

471-000-82 Explanation of Completing Turnaround MC-4, "Long Term Care Facility Turnaround Billing Document"

Use: Turnaround MC-4, "Long Term Care Facility Turnaround Billing Document," is a computer-generated billing document that is prepared by the Department for each long term care facility on a monthly basis for those eligible clients with active prior authorization records. Facility staff must review Turnaround MC-4 for accuracy and completeness. Facility staff must make any adjustments and correct any errors using red ink. Facility staff must return one copy of the printout to the Department. Payment for services listed on Turnaround MC-4 is then processed.

Changes in the client's level of care must be authorized by the Central Office. These changes are authorized on Form MC-10, "Prior Authorization Document Adjustment," (see 471-000-211). If facility staff have received copies of Form MC-10 authorizing a change not reflected on the Turnaround MC-4, facility staff must make the adjustment on the Turnaround MC-4 and attach a copy of Form MC-10.

Turnaround MC-4 is generated on a monthly basis. The claims on the Turnaround MC-4 are for the specific clients listed only for the month designated at the top. "Blank" documents (add-on) are printed at the end of each facility's turnaround. Facility staff must complete an add-on document for each Medicaid patient in the facility for whom prior authorization has been received but whose name does not appear on the pre-printed portion of the turnaround. See section 2, "Instructions for Completing the Add-on Turnaround MC-4," starting on page 7 of 471-000-82.

Number Prepared: Each month the Department sends two copies of Turnaround MC-4 to each active long term care facility.

Completion: The heading of Turnaround MC-4 contains:

1. The facility's Medicaid provider number;
2. The facility's name;
3. The address, city, state, and zip code;
4. The number that corresponds to the facility level (i.e., 1 - Skilled, 2 - ICF); and
5. The month and year which the claims cover.

The remainder of the report contains individual claims separated by rows of asterisks.

1. Explanation of the Completed, Pre-Printed Turnaround MC-4: Each claim contains the following elements. Facility staff may change and/or complete those marked with asterisks.

Recipient: The client's name, last name first, and case number. Clients are listed in alphabetical order.

Document Number: A unique, non-repeating nine-digit number. This number appears on the Remittance Advice, "Explanation of Medical Claims Activity." All inquiries regarding a particular claim document must contain the document number.

Prior Auth/NBR: The nine-digit prior authorization document number. This is the number on Form MC-9, "Prior Authorization Document".

Payment Effect Date: The current payment effective date from Form MC-9 or subsequent Form MC-10's.

*Level of Care: The authorized level of care. Facility staff should adjust this element if the facility has received a Form MC-10 indicating a different level of care for this month of service. (A copy of Form MC-10 must be submitted with the Turnaround MC-4.) In addition, monthly care level reports indicating the level of care for the current month are sent to the facilities. If the report reflects a different level of care than the turnaround MC-4, staff should adjust the numeric level of care.

*Room Number: The client's room number may be entered by facility staff.

Daily Rate: The authorized Medicaid per diem rate for the client's level of care.

*Admit Date: The date the client was admitted to the facility for the current stay.

*Discharge Date: The date the client was discharged from the facility. Facility staff complete this element in month/day/year format. This information may be pre-printed on the turnaround document if the discharge date or date of death has been received from the local office that handles the client's case.

*Discharge Rsn (Reason): Facility staff must enter the number of the discharge reason, using the National Patient Status Codes maintained by the National Uniform Billing Committee (NUBC):

National Code	Description
01	Discharged to Home or Self Care
02	Discharge/transferred to another short term general hospital for inpatient care
03	Discharged/transferred to SNF with Medicare certification
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged/transferred to a designated cancer center or children's hospital
06	Discharged/transferred to home under care of organized home health service
07	Left against medical advice or discontinued care
09	Admitted as an inpatient to this hospital
20	Expired
30	Still Patient (Use only on UB92 Forms, not Turnaround Billing Documents)

