Web Census Manual 2017
Web Census Manual

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Logging Into the Web Census Program

Go to census.petersenhealthcare.net
You will be at the Login screen as shown above.

Once you have been through training, you will be given access to the web census for your facility. Your Username and Password will be the same that you use to log in to your e-mail account.

Enter Username and Password and your facility will appear in the Facility box. Click on Log in.

When you log in, you will come to the **Summary Screen** for your facility, as shown. On the left of the Summary screen is a menu of options to choose from, with the
Activities options listed on the left. There are also tabs for options under Reports and Maintenance. Click on the blue tabs to display the options under each category.

In the larger box to the right you find the Census Summary and Aging Summary which are based on the last updated day of census. The Census Summary shows the last census date updated, and gives you a breakdown of census details, including Paid Census (number of beds paid for including paid bed holds), Midnight Census (actual count of residents in facility as of midnight), the facility available beds, and the Census Goal as set by Marketing/Census Development. The Aging Summary reflects total balances through the previous day’s business and postings, adjustments, deposits, etc. The aging itself updates overnight, so changes made today won’t be seen until tomorrow.

Below the Census and Aging summary you can see your facility’s Occupancy Rate and percentage of Facility census goal. The Occupancy Rate is important in determining if your facility qualifies for paid Medicaid bed holds if you are a SNF facility (the rules are different for SLF facilities). Occupancy rate is calculated by dividing actual census for the day by the number of available beds.

View Roster

Clicking on View Roster will bring you to this page, which displays your facility roster as of the last updated day of census. This roster displays ID, Resident Name, Room Number, Payer Type, Level of Care, and Status.

You cannot make changes to this roster from this field, but you can sort the information shown by clicking on any of the blue headers at the top of each column. You can sort by ID number, by Resident alphabetically, by Room Number, by Payer type, and so forth. This roster is a “snapshot” of your census for the day and could be printed and taken to morning meeting each day. There is a roster available for any census day that you can access through Submit Census. This is also a good place to get all of your Resident ID numbers in one list.
**Submit Census**

“Daily Census Home”

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**Login > Home > Census Home**

**Aledo - Daily Census Home**

Send to printer

<table>
<thead>
<tr>
<th>Start Date: 9/13/2011</th>
<th>End Date: 9/20/2011</th>
<th>Go</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Census Date</th>
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<th>View Roster</th>
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</tr>
<tr>
<td>9/20/2011</td>
<td>0</td>
<td>View Roster</td>
</tr>
</tbody>
</table>

**Today's Roster**

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Clicking on Submit Census brings you to this screen. You can see a Start Date and an End Date with fields that span 7 days. You can click in these fields and change the date span to show additional days and access the roster for those days if needed. Be sure to click on GO if you change the date span.

Below the heading “Census Date” is a column listing the last 7 days along with the midnight census for each day and the roster for each day. You can view the roster for any of these days by clicking on the specific date shown in blue or on the View Roster prompt for each day. You can also access the roster for census days not shown here by changing the date spans in the Start date (and clicking Go).

You can determine the last updated day of census by noting the Midnight Census total shown – if it is listed as “0” the census for that day has not been submitted yet. You would click on the date, then, to update the census for the first “0” date. You must update census days in order – you cannot skip ahead without updating the previous day first.

Click on the blue date of the census day to be updated. This will open up the roster which displays the census from the last updated day. This roster can be changed by clicking on Edit, which opens up the fields allowing you to make changes to the residents’ Room Number, Payer Type, Level of Care, and/or Status.

---

<table>
<thead>
<tr>
<th>Resident</th>
<th>Room Number</th>
<th>Payer Type</th>
<th>Level Of Care</th>
<th>Status</th>
<th>Action</th>
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<td>Intermediate</td>
<td>0-Facility</td>
<td>Start Census</td>
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<td>Private Pay / Private Pay</td>
<td>Intermediate</td>
<td>0-Facility</td>
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<td>AR11</td>
<td>Medicare / Private Pay</td>
<td>Resident</td>
<td>0-Facility</td>
<td>Start Census</td>
</tr>
</tbody>
</table>
After clicking Edit, click on the arrows to display the drop-down boxes with the available options for each field. Select your option by clicking on it. When you have made the necessary changes, click “Save” to save the change you made. Make all needed changes to your roster.

**If a resident had no changes in these census categories, you do NOT need to edit the roster.**

When you have finished making changes in the roster, click on “Continue” at the bottom right of the page. You will then see this screen.

“Daily Census Summary” is now displayed showing you the results of the changes you have made (or not made) to the roster. If you find that these totals are not correct, you can still go back to the roster by clicking “daily Census” from the list on the top left of the page. Make whatever changes are necessary, click Submit Census, and review the summary until correct.

When you have made all necessary changes and have verified that they are correct and accurate, you can finalize the process by clicking the “Submit” button on the bottom right of the page. This updates your changes (or no changes if you didn’t make any) and creates the census/roster for the day you updated.

You may be notified of an 1156 that needs to be completed as a result of your census update. If so, this will be the next screen to appear after you have submitted census. (See section on 1156 Form History for more details).
Once you have submitted census for the day, an e-mail notification is sent to the census supervisor (Jessica Galladora or Sausha Payne), your facility Administrator, and to yourself that lists any changes to census and includes the biographic form for any new residents you have admitted for that day.

