



COMMISSIONER  
Adelaide Horn

February 26, 2009

To: Nursing Facility Providers

Subject: Information Letter No. 09-27  
**Clarification of Purpose Codes E and M**

Note: This letter replaces DADS Information Letter No. 08-181, *RUGs Information Requiring Special Attention*, which is hereby rescinded.

The purpose of this information letter remains to provide clarity regarding the Purpose Code E and Purpose Code M. Only Question 1 has been revised to further clarify Purpose Code M. No changes have been made to Questions 2, 3, and 4 as they were published in No. 08-181 on December 28, 2008.

The purpose of this Information Letter is to share with Nursing Facilities (NFs) several questions that require special attention. While all publications about Resource Utilization Groups (RUGs) in the form of alerts, frequently asked questions (FAQs) or banners are important, these are questions that DADS thinks need to be emphasized.

The first question/response relates to the submittal of Purpose Codes E and M. Question 2 relates to submission of Forms 3619, particularly the Dates of Qualifying Stay. Questions 3 and 4 explain when an NF should call the Texas Medicaid & Healthcare Partnership (TMHP) versus when the facility needs to call DADS Provider Claims Services (PCS), and what calls to PCS may need to be escalated to the PCS Supervisor.

DADS is requesting that NFs have their staff who are responsible for submitting forms review these responses carefully so forms can be submitted correctly for claims to be paid on a timely basis. Following the information provided below should assist NFs in avoiding/resolving the issues discussed. This will help NFs avoid problems on the LTC Online Portal that necessitate calls to a Help Desk and can delay claim payments.

**Question 1: Explain when a Purpose Code E and Purpose Code M should be submitted.**

**Response:**

**Purpose Code E - What is a Purpose Code E and how do you complete a Purpose Code E?**

**Important:** Nursing Facilities **SHOULD NOT** modify an existing MDS and make it a Purpose Code E. If this is done, the result of this action is that the existing MDS is cancelled and replaced with the Purpose Code E service period, and all services previously billed and paid at the RUG level of the cancelled MDS will be recouped. The client also no longer has an ongoing RUG. If you have already used a previously paid MDS to create a Purpose Code E, you will have to submit a new MDS as soon as possible to restore a RUG for the client. The previous Purpose Code E date can then be extended to close the new gap created until the new MDS R2b.

There typically are four situations when a Minimum Data Set (MDS) Purpose Code E (PC E) should be submitted:

1. TILEs to RUGs Conversion Gap. A PC E must be used to fill the gap if the TILE was allowed to expire prior to the date when the Resource Utilization Group (RUG) was started during the conversion from the TILEs to RUGs. Depending on how long it took to establish the RUG, this gap could be from one to 92 days. When a TILEs to RUGs conversion gap occurs, payment for the gap period (ranging to no more than 92 days) will be paid at the PC E default rate. To fill the gap, submit an off-cycle MDS Quarterly Assessment including the Long Term Care Medicaid Information (LTCMI) by completing:
  - the S1e field on the LTCMI completed as the PC E;
  - the Missed Assessment Start Date (S1f); and
  - the Missed Assessment End Date (S1g).
2. RUG Gap. Once the client has been established as a RUG client, a PC E will be needed if the next MDS assessment submission completely misses the anticipated assessment quarter. Each R2b establishes a 92-day period (R2b + 91 days), so the next assessment should be completed and submitted within the 92-day anticipated MDS assessment quarter following the 92-day span of the current MDS assessment.
  - DADS will stop payment following 31 days after the first 91 days from the R2b for the current assessment, unless the next MDS has continued the cycle.
  - The next MDS assessment will not be considered missed if it has an R2b date within the anticipated MDS assessment quarter and the LTCMI is completed on the LTC Online Portal within 91 days of the new MDS assessment R2b date.
    - If the new MDS assessment is submitted within the anticipated quarter and the LTCMI is completed within 91 days of the new R2b date, the gap following the 31 days and prior to the new R2b date will automatically be filled. The calculated RUG rate will be paid for the entire period in this situation.
    - If the new MDS is not submitted within the anticipated quarter or the LTCMI is not completed within 91 days of the R2b date, a gap will be created following the 31 days until the R2b date of the new assessment. Payment for this gap will be made at the PC E default rate. To fill the gap, submit an off-cycle MDS Quarterly Assessment including the LTCMI by completing:
      - the S1e field on the LTCMI completed as the PC E;
      - the Missed Assessment Start Date (S1f); and
      - the Missed Assessment End Date (S1g).
3. Missed Admission MDS. If a new client is admitted to the facility and the admission assessment is submitted more than 91 days after R2b of that admission assessment, the admission assessment will have to be submitted as a PC E. Payment for this gap will be made at the PC E default rate. Submit the admission assessment including the LTCMI by completing:
  - the S1e field on the LTCMI completed as the PC E;
  - the Missed Assessment Start Date (S1f); and
  - the Missed Assessment End Date (S1g).

