A. Type of Handbook

Part Y, Nursing Home Services, is the service-specific portion of the Wisconsin Medicaid Provider Handbook. Part Y includes information on provider eligibility criteria, recipient eligibility criteria, covered services, reimbursement and billing instructions. Use Part Y in conjunction with Part A of the Wisconsin Medicaid Provider Handbook which has general policy guidelines, regulations, and billing information for all providers certified in Wisconsin Medicaid. Nursing homes should use Part N of the provider handbook which contains the information on Durable Medical Equipment (DME) and Disposable Medical Supplies (DMS), including covered services and prior authorization for specialized wheelchairs, respiratory equipment, and exceptional supplies for nursing home recipients.

Note: This handbook has references to various organizational units of the Department of Health and Social Services (DHSS), Division of Health (DOH), Bureau of Health Care Financing (BHCF). The DHSS is the designated single state agency for administration of the Medicaid program in Wisconsin; and the BHCF is the designated State Medicaid Agency for overall program administration. A copy of a current organization chart is available upon request.

B. Provider Information

Nursing Homes - General Definitions

Nursing home is defined in Chapter 50, Wis. Statutes, as: "a place which provides 24-hour services including board and room to three or more unrelated residents who because of their mental or physical condition require nursing care or personal care in excess of seven hours a week." Nursing homes participating in Medicaid are called nursing facilities (NFs). Nursing homes which also participate in Medicare are called skilled nursing facilities (SNFs). Facilities, or their distinct parts, which predominantly serve the developmentally disabled are called intermediate care facilities for the mentally retarded (ICF-MRs) or facilities for the developmentally disabled (FDDs).

Provider Eligibility and Certification

Wisconsin Medicaid certifies nursing homes to provide skilled and intermediate care. Under Wisconsin Medicaid, all NFs, ICF-MRs, or FDDs must be licensed according to s. 50.03, Wis. Stats. by the Bureau of Quality Compliance (BQC) in the Department of Health and Social Services (DHSS). Additional Medicaid certification requirements are:

1. SNFs which are also certified as an NF must meet the requirements for participation in Medicare as well as those specifically stated in HSS 105.08, 105.09, and 132, Wis. Admin. Code. These Medicaid requirements include the Medicare bed requirements defined in ss. 49.45(10) and 50.02(2), Wis. Stats.
2. ICF-MRs providing services to the developmentally disabled must meet the certification requirements stated in HSS 105.12 and 134, Wis. Admin. Code.

Providers interested in certification requirements specific to NFs or FDDs should contact the BQC. Refer to Appendix 22 of this handbook for the BQC addresses, including district offices.

Scope of Service

The policies in Part Y govern services provided within the scope of the practice of the profession as defined in s. 50.01, Wis. Stats., s. 49.45(6m), Wis. Stats. and HSS 107.09, Wis. Admin. Code. Covered services and related limitations are addressed in Section II of this handbook.

B. Provider Information (continued)

Nursing Home Reimbursement

Medicaid-certified nursing homes are reimbursed according to a prospective rate-setting methodology as stipulated in s. 49.45(6m), Wis. Stats. The DHSS establishes this methodology annually. The methodology is called "the formula" or "the Methods of Implementation." The payment formula determines nursing home payment rates for the annual rate year (defined as July 1 through June 30 of each year). The formula is annually transmitted to certified nursing homes by the Bureau of Health Care Financing (BHCF). For rate setting, nursing homes must complete an annual cost report which corresponds to the individual nursing home's fiscal year. In addition, nursing homes must provide other information on the annual formula to determine the actual payment rates.

Generally, the individual nursing home's payment rate from Wisconsin Medicaid is based on the nursing home's allowable costs during the previous 12-month fiscal year period, increased by a projected inflation percentage for the effective rate period (current year), and limited by the nursing home formula parameters. Nursing homes are required to annually submit a twelve-month cost report, and the payment formula is part of the Medicaid State Plan referred to as the annual Methods of Implementation. Medicaid regional auditors set the rates. The addresses of the regional auditors are listed in Appendix 21. Questions regarding the actual payment formula should be directed to the Nursing Home Section of the BHCF.

