On June 30, 1988, Public Law 100-360, known as the Medicare Catastrophic Coverage Act of 1988, (MCCA) was signed into law. Under this law, the scope of Medicare coverage for persons in nursing facilities was greatly expanded and major changes were made to the federal Medicaid program.

However, this November, Congress repealed the MCCA provisions expanding Medicare coverage in nursing facilities. As a result, persons in nursing facilities will again be subject to the former requirements when eligibility for Medicare payment is determined. These include a 3 day prior hospitalization; a 100 day limit on the number of days of nursing facility services covered per spell of illness; as well as reinstatement of the coinsurance requirement for the last 80 days of the 100 day period.

These and other recent changes in the Medicare and MA programs, have required that the Department reassess its current approaches for maximizing Medicare benefits for persons in nursing facilities. Accordingly the Department is now re-emphasizing its long-standing policy relative to Third Party Health Insurance (TPHI) in nursing facility situations.

Effective January 1, 1990 dual billing of MA and Medicare will no longer be allowed. Social services districts should not authorize MA for nursing facility services for patients admitted or readmitted to such facilities (subsequent to January 1, 1990), who fall within the following RUGS categories until they receive from the facilities Medicare determinations and redeterminations of coverage.
RUGS CATEGORY

- Rehabilitation A
- Rehabilitation B
- Special Care A
- Special Care B
- Clinically Complex D

Social services districts will be provided with the relevant page from the Patient Review Instrument (PRI) by the nursing facility, for all nursing facility patients. This will be the vehicle for identifying the aforementioned RUGS categories.

For persons in nursing facilities who do not fall within the identified RUGS categories, the local district should authorize MA if the client is found to be otherwise eligible.

This policy will be systemically supported by the use of Payment Exception Type codes on the Principal Provider Subsystem. The specific steps in the process are:

1. WMS will set all Principal Provider Subsystem (PPS) Payment Exception Type codes to 2 (Per Diem Payments to Provider Allowed) where the Date of Service From Date is prior to January 1, 1990;

2. For each nursing facility admission with a Date of Service From Date of 01/01/90 or later, where the recipient is eligible for Medicare reimbursement, districts should make customary entries on PPS, but with a Payment Exception Type of 1 (Per Diem Payments to Provider Not Allowed).

3. In bed reserve situations, a new line (in addition to the one recording the initial placement) should be entered on the PPS with the Provider ID number, Date of Service From Date and Payment Exception From Date equal to the date of return to the nursing facility, and a Payment Exception Type of 1.

4. After verifying that Medicare reimbursement is no longer available, the district should enter on PPS a Payment Exception Type of 2 and a Payment Exception From Date equal to the date that MA is authorized for nursing facility care.

We expect that the WMS run described in Item 1 above will be completed by early February, 1990 and that the necessary MMIS edits will be set to deny claims immediately thereafter. Districts will be notified by a General Information System (GIS) message with more specific schedule information as soon as it is available.
Questions regarding this policy should be directed to Barry T. Berberich, Director, Bureau of Long Term Care, at 1-800-342-3715 extension 3-5611, or your County Representative at extension 3-7581, and in NYC at 1-212-587-4853.

Sincerely,

Jo-Ann A. Costantino  
Deputy Commissioner  
Division of Medical Assistance