

Nursing Facility Reimbursement FAQ

(Updated for RUG-IV Grouper 48 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" for SFY 18 or later.

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. Myers and Stauffer, LC (MSLC) will continue to collect and audit reports, but will not retroactively adjust price-based rates.

Q. How do I find out my facility's Case Mix Index (CMI) under RUG-IV Grouper 48?

- A. DMAS will provide a quarterly CMI report during the transition from RUG-III Grouper 34 to RUG-IV Grouper 48. This report will be loaded to the facility's eDoc Management folder. DMAS will update this information quarterly through the 2nd quarter of State Fiscal Year 2018.

Q. Are nursing facility claims paid by RUG weights or facility Case Mix Index?

A. Nursing Facilities are paid by the RUG weights submitted on the claim. RUG adjusted price-based weights can be found on the DMAS website at <http://www.dmas.virginia.gov>. Click on Provider Services, Rate Setting Information, Nursing Facilities and “RUG Adjusted Nursing Facility Price-Based Reimbursement Rates”.

Q. What's the difference between the “Nursing Facility Price-Based Reimbursement Rates” link and the “RUG Adjusted Nursing Facility Price-Based Reimbursement Rates” link?

A. The “Nursing Facility Price-Based Reimbursement Rates” link displays a provider’s base rate. The “RUG Adjusted Nursing Facility Price-Based Reimbursement Rates” link displays what a claim will be paid according to the RUG(s) submitted on the claim. Both links show Per Diem calculated rates.

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

A. The formula to calculate nursing facility price-based rates is = ((Direct rate X RUG weight) + Indirect rate + NATCEP + Criminal Records + Plant Rate). Values contained in parenthesis are rounded to two decimal places. 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 nursing facility providers. Facility rates and provider resources are published on the nursing facility webpage at http://www.dmas.virginia.gov/Content_pgs/pr-nursing.aspx. 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. 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. What changes were granted by the Virginia General Assembly for nursing facilities effective 7/1/2017?

A. The 2017 Virginia General Assembly made three changes that affect nursing facility rates: the adjustment factors used for calculating price-based rates were increased; facilities in the former Danville MSA will be paid Other MSA (Urban 4) rates; and the Virginia Home rates were increased. For more detailed information, please see the Medicaid Memo entitled "New Rates and RUG Grouper Version Change for Nursing Facility Claim Payments – Effective July 1, 2017" dated May 8, 2017.

RUG-IV Grouper 48 Transition

Q. When will RUG-IV Grouper 48 be effective?

A. Effective July 1, 2017 DMAS will use RUG-IV Grouper 48 to develop price-based rates and pay claims.

Q. If I submit a claim after the RUG-IV implementation with dates of service before 7/1/2017 will the claim be paid under RUG-IV Grouper 48 or RUG-III Grouper 34?

A. Nursing facility claims will be paid according to the date of service on the claim. Claims with dates of service prior to July 1, 2017 will be paid under RUG-III Grouper 34.

Q. Where can I find the list of allowed RUG codes for RUG-IV Grouper 48 and the weights?

A. A list of allowed RUGs can be found on the Nursing Facilities Website at http://www.dmas.virginia.gov/Content_pgs/pr-nursing.aspx under the section "Resource Utilization Group (RUG) Weights". Click on the appropriate link to locate RUG-III Grouper 34, and [RUG-IV Grouper 48](#).

Q. How will Medicare claims be paid under RUG-IV Grouper 48?

A. DMAS has mapped the Medicare RUG-IV Grouper 66 RUGs to Medicaid RUG-IV Grouper 48 RUGs to calculate what Medicaid would have paid. This action determines how much Medicaid will pay and is used for copayment calculations. The Medicare crosswalks for RUG-III and [RUG-IV](#) can be found on the nursing facility website http://www.dmas.virginia.gov/Content_pgs/pr-nursing.aspx under the section "Resource Utilization (RUG) Weights". Click on the link that begins with "Crossover Claim Map" with the appropriate RUG Grouper Version.

Q. If claims are being paid using RUG-IV starting in SFY 2018, how were rates calculated to take this into account?

- A. MDS assessments used to develop the SFY 2018 rates correspond to the provider's fiscal year cost report data ending in calendar year 2014, which was used as the base year for calculating SFY 2018 rates. DMAS has collected RUG-IV Grouper 48 data since the second quarter of 2013 and used this data for calculating rates effective July 1, 2017.

