257 QUESTIONS AND ANSWERS

Maryland Department of Health and Mental Hygiene *December 2012*

257 Q&A topics:

1. **How do I complete the 257 to reflect a Medicare coinsurance time period?**

The most prevalent 257 errors occur when submitting Medicare coinsurance 257 documents. Please see the instructions below to assure that your documents are completed correctly.

Community Coverage/Less than 30-day or up to 80-day Medicare stay

A. Begin Payment:
   - Item #2: Medicare A Co-payment: must include both a begin pay date and an end pay date.

B. Cancel Payment:
   - You must report the discharge status of this patient.
   - If the patient has not been discharged from your facility, the DHMH 257 will be returned for completion of LTC application and conversion of eligibility coverage to LTC.

LTC Coverage/Medicare Coinsurance to Full MA

A. Begin Payment:
   - Item #2: Medicare A Co-Payment: Must include both a begin pay date and an end pay date.
   - Item #1: Full MA coverage: Must include a begin pay date.

Note:
- ***To begin full MA, a DHMH 257 must be signed by UCA for level of care certification.***
- ***In Section A. Begin Payment, any "end pay date" entered must be equal to the discharge date reported in Section B or must be equal to the full MA begin pay date reported in Section A.***
- ***Section B. Cancel Pay should not be completed if your patient still resides in your facility.***

Less Than 30-Day MA Stay

A. Begin Payment:
   - Item #1: Complete for full MA coverage.

B. Cancel Payment:
   - You must report the discharge status of this patient.
   - If the patient has not been discharged from your facility, the DHMH 257 will be returned for completion of the LTC Application and conversion of eligibility coverage to LTC.

Note: The 257 form must be certified by the UCA.

2. When is an IMA-81 letter issued for a 257 with older dates of service?

The Medical Assistance Problem Resolution Unit (MAPR/LTCPR) will only issue an IMA-81 letter if after review of the case it has been determined that there has been agency delay in processing a case. If a 257 is received for older dates of service, but is signed by the UCA with a current date, staff will research the following:

- Was there a retroactive eligibility decision date that places the dates of service in statute at receipt?
- Is there any indication in CARES that the 257 had previously been presented to a caseworker, was processed, but does not appear in MMIS?
    - If the 257 information is in CARES, or if there is history of narration indicating that the facility presented a 257, MAPR staff will correct MMIS to correlate with the CARES system.
    - An IMA-81 retro letter will only be issued if the inquiry to correct MMIS has been received in a timely manner.
    - If the request to correct spans in MMIS has been received over a year after the information was updated in CARES, the IMA 81 letter will not be issued.

3. How do I complete transfers to another facility?

You must report your cancel pay/discharge date in Section B, making sure that your discharge date reflects the date of actual discharge (which is usually the admit date into the new facility). DHR/DHMH staff will end your LTC spans the day prior to the date of discharge reported. The date of admit to the new facility is also their first billable day of service. It is not appropriate for the discharging facility to submit claims for payment of the discharge date.

4. How do we complete a 257 for a patient who resides in our facility but has elected the Hospice benefit?

It is not necessary for the nursing home to submit a discharge 257 in this situation. The Program has put internal procedures in place that will utilize the hospice election document to end nursing home spans the day before the hospice election begin date (or hospice admit).

What do I do if a patient who has elected the hospice benefit decides to revoke their hospice benefit?

At that time the nursing facility will need to complete a new 257 and obtain a UCA certification sign-off. Complete the 257 as follows:

A. Begin Payment:
    - Item #4: Revocation of Hospice care and return to NF care - fill in effective date.

<u>Note</u>: Effective date should be the hospice actual discharge date and the nursing home actual admit date. These dates should be equal.

5. What other instances will cause my 257 to be returned?

- No level of care obtained from UCA to certify necessity to begin full MA
- Incorrect level of care obtained
- Chronic facility with level of care marked as nursing facility

6. Is it necessary to submit multiple 257s when the patient changes levels; either from Medicare coinsurance to full MA, or to full MA back to full Medicare?

For Medicare coinsurance to full MA 257s, please see instructions in question #1. Once full MA LTC spans are established in MMIS for your facility through 999999, it is not necessary for you to report via DHMH 257 when the patient reverts back to full Medicare, and then to full MA again. When billing, make sure your facility does not submit claims for those full Medicare dates of service. We will only need to see another 257 when the patient discharges from your facility; due to death, out to the community, or transferred to another facility.

7. When should I complete a 257 to report a cancel pay in Section B?

- If your patient leaves your facility:
  - Discharge to community
  - Transfer to another facility

- Date of death

Note: ***It is imperative that cancel pay 257s are submitted by LTC facilities. Lack of cancel pay documents cause denial of community services and disruption to continuity of care for the patient.***

8. What happens to the 257 if the case has been denied for reasons other than lack of information?

The 257 will be returned to the sender along with the 726.

Reasons for return:

- Your case has been forwarded to another jurisdiction
- Because we have not yet received an application for Medical Assistance/Long Term Care for the patient
- It has not been authorized by the Utilization Control Agent
- The client has been determined ineligible for Medical Assistance/Long Term Care
- Other reason as identified

ADDENDUM - BEDHOLD/HOSPITAL LEAVE

Note: ***As of July 1, 2012, hospital leave is a non-covered service in the Maryland Medical Assistance Program. Please refer to the Programs' Nursing Home Transmittal No. 241 issued 7/12/2012 regarding this policy change and follow the appropriate instructions below.***

9. How do I complete the 257 to reflect a full Medicare hospital leave/bed reservation time period?

For *on or after* July 1, 2012

As of 7/1/12, there is no need to notify the Program of a hospital admission for a patient on straight MA, and the Program no longer requires a cancel pay after 15 days. Do not submit a discharge 257 unless the recipient is deceased, discharged to community, or is transferred to another facility from the hospital.

For hospital leave/bed reservations *prior to* July 1, 2012

A. Begin Payment:
   - Item #3: Bed reservations for full Medicare coverage period. Fill in the begin pay date field and the end pay date field.

B. Cancel Payment:
   - If your patient remains in the hospital and exceeds the 15 day bed reservation maximum, check "discharge to", fill in the discharge date field, and under discharge to another provider, write "hospital leave exceeded 15 day maximum."
   - If the patient returns to the facility into a Medicare co-payment time period, complete the 257 as instructed in question #1.
   - If the patient returns to the facility into a full MA time period, complete a new DHMH 257 and forward to UCA for certification signatures.