

Nursing Facility Reimbursement FAQ

(Updated for PDPM Implementation)

Nursing Facility Rate and Rate Calculations Under the 100% Brice-Based Methodology

Q. What are the peer groups for the price-based payment methodology?

- A. The peer groups are derived from a combination of Centers for Medicare and Medicaid Services (CMS) MSA wage regions, geographic location and bed size. The table below depicts the peer groups used for direct and indirect rate calculations.

Direct Peer Groups	Indirect Peer Groups
Northern Rural (Rural 1)	Northern Rural (Rural 1)
Southern Rural (Rural 2)	Southern Rural (Rural 2)
Northern Virginia MSA (Urban 3)	Northern Virginia MSA (Urban 3)
Other MSA (Urban 4)	Other MSA (Urban 4)
	Rest of State- 60 beds or less (Small) <i>(NOVA excluded)</i>

Q. How do I find out my facility's peer group?

- A. Facility Peer Groups are posted on the "Nursing Facility Price-Based Reimbursement Rate" Sheet located on the DMAS website <http://www.dmas.virginia.gov>. Click on Provider Services, Rate Setting Information, Nursing Facilities Page and "Nursing Facility Price-Based Reimbursement Rates".

Q. Do I still have to file a cost report if I am paid 100% price-based rate? If so, why is it important to file a timely cost report?

- A. Yes, it is imperative that nursing facilities continue to timely file cost reports. Cost data are used in the development of price-based rates for the Day-Weighted Median and floor calculations as well as monitor the adequacy of the reimbursement methodology.

Q. Are nursing facility price-based payments cost settled?

- A. Payments for services with dates of service on or after July 1, 2014 will not be cost settled. Our cost settlement and audit contractor will continue to collect and audit reports, but will not retroactively adjust price-based rates.

Q. How do I determine my Medicaid PDPM rates from the rate posted online?

- A. The formula to calculate nursing facility price-based rates is = ((Direct rate X PDPM weight) + Indirect rate + NATCEP + Criminal Records + Plant Rate). Nursing facility crossover claims will use a PDPM weight of 1.0 in the formula. Please see Appendix F of the Nursing Facility Provider Manual for rate calculation examples.

Q. How can I obtain a current Medicaid Rate letter for my facility?

A. DMAS no longer sends rate letters to price-based nursing facility providers. Facility rates and provider resources are published on the nursing facility webpage at [Nursing Facilities](#). Click on the “Nursing Facility Price-Based Reimbursement Rates” link for the appropriate rate year.

Q. How often are rates recalculated and distributed to facilities?

A. Nursing Facility rates are rebased every three years and updated on an annual basis or as directed by the Virginia Appropriations Act. Rate updates (if applicable) are posted on the nursing facility website at the beginning of each fiscal year (July 1st).

Q. How will the price-based payment methodology impact Fair Rental Value (FRV) rates?

A. DMAS will continue to reimburse freestanding nursing facilities for capital costs through FRV. To make FRV prospective with the state fiscal year, providers are required to submit calendar year FRV reports directly to our Cost Settlement and Audit Contractor. FRV rates for an upcoming fiscal year are based on the prior calendar year information aged to the state fiscal year using RS Means factors and rental rates corresponding to the fiscal year. DMAS will make mid-year FRV rate adjustment for new beds or a major renovation. No mid-year rate changes shall be made for an effective date after April 30th of the fiscal year.

Q. What is the Fair Rental Value (FRV) rental rate floor?

A. The rental rate floor has been 8% since SFY 2015.

Q. Since DMAS will make a mid-year FRV rate adjustment for new beds or a major renovation (\$3,000 per bed), is the old FRV capital rule of \$50,000 per project no longer valid?

A. The Schedule of Assets grouping of \$50,000 per project is still valid. The Schedule of Assets Reporting should not be confused with the \$3,000 per bed threshold for major renovations. The regulations in 12VAC30-90-38, subsection D remain in effect.