4. Late LTCMI for MDS Admission Assessment. Any LTCMI that is completed more than 91 days after the R2b date of that assessment will require a PC E. Payment for this gap will be made at the PC E default rate and should be submitted with:
  - the S1e field on the LTCMI completed as the PC E;
  - the Missed Assessment Start Date (S1f); and
  - the Missed Assessment End Date (S1g).

### **Purpose Code M**

#### **What is a Purpose Code M and how do you complete a Purpose Code M?**

Purpose Code M – an MDS submitted if three months prior to application is granted after the client is certified for Medicaid. When there is an application for Medicaid the client's financial eligibility is considered and reviewed based on the month of application. If the client is determined to be Medicaid eligible, the worker does a consideration on the three months prior to the application to determine if the client may have been financially eligible at an earlier date. The Purpose Code M was designed to allow the provider to submit a MDS Purpose Code M to cover those 3 months so the payment could be made at a RUG value rather than the default PCE rate. The retroactive Medicaid is shown on the MESAV as a TP 14 Coverage Code P or TP 11/ TP 12 which are retroactive TP13 SSI coverage.

To fill a period approved by the financial worker for dates prior to the application the provider has two options:

1. Submit an off-cycle MDS quarterly assessment including the Long Term Care Medicaid Information (LTCMI) by completing
  - The S1e field on the LTCMI completed as the PC M
  - The start date of the approved prior period (S1f); and
  - The end date of the approved prior period (S1g)
2. Modify an earlier MDS that has not been used for the Medicaid cycle and complete the LTCMI as a PC M by completing
  - The S1e field on the LTCMI completed as the PC M
  - The start date of the approved prior period (S1f); and
  - The end date of the approved prior period (S1g)

#### **Question 2: Explain the submission of Forms 3619, particularly the Dates of Qualifying Stay.**

**Response:** Submission of the Form 3619-*Medicare/SNF Patient Transaction Notice* for an admission has always required that the Dates of Qualifying Stay be entered. The Dates of Qualifying Stay are now being recorded and monitored.

**For traditional Medicare, the Dates of Qualifying Stay must reflect the 20 days of Full Medicare.** In order for a recipient to qualify for a Medicare stay, a Hospital stay is required. Completion of the 20 days of Full Medicare qualifies the recipient for Medicare Co-Insurance. When entering the NF qualifying stay dates, the provider must enter the 20 days of Full Medicare, not the dates of the acute hospital stay.

The Dates of Qualifying Stay on the Form 3619 validate that the Full Coverage requirement has been met and that Medicare Co-Insurance can begin. If the Recipient has a Medicare

replacement, fax the Form 3619 and Medicare replacement policy EOB (explanation of benefits) to 512/438-3400 because the Full Coverage requirement can vary.)

The Dates of Qualifying Stay fields allow for two separate timeframes. If more than two timeframes are needed to reflect the 20 days of Full Medicare, a second admission Form 3619 is submitted, both with the same Date of Above Transaction and the additional timeframes entered in the Dates of Qualifying Stay field.

Different admission Forms 3619 that have the same Date of Above Transaction but different Dates of Qualifying Stay are not considered duplicates. As each admission Form 3619 is submitted, DADS records the Dates of Qualifying Stay until the 20 days have been met. Once 20 days have been reached, the system will start processing the Medicare Co-Insurance Service code of "3" based on the Date of Above Transaction.

**Question 3: Regarding RUGS, what types of calls should be referred to TMHP/PCS?**

**Response:**

Call TMHP at 1/800-626-4117, Option 1, about the following:

- Nursing Facility forms completion – including Pre-admission Screening and Resident Review (PASARR) screening
- Rejection codes on the forms
- Management of the "Provider Action Required" status

Call PCS at (512) 438-2200, Option 1, about the following:

- Denials or pending denials of clients who have established prior permanent Medical necessity
- If the ME/SSN numbers and the name match and the Status of the form is *ID Invalid*
- If the previous nursing facility has not processed discharge Forms 3618/3619 within 10 business days of admission to your facility

**Question 4: When calling PCS, what type of calls can be escalated to the supervisor?**

**Response:** A delay in the processing of the form which will cause the form or the claim to be out of compliance may be escalated to DADS Provider Claims Services (PCS); for example:

- A pending denial or denial of a client who has already established permanent Medical Necessity
- The 3618/3619/3652 PC E form or claim may be nearing the 12-month rule

Please contact Provider Claims Services at 1/512-438-2200, Option 1 with questions about this information letter.

Sincerely,

[Signature on file]

Gordon Taylor  
GT:mgm