**Roster Categories**

**ID Numbers**: You do not have to create ID numbers for residents. When you admit a new resident into the census program, it assigns them an ID number.

**Room Number**: It is very important that the room and bed roster is accurate. You cannot retroactively change any days already submitted and they must be corrected by the census supervisors, Jessica Galladora or Sausha Payne. Please notify her of corrections that need to be made.

**Payer Type** See below for summary of each payer option in the census program:

**Day Care**: Day Care is selected for a resident who does not live in the facility full-time, but a fee is charged for the person to spend periods of time in the facility. The fee is usually established as a daily rate. You will complete the admission in Admit a Resident, using Daycare as the payer type and specifying the rate the same way you would for private pay. When you update census each day, “Daycare In” would be the status when this person is in the facility, and “Daycare Out” would be the status when the person is not in the facility. You discharge the person if he or she is not going to be coming back.

**Medicaid**: This resident has been approved for payment by Medicaid in your facility, has a recipient number and appears on your prepayment reports and other Medicaid reports. The resident pays his or her monthly income, minus allowable deductions, as determined by the caseworker, and MCAD pays the portion of the total monthly charge that exceeds the resident’s liability. The daily rate is your facility’s per diem rate, found at the top of each month’s prepayment report.

**Secondary Insurance** refers to a type of insurance that may pay the co-pays and deductibles that a primary payer does not pay. The Primary payer is billed first, and after it pays then the remaining balance is billed to the Secondary payer.

**Medicaid/Secondary Insurance**: The resident’s primary payer is Medicaid. The resident has been approved for payment in the facility, has a recipient number and appears on your prepayment reports and other Medicaid reports. The resident pays his or her monthly income (resident liability) as determined by the caseworker and MCAD pays the remaining portion of the total monthly charge (facility per diem rate times number of census days). The secondary insurance indicates that if the resident uses Medicare benefits, the co-pays and deductibles related to Medicare would be billed to the resident’s insurance. This insurance does not pay room & board or the resident’s liability – it is only utilized if the resident goes on to Medicare A or has therapy that is billed to Medicare part B. It could also be insurance that is secondary to a Medicare Replacement policy, primary insurance, or HMO that a Medicaid resident could have and would use for skilled services (just like Medicare A) or for therapy benefits (just like Medicare B).

**Medicaid/Hospice**: The resident’s primary payer is Medicaid and the resident has been approved for payment in the facility, has a recipient number, and appears on your prepayment reports and other Medicaid reports. The resident pays the monthly income to the facility just like any other Medicaid resident. On the reports, the resident is coded as a 41b, indicating “hospice” is the level of care. The prepayment reports will show payment rate, patient income, and payment amount as $0.00 because the MCAD payments are diverted to the hospice company, and AR bills the hospice company for the MCAD payments.
payment each month. The hospice company does the paperwork to admit the resident to hospice (changes the level of care to 41b).

**Medicaid Pending:** All new admissions to the facility that are going to use Medicaid as the primary payer are entered into the system as Medicaid Pending. The resident may have a recipient number and an active Medicaid status in the community, but when admitting to the nursing facility, the resident is “pending” until we receive notice that Medicaid has admitted him or her to the facility and approved payment for the resident in the facility. Of course, if the resident is going to be new to the Medicaid system, the resident is pending while the application is completed and accepted by Medicaid and approval for payment in the facility is received. (Approval is accepted as the resident appearing on the 2449A and on the LTC Prepayment Report).

**Medicaid Pending/Secondary Insurance:** A new admission to the facility who is going to use Medicaid as the primary payer. The resident is either applying for Medicaid for the first time, or is a Medicaid recipient in the community and is admitting to the nursing home as pending while we wait for approval from Medicaid for admission and payment to the facility (see Medicaid Pending). The resident has a secondary insurance policy that would pay the co-pays and deductibles if this resident were to become skilled and qualify for Medicare A benefits (or other primary insurance – a replacement policy or an HMO), or if the resident received therapy and has Medicare B benefits (or a replacement B policy, or HMO that covers therapy). The insurance DOES NOT pay the resident’s liability or in any way cover room & board charges.

**Medicaid Pending/Hospice:** A new admission to the facility who is going to use Medicaid as the primary payer, and will be receiving hospice services. In the admission box of the 1156 form, there is a small checkbox indicating the resident is going to be receiving hospice care – this should be checked when you do the 1156 for the admission. The hospice company will still have to do their own paperwork as well. Once the resident is admitted to the facility and approved for Medicaid as a 41b, AR will bill the hospice company for the MCAD payment. The resident pays his or her monthly income to the facility just as any other Medicaid or Medicaid Pending resident does.

**Medicare/Medicaid:** The primary payer is Medicare. We bill Medicare A for all charges (room & board, pharmacy, med supplies, labs, x-rays, etc.). Medicare A covers all of the charges for the first 20 days of the benefit period. While this resident is on Medicare, during the 1st 20 days of the Medicare benefit period, there is no charge generated to the resident. While this resident goes into Medicare days 21-100, there is a charge of $164.50 (for 2017) for each day. This charge is not generated until the month is closed (by AR) and so there is not a pre-bill generated for this resident at statement time. This resident does not have a secondary insurance policy that will pay the Medicare A co-insurance charges, so when the month is closed, a charge is generated for each co-insurance day, then the system contracts off any charge above the resident’s normal monthly liability. Therefore, the resident is charged the usual patient liability and pays the same as he or she did while on Medicaid. (This resident is approved for Medicaid already). There is no payment from Medicaid while the resident is coded as a 65 or 72 for Medicare.

