

**Affected Programs:** BadgerCare Plus, Medicaid

**To:** Nursing Homes, Hospice Providers, HMOs and Other Managed Care Programs

## **Nursing Home Care Determinations and Hospice Policies for Nursing Home Residents**

This *ForwardHealth Update* contains the following:

- A revised Request for Nursing Home Care Determination form, F-01020 (06/12), and completion instructions.
- Policies for nursing homes on when and when not to submit the Request for Nursing Home Care Determination form.
- Policy regarding patient discharge status codes submitted on claims and their impact on future reimbursement.
- Policy relating to a member's election and revocation of hospice care.

This *ForwardHealth Update* contains the following:

- A revised Request for Nursing Home Care Determination form, F-01020 (06/12), and completion instructions for non-developmentally disabled (non-DD) fee-for-service members.
- Policies for nursing homes on when and when not to submit the Request for Nursing Home Care Determination form.
- Policy regarding patient discharge status codes submitted on claims and their impact on future reimbursement.
- Policy relating to a member's election and revocation of hospice care.

### **Request for Nursing Home Care Determination Form Revised**

The Request for Nursing Home Care Determination form has been revised. Effective for date of receipt on and after July 1, 2012, nursing home providers are required to submit the revised Request for Nursing Home Care Determination form, dated 06/12. Previous versions of the Request for Nursing Home Care Determination form will not be accepted on and after July 1, 2012, and will be returned to the provider unprocessed. Nursing homes should destroy old versions of the form.

A copy of the revised Request for Nursing Home Care Determination form and instructions can be found in Attachments 1 and 2 of this *ForwardHealth Update*.

As a reminder, the Request for Nursing Home Care Determination form is not used for developmentally disabled or brain injury residents when a nursing home is establishing a nursing home authorization segment on the member's enrollment file. Nursing Home authorization segments for developmentally disabled nursing home residents are assigned by the Division of Quality Assurance. A brain injury authorization for a resident requires prior authorization.

### **When to Submit the Request for Nursing Home Care Determination Form**

The Request for Nursing Home Care Determination form should only be submitted for non-DD members enrolled in

the BadgerCare Plus Standard Plan, the BadgerCare Plus Benchmark Plan, and Wisconsin Medicaid to establish a nursing home authorization segment. As a reminder, under the Benchmark Plan, nursing home services are limited to 30 days in a nursing home per member per enrollment year.

Providers should always verify a member's enrollment before providing services, both to determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage.

Nursing homes are required to submit the Request for Nursing Home Care Determination form to establish a nursing home authorization segment for the following nursing home residents:

- A non-DD nursing home resident is a Medicaid or BadgerCare Plus fee-for-service member.
- A non-DD nursing home resident becomes a Medicaid or BadgerCare Plus fee-for-service member.

To establish a nursing home authorization segment for these residents, the nursing home should select “New or Initial Request” in Element 9 on the Request for Nursing Home Care Determination form. However, for a new nursing home admission, the Request for Nursing Home Care Determination form should not be submitted to ForwardHealth until the member's Minimum Data Set (MDS) Admission Assessment has been submitted to the Centers for Medicare and Medicaid Services (CMS) MDS system. Nursing home providers should check with their facilities' MDS coordinator on the status of the member's MDS Admission Assessment submission prior to submitting the Request for Nursing Home Determination form to ForwardHealth. The MDS determines if the member qualifies for the nursing home benefit.

### ***Process for Establishing a Nursing Home Authorization Segment***

In order for ForwardHealth to establish a nursing home authorization segment for a non-DD, fee-for-service member, ForwardHealth needs a qualifying MDS and a

properly completed Request for Nursing Home Care Determination form. The following is the process for establishing a nursing home authorization segment:

- The nursing home submits a completed and legible Request for Nursing Home Care Determination form to ForwardHealth. If the member is a “new admission,” do not submit the form until the member's MDS admission assessment has been submitted to the CMS MDS system. Do not attach a copy of the MDS to the form.
- The CMS submits all MDS assessments to ForwardHealth within 24 hours of their submission to the CMS MDS system.
- Upon receipt of the MDS, ForwardHealth executes logic to determine if the member qualifies for the nursing home benefit.
- ForwardHealth cycles “pending” Request for Nursing Home Care Determination forms every Tuesday night. If there is a qualifying MDS assessment, a nursing home authorization segment is systematically added to the member's enrollment file on the following Friday night.
- A “pending” Request for Nursing Home Care Determination remains active for 60 days. If the Request for Nursing Home Care Determination has not been matched with a qualifying MDS within 60 days, it is “inactivated” and a new Request for Nursing Home Care Determination must be submitted.