Q. Where can I find the list of allowed PDPM codes for PDPM and the weights?

A. A list of allowed PDPMs can be found on the Nursing Facilities Website at [Nursing Facilities](#).

Q. How will Medicare claims be paid under PDPM?

A. DMAS will use a PDPM weight of 1.0 for claim adjudication.

MDS and MDS Software Technical Guidance

Q. How does DMAS define a late assessment?

A. DMAS follows the rules for the Omnibus Budget Reconciliation Act (OBRA) assessments. If the assessment does not have an Assessment Reference Date ARD within the timelines as defined by the requirements in the Resident Assessment Instrument (RAI) manual

published by CMS, the assessment shall be considered late. The nursing facility shall bill the default PDP code until a new assessment has been completed and accepted. Assessments with Assessment Reference Dates (ARD) that do not comply with OBRA scheduling requirements are subject to default. For example, a quarterly assessment is required to have an ARD no more than 92 days after the most recent OBRA assessment's ARD. If the provider does not open this assessment until after the last required date, then the provider will need to bill the default rate from 92 days after the most recent OBRA assessment until the next OBRA assessment's ARD. All OBRA scheduling requirements as listed in the RAI manual apply.

Q. If a resident discharges from the facility prior to the due date of his quarterly assessment and returns after the quarterly assessment was due, how can the facility prevent receiving the default PDP payment? Since facilities do not bill for days in the facility, would an ARD need to be set upon returning to the facility to prevent default PDP payment or combine the quarterly due with the discharge?

A. If a resident has an OBRA assessment due and the resident has been discharged to a hospital, the provider has 14 days after the return (counting the return as day 1) to complete the OBRA assessment.

From RAI manual: When the resident returns to the nursing home, the Interdisciplinary Team (IDT) must determine if criteria are met for a Significant Change in Status Assessment (SCSA) (only when the OBRA Admission assessment was completed prior to discharge).

1. If criteria are met, complete a SCSA.
2. If criteria are not met, continue with the OBRA schedule as established prior to the resident's discharge.
3. If a SCSA is not indicated and an OBRA assessment was due while the resident was in the hospital, the facility has 13 days after reentry to complete the assessment (this does not apply to admission assessment)

Billing and Edits

Q. Will all of the edits for nursing facilities still apply when DMAS switches to PDP?

A. Yes.

Q. What is the billing period for nursing facility providers? Can I bill multiple months in one claim?

A. Providers may bill nursing facility claims daily, weekly or monthly. However, claims cannot span calendar months. Claims that span calendar months will deny for Edit 82. The PDP code billed must match the PDP code documented on the MDS assessment that applies to the dates of service submitted on the claim. Billers may choose to report multiple PDP codes on individual revenue lines on the same claim for different dates of service during the billing period.

Q. What MDS assessment and PDPM code should be billed at the start of an admission?

- A. If the MDS is an admission MDS, it will pay from the day of admission until the next Assessment Reference Date (ARD) date of the scheduled quarterly assessment. However, if there is a significant change after the admission, the new PDPM score will be effective as of the ARD date of the significant change assessment. If a resident is discharged before an admission assessment can be completed, the facility can bill the default PDPM ZZZZ. Please see the RAI manual for additional details.

Q. Where should the assessment date be reported on the claims?

- A. The nursing facility should report the Assessment Reference Date with the Occurrence Code 50 for each unique PDPM and assessment code in the Health Insurance Prospective Payment System (HIPPS) field on the claim. This billing requirement is similar to Medicare. The date of service reported with Occurrence Code 50 must contain the ARD associated with the applicable OBRA assessment. An Occurrence Code 50 is not required with the HIPPS code reported for default PDPM ZZZZ. For more detailed information regarding Occurrence Code 50 and Edit 1736 please see the Medicaid Memo "Occurrence Code 50 Billing Edit" dated July 26, 2016.

Q. If a member exhausts Medicare benefits and Medicaid becomes the primary payer, which MDS should be used to bill the initial PDPM under Medicaid?