**Medicare/Medicaid Pending:** The primary payer is Medicare, and this resident is applying for Medicaid or awaiting approval for Medicaid in the facility. The resident does not have a secondary insurance policy to cover Medicare co-insurance. We bill Medicare A for all charges (room & board, pharmacy, med supplies, labs, x-rays, etc.). Medicare A covers all of the charges for the first 20 days of the benefit period. On days 21-100, there is a co-insurance charge of $164.50 per day. There is no charge generated to the resident while on the 1st 20 days of the Medicare benefit period, but when the resident is in the Medicare co-insurance days 21-100 of the benefit period, a charge of $164.50 per day (for 2017) is generated. This charge is generated when the month is closed by AR and the entire charge is contracted off the resident account and posted to “Medicaid Pending” at this time. Later, when the resident is officially approved for Medicaid and the patient liability is known, the charges are regenerated, and the resident will be charged his or her usual liability while on the co-insurance days ($164.50 per day up to the maximum amount of the resident liability – anything over is contracted off the resident account).
**Medicare/Private Pay**: The primary payer is Medicare, and all co-insurance charges will be billed directly to the resident. For 2017, the charge is $164.50 per day for Medicare Days 21-100. There is no charge to the resident for the first 20 days of the Medicare benefit period. (This choice of payer combination indicates that the resident does not have a supplemental insurance policy that will pay the Medicare co-insurance charges.) We bill Medicare A for all charges (room & board, pharmacy, med supplies, labs, x-rays, etc.). Medicare A covers all of the charges for the first 20 days of the benefit period. On days 21-100, there is a co-insurance charge of $164.50 per day. When the resident comes off of the Medicare benefit period, the resident will be private pay and charged the private pay room & board rate.

**Medicare / Secondary Insurance**: The resident’s primary payer is Medicare A. We bill Medicare A for all charges (room & board, pharmacy, med supplies, labs, x-rays, etc.). Medicare A covers all of the charges for the first 20 days of the benefit period. On days 21-100, there is a co-insurance charge of $164.50 per day. If you select this payer combination, there is initially no charge billed to the resident privately. The first 20 days are billed only to Medicare. Starting on day 21 of Medicare and lasting only as long as the resident continues to be on Medicare, a charge of $164.50 is generated for each day. This means that Medicare will cover all of the charges EXCEPT $164.50 each day – this is the co-insurance charge. If you have selected “Secondary Insurance” as the secondary payer, the $164.50 per day charge goes to the payer INS (insurance). This then creates an insurance claim form (insurance bill) that AR will send to the insurance company you have listed for payment. If the insurance pays the entire amount billed, there is no charge generated to the resident. If the insurance only pays some of the charge, the remaining balance is then moved back to the resident’s Private account. If this resident is private pay when not on Medicare, the resident will then be billed for the unpaid balance on the next statements. If this resident is Medicaid when not on Medicare, the unpaid balance is written off.

**Primary Insurance**: The resident is admitting to the facility at a skilled level of care and has an insurance policy that will cover room and board and all skilled services (usually just as Medicare would – therapy, pharmacy, labs, etc.). Of course, Verification of Insurance is required before admission; often pre-authorization of services is required. This is not a Medicare Replacement policy – often residents with these policies are not old enough for Medicare benefits. Benefits and coverage may vary.

**Private Hospice**: The resident is private pay, but will be receiving hospice services. All of the billing we generate will be private pay – AR does not bill hospice for anything, the resident pays private pay rate the same as any other private pay resident. The private pay rate covers room & board. Additional services have to be billed separately – just as we do for any other private pay resident.

**Private Pay/Private Pay**: This resident pays room & board from personal funds and does not have any insurance coverage that will cover any services in the nursing facility. If this resident were to go on to use Medicare benefits, he or she would be billed privately for the co-insurance charges and any deductibles or other charges not covered by Medicare - $164.50 per day for Medicare A co-insurance, 20% of total billed for Medicare B co-insurance.

**Private Pay / Secondary Insurance**: The resident’s primary payer is Private Pay. The resident pays for Room & Board from his or her own personal funds. If the resident happens to qualify for Medicare A and comes back from the hospital as Medicare A, we would know that the co-insurance charges of $164.50 per day would be billed to an insurance company. Whatever the insurance company did not pay would then be moved back to private and the resident would be billed for the balance. If the resident remained private pay, but received physical therapy, occupational therapy, and/or speech therapy, the resident is still billed private pay for room & board, but the therapy charges must be billed as well. If the resident has Medicare Part B benefits, the therapy charges are billed first to Medicare B. Medicare B covers 80% of the billed charges, once the annual deductible ($183 for 2017) has been met. The remaining 20% balance is then billed to the secondary insurance. Any portion not covered by the insurance is then billed back to the resident.