MDS and MDS Software Technical Guidance

Q. How do I make my software compatible for RUG-IV Grouper 48, and by what date should my software be set up?

- A. Nursing Facilities will need to contact their MDS software vendor to configure their facility's software to collect RUG-III Grouper 34 and RUG-IV Grouper 48 in compliance with DMAS requirements. These changes should be made prior to July 1, 2017. Please see the Medicaid Memo "New Rates and RUG Grouper Version Change for Nursing Facility Claim Payments Effective July 1, 2017".

Q. Can I use the same software that I currently use for RUG-III Grouper 34 for RUG-IV Grouper 48?

- A. Yes, providers can continue to use their existing MDS software. Existing software must be updated prior to July 1, 2017 for the RUG-IV Grouper 48 transition.

Q. What if my facility's software was not updated by July 1, 2017? How do I obtain a RUG-IV Grouper 48 code?

- A. Providers can access the RUG-IV Grouper 48 Code by using the Alternate State Billing data item or viewing their Quality Improvement and Evaluation System (QIES) final validation report. For questions regarding the use of the MDS and QIES final validation report, contact the VDH MDS/RAI Coordinator at 804-367-2141.

Q. What should I do if my facility didn't set up the MDS software to collect RUG-IV Grouper 48 for the test in the Alternate State Billing Item (Z0250)?

- A. While there is no penalty for not using the Alternate State Billing item in the past, providers should be sure to configure their software to put the RUG-IV Grouper 48 codes in the State Billing item (Z0200) in order to correctly bill for dates of service on or after July 1, 2017.

Q. If I can still find the RUG-IV Grouper 48 code to correctly bill nursing facility claims without updating my facility's MDS software (by using the RUG-IV Grouper 48 code in the Alternate Billing item or by viewing the Quality Improvement and Evaluation System QIES final validation report), why should my facility update the software?

- A. DMAS uses quarterly facility CMI data based on the average RUG for each Medicaid resident at the end of a quarter during the rate setting process and to monitor statewide, regional or facility acuity changes. Unless the MDS software is updated, DMAS cannot collect accurate CMI data for your facility.

Q. RUG data is submitted on claims to Virginia Medicaid. At what point should providers stop submitting RUG-III data and start submitting RUG-IV data?

A. Providers must continue to submit RUG-III Grouper 34 for claims with dates of service through June 30, 2017. Providers are required to submit RUG-IV Grouper 48 MDS data in the State Medicaid Billing Data Item Z0200 for dates of service on or after July 1, 2017.

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 RUG 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 RUG 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 RUG 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)

Q. Can I use prior MDS assessments prior to July 1, 2017, which I used to calculate the RUG-III Grouper 34, or does DMAS require new assessments?

A. Yes, facilities can use the same MDS assessment, which can also calculate the RUG-IV Grouper 48 as long as the MDS assessment meets all OBRA requirements. Facilities are not required to complete a new MDS assessment prior to billing RUG-IV Grouper 48.

Q. What MDS assessments can I use to bill Medicaid RUG-IV Grouper 48 until a RUG-IV Grouper 48 MDS assessment is completed?

A. OBRA MDS assessments set prior to July 1, 2017 can be used to assign a RUG-IV Grouper 48 RUG code by using the Z0250A data item for MDS software that has not been updated or the QIES final validation report. For questions regarding the use of the QIES final validation report, contact the VDH MDS/RAI Coordinator at 804-367-2141.

Q. What types of assessments in A0310 may be used for payments?

A. Only the federally required OBRA assessments listed in A0310A can be used.

Billing and Edits

Q. Will all of the edits for nursing facilities still apply when DMAS switches to RUG-IV Grouper 48?

A. Yes, all existing price-based nursing facility billing edits in place for RUG-III Grouper 34 will be maintained and applied during claims adjudication, including Edit 1736 (Occurrence Code 50).