- A. The nursing facility should bill the Medicaid PDPM calculated and in effect on the dates of service billable to Medicaid. All residents admitted to a Medicaid-certified bed must have assessments completed as per the OBRA requirements. These requirements are detailed in the RAI Manual. The provider must follow the OBRA assessment requirements if the resident is in a Medicaid-certified bed. This requirement applies regardless of payer e.g., a resident is admitted to receive Medicare Part A services, is covered under a Medicaid managed care contract or non-managed care Medicaid or is paying privately. When a resident admitted under a different payer converts to Medicaid, the provider will bill using the PDPM score from the most recent OBRA assessment. The most recent OBRA assessment may have been combined with an assessment for Medicare Part A.

Q. What amount will DMAS pay if the calculated price-based reimbursement is greater than actual charges?

- A. If the calculated price-based reimbursement exceeds the charges, DMAS will pay the calculated rate. The lesser of billed charges payment rule does not apply to price-based reimbursement payments.

Q. What is the procedure for adjusting claims for revised PDPMs?

- A. If a provider completed an MDS assessment and later corrected the assessment that resulted in a different PDPM code, the provider *must* adjust claims and submit the revised PDPM code.

Providers should follow the claim adjustment procedures. The guidelines for claim adjustments are documented in the Nursing Facility Provider Manual.

Other Questions

Q. How will rates for new facilities be established under the price-based reimbursement methodology?

- A. 1.) Our Cost Settlement and Audit Contractor, Myers and Stauffer LC (MSLC) will request that the provider complete an annual FRV report to set the FRV rate. 2.) MSLC will request documentation of licensing for NATCEP services. 3.) DMAS will calculate all other rate components (indirect and direct operating rates, NATCEP rate based on facility NATCEP costs and an average criminal records check (CRC) rate to include facilities with zero CRC costs).

Q. Could the nursing facility set the ARD early before the resident leaves for their therapeutic leave of absence if a resident's MDS assessment is due before the resident returns to the facility?

- A. For a leave of absence (LOA), the resident remains admitted to the Medicaid bed at the facility. Therefore, the provider will need to make sure that any assessment due during the LOA is completed timely. Setting the ARD early is acceptable. Note that if there is no assessment generating a PDPM score when the assessment is due, the default days will apply.

Q. How should facilities bill the PDPM units for claims with therapeutic leave?

- A. The PDPM units billed must match the covered days on the claim. If a revenue code is billed for accommodation or room and board, the service units billed for the revenue code must equal to the number of days covered by the from-thru dates of service for the payment request.

Q. For new admissions, should providers wait until the assessment is performed to submit the PDPM-adjusted per diem on the DMAS-225?

- A. Providers should not delay submission of the DMAS-225. The DMAS-225 should be submitted timely. If necessary, the LDSS worker will contact the facility to obtain the PDPM- adjusted per diem.

Q. How can I contact DMAS if I have additional questions regarding nursing facility payments and payment methodology?

- A. Please contact DMAS at PRD-ratesetting@dmass.virginia.gov for questions or concerns regarding nursing facility payments and payment methodologies.

Hospice, Specialized Care, Intermediate Care Facilities (ICFs) and Other State Owned Nursing Facilities

Q. How will Specialized Care Facilities, State Nursing Facilities or Intermediate Care Facilities (ICFs) be affected by the transition of PDPM?

A. Specialized Care, State Nursing Facilities, and ICFs operated by DBHDS will not be impacted by the PDPM transition. Only providers that bill PDPM rates will be impacted.

Q. How will hospice rates be affected by the transition of PDPM?

A. Hospice services provided in a nursing facility will be paid 100% of the PDPM rate for claims with dates of service on or after October 1, 2025. Hospice providers that do not provide services in nursing facilities will not be impacted by the grouper transition.

Q. Where can I find the new room and board PDPM rates for hospice?

A. Hospice providers that render services in nursing facilities are paid 100% of the facility's PDPM rates.

Q. Are Hospice providers required to submit the Occurrence Code 50 on the claim?

A. Hospice providers are required to submit the Occurrence Code 50 values on the UB-04. Nursing facilities will need to communicate to the hospice provider the Occurrence Code 50 values in effect for the dates of service the hospice provider furnished services to the nursing facility resident. For more detailed information regarding Occurrence Code 50 and Edit 1736 please see the Medicaid Memo "Occurrence Code 50 Billing Edit" dated July 26, 2016.