**Replacement A/Medicaid**: This resident is receiving skilled care and has an insurance policy that replaces the resident’s Medicare benefit and covers the package of skilled care including room & board, therapy, pharmacy, labs, etc. You will have contacted the insurance company and verified the benefits and obtained
preauthorization if required. The billing will probably require RUGS as well. When the resident goes into co-insurance days, after the month is closed, the charges are generated and any charges over the amount of the resident’s patient liability (as determined by the caseworker) are contracted off, resulting in the resident paying the monthly income as usual.

**Replacement A/Medicaid Pending:** This resident is receiving skilled care and has an insurance policy that replaces the resident’s Medicare benefit and covers the package of skilled care (room & board, pharmacy, therapy, etc.), but is also applying for Medicaid and will be Medicaid Pending (or Medicaid if approved) when he or she is no longer qualified for the skilled care. Any co-insurance charges generated while using the Replacement A benefit are posted to Medicaid Pending at this time and there are no charges billed to the resident at this time. Once the resident is approved, the charges are moved and the resident is responsible for paying his or her patient liability as established by the caseworker.

**Replacement A/Private Pay:** This resident is receiving skilled care and has an insurance policy that replaces his or her Medicare benefit and covers room and board and the package of skilled care just as Medicare would. Any co-insurance charges that are generated (or resident portions or member responsibility) are billed directly to the resident and will be on the monthly statement. Once the resident’s level of care is no longer skilled or the replacement policy benefits end, the resident will be private pay.

**PPMI – Private Pay Medicaid Intended:** This payer will be used for residents who intend to apply for Medicaid. This payer category will allow us to separate the truly private pay residents from those that go into the system as Private Pay but are on the path to Medicaid - those from whom we can collect only the anticipated CP amount. This is not to be confused with residents who are truly Medicaid Pending with applications submitted and waiting on the caseworker, etc. These are residents who have not even completed the application. This payer will pre-bill the resident at the Private Pay rate. You will need to be sure to enter the private pay rate in the census program when you admit this resident. We will admit the resident as Private Pay/Medicaid Intended until you have applied for Medicaid online and submitted your confirmation of application to the 1156 e-mail box. Once AR has received the confirmation that application has been submitted, you will then be able to change the resident in the census to Medicaid Pending.

**Level of Care:** You have two possible options, Skilled or Intermediate. “Skilled” must always be the choice when using Medicare, Primary Insurance, or Replacement A as a payer. However, you have the choice of Intermediate or Skilled for the other payers. It is important to report the Level of Care accurately. You should be able to verify with nursing which residents are skilled and have a system of being notified when there is a change in level of care.

**Status** See below for summary of your options for status in the census program:

**Day Care In:** For a facility that has a Day Care program, Day Care In indicates that the day will be billed at the Day Care rate. The “Day Care resident” is admitted to the census program using the payer type Day Care.

**Day Care Out:** This status indicates that we are not billing the “Day Care resident” for the day – the resident not in the facility that day.

**Discharge:** This code indicates the resident is out of the facility and not expected to return. This indicates that we are not billing for the day and is always used to discharge residents on Medicaid, Medicare, Primary Insurance, and Replacement A. We may use this code for a private pay resident discharge if we are not charging for the day of discharge – usually only if the resident is going to a sister facility.

**Discharge to Hospital** This code is ONLY used to discharge the admission record for a Medicare or Medicare Replacement or Primary Insurance resident on the day of return from the hospital – then the resident is re-admitted on the same day and a new admission record begins. On the census grid (Resident
Daily Census Report) you should never see DH because the resident actually is re-admitted on the same day. So, on the census grid we would have seen the resident as Medicaid, Medicaid Pending, or Private Pay (you changed to secondary payer when the resident went to hospital) while the resident was in the hospital, then on the day of return you discharged that record and payer and re-admitted as Medicare, Replacement A, or Primary Insurance. Please review the attached summary of this process!

**Expired** Indicates that the resident expired in the facility and a payable day. This code is used for all payers.

**Expired in Hospital** Indicates that the resident expired in the hospital and is not a payable day for Medicaid residents. For a private pay resident who expired in the hospital, if you are charging the resident for the day use Expire, which generates a charge. If you are not charging for the day, use Expire in Hospital.

**Home Visit**: Indicates the resident is out of the facility the full 24 hours. This code also indicates that we are not generating a charge for the day no matter which payer type.

**Paid Home Visit**: For a Medicaid resident, this code indicates that this is the day the resident went out on home visit, and we do get paid for the day. For a Private Pay resident, this indicates we are charging the resident for the day. SLF facilities will use Paid Home Visit for a maximum of 30 paid bed hold (home visits and hospital) days per year (July – June). Remember that the day the resident leaves the facility to go on a home visit is a paid HV day and does not count toward the 30 paid days.

**Hospital**: This code indicates that the resident is in the hospital and that we are not generating a charge for the day. This is used for Medicaid residents. If the resident is at the hospital but is on OBSERVATION, is not admitted and returns to the facility before the next midnight, you would NOT change the status to Hospital. If the resident is on observation but is out of the facility for 2 midnights or more, you would change all of those census days to Hospital.

We should never see a Hospital status on a Medicare, Replacement A, or Private Insurance payer – you will have changed this resident’s payer to the secondary payer when you change the status to hospital!