Separate accommodation rates are established for each level of care (medical intensive skilled, head injury skilled, skilled, intermediate nursing care levels and developmentally disabled care levels). A list of the accommodation codes, including bedhold codes, is in Appendix 15 of this handbook. The following Medicaid accommodation codes and their corresponding nursing home care levels are as follows:

Accommodation Code	*Care Level*
20	Skilled Care
21	Intermediate Care 1 and Intermediate Care 2-Limited
22	Intermediate Care 3-Personal
23	Intermediate Care 4-Residential
25	Intensive Skilled Nursing
26	Developmentally Disabled 1A
27	Developmentally Disabled 1B
28	Developmentally Disabled 2
29	Developmentally Disabled 3
80	Brain Injured (Prior Authorization Required-See Section III)

Intermediate care level three (personal) and care level four (residential) are not reimbursable except for:

- residents who entered a facility before October 1, 1981, and have continuously resided in a health care facility since that date; and
- residents who have a primary diagnosis of developmental disabilities (DD) or chronic mental illness (CMI) and who entered a facility before November 1, 1983, and continuously resided in a nursing home.

B. Provider Information (continued)

Nursing Home Appeals Mechanism

A nursing home appeals mechanism exists under Section 49.45 (6m)(e) of the Wisconsin Statutes. Called the "Nursing Home Appeals Board," its purpose is to review applications from nursing homes for financial relief if demonstrated, substantial inequities exist in the individual nursing home Medicaid rates resulting from the annual nursing home payment formula. The Statute lists various criteria which may qualify a nursing home for appeals mechanism funding.

The Nursing Home Appeals Board is separate from the Chapter 227 administrative hearing process and the Administrative Review Process (below) which both address Wisconsin Medicaid rate decisions. The Appeals Board functions retrospectively following the completion of the rate year. Nursing homes interested in this mechanism must submit a 12-month cost report coinciding with the formula rate year along with an appeal application.

Nursing homes are annually notified through a BHCF Memorandum when the appeal requests are due. Additional information can be obtained by contacting the Wisconsin Medicaid Nursing Home Appeals Auditor, Nursing Home Section, BHCF.

Administrative Review Process

The BHCF has established an administrative review process for nursing home rates calculated by the BHCF regional auditors. This process is different from the formal administrative hearing process described in Chapter 227, Wis. Stats., and from the nursing home appeals mechanism which addresses payment formula inequities.

The purpose of the administrative review process is twofold. The first is to allow nursing homes a vehicle to contest interpretations by Medicaid regional auditors when setting Medicaid nursing home payment rates. According to the Nursing Home Methods of Implementation, a nursing home may request an administrative review of the DHSS' cost finding decisions in the rate-setting process. For example, this could mean a disputed adjustment by the Auditor to costs reported in the annual cost report. The request must be filed within 30 days of the facility's receipt of notification of the Medicaid nursing home proposed rates.

The second purpose of the administrative review process is to develop payment policies and formula interpretations which may be initiated by the BHCF or which may be requested by nursing home providers or their representatives.

The administrative review process uses a review committee composed of the BHCF Nursing Home Section's Chief, one of the Section's Financial Supervisors and the Section's Review Auditor. A staff person from the Nursing Home Section's Policy staff is included in the Administrative Review Process for policy or payment formula interpretations and coordination. The assigned auditor may also be involved in instances of cost finding, allowable cost determinations, or rate disputes. The Administrative Review Committee meets whenever there are rate-setting interpretation requests to review or payment policy/formula interpretations to develop. The committee's decisions are subject to review and approval by the Director of the BHCF.

Requests from nursing homes for Medicaid Auditor interpretations or for policy/formula statements/interpretations may be requested through one of the nursing home associations for represented homes. The association provides initial screening and assists in the review process by assuring valid, complete and adequate requests, including combining multiple requests of a similar nature (i.e. several nursing homes with the same type of request). A nursing home may, also, submit a request directly to the Review Committee through the BHCF Nursing Home Section Chief.

B. Provider Information (continued)

Requests should contain specific data and factual information for consideration and not provide only generalizations. Requests contesting Medicaid Auditor interpretations must also be timely for consideration (within 30 days of the nursing home's receipt of notification of Medicaid rates).

For requested reviews contesting Medicaid Auditor interpretations in rate setting, the request must be submitted within the 30-day time frame; and a decision on the request will be submitted to the association and/or nursing home following the Committee's review and BHCF Director's approval (unless delegated). For payment policy or formal interpretation requested by nursing homes, the Committee will determine whether a policy statement is necessary.

