

# LTC Provider Refresher Workshop FAQ

## Responses to the questions asked during the Long Term Care (LTC) Provider Refresher Workshop on October 25, 2023.

### 1. What is the Pay Start Process:

A W-9 is required for each facility admission. The required denials are scenario specific and outlined in the instructions for the W-9.



W-9 Long Term Care  
Form.doc

- For scenario A1 - Medicare covered upon admission, the denial should be for a 30-day period - unless the client discharged (or passes away) prior to day 30. DSS is looking for a code 96 or 50 (and we may accept code 116). The denials should always be submitted timely to allow for appeals. If less than 30 days, the discharge date should be noted on the W-9.
  - For scenario A2 - the 100 days Medicare covered should be listed. A code of 119 is needed.
  - For scenario A3 - no additional documentation is needed.
  - For scenario A4 - DSS is looking for a 30-day denial code 96 or 50 (possibly 116) - unless the client discharged prior to day 30.
  - For scenario B1 - DSS is looking for a 30-day denial code 96 or 50 (possibly 116) - again, unless the client discharged prior to day 30.
  - For scenarios B2a and b - copied from the W9 instructions:
    2. If the client did not meet one of the technical requirements for Medicare coverage, check the box indicating the reason for the denial as follows:
      - a. If the client did not have a qualifying hospital stay, and did not reside in the community within 30 days of the admission date, you may submit either a hospital W-10 if there was a hospital stay of less than three days, or if there was no hospital stay and the client was transferred from another facility or another level of care within your facility you may just indicate that in the comments section and no additional documentation is required. If the client resided in the community (including boarding homes or homes for the aged) within 30 days of the admission into your facility, you must attach a Medicare Determination Notice, RA, or HMO denial letter.
      - b. Check this box if the client's benefits were previously exhausted for this spell of illness. All benefit days previously used at your facility or another nursing facility must be listed in the fields provided. If the last day of Medicare coverage is greater than 60 days from the admission for which you are seeking payment, a Medicare Determination Notice, RA, or HMO denial letter is required. If the last day of coverage is less than 60 days, submit a copy of the facility denial notice.
  - For scenarios B2c and B2d - under/over 65 not receiving Medicare A - no additional documents are needed.
  - If the client has Third Party Liability that covers Long Term Care, a W-9a is required, along with a denial from the insurance company.
2. If a resident goes to the hospital, but for less than 3 days, Medicare will not provide coverage even if the care meets skilled requirements because of a technical denial for a qualifying hospital stay. So having to submit a denial in that situation seems incorrect.
- See excerpt above, copied from the W-9 instructions.
3. I just want to confirm - residents in a SNF (slide #60) that residents are entitled to 36 "home leave" days, just confirming that this is the same as LOA/overnights. Or is this only ICF.

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- Slide #60 was a reference to bulletin [PB21-29](#) addressed to ICF/IID providers only. The reference to 36 home leave days is for ICF/IIDs only.
4. We'd like more information on the Medicare/Managed care denials needed for pay starts to be approved.
    - Proper documentation/denials are needed by the Convalescent Unit to ensure all resources (Medicare/Managed Care) are exhausted prior to Medicaid being able to pay for the stay. They are also required for appeals to Medicare.
  5. Crossover Medicare claims are Paid but Medicaid paid zero. What did I do wrong?
    - The Medicare payment you received exceeded what Medicaid would have paid for the services provided on the claim. Medicaid will not pay the coinsurance / deductible if the paid amount exceeds the amount that Medicaid would pay you for that claim.
  6. If Medicaid does not pay the coinsurance/deductible on the Medicare crossover, may I bill the patient?
    - Medicaid patients cannot be billed for the coinsurance/deductible.
  7. Waterbury has 1 worker that insists that on a W353 Discharge/Transfer Notice; I add in a date of admission of the last time the individual was discharged. I have not been asked by anyone else to complete this. Is this correct, for me to enter in a date of admission?
    - DSS would expect all fields on the W353 to be completed. Entering the prior admit date does help to ensure we are not missing any admits or discharges. In my experience this is typically filled in. Also, if DSS makes updates to the system and then realize there were prior admits and discharges we did not have it is more difficult to make the corrections. Most facilities are completing the entire form. DSS doesn't think it would be necessary to hold up entry of the admits and discharges for this, but it should become normal practice. If you can let us know the name of the worker, we can address.
  8. The manager at Waterbury told me that her LTSS workers have 10 days to complete entering in my W352 & W353's. However, my submissions still have not been entered, and I then have to send my email to the manager.
    - LTSS does have 10 days to act on any newly received information. Some staff may be behind on these as pending applications will take priority. If this is isolated to 1 or 2 staff, it can be addressed individually. We would need to know if it is more widespread. There can also be other reasons why the entry was not completed. For example, the case may have closed at renewal or during other updates and that will need to be addressed before these admits and discharges can be entered.
  9. Bridgeport has one worker, that has told me, I cannot submit my W352 & W353 directly to her email. She tells me that I am supposed to submit via the portal, or I am to drop off the paper forms at our local office. From there the forms will be sent to the scanning center. I was sent the listing of who, in the Bridgeport office handles each claim, based on the alphabet. This came from the manager of Bridgeport. Is there a rule that says that a Provider cannot send the W352 & W353 directly to the LTSS worker?
    - Intermediate Care Facilities (ICF's) do not use Assessment pro to enter their admits and discharges, so they have to send them in paper form (352/353). They are allowed to send them via email to the covering alpha worker. If they send

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to scanning, nobody is searching those to be worked timely so email is the preferred method.

10. When I submit our W353 I have been asked to hand write in our Provider Number. I have only been asked to do this for one LTSS worker. Is this required?
  - It is helpful to add the provider number to the W353. The older version of this form did have a provider number field. It was later changed to the NPI number. However, to update the case in the eligibility system, staff need the provider number. It is not required but will save staff from needing to look it up before your admit can be entered. It will also ensure no errors are made when looking up the number. Again, the system does not accept the NPI number. We must use the provider number. Many ICFs and chronic disease hospitals do include the provider number already.
11. I am sending in my forms via email to the LTSS worker whose name is in charge of my client's last name. Is this ok to do?
  - The alpha breakdown for the LTSS staff is provided to the facilities so they can contact staff directly. That includes via email. It is ok to email these forms to the alpha worker. The worker will then send the document to scanning, so it becomes part of the case record.
12. Regarding the Leave Days for Hospitalization- providers can bill for 15 days, is this for a year or Fiscal Year?
  - Please see Provider Manual, Chapter 8 for Nursing facilities, ICF/IID and Chronic Disease Hospitals Claim Submission Instructions, section 8.9 Bed Reserve. For hospital leave, the Department of Social Services may pay to reserve the bed for up to 15 days per hospital admission.