**Paid Hospital**: This code is used primarily for Private Pay residents who are being charged to hold the bed while in the hospital. SLF facilities will use Paid Hospital for a maximum of 30 paid bed hold days per year (July – June) for Medicaid residents.

**Private Discharge**: This code is used for Private Pay residents on day of discharge and generates a charge for the day. We do charge Private Pay residents for day of discharge unless resident is admitting to a sister facility.

**Non-Billable**: This code is used only on Medicare, Replacement A, and Primary Insurance. Non billable days are used for 24 hours or less on Observation at the hospital or if one of these residents are on a home visit. Do NOT change the resident's payer type.

**Special Census Situations**

Medicare, Replacement A, and Primary Insurance residents in the census program require a little additional attention to detail. If the resident has a break in stay and goes out to the hospital and then comes back continuing Medicare, follow the procedure shown below. If the resident has exhausted Medicare or is simply going off of Medicare to another payer, you simply change the payer to the new payer on the roster and do not have to start a new admission record.
**Medicare Resident to Hospital:** When a Medicare resident goes to the hospital, we want the census to stop counting Medicare days while the resident is out. In order to do that, you must follow the steps listed:

1. When a Medicare resident goes out to the hospital, you do **not** have to discharge them on the census.
2. You **MUST** change the resident’s payer type to the resident’s **Secondary payer type**. Choices: Medicaid, Medicaid Pending, Private Pay. You will never admit a resident as Medicare without establishing the secondary payer. If the resident has Secondary Insurance, be sure to leave that one as well (for example, from Medicare/Insurance to Medicaid/Insurance while the resident is in the hospital).
3. Next, change the resident’s status from “In Facility” to “Hospital” for a non-paid bed hold, or “Paid Hospital” for a paid bed hold.
4. **Non-Billable Day:** If the resident is out of the facility less than 24 hours and is not admitted to the hospital, you use the “Non-Billable” status and you would have to change the payer for the day. When the resident returns to the facility, you do **NOT** have to re-admit, just change status to In Facility.

**Medicare Resident Returns from Hospital:** These are the steps to re-admit your Medicare resident who has gone to the hospital and is now returning from the hospital as Medicare:

1. Go to Resident Maintenance and discharge the resident on the **day of return** to the facility, **NOT** on the day the resident went to the hospital. Do not change the payer type, or admit date, just discharge to hospital.
2. This also applies if a Medicaid or Private Pay resident on your census goes on to Medicare within 30 days, but not on the day of return from the hospital. Discharge on the day of admission to Medicare, not on the day of return to facility. Use Discharge Reason: Discharge to PHC Facility.
3. Go to Admit a Resident. Re-admit the resident as Medicare including the correct secondary payer. Be sure to fill in the “**Previous Days on Medicare**” box indicating how many Medicare days in the benefit period the resident has used. This includes days (in this benefit period) the resident used in your facility as well as any swing bed days the resident may have used in the hospital or at another facility before admission. This controls the Medicare day number (1-100) that the system will begin counting at on the day of re-admission.
4. Follow the fields through the end. You will have to fill in the Swing Bed Days box showing the same number of days as you listed in the Previous Days on Medicare box. Save. Make sure your Qualifying Hospital Stay is also listed and accurate.
5. Now go to Submit Census and continue as always.
6. These same rules apply for the Primary Insurance payers and the Medicare Replacement Policy payer as well.
7. Don’t forget to review the Resident Daily Census Report to be sure your Medicare numbers for this resident flow properly.

**Change a resident from Medicaid Pending to Medicaid or Private Pay to Medicaid**

When AR receives the LTC 2449A report and sends it to you showing the resident has been admitted to the Medicaid system and details the resident liability and level of care and so forth, then you will be directed to go into the web census and change the payer in **Census Maintenance** from Medicaid Pending to Medicaid, or possibly from Private Pay...
to Medicaid. This will retroactively change the payer back to the date of approval for Medicaid. Of course, you must be careful to review the census and be sure you do not overwrite any Medicare days!

When using Census Maintenance to make changes in payer source – such as from Medicaid Pending to Medicaid - please be sure you review your resident’s history before overwriting a span of days. You will notice that on the bottom left corner of the Resident Census Maintenance screen, there are the words View Census History in blue. Click on the blue words to view a year’s worth of the resident’s census history.

You should review the resident’s census history before making the change, and after you make the change to be sure it is correct. Be sure you do not overwrite any Medicare days, and that you do not drop the resident’s Secondary Insurance or Hospice. Also, do not change the resident’s status when changing the payer source (unless appropriate) or you may overwrite bed hold days. This is why it is important that you review View Census History after you have made the changes to be sure it is correct!

Admit a Resident
Resident Search

Select this option under Activities to add a new resident to the roster. You should not update census for the day without including any new admissions to the facility on that same day. (Be sure to fill in status field on roster to “In Facility” when you go to update census after you have added your new admission.)

The Resident Search screen is displayed. You will type in the new resident’s name and then click on “Search” to display the results. The census program actually searches the profiles for ALL residents from all facilities.

If the resident does already exist in the system, or multiple residents with the same name exist, they will be displayed with Social Security number, name, and birth date. If one of those listed is the appropriate resident you wish to admit, click on the blue Social Security number on the left of the name to open the profile. If you notice that the Social Security number or Date of Birth is wrong on an existing profile, please correct this in Resident Maintenance before admitting the resident so that you do not create a second profile.
**Admission History**
You will then see the “Admission History” box which displays the resident’s history of previous admissions and discharges as well as any outstanding balances.