For payment policy and/or formula interpretation development initiated by BHCF or by the Review Committee, a policy statement is drafted and reviewed by BHCF and then submitted to the nursing home associations and the Board on Aging and Long Term Care (BOALTC) for review and comment. The policy statement will include a preliminary recommendation. The associations and BOALTC have 10 working days to respond indicating either concurrence with the preliminary recommendation or factual and documented disagreement along with an alternative preliminary recommendation. An opportunity to present such a statement to the Review Committee may also be requested. Payment policy statements and/or formula interpretations will be coordinated by one of the Section's Financial Supervisors and a Nursing Home Policy Staff person.

Policy statements will constitute a nursing home formula policy manual and copies of the manual or various policy statements will be available to the industry and consumer advocacy agencies following final approval by the BHCF Director or a designee.

Administrative review request form instructions and the Nursing Home Rate Administrative Review Request form are included in Appendices 11 and 12 of this handbook. Nursing homes must complete this form to qualify for review.

Provider Responsibilities

Specific responsibilities as Medicaid providers are stated in Section IV of Part A of the provider handbook. Reference Section IV for detailed information on fair treatment of the recipient, maintenance of records, recipient requests for noncovered services, services rendered to a recipient during periods of retroactive eligibility, grounds for provider sanctions, and additional state and federal requirements.

C. Recipient Information

Eligibility For Wisconsin Medicaid

Eligible recipients for Wisconsin Medicaid are issued identification cards. The identification cards include the recipient's name, date of birth, 10-digit identification number, medical status code, and an indicator of private health insurance coverage, managed care coverage, and Medicare coverage.

Medicaid identification cards are sent to recipients monthly. All identification cards are valid only through the end of the month in which they are issued. It is important that the provider or the designated agent check a recipient's identification card *prior* to providing service to determine recipient eligibility and limitations to the recipient's coverage.

If the recipient's identification card is held by the nursing home, it is the nursing home's responsibility to provide eligibility information to other providers of service.

C. Recipient Information (continued)

Nursing home residents who have Wisconsin Medicaid are allowed to retain a small portion of any pension or other income they may have. These retained funds are known as the recipient's *personal needs allowance* and are used, with the recipient's permission, or the permission of the recipient's legal representative, to pay for items or services not generally covered by Wisconsin Medicaid or routinely provided through the nursing home daily rate. This allowance is for items or services not typically provided but available, such as items preferred by the resident rather than the brand item provided by the home and services (e.g., beauty salon permanents). The personal needs allowance is set by Wisconsin statute and is currently $40 per month.

Any income in excess of the personal needs allowance is used to cover the recipient's cost of care in the nursing facility. This amount is known as *resident liability*. The fiscal agent deducts the resident liability amount from amounts due to the provider as part of claims processing. If the liability amount is incorrect for any reason, the nursing home should notify the agency which certified the recipient for Wisconsin Medicaid eligibility.

Section V of Part A of the provider handbook has detailed information on eligibility for Wisconsin Medicaid, identification cards, temporary cards, restricted cards, and how to verify eligibility. Providers should review Section V of Part A of the provider handbook before services are rendered. A sample identification card is in Appendix 7 of Part A of the provider handbook.

Eligibility/Authorization Report

Nursing homes receive a monthly eligibility/authorization report on all of the nursing homes' recipients who have been eligible or authorized for services during the previous 60 days. The report is printed by the fiscal agent following the printing of the identification cards, and is generally sent to nursing homes during the first week of each month. The report's information is valid for the month in which the report is received or dated, *not* for the previous month (e.g., a report dated 07/31/95 contains eligibility information for July 1995).

In addition to current eligibility information, the report also includes level of care (LOC) authorization and recipient liability information. Carefully review this report to avoid claim denials and incorrect payments. An example of an Eligibility/ Authorization Report form and the instructions are Appendices 13 and 14 of this handbook.

Care Level Determinations

Care level determinations for Medicaid recipients are made by the BQC. Care levels are determined at admission, when a resident becomes eligible for Medicaid benefits, and when the health care needs of the resident change. BQC reviews the recipient's care level annually.

Services are reimbursed when confirmation of care level determinations are received by the fiscal agent from the Division of Health, BQC. Medicaid care level codes are listed above under Nursing Home Reimbursement and in Appendix 15 of this handbook. If the nursing home bills before the care level is on file, the claim is denied. If the incorrect accommodation codes are used on the claim form, the claims will be denied pending proper care level verification through the Bureau of Quality Compliance.

BQC notifies the fiscal agent weekly to update the care level file. Nursing homes should contact the BQC if care level information is incorrect. Appendix 22 of this handbook contains the addresses of the BQC regional offices.

C. Recipient Information (continued)

Notice of Care Level Change

The Notice of Care Level Change is completed for Medicaid nursing home recipients whose care level is changed by the BQC staff. Nursing homes may request a care level review from the Division of Health regional office.