If an authorization segment has not been added to the member's enrollment file after three weeks of the submission of the Request for Nursing Home Care Determination form, the nursing home may contact Provider Services at (800) 947-9627. Nursing home staff should coordinate with their facilities' MDS coordinator on the status of the member's MDS admission assessment submission to CMS before contacting Provider Services.

If the effective date of a nursing home authorization segment for a member needs to be changed, submit a Request for Nursing Home Care Determination form and select “Revised Start Date” in Element 9 on the form.

### ***Short Term Stay***

If an MDS admission assessment will not be submitted to CMS due to a short term stay (defined as a stay of 13 days or less), nursing home providers are required to attach a copy of the following supporting documentation to the Request for Nursing Home Care Determination form so ForwardHealth can determine if the member qualifies for the nursing home benefit for the short term stay:

- Physician's orders admitting the member to the nursing home.
- All nursing notes.
- Member's discharge summary.

If an MDS Admission Assessment was submitted to CMS for a member who was in the nursing home for 13 days or less, supporting documentation is not required to be submitted with the Request for Nursing Home Care Determination form.

### ***Enddating a Nursing Home Authorization Segment with a Discharge Date***

Nursing homes are required to submit the Request for Nursing Home Care Determination form with the following information to enddate a nursing home authorization segment when a member is officially discharged from the nursing home:

- Check "Added or Revised Discharge Date" in Element 9.
- The date of discharge from the nursing home in Element 16.

The enddating of a nursing home authorization segment on a member's enrollment file allows the member to access services, such as transportation services by the transportation manager, after the member has been discharged to a community setting and allows other providers, such as pharmacies, to be reimbursed for services provided to the member.

### **When Not to Submit the Request for Nursing Home Care Determination Form**

Nursing homes should not submit the Request for Nursing Home Care Determination form when the member is enrolled in any of the following plans or programs:

- The BadgerCare Plus Basic Plan.
- The BadgerCare Plus Core Plan.
- FamilyCare.
- FamilyCare Partnership.
- Family Planning Only.
- Medicaid or BadgerCare Plus hospice benefit.
- Qualified Disabled Working Individuals (QDWT).
- Qualifying Individuals 1 (QI-1).
- Qualified Medicare Beneficiary Only (QMB).
- Program for All Inclusive Care for the Elderly (PACE) Partnership.
- Specified Low-Income Medicare Beneficiary (SLMB).
- SeniorCare.
- Tuberculosis-Related Services-Only (TB-only) benefit.

Nursing home services are not covered for members enrolled in the plans or programs listed above or nursing home services are reimbursed by the managed care organization (MCO) if the member is enrolled in FamilyCare, FamilyCare Partnership, or PACE Partnership.

### **Patient Discharge Status**

Nursing homes are required to submit an updated Request for Nursing Home Care Determination form with the discharge date when a member is officially discharged from the nursing home. Effective for dates of service (DOS) on and after July 1, 2012, ForwardHealth will systematically enddate a member's nursing home authorization segment when one of the following patient status codes is submitted on a claim if the authorization segment is still "active":

- 01 (Discharged to home or self care [routine discharge]).
- 06 (Discharged/transferred to home under care of organized home health service organization).
- 20 (Expired).
- 50 (Hospice-home).
- 51 (Hospice/in-house care).

If one of the previously listed patient discharge status codes is indicated on a claim, ForwardHealth will enddate the nursing home authorization segment on the last day of the month for the DOS indicated on the claim. For example, if a nursing home submits a claim with a patient status code of “01” for DOS April 1 through April 20, the enddate of the nursing home authorization segment will be April 30.

The incorrect use of the patient status code “01,” “06,” “50,” or “51” in Form Locator 17 on the UB-04 Claim Form or in 2300 loop, CL 103 reference designator, 1352 data element on the 837 Health Care Claim Form: Institutional will require the nursing home to submit a new Request for Nursing Home Care Determination form to establish a new nursing home authorization segment. The effective date on the new request must be after the enddate of the nursing home authorization segment that was enddated.

Nursing home providers are reminded that patient status code “30” (Still Patient) should be used for a resident who is on a therapeutic or hospital leave of absence on the “To Date of Service” on the claim. Resident on “leave” does not meet the definition of a “discharge” under federal Preadmission Screening and Resident Review (PASARR) regulations.

ForwardHealth will enddate a members’ nursing home authorization segment if there have been no long term care claims submitted for three consecutive months.