![Admission History Box](image)

The Balance displayed here is a total balance of all payers, not necessarily a balance that is actually due from the resident! If you hold your cursor over the amount displayed in red, you will see a breakdown of the balance into payers.

**Resident Bio Sheet**

You can obtain a Resident Bio by clicking on the blue facility name shown in the Admission History box. If the resident has had more than one admission record, there will be a bio sheet for each admission available. The biographic sheet summarizes the information from all of the fields onto one page.

To admit the resident, click on Continue (from the Admission History box).

If the resident does not exist in the census program – has never been a resident in a Petersen facility – no results will be shown and you would simply proceed by clicking on the blue “Admit New Resident.” The next several screens must be filled in with the biographic data. Fill in the fields completely and go to Next to continue as you complete each screen. Fill in ONLY the Primary or Admitting Diagnosis code! Be sure to include Private Pay rates and the correct room and bed number. Also be sure to include the Medicare number even if the resident is not admitting as Medicare. Do not list information for insurance that we cannot bill: prescription plans or long-term care insurance, for example.

DO NOT update your census for the day without including your new admission! Doing so will cause both your census and the census in the billing system for AR to be incorrect, and both systems will have to be corrected. If you are missing critical information for the biographic screens, please communicate this to your Administrator as well as to the
census supervisor (Jessica Galladora or Sausha Payne). We would rather your census be submitted late than incorrect, as long as you notify AR of the issue.

**Medicare Admissions**

You will need to enter additional details for Medicare Part A, Replacement a, or Primary Insurance admissions.

![Medicare Admissions Form](image)

**Resident Admission for Aledo**

**Previous Days on Medicare and Swing Bed Days:** This field will set the “count” of Medicare days in the census program and tell the system where to begin counting Medicare days, from 1 -100. Previous Days on Medicare also become “Swing Bed Days” at the end of the admission fields, and must be consistent. For example, if you fill in the Previous Days on Medicare Box with 0 days, you are telling the census program to start counting the Medicare days with Day 1 on admission. If the resident is on Day 1 of the Medicare benefit, there will then be 0 swing bed days (in the census program, a “swing bed day” is a used Medicare day within the benefit period). However, if you fill in the Previous Days on Medicare Box with 5 days, you are telling the census program to start counting with Day 6 being the day of admission. In addition, you will have to report the date span of the 5 Swing Bed Days.
Hospital Stay Dates: You enter your original qualifying hospital stay dates in this field. You must have at least 3 midnights, admitted to the hospital (verify with hospital – not observation days) entered in the field. You do not usually add later hospital spans for bed holds if your current Medicare resident goes out to the hospital and then comes back.

Medicare/Replacement A/Primary Insurance Resident Returns from Hospital: Remember that when you are creating a new admission record for your Medicare resident who went to the hospital and is returning, you will need to carry over the previous Medicare days which you are now adding to your Swing Bed days. You must again fill in the “Previous Days on Medicare” box to set the count of days, and whatever number of days shown in this field, you must enter the date spans to match in the SNF/Swing Bed Dates field. Please also review the procedure for correctly submitting census when the resident goes out to the hospital, then returns.

Hint: After you have submitted census for the day, you should later review (after the system updates) the Resident Daily Census Report (in reports) to verify accuracy. Be sure you review all Medicare/Replacement A/Primary Insurance to be sure the Medicare numbers flow correctly (that the count is correct).

Print Mailing Labels

Click on Print Mailing Labels to display the resident contacts as pulled from the Contact screen in Admit a Resident. Click on Filter to proceed.

This was intended to be formatted to allow you to print mailing labels on label paper. You could also print on white contact paper and cut the labels neatly. This does not seem to format properly for label paper, and the contacts it contains may not be accurate.
Notification History

This report will summarize the history of census activity, showing who has submitted census for which dates, and will give you access to view the changes made when census was submitted.

Each day when census is submitted, an e-mail notification is generated and sent to the BOM (or whoever submits facility census), the Administrator, and the Census Supervisor at Corporate.

We cannot rely solely on the census Notification system, so please be sure you actually send an e-mail to the Census Supervisor – Jessica Galladora or Sausha Payne – anytime you make any changes to the census program, especially changes in Resident Maintenance.

1156 Form History

The census program will inform you of certain instances when you need to complete an 1156 for a change in a Medicaid resident’s status and the date of the change. Click on 1156 Form History. Remember, 1156s only apply to Medicaid Pending and Medicaid residents. Keep in mind this report cannot prompt you to complete 1156s for income adjustments or financial issues – only census related status changes!

The Summary you get will show you recent census changes that require an 1156:

1. **Resident Added to Medicaid**, for a new Medicaid Pending admission
2. **Resident Discharged** (Medicaid Pending or Medicaid resident)
3. **Resident Added to Medicare**: indicates a Medicaid Pending or Medicaid resident currently on Medicare
4. **21 Days of Medicare**: indicates a Medicaid Pending or Medicaid resident current on Medicare who has changed from full-covered Medicare census days (day 1-20) to Medicare co-insurance days (day 21-100).
5. **Resident Removed from Medicare** indicates the resident has changed payers back to Medicaid Pending or Medicaid.
6. **Resident Expired** indicates the resident expired in the facility.
Unfortunately the census program cannot distinguish between an actual discharge, and the discharge and re-admission that is created when you are re-admitting the resident on Medicare in the census program following a hospital break in stay. Do not do an 1156 to discharge the resident to the hospital or following a hospital stay!