40	Expired at home
41	Expired in a medical facility
42	Expired – place unknown
43	Discharged to a Federal Hospital
50	Discharged to Hospice - home
51	Discharged to Hospice – medical facility
61	Discharged/transferred within this inst. To hospital-based Medicare swing-bed
62	Discharged/transferred to an inpatient rehabilitation facility
63	Discharged/transferred to an Medicare certified long term care hospital
64	Discharged/transferred to a nursing facility certified under Medicaid
65	Discharged to a psychiatric hospital
66	Discharged to a Critical Access Hospital (CAH)
70	Discharged/transferred to another type of health care institution

The discharge reason element must be completed if a discharge date is entered. If the discharge reason is pre-printed, the facility staff should correct if necessary.

*Nur Home Days (Nursing Home Days): The number of inpatient days for the month's service is pre-printed. The facility staff must adjust this element, if necessary, to reflect those days the client was in the facility at midnight.

*Leave Days Therapeutic: Facility staff must enter the number of days in the month that the client was on allowable therapeutic leave and the bed was held. Enter the dates of leave under the claim number. If the therapeutic leave taken exceeds the allowable amount, only the allowable days may be claimed. An explanation should be written on the Turnaround MC-4 to account for days not claimed.

*Leave Days Hospital: Facility staff must enter the number of days in the month that the client was on allowable hospital leave and the bed was held. Enter the dates of the hospital stay under the claim number. If the hospital stay exceeds the allowable bed holding days, or if there were two or more stays in the month, only the allowable days are claimed, and an explanation must be written on the Turnaround MC-4. Hospital leave days are allowable per hospital stay, not per month.

Note: The total of nursing home days, therapeutic leave days, and hospital leave days must not exceed the number of days in the month.

*Total Amount: This is the total amount of the claim (total days multiplied by Medicaid per diem rate). Facility staff may adjust, if necessary.

*Paid Other Sources Amt: This amount is pre-printed. If the amount is incorrect, facility staff may correct it and attach the Notice of Action received from the local DHHS office.

Net Amount: Facility staff are not required to enter the net amount on the copy that is returned to the Central Office. The net amount of each claim is calculated by the computer. Facility staff may wish to calculate and enter the net amount on the facility copy.

Any additional information that will assist in processing the claim should be entered in the blank area by the individual claim.

Following the last claim, a line with the total amount of the Turnaround MC-4 is printed. This amount is the total of all claims on the turnaround before adjustments and "paid by other sources" amounts are calculated. Facility staff may calculate the total amount, the total "paid by other sources" amount, and the total net amount; however, it is not required.

Signature of Administrator/Authorized Representative and Date: The long term care facility administrator or his/her authorized representative must sign and date the Turnaround MC-4. The signature binds the provider to this statement which appears on Turnaround MC-4:

The undersigned certifies under penalty of applicable federal and state laws that the above services were provided in compliance with the provisions of Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973, that the amounts claimed are in accordance with the regulations of the Department of Social Services, that no additional charge has been or will be claimed, and that each service is documented and the documentation is open to the authorized representatives of the Department of Health and Human Services and Federal and/or State Fraud and Abuse Units. I further certify that medical records document that all new clients were certified for care by the physician at the time of admission.

Distribution: Turnaround MC-4 is generated on approximately the twentieth day of each month. The Department sends two copies to each facility. Facility staff indicate any changes necessary by crossing out inaccurate information and clearly indicating the correction in red.

Facility staff submit one copy of the completed Turnaround MC-4, signed and dated by the administrator or authorized representative of the facility, directly to the Nebraska Department of Health and Human Services, Division of Medicaid and Long-Term Care, P. O. Box 95026, Lincoln, NE 68509. One copy is retained in the facility files.

Note: Turnaround MC-4's received by the Department that are incorrectly or insufficiently completed or not signed and dated will be returned in their entirety to the provider for correction or completion.

Turnaround MC-4 may not be submitted to the Department before the first day of the month following the month for which it was generated (i.e., the April turnaround may not be signed or submitted before May 1).

Payment of each claim is dependent on the authorized per diem rate and the prior authorization record regardless of changes made to the Turnaround MC-4 by the facility.