## **Residents Electing or Revoking Hospice Services**

When a resident of a nursing home elects to receive hospice services and remains in the nursing home, the hospice must contract with that nursing home to provide the member's nursing home *room and board*. The hospice assumes responsibility for the management of the individual's care. Hospice claims for nursing home room and board are not reimbursable if the Notification of Hospice Benefit Election, F-1008 (10/08), information is not in the member’s enrollment file with the nursing home’s National Provider Identifier (NPI).

Effective for DOS on and after July 1, 2012, an “active” nursing home authorization segment will be enddated systematically when the hospice benefit is added on the member’s enrollment file. The enddate of the nursing home authorization segment will be one day prior to the effective date of the member’s enrollment in the Hospice Benefit.

Hospice providers may be reimbursed for services rendered up to midnight on the date the member revokes their enrollment in the hospice benefit. If a member continues to reside in the nursing home after revoking their hospice benefit enrollment, the nursing home is required to submit a Request for Nursing Home Care Determination form to establish a new nursing home authorization segment. A new nursing home authorization segment will be inserted into the member’s eligibility file if both of the following are true:

- The member’s current MDS indicates the member qualifies for the nursing home benefit.
- The member is enrolled in the Standard Plan, the Benchmark Plan, or Wisconsin Medicaid.

The effective “start” date on the Request for Nursing Home Care Determination form must be after the day the member revokes his or her enrollment in the hospice benefit. The provider should not indicate the member’s initial nursing home admission date on the Nursing Home Care Determination form.

The hospice provider is required to notify ForwardHealth immediately when a member elects or revokes hospice services. Providers may refer to the Hospice service area of the ForwardHealth Online Handbook for more information about “Notification of Hospice Benefit Election” (topic #1176) and “Discontinuation or Transfer” (topic #1134).

## **E-mail Subscription**

Nursing home and hospice providers, including billing staff and social workers, may register for e-mail subscription on the Portal to receive e-mail notifications of new provider publications. Users are able to select, by program (Wisconsin Medicaid, BadgerCare Plus, or Wisconsin Chronic Disease

Program) and provider type (e.g., physician, hospital, durable medical equipment vendor), which publication notifications they would like to receive. Any number of staff or other interested parties from an organization may sign up for an e-mail subscription.

## **Information Regarding Managed Care Organizations**

This *Update* contains fee-for-service policy and applies to services members receive on a fee-for-service basis only. For managed care policy, contact the appropriate MCO.

Managed care organizations are required to provide at least the same benefits as those provided under fee-for-service arrangements.

The *ForwardHealth Update* is the first source of program policy and billing information for providers.

Wisconsin Medicaid, BadgerCare Plus, SeniorCare, and Wisconsin Chronic Disease Program are administered by the Division of Health Care Access and Accountability, Wisconsin Department of Health Services (DHS). The Wisconsin Well Woman Program is administered by the Division of Public Health, Wisconsin DHS.

For questions, call Provider Services at (800) 947-9627 or visit our Web site at [www.forwardhealth.wi.gov/](http://www.forwardhealth.wi.gov/).

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This *Update* was issued on 06/06/2012 and information contained in this *Update* was incorporated into the Online Handbook on 06/15/2012.

# **ATTACHMENT 1**

## **Request for Nursing Home Care Determination Completion Instructions**

(A copy of the "Request for Nursing Home Care Determination Completion Instructions" is located on the following pages.)

## FORWARDHEALTH REQUEST FOR NURSING HOME CARE DETERMINATION COMPLETION INSTRUCTIONS

Wisconsin Medicaid required certain information to enable Medicaid to authorize and pay for medical services provided to eligible members.

Members are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (DHS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and members is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization request, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of Medicaid payment for the services.

Completion of this form is required to establish or update a nursing home authorization segment for a member.

This is a mandatory form. Wisconsin Medicaid will not accept other versions of this form. Print or type the information on the form so that it is legible.

Providers may submit forms by fax to Wisconsin Medicaid at (608) 221-8815 or by mail to the following address:

Wisconsin Medicaid  
Eligibility Unit  
313 Blettner Blvd  
Madison WI 53784

### SECTION I — PROVIDER INFORMATION

**Element 1 — Name — Billing Provider (Practice Location)**

Enter the billing provider's name.

**Element 2 — National Provider Identifier (Required)**

Enter the billing provider's 10-digit National Provider Identifier.

**Element 3 — Taxonomy Code (Required)**

Enter the billing provider's taxonomy code.

**Element 4 — ZIP+4 Code**

Enter the billing provider's practice location's ZIP+4 code.