You can click on the blue Resident Name in the Summary Report, and this will open an 1156 form with many of the fields filled in. Unfortunately, the format of the 1156 form in the census program is too small and many caseworkers do not like this form. You may need to save an actual 1156 form on your desktop, so when prompted to complete an 1156 after you update census, you can just pull it up and complete it then.

**Making Corrections or Changes in the Census Program**

**Maintenance Screens**

**Editing the Resident’s Information:** To change or add information to the resident’s profile, go to Maintenance, Resident Maintenance. At the top left of the screen next to the resident’s name, you will see the blue words **Edit this Resident**. Here you can correct the resident’s name, Date of Birth, Social Security Number, Medicare Number, and Medicaid Recipient Number. Unfortunately you cannot change the resident’s contact information – here or in Admit a Resident once you have already entered it on admission. For corrections in contact information (billing addresses), e-mail Jessica Galladora or Sausha Payne and she will make the correction in the billing system.

**Problems with Medicare days count:** If the flow of days from 1-100 is incorrect in the census program, there is an error. To determine what needs to be corrected, go to Maintenance, then to Resident Maintenance. You will have to enter the resident’s name and click on “Search.” When the box with the resident’s name and Social Security number comes up, click the blue Social Security Number to proceed. The “Admission
History Box” will open. This will display the history of admissions and discharges – check these for accuracy! Click Continue to go in to the Maintenance screen.

Here you will see the admission records for the resident. For a Medicare/Replacement A/Primary Insurance resident, there is a new admission record each time the resident has returned from a break in stay (hospital). Verify that the date of the admission records match the date the resident returned to the facility.

You can also open the drop-down box “Summary” to display the individual resident’s census for review.

Determine which admission record needs to be corrected – usually the most current record or the record just before the most current. Click on the bar displaying the date of the record you wish to review. Then click on Edit this admission record to open the record for review and correction.
Areas most often causing the error include the admission date, the discharge date, the Previous Medicare Days Used, or the SNF/Swing Bed Dates. Errors here will cause the count of Medicare days to be incorrect.

Review the process for re-admitting a Medicare/Replacement A/Primary Insurance resident.

Remember that the Previous Medicare Days Used field has to be consistent with the SNF/Swing Bed Dates spans you listed. Did you change those fields when you re-admitted the resident from the hospital? Did you add the previous Medicare days in your facility to the SNF/Swing Bed Dates field? Did you follow the procedure correctly?

This screen allows you to make changes to the fields. When you have made the necessary changes, click on Save. The system will then correct the admission record, and in approximately 2 hours, you should be able to see the correction.

**Census Maintenance:** If the corrections made in Resident Maintenance do not correct the problem completely, you may need to go to Census Maintenance to correct days already updated.

Go to Maintenance, then Census Maintenance. You will again have to enter the resident’s name and click on Search. Select the resident by clicking on the blue Social Security Number. Click on Continue.
Resident Census Maintenance will allow you to correct the payer type, level of care, and or resident status for a specific set of dates. Remember that you can only change census days that you have submitted! You can also click on the blue View Census History to view up to a year of the resident’s census. Fill in the fields with the correct information for the dates desired.

Be careful not to incorrectly overwrite census days! Always review the census history before making any changes, and always review after you have made the changes to be sure they are correct!

**Medicaid Pending to Medicaid**

When you receive notification that your Medicaid Pending resident has been approved, either through the 2449 LTC Transaction Report or the resident appears on the Prepayment Report and A/R has e-mailed you to make the change, you will need to change the resident’s payer from Medicaid Pending to Medicaid. You will make the change back to the date of approval/admission to the Medicaid system. It would also be possible for a resident to change payers from Private Pay to Medicaid.

Go to Maintenance, then to Census Maintenance. Click on View Census History and carefully review the span of days back to the date of approval to be sure there are no Medicare/Replacement A/Primary Insurance days – you do not want to overwrite these spans. If there are spans of these days, you will need to change census days in chunks instead of all at one time in order to preserve those Medicare days while changing Medicaid Pending to Medicaid. If the resident was Medicare/Medicaid Pending, you will need to change the payer now to Medicare/Medicaid. If the resident was on Medicare/Insurance, you will NOT need to change anything for that date span until the resident comes off of Medicare and back to Medicaid. If the resident was Medicaid Pending/Secondary Insurance, be sure you select the Medicaid/Secondary Insurance category – don’t “lose” the insurance in your payer.
Do not change anything in the **Resident Status** field. Doing so will potentially overwrite any bed hold days the resident had during the date span. You do not need to change Level of Care either. The fields may be yellow and appear to need attention, but you do not have to fill in these fields to continue. Only fill in the fields you want to change!

Be sure to review the census history after updating the changes you have made to check for accuracy!

