SECTION S: STATE SPECIFIC ITEMS (New York)

Intent: The intent of this section is to support the semi-annual determination of each RHCF's Medicaid payment rate.

Effective: The version of Section S to use for a particular assessment is determined by the *assessment date.* The *assessment date* is one of three dates in Section A. The specific date used is based on the Entry/Discharge Reporting code (A0310F).

If the Entry/Discharge Reporting (A0310F) is coded:

- [**01**] (entry), then the *assessment date* is equal to **A1600** (entry date).
- [**10**, **11**, or **12**] (discharge or death in facility), then the *assessment date* is equal to **A2000** (discharge date).
- [**99**] (not entry/discharge), then the *assessment date* is equal to **A2300** (assessment reference date).

After determining the *assessment date* as described above, select from the table below the correct version of Section S to use for the assessment.

Section S Version	Effective for *Assessments Dated* (A1600 or A2000 or A2300)	
	Start Date	**End Date**
08/13/2010	10-01-2010	03-31-2011
01/31/2011	04-01-2011	none

Instructions:

- Complete Section S for all nursing home assessments, except the Tracking (NT) Item Set:
  - NC Nursing Home Comprehensive
  - NQ Nursing Home Quarterly
  - NP Nursing Home PPS
  - ND Nursing Home Discharge
  - NS Nursing Home OMRA – Start of Therapy
  - NSD Nursing Home OMRA – Start of Therapy and Discharge
  - NO Nursing Home OMRA
  - NOD Nursing Home OMRA – Discharge
- Section S is not required for swing-bed program assessments.

S0160. Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions

S0160. Specialty Unit/Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions	
Enter Code [ ]	**01** Discrete AIDS Unit
	02 Ventilator Dependent Unit
	03 Traumatic Brain (TBI) Unit
	04 Behavioral Intervention Unit
	05 Behavioral Intervention Step-Down Unit
	06 Pediatric Specialty Unit / Facility
	07 AIDS Scatter Beds
	08 Traumatic Brain (TBI) Extended Care
	99 None of the Above

Item Rationale*:*

- To identify whether the resident:
  - Resides in a discrete specialty unit or facility that is eligible for a discrete specialty Medicaid reimbursement rate in accordance with the applicable regulation or statute,

  OR
  - is eligible for enhanced Medicaid reimbursement (Add- On) for an approved specialty program in accordance with the applicable regulation or statute.

Definitions and Coding Instructions:

Enter the single code that applies.

To be eligible for a discrete specialty unit/facility rate the resident must reside in a unit or facility that is approved by the Commissioner of Health in accordance with the cited regulation(s) and/or statute(s).

S0160. Specialty Unit / Facility Reimbursement, or Resident Eligible for Enhanced Reimbursement (Add-On) for AIDS or TBI Conditions (cont.)

- **Code 01, Discrete AIDS Unit/Facility -** Approved pursuant to 10 NYCRR Part 86-2.10 (p) and Part 710 or any successor regulation and/or statute.

- **Code 02, Ventilator Dependent Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (q) and Section 415.38 or any successor regulation and/or statute.

- **Code 03, Traumatic Brain-Injured (TBI) Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (n) and Section 415.36 or any successor regulation and/or statute.

- **Code 04, Behavioral Intervention Unit** - Approved pursuant to 10 NYCRR Part 86-2.10 (w) and Section 415.39 or any successor regulation and/or statute.

- **Code 05, Behavioral Intervention Step-Down Unit** – This code does not apply to any NY facilities.

- **Code 06, Pediatric Specialty Unit / Facility** – Approved pursuant to 10 NYCRR Part 86-2.10 (i) or any successor regulation and/or statute. Department of Health policy ONLY recognizes pediatric residents up to age 21 for purposes of specialty reimbursement (see Dear Administrator Letter of July 12, 2006).

OR

To be eligible for an enhanced Medicaid reimbursement rate (Add-On) the resident must be enrolled in a specialty program that is approved by the Commissioner of Health in accordance with the cited regulations.

- **Code 07, AIDS Scatter Bed** - Approved pursuant to 10 NYCRR Part 86-2.10 (p) (3) and Part 710 or any successor regulation and/or statute.

- **Code 08, Traumatic Brain-Injury (TBI) Extended Care** - Approved pursuant to 10 NYCRR Part 86-2.10 (v) and Section 415.40 or any successor regulation and/or statute.

- **Code 99, None of the Above** - if the resident does not reside in a unit or facility that is approved by the Commissioner of Health in accordance with the cited regulation(s) and/or statute(s), and the resident is not enrolled in a specialty program that is approved by the Commissioner of Health in accordance with the cited regulations.

S8055. Primary Payor

S8055. Primary Payor	
Enter Code	**1** Medicare
	2 Medicaid
	3 Medicaid Pending
	9 None of the Above

Item Rationale*:*

- To determine the primary payment source as of the MDS Assessment Reference Date (A2300).

Steps for Assessment:

- Check with the billing office to review current payment source(s). Do not rely exclusively on information recorded in the resident's clinical record.

Definitions and Coding Instructions:

Enter the Code of the **one** source of coverage that has primary responsibility for and pays for most of the resident's current nursing home stay on the Assessment Reference Date (A2300).

- **Code 1. Medicare** – Medicare Part A (traditional) or Medicare Part C (Medicare Choice/HMO) is the primary payor. Medicaid may pay for the Medicare co-insurance and/or deductibles.

- **Code 2. Medicaid** – Medicaid is the primary payor (includes Medicaid HMO). Residents with Medicaid coverage supplemented by Medicare Part B should be recorded as Medicaid payor.

- **Code 3. Medicaid Pending** - There is no other primary third-party coverage being used for the resident's present stay, **and** the facility has sought, or intends to seek, establishment of Medicaid eligibility for coverage as of the Assessment Reference Date (A2300).

- **Code 9. None of the Above** - The primary third-party payor is not Medicare or Medicaid, and Medicaid is not pending. The payor may be commercial insurance, or a resident who pays privately, or one who receives charity care.

S8055. Primary Payor (cont.)

CAUTION: Coding Changes.

- This item continues to collect the same primary payor information as in the prior version of Section S. However, the responses in this version are in a different order.
- The first response is now *Medicare.*
- *Medicaid* is now the second response.
- The response *None of the Above (9)* replaces the *Other Payor* response used in the prior version of Section S.