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MEMORANDUM ACS M05-07

TO: All Hospitals

FROM: Angie Payne, Acting Med-QUEST Division Administrator

SUBJECT: **CLAIMS FOR PATIENTS WITH CONTINUOUS CONFINEMENTS**

Since July 1, 2002, Medicaid Fee-For-Service (FFS) has been responsible for patients who are enrolled in the Medicaid FFS program on the day of admission to an acute level of care. In situations where a patient is enrolled into a QUEST health plan during the hospitalization, FFS will continue to be responsible until the patient is discharged from the hospital.

Therefore, if a patient remains in the same hospital, but is no longer at the acute level of care, the facility should obtain approval from the Department of Human Services contracted PRO (now Health Services Advisory Group-HSAG) for the patient's appropriate level of care. Claims for the acute level and the lower level of care should be submitted to the Medicaid FFS program and NOT to the QUEST plan.

However, if the patient who has become enrolled in a QUEST plan and has been covered by Medicaid FFS program for his/her entire stay, is discharged from a hospital (regardless of his level of care on discharge) and subsequently returns to the acute hospital, the QUEST plan in which he/she is enrolled is responsible from the time of readmission.

If a patient who is a QUEST enrollee is admitted to a hospital at an acute level of care and subsequently there is a lowering in the level of care, the financial responsibility is different depending upon when the patient is disenrolled from the QUEST plan and enrolled into Medicaid FFS.

If the level of care is lowered **prior** to enrollment into Medicaid FFS, the plan is responsible for the acute care and the lower level of care through discharge or up to 60 days of long term care.

If the level of care is lowered **after** enrollment into Medicaid FFS, the Medicaid FFS program is responsible from the effective date of the lowering in level of care.

If a patient, who was a QUEST member at the time of admission at an acute level of care is determined disabled during his/her confinement through the ADRC process and eligibility has changed to FFS, the QUEST plan is ONLY responsible for the acute care stay. Thus, if the patient is no longer at the acute level of care, the hospital should obtain approval from HSAG for his/her appropriate level of care. Claims for these approved levels of care should be submitted to the .Medicaid FFS program and NOT to the QUEST plan.

Hospital providers billing for facility services on a UB92 form should bill the continuous stay with an occurrence code of '40' and the initial acute admission date should be noted in the occurrence date form locator. Providers should submit claims with occurrence code '40' only if the patient was Medicaid FFS on the initial date of admission and the patient has been continuously confined in the same facility throughout the stay.

Providers should submit new or adjustment claims with occurrence code '40' for claims that have been denied for edit H179.1 or H179.2 (recipient enrolled in a QUEST plan) that meet the requirements. Claims billed with occurrence code '40' are subject to review.

If a provider has submitted the claims for the downgrade stay to a QUEST health plan and received payment from the plan, they do not need to void the claim and bill Medicaid FFS. However, the provider is not to duplicate bill Medicaid FFS for the stay unless the claim to the QUEST health plan is voided and refunded.