Nursing Home Discharges and Notification of Death

Providers must send notification of nursing home discharges and notifications of death to the recipient's certifying agency, such as the county which certified the recipient for Medicaid eligibility. The certifying agency is responsible for updating recipient information.

Nursing homes must notify the BQC regional office of all discharges and deaths of Wisconsin Medicaid recipients.

Notifications must include the:

- recipient name and Medicaid identification number;
- recipient date of birth;
- date of death or discharge; and
- nursing home's eight-digit Medicaid provider number.

Nursing homes must notify the BHCF within 30 days of a recipient's death if the DHSS' Estate Recovery Program applies (Refer to "Estate Recovery Program" in Section I of this handbook). When the Estate Recovery Program applies, the nursing home must send the "Estate Recovery Program Notification of Death" form in Appendix 28 of this handbook.

Documentation Requirements for ICF-MR or FDD Services

A physician must certify that ICF-MR services are needed. This certification is made at the time of admission, or if an individual applies for Wisconsin Medicaid while in a nursing home, before reimbursement can occur. Recertification by a physician must occur at periodic intervals after initial certification.

Individual Written Plan of Care - ICF-MR or FDD Services

Prior to initial admission to an ICF-MR, the attending physician must establish a written plan of care for each recipient. The plan of care must include:

- diagnoses;
- symptoms;
- complaints and complications indicating the need for admission;
- a description of the individual's functional level;
- objectives;
- any orders for medications;
- treatments;
- restorative and rehabilitative services;
- activities;
- social services and diet;
- plans for continuing care; and
- plans for discharge.

NOTE: The attending physician and other personnel involved in the recipient's care must review the plan of care at least every 60 days.

C. Recipient Information (continued)

Comprehensive Resident Assessment - NF and SNF

All nursing homes must enter a written comprehensive resident assessment in the recipient's record (according to HSS 132.60(8)(d), Wis. Admin. Code). Periodic reassessment is also required.

Any nursing facility that participates in the Medicaid or Medicare programs must use the resident assessment instrument specified by the state to assess all residents. Sections 1819 and 1919 of the Social Security Act specify assessment requirements for skilled nursing facilities for Medicare and nursing facilities for Medicaid, that provide nursing, medical, and rehabilitative care to Medicare and/or Medicaid beneficiaries. Section 49.498, Wis. Stats., includes the requirement for a resident assessment instrument.

These provisions require facilities to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity using a resident assessment instrument specified by the state. The resident assessment instrument consists of the minimum data set (MDS) and resident assessment protocols (RAPs). The MDS is a functionally based assessment tool; RAPs use MDS assessment information to identify potential problem areas for nursing home follow-up. RAPs also contain guidelines to help identify key causal or contributing factors to consider in developing, reviewing and revising a resident's care plan.

Appendices 23 and 24 of this handbook include the current, required MDS forms (effective January 1, 1996) for Medicaid nursing homes. More information, including a training manual and reference guide, for the resident assessment instrument is available from the BQC.

Nursing Home Pre-Admission Screening for Developmentally Disabled and Mentally Ill Recipients (PASARR)

The Omnibus Budget and Reconciliation Act of 1987 established resident review requirements for current and prospective nursing home residents. The requirements are called the Pre-Admission Screen/Annual Resident Review (PASARR). Wisconsin began implementation of the PASARR requirements on January 1, 1989. Nursing homes are notified of program changes through the DHSS' program memoranda.

PASARR - Purpose and Process

PASARR determines if a current or prospective resident is suspected of having a serious mental illness or a developmental disability and if the person is appropriate for nursing home placement. Nursing facilities may not admit individuals suspected of having a serious mental illness or a developmental disability until an assessment determines that the person needs nursing home placement and specialized services.

This process begins with a nursing home conducting a Level I screen prior to admission for *any* individual seeking admission. Appendix 25 of this handbook includes the Level I screening form. Based on the information collected from the Level I screen, an individual may also require a Level II screen. A Level II screen is required for all potential residents whose Level I screen indicates a possibility of major mental illness or a developmental disability. Level II screens must be conducted by the respective nursing facility's regional PASARR agency contracted by the Division of Community Services, Bureau of Community Mental Health.

C. Recipient Information (continued)

If a Level II screen is required, the Level I screener must notify their Regional PASARR Contractor. The contractor will perform the Level II screen and determine the appropriateness of nursing home placement and the need for specialized services. A person may not be admitted to a nursing home until the screening process is completed.

