Provider Memorandum

Patient Credit File and Long Term Care Claims

The Patient Credit File (PCF) is submitted to Managed Care Organizations (MCOs) monthly by the Department of Healthcare and Family Services (HFS) during the first half of each month. The PCF incorporates data regarding eligible long-term care services rendered to a MCO's membership for a rolling 36-month period. It is composed of individual member segments, each of which relay the following information:

- Recipient Identification Number (RIN)
- Last Name
- First Name
- LTC Provider ID
- Hospice Provider ID (Conditional)
- Patient Credit Amount
- Segment Begin Date
- Segment End Date

Per HFS guidance, the PCF is a MCO's source of truth for validation of HFS authorization of a member's long term care (LTC) eligibility. Generally, MCOs will deny claims for residents not appearing on the PCF. These claims will be reprocessed once the resident appears on the MCO's PCF. There are two limited exceptions to this policy which will be explained below.

Patient credit amount signifies the cost of care a recipient is responsible for paying that month. Patient credit amounts will not include a member's income which is exempt from the cost of care. Patient credit amount is subject to change and will be reflected on the PCF.

MCOs will pay claims for retrospective entries to the PCF back to the effective date of the member segment applied. Providers must adhere to MCO timely filing requirements even if a member is not currently present on the PCF. Adjudication processes may vary by MCO for claims submitted prior to PCF validation.

PCF Validation Exceptions

As mentioned above, two exceptions apply to the requirement that MCOs rely on the PCF for validation:

1. If a member has termed with the MCO and HFS makes a retrospective adjustment to the PCF; or
2. HFS makes a retrospective adjustment to the PCF which exceeds the timeframe of the PCF.

In these particular cases, a MEDI screenshot can be applied to override the PCF as the source of truth. Providers must submit MEDI screen shots to the MCO for review. If the MCO validates the MEDI screenshot, the claim will re-adjudicate for appropriate payment. MCOs may apply individual processes to determine how MEDI screen shots should be submitted or evaluated.

Providers on PCF

The following residential provider types on the PCF submit claims to MCOs and will need to rely on the business rules surrounding the PCF in managing those financial transactions:

- Supportive Living Facilities, or SLFs (028)
- Nursing Facilities (033)
- Specialized Mental Health Rehabilitation Facilities, or SMHRFs (038)

ICF/IIDs, ICF/MRs and skilled pediatric facilities (Provider Type 029) will not appear on the PCF. MCOs may have residents of these facilities enrolled in their program if they manage the Family Health Program/Affordable Care Act (FHP/ACA) or Integrated Care Program (ICP). However, these providers offer services managed by the Department of Human Services-Division of Developmental Disabilities (DHS-DDD) and are not covered by MCOs.

PCF and MEDI

A member segment on the PCF will populate in any of the following circumstances:

- Admission approval
- Change in income
- Transfers facilities
- Leaves a facility
- Moves to hospice

A member segment will populate when an admission transaction has been processed by the state, only after it has been entered in MEDI. Outstanding transactions submitted by LTC providers on MEDI which have yet to be processed by the state will not be included. Once a transaction is authorized, it is effective retrospectively to the date of the request for authorization. In some cases, a member's situation may have changed by the time the member segment is authorized.
Once the transaction is authorized on MEDI, LTC providers are able to view the authorization on MEDI. MCOs must rely on the monthly PCF for their most updated information. This may create scenarios where providers have more current information than the MCO.

All long-term care stays eligible for Medicaid reimbursement require PCF authorization for reimbursement.

Hospice Services and PCF

Section 1905 (o)(3) of the Social Security Act mandates that when a resident of a long term care facility receives hospice services, the hospice agency receives payment for the LTC facility's room-and-board charges. LTC facilities may not bill hospice patients nursing home room and board charges directly. The hospice is responsible for paying the facility.

Once a LTC facility resident is approved for hospice by HFS, two member segments will appear on the MCO's PCF. The first will end the segment intended to direct payment to the LTC provider. The second will initiate a member segment directing the MCO to reimburse the hospice provider for payment. As with LTC Provider member segments, hospice approval may occur retrospectively. MCOs will not pay hospice claims until hospice is authorized by the PCF. This process applies to Supportive Living Facilities as well as nursing facilities. This section is limited to hospice services accompanied by a LTC facility admission.

Revenue Reconciliation

LTC providers may utilize Value Code 23 to denote Patient Credit amounts on their 837I claim submissions as a means to manage revenue reconciliation.