization documentation.	XXXXXX	
Individuals admitted from an acute setting with complete Medicare Maximization documentation.		XXXXXX
Individuals who have exceeded 20 days of full Medicare coverage.		XXXXXX
Individuals with TPHI not exhausted.	XXXXXX	