Q. If I submit the wrong RUG Version on the claim, will the claim pay?

A. No, the RUG(s) billed on the claim must correspond to the correct RUG version according to the dates of service. Claims with dates of service before July 1, 2017 must bill RUG-III Grouper 34, and claims with dates of service on or after July 1, 2017 must bill RUG-IV Grouper 48. Claims that bill the incorrect RUG version will deny for Edit 1726 (Invalid RUG).

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 RUG code billed must match the RUG code documented on the MDS assessment that applies to the dates of service submitted on the claim. Billers may choose to report multiple RUG codes on individual revenue lines on the same claim for different dates of service during the billing period.

Q. What MDS assessment and RUG 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 RUG 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 RUG AAA. 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 RUG 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 RUG AAA. 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 RUG under Medicaid?

- A. The nursing facility should bill the Medicaid RUG 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 RUG score from the most recent OBRA assessment. The most recent OBRA assessment may have been combined with an assessment for Medicare Part A.

Q. If an OBRA is combined with a PPS MDS, will the facility use the A0310A for the assessment type/modifier for billing even though the MDS is combined?

- A. Only the federally required OBRA assessments listed in A0310A will be used for the Medicaid price-based payment methodology. The assessment type/modifier billed with the RUG should be the values in item A0310A.

Q. My facility submitted a claim to DMAS with a Medicare rehabilitation RUG and DMAS didn't pay me correctly. Why does it look like I am being paid a different RUG code for the Medicare Rehab claims?

- A. DMAS matched Medicare RUG-IV Grouper 66 RUG codes to a Medicaid RUG code to determine what Medicaid would have paid. All Medicare rehabilitation codes have been mapped to the five Medicaid RUG-IV Grouper 48 Rehabilitation RUG codes RAA, RAB, RAC, RAD and RAE.

Q. Where do I find the RUG-IV Grouper 48 RUG code if I did the MDS assessment prior to 7/1/2017 without doing a new MDS assessment for all of my residents?

- A. Providers that configured their software to collect RUG-IV data in the Alternate State Medicaid Billing (Data Item Z0250 of the MDS Version 3.0) may use the RUG-IV Grouper 48 code generated by their software. Providers that did not configure their MDS software to collect RUG-IV Grouper 48 data can find the RUG-IV Grouper 48 code in the QIES Final

Validation Report. Please see the Medicaid Memo entitled “New Rates and RUG Grouper Version Change for Nursing Facility Claim Payments – Effective July 1, 2017” dated May 8, 2017.

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 RUGs?

- A. If a provider completed an MDS assessment and later corrected the assessment that resulted in a different RUG code, the provider *must* adjust claims and submit the revised RUG 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 RUG score when the assessment is due, the default days will apply.

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

- A. The RUG 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. How does the price-based reimbursement methodology impact the submission of the per diem rate on the Medicaid LTC Communication form (DMAS-225)?

A. When submitting the DMAS-225 to the local DSS, nursing facilities are required to enter the Medicaid per diem rate. Effective November 1, 2014, each resident has his or her own per diem rate based on the RUGS score. To assist nursing facilities in completing the DMAS-225, DMAS has posted a rate file with the per diem rate for each RUGS score by each facility. The rate file is posted on the DMAS website www.dmas.virginia.gov under Provider Services, Rate Setting Information, Nursing Facilities Page, then select the correct rate year for the “RUG Adjusted Nursing Facility Price-Based Reimbursement Rates” link.

Q. For new admissions, should providers wait until the assessment is performed to submit the RUG-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 RUG- 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 NFPayment@dmas.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 RUG-III Grouper 34 to RUG-IV Grouper 48?

A. Specialized Care, State Nursing Facilities, and ICFs operated by DBHDS will not be impacted by the RUG-IV Grouper 48 transition. Only providers that bill RUG rates will be impacted.

Q. How will hospice rates be affected by the transition of RUG-III Grouper 34 to RUG-IV Grouper 48?

A. Hospice services provided in a nursing facility will be paid 95% of the RUG-IV Grouper 48 adjusted rate for claims with dates of service on or after July 1, 2017. 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 RUG rates for hospice?

A. Hospice providers that render services in nursing facilities are paid 95% of the facility’s RUG adjusted price-based rates. These providers can only bill RUGs listed on the “RUG Adjusted Price-Based Reimbursement Rates” link located on the nursing facility website.

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.