# APPENDIX C

## "TAD"

## Long Term Care Turnaround Document

## and Instructions

# Long Term Care Turnaround Document Instructions

A. General Instructions

1. Enter only those changes imperative to proper payment.
2. If the information in items 1 - 12 are absolutely correct and no changes are appropriate, (i.e. leave days not used or no level of care change) then make no entries in items 13 through 29.
3. Completion of items 30 through 33 is mandatory.

B. Itemized Instructions

1 - 12. Identifying Information

These items will have been completed by the computer before the form is mailed. These items must be carefully verified by the facility for each claim (1 - 5).

13. A/R (Action/Reason Code)

If the resident uses hospital days or changes level of care enter one of the following codes:

| | |
|---|---|
| Hospital Leave Days | 1 |
| Level of Care Change | 3 |
| Medicare Days | 8 |

14. BEGINNING DATE OF SERVICE

Enter the beginning hospital day, day of level of care change or Medicare day. Use 2 digits each for month, day and year (MMDDYY).

15. ENDING DATE OF SERVICE

Enter the ending hospital day, day of level of care change, or Medicare day. Use 2 digits each for month, day and year (MMDDYY). If the level of care change continues through the billing period of the turnaround document, enter the same date as in item 7.

16. A/R

Follow the same instructions as in item 13. More than one space is provided to account for more than one leave period or level of care change or any combination of the two.

17. BEGINNING DATE OF SERVICE

Follow the same instructions as in item 14.

18. ENDING DATE OF SERVICE

Follow the same instructions as in item 15.

19. A/R

Follow the same directions as in item 13.

20. BEGINNING DATE OF SERVICE

Follow the same directions as in item 14.

21. ENDING DATE OF SERVICE
Follow the same directions as in item 15.

22. AMOUNT FROM OTHER RESOURCES
Enter in the appropriate box any income received from the family or any other third party resource.

23. TOTAL DAYS BILLED
Enter the total number of days being billed by the facility. If the only adjustment is for hospital leaver days (action/reason code “1") subtract the number of hospital leave days from the number of days in the billing period; i.e. if there are 30 days in the billing period and 2 hospital leave days were used, then enter the number 28.

24. HOSPITAL LEAVE DAYS
Enter the total number of hospital leave days used during this billing period (2 days or less).

25. THERAPEUTIC LEAVE DAYS
Enter the total number of therapeutic leave days used during this billing period.

26. DISCHARGE DATE
Using 2 digits each for month, day and year (MMDDYY), enter the date the resident was discharged from the facility. This is mandatory for a discharge or for death.

27. DISCHARGE DIAGNOSIS CODE
NA

28. ADJUSTED NET CHARGE
Enter the adjusted net charge or the correct amount the facility is to be paid.

29. CHARGE CODE
NA

30. PROVIDER NAME AND ADDRESS
    Enter the facility provider (billing) name and addresss.

31. PROVIDER NUMBER
    Enter the facility's assigned 12 digit Medicaid Provider Number.

32. PROVIDER SIGNATURE
    (Optional)

33. BILLING DATE
    Enter the date the form was sent to the Bureau of Medicaid Operations. Use 2 digits each for month, day and year (MMDDYY).