For further information on the Level II screening process, contact the DHSS Bureau of Developmental Disabilities at (608) 266-3717 or the Bureau of Community Mental Health at (608) 266-9316 or 266-7072.

Annual Resident Reviews (ARR)

Any resident with a serious mental illness or a developmental disability admitted to a nursing facility through the Pre-Admission Screening process must be re-screened on an annual basis. This is referred to as an Annual Resident Review (ARR). Annually is considered as occurring within every fourth quarter after the previous Level II screen or the previous ARR. The ARR can be performed only by the regional PASARR contractor.

PASARR Screening and Specialized Services Reimbursement

Nursing homes receive $30 for each Level I screen performed, regardless of the pay source of the recipient. Appendices 16 and 17 include the reimbursement request form and instructions.

Nursing homes are also eligible for a $9 per patient, per day supplement to the daily rate for individuals with a serious mental illness who have been determined by PASARR to require specialized services. This does not include private pay residents. The reimbursement supplement is only for days in which the resident is in the facility and receiving specialized services, excluding therapeutic and hospital bed-hold days. There is no supplement to the daily rate for the developmentally disabled residents due to other funding sources for specialized services, including the Medicaid nursing home formula.

Requirements for Specialized Services Reimbursement

To be eligible for specialized services reimbursement, the nursing facility must have a resident(s) determined by a Level II Pre-Admission Screen or by an ARR to need facility placement and require specialized services. The facility must submit an individualized Specialized Services Plan of Care to BHCF, Nursing Home Section. The nursing facility must submit a specialized services roster claim form monthly to the BHCF's Nursing Home Section. Appendix 26 of this handbook includes the specialized services roster claim form. Payments are made quarterly and are reflected on the nursing home's Remittance and Status Report by the Medicaid fiscal agent.

Nursing facilities must complete residents' ARRs within the calendar quarter in which they are due. Reimbursement will be withheld if the ARRs are past due. Reimbursement will be reinstated when the ARRs are completed and the specialized services determination date is updated on the roster claim form.

For further information on reimbursement, please contact the BHCF Nursing Home Section Analysis Unit.

C. Recipient Information (continued)

Managed Care Program Coverage

Wisconsin Medicaid managed care programs are developed principally for the Aid for Families with Dependent Children (AFDC) and Healthy Start population. There are a few pilot managed care projects for the elderly and disabled population. The emphasis is prevention, primary, and acute care services. Nursing home services *may* be included in the plan. Providers should be aware of managed care as an initiative of Wisconsin Medicaid, and should be aware that Medicaid recipients may be enrolled in contracted managed care programs. Managed care plans may include nursing home services subject to the conditions and terms of the individual plans themselves.

Medicaid recipients enrolled in Medicaid-contracted managed care programs receive a yellow Medicaid identification card. This card has a six-character code in the "Other Coverage" column designating the recipient's managed care program. These codes are defined in Appendices 20, 21, 22, 22a, and 22b of Part A of the provider handbook.

Providers must always check the recipient's current Medicaid identification card for managed care program coverage before providing services. Claims submitted to the fiscal agent for services covered by Medicaid-contracted managed care programs are denied.

For recipients enrolled in a Medicaid-contracted managed care program, all conditions of reimbursement and prior authorization for nursing home services are established by the contract between the managed care programs and certified providers.

Additional information regarding managed care program noncovered services, emergency services, and hospitalizations is included in Section IX of Part A of the provider handbook.

Estate Recovery Program

According to s.49.496, Wis.Stats., the DHSS administers an estate recovery program as part of the Medicaid Program. The BHCF is the administering entity. The Wisconsin Estate Recovery Program (ERP) entails Medicaid collecting funds from the estate of a deceased Medicaid-nursing home recipient under certain conditions. The DHSS may recover funds from the estate of a deceased recipient if:

- the recipient has no surviving spouse; and
- no minor or disabled child.

The nursing home must notify the DHSS within 30 days of a resident's death if the above conditions apply by completing the "Estate Recovery Program Notification of Death" form. Refer to Appendix 28 of this handbook for a copy of this form.

If the DHSS is initiating an estate recovery action, the BHCF sends the nursing home an affidavit 20 days after the date of death. The affidavit claims the funds and advises the nursing home to transmit the funds to the DHSS. Refer to Appendix 27 of this handbook for a copy of the affidavit.

For additional information on the Estate Recovery Program, please contact the Coordination of Benefits Unit of the BHCF.