The Department must receive each Turnaround MC-4 within 12 months after the last day of the month for which Turnaround MC-4 was generated (see 471 NAC 3-002.01). If more time has elapsed, facility staff must attach justification to Turnaround MC-4 so that the claims may be considered for payment.

The long term care facility has 90 days from the date of the Remittance Advice (471-000-85) to request reconsideration or adjustment of a claim that has been denied, reduced, not paid, or paid incorrectly (see 471 NAC 3-002.07).

2. Instructions for Completing the Add-on Turnaround MC-4

"Blank" documents (add-on) are printed at the end of each facility's turnaround. Facility staff shall complete an add-on document for each Medicaid patient in the facility for whom prior authorization has been received but whose name does not appear on the completed, pre-printed portion of the turnaround, and/or for whom payment for previous months is due.

If the facility's turnaround does not contain enough "add-on" documents to submit claims for approved Medicaid patients, facility staff may request additional pages from the Department.

The top of each add-on turnaround page contains the same heading as the preprinted pages. Below the heading is the statement: "Claims on this page will not be accepted by the Department after xx/xx/xx." (The Department will not accept an add-on turnaround document after the date indicated at the top of the page.)

Facility staff shall complete an individual claim (separated by rows of asterisks) as follows.

Line 1, left to right:

Document Number: A unique, non-repeating nine-digit number. This number will appear on the Remittance Advice (471-000-85) (ASC X12N 837) electronic claim activity report. All inquiries regarding a particular claim document must contain the document number. This number cannot be altered, nor can it be used more than once.

Prior Auth Nbr: Disregard.

Recipient Number/ID: Enter the patient's 11-digit Medicaid case number.

Level of Care: Enter the appropriate number only (i.e., "70"):

70 (ESC3)	49 (IC2)
69 (ESC2)	48 (IC1)
68 (ESC1)	
	45 (CB2)
62 (SSC3)	44 (CB1)
61 (SSC2)	
60 (SCC1)	39 (PF5)
	38 (PF4)
56 (CC4)	37 (PF3)
55 (CC3)	36 (PF2)
54 (CC2)	35 (PF1)
53 (CC1)	
	50
	51
	52

Payment Effective Date: Enter the payment effective date shown in element 20 of the most recent prior authorization or adjustment (Form MC-9 or MC-10).

Daily Rate: Enter your facility's Medicaid per diem for the appropriate level of care.

Diagnosis Prim/Sec: Disregard.

Service Date Beginning/Ending: Enter the date of services which are being claimed on this document. Each calendar month, or partial month, must be on a separate document.

Patient Account Nbr: If your facility has a patient account number system, enter the client's patient account number here.

Admit Date: Enter the date of the current admission.

Discharge Date/Rsn: If applicable, enter the discharge date and reason code. Refer to 471-000-82 National Patient Status Codes 471-000-82, page 2 of 7.

Line 2 left to right:

Nursing Home Days: Enter the number of days the patient was in the facility at midnight in the month which this claim covers.

Therapeutic Leave Days: Enter the number of days the patient was on therapeutic leave at midnight, not to exceed 18 days per calendar year for an ICF or SNF client, or 36 days per calendar year for an ICF/MR client. Enter the dates of leave in the blank space located to the right side of the claim information.

Hospital Date: Enter the number of days the patient was in the hospital at midnight, not to exceed 15 days per hospitalization. Enter the dates of the hospital stay in the blank space located to the right side of the claim information.

Note: The total number of nursing home, therapeutic leave, and hospital days cannot exceed the total number of days in the month the claim covers.

Signature: See page 4 of 471-000-82.

Distribution: See page 4 of 471-000-82.

Inquiries: If no payment or response is received within 45 days from the date the form is submitted to the Department, contact Medicaid Inquiry. The inquiry line is 1-877-255-3092. For providers located in Lincoln, call 471-9128. The Medicaid Inquiry service is available on Monday through Friday, from 8:00 a.m. to 5:00 p.m. (Central Time).