**Element 5 — Billing Provider's Medicaid Provider Number**

Enter the eight-digit Medicaid provider number of the provider who will be submitting claims.

**Element 6 — Address — Billing Provider**

Enter the billing provider's address, including the street, city, state, and ZIP+4 code.

**Element 7 — Name — Nursing Home Contact Person**

Enter the name of the person who is most able to answer questions that may arise regarding all aspects of the nursing home authorization segment determination for the member.

**Element 8 — Telephone Number — Nursing Home Contact Person**

Enter the telephone number, including the area code, of the nursing home contact person.

## SECTION II — MEMBER INFORMATION

### Element 9

Indicate whether this is a new or initial request, a revised start date, or an added or revised discharge date.

To establish a nursing home authorization segment, the nursing home should select “New or Initial Request.” If the effective date of a nursing home authorization segment for a member needs to be changed, select “Revised Start Date.” If “Revised Start Date” is selected, the provider is required to complete Element 15. If a member is discharged from a nursing home, providers are required to select “Added or Revised Discharge Date.” If “Added or Revised Discharge Date” is selected, Element 16 must be completed.

### Element 10 — Name — Member

Enter the member's last name, first name, and middle initial. Use Wisconsin's Enrollment Verification System (EVS) to obtain the correct spelling of the member's name. If the name or spelling of the name on the ForwardHealth identification card and the EVS do not match, use the spelling from the EVS. It is important that the spelling of the name on this form matches the spelling of the name on the member's Minimum Data Set (MDS) Admission Assessment.

### Element 11 — Member Identification Number

Enter the member ID. Do not enter any other numbers or letters. Use the ForwardHealth card or the EVS to obtain the correct member ID.

### Element 12 — Social Security Number — Member

Enter the member's nine-digit Social Security number. Do not enter any other numbers or letters.

### Element 13 — Date of Birth — Member

Enter the member's date of birth in the MM/DD/CCYY format.

### Element 14 — Gender — Member

Enter an “X” in the appropriate box to specify male or female.

### Element 15 — Requested Start Date for Nursing Home Authorization Segment

Enter the requested start date for the nursing home authorization segment in the MM/DD/CCYY format.

### Element 16 — Nursing Home Discharge Date

Enter the requested discharge date for the nursing home segment in the MM/DD/CCYY format.

### Element 17 — Minimum Data Set (MDS) Admission Assessment Submittal

Enter an “X” in the appropriate box.

For cases where an MDS admission assessment will not be submitted due to a short term stay, providers are required to submit a copy of the following information:

- Physician's orders admitting the member to a nursing home.
- All nursing medical notes.
- Member's discharge summary.

This information will be used in the nursing home care determination process.



# **ATTACHMENT 2**

## **Request for Nursing Home Care Determination**

(A copy of the "Request for Nursing Home Care Determination" form is located on the following pages.)

**FORWARDHEALTH**  
**REQUEST FOR NURSING HOME CARE DETERMINATION**

**Instructions:** Type or print clearly. Before completing this form, refer to the Request for Nursing Home Care Determination Completion Instructions, F-01020A.

**SECTION I — PROVIDER INFORMATION**

1. Name — Billing Provider (Practice Location)

2. National Provider Identifier (Required)

3. Taxonomy Code (Required)

4. ZIP+4 Code

5. Billing Provider's Medicaid Provider Number

6. Address — Billing Provider (Street, City, State, ZIP+4 Code)

7. Name — Nursing Home Contact Person

8. Telephone Number — Nursing Home Contact Person

**SECTION II — MEMBER INFORMATION**

9. Select One

☐ New or Initial Request

☐ Revised Start Date (Element 15)

☐ Added or Revised Discharge Date (Element 16)

10. Name — Member (Last, First, Middle Initial)

11. Member Identification Number (Required)

12. Social Security Number — Member

13. Date of Birth — Member

14. Gender — Member

☐ Male

☐ Female

15. Requested Start Date for Nursing Home Authorization Segment

16. Nursing Home Discharge Date

17. Minimum Data Set (MDS) Admission Assessment Submittal

- ☐ An MDS Admission Assessment will be submitted to the Centers for Medicare and Medicaid Services (CMS) MDS system.  
☐ An MDS Admission Assessment will not be submitted to the CMS MDS system.

For cases where an admission assessment will not be submitted to CMS (i.e., for a short term stay [13 days or less]), providers are required to submit a copy of the following with this form:

- Physician's orders admitting the member to the nursing home.
- All nursing medical notes.
- Discharge summary.