**Resident Missing Census Days**

A resident may have missing census days for one of two reasons: either the admission date entered into the system is incorrect and the resident actually admitted sooner than indicated and those days are missing, OR the discharge date was incorrect and the resident was actually in the facility longer than is shown and those days are missing. If census days are missing, you will NOT be able to correct the problem through Census Maintenance.

Go to **Resident Maintenance**. Select the admission record that contains the missing days. Click on Edit this admission record. For an admission to be open and active, the discharge date field must read 1/1/9999. Make corrections to the incorrect admission date or discharge date, then click on Save. The system will then update the record to reflect the change.

Next, you have to go to **Submit Census** to add the missing days back to the resident’s record. In the date span fields, enter the start and end date of the missing days and click on Go. You will click on each date on the left (in blue) to open the roster for that day. Scroll to find the resident you are correcting, and click on Edit. In the **Status** field, select In Facility. Click on Continue and the bottom right of the page, then click Submit. Continue this process until all missing census days have been added.

When you are finished with updating the missing days, go to Maintenance, Census Maintenance and click on View Census History to be sure you have made the correction and it is completed.

**Reports**

There are several reports available to provide you with the information you need. Click on **Reports** and you come to the following screen.
There are 3 categories of reports available to you: Census Reports, Admission Reports, and A/R Reports. All of these reports can then be exported to a different format – Excel, or as a PDF file (see end of section for instructions).

Census Reports
There are 3 types of Census Reports available to you. There are Monthly Census Reports, Daily Census Reports, and Resident Daily Census Report.

Remember to fill in the fields for each report you generate (date spans or year and month, etc.) and to click on View Report on the far right at the top of the screens to generate the report.

Shown below is the Monthly Census Report.
This report displays your facility statistics over the year month by month. You can then access the 2<sup>nd</sup> report in the category by clicking on one of the blue months listed in the left column and view the Daily Census Report.

This report breaks down the total census by payer for each day of the month.

The third census report is the Resident Daily Census Report. This report is the “grid sheets” report and was made to resemble the older Excel census program we used prior to the web census program. This is the report used most often, and used by AR, and should be reviewed regularly for accuracy! See below:
The days of the month are shown across the top of the report, and the names of the residents are listed down the left side of the page. Above the resident column, the Payer is displayed as the report has sorted the residents by Payer. You may have a page for Medicaid, Private Pay, Medicare (if SNF facility), Hospice (these are Medicaid Hospice residents – private pay Hospice will be on the Private Pay page), Replacement A, Primary Insurance, Day Care (if applicable), VA (if applicable) and the total page.

These Medicaid residents are shown in the facility if there is an X in the box. Numbers in the box indicate a Medicaid resident currently on Medicare days. Note that the resident will appear the Payer page AND on the Medicare page – the Medicare page summarizes all of the Medicare residents – but they are not counted twice in the total even though they do appear on two pages.

**Status Codes for the Resident Daily Census Report**

**PHV** indicates “paid home visit” – for a Medicaid resident this shows the day the resident actually left the facility to go on home visit, and is still a payable day (for the nursing homes).

**HV** would indicate a non-paid home visit.

**H** indicates a hospital bed hold. This is a non-payable day.

**PH** indicates paid hospital bed hold – this would be for up to 30 days for a SLF Medicaid resident (year heat, June – July) or a paid bed hold for a private pay resident.

**PD**: Private Discharge, used only for Private Pay residents and indicates we are generating a room & board charge for the day of discharge.

**D** indicates discharge. This is a non-payable day (no charge is generated for the day).

**EX** indicates the resident expired in the facility and is a payable day.

**NB** is a non-billable day is used for Medicare/Replacement A/Primary Insurance only. This is used when the resident is at the hospital for less than 24 hours on observation, or on a home visit.
DH: Discharge to hospital. We should never see a DH on the Resident Daily Census Report. This is used only in the process of re-admitting a Medicare resident following a hospital stay.

This is the most “visual” way to review your census for accuracy. This report also needs to be sent to your pharmacy representative and your therapy director daily!

Admission Report: this report allows you to set a date span and to view all of the admissions added to the census during that span. It will display the admission date and show the total number of days admitted. Note: If a resident has been admitted and re-admitted due to the procedure for Medicare/Replacement A/Primary Insurance – this report will count and display each of those admissions and re-admissions.

Discharge Report: This report will also allow you to set a date span and view all of the discharges from the census during that span. Note: If a resident has been discharged and re-admitted due to the procedure for Medicare/Replacement/Primary Insurance – this report will count and display each of the discharges when you re-admit the resident.

Formatting Reports

Often times it is useful to change the format of the web census report so that we can e-mail it, make changes to it, add information to it, etc. We can do this with any of the
census reports by using the field Select a Format and Exporting the report into one of the formats chosen from the list of options.

Click on the arrow at Select a Format to choose from the options. The options given are: XML File with report data, CSV (comma delimited), TIFF file, Acrobat (PDF) file, Web Archive, or Excel. We most frequently use Excel and Acrobat PDF. Select the option and then click the blue word Export to the right of the arrow. This will convert your file.

You will then see the above message. You can click on Open if you want to view the report and make changes or additions to it, or click Save if you just want to save it. If you click Open, you may want to save it when finished and will have to select where to save it and name it. If you click save, you will then be prompted to select where to save the file and to rename it.