Nursing Facility

Nursing Facilities (NF) provide health-related care and services on a 24-hour basis to individuals who, due to medical disorders, injuries, developmental disabilities, and/or related cognitive and behavior impairments, exhibit the need for medical, nursing, rehabilitative and psychosocial management above the level of room and board.

For policy-related questions, please contact the Division of Health Care Financing and Policy (DHCFP) Long Term Services & Supports (LTSS) at ltss@dhcfp.nv.gov.

Covered Services

Services included in the NF per diem rate are identified in the Nevada Medicaid Services Manual (MSM), Chapter 500 Nursing Facilities.

Facilities that request and are approved to administer care to recipients under the Behaviorally Complex Care Program (BCCP) are referred to MSM Chapter 500 for information and requirements.

Billing Authorization

Prior to any nursing facility admission, three required steps must be followed for all recipients submitted through the Long-Term Care (LTC)/PASRR system; otherwise, claims will be denied.

1. **Pre-Admission Screening and Resident Review (PASRR)**
2. **Level of Care (LOC)** determination
3. **Nursing Facility Tracking** within 72 hours of any occurrence listed below for Medicaid eligible individuals:
    - Any admission;
    - Service level update and/or change;
    - New or retro-eligibility determinations;
    - Medicaid Managed Care Disenrollment;
    - Hospice enrollment or disenrollment; or
    - Discharge or death

For additional information, see MSM Chapter 500 and the "PASRR, Level of Care (LOC) and Nursing Facility Provider Training" presentation: https://www.medicaid.nv.gov/providers/training/training.aspx.

Once the tracking form has been completed and approved in the Long-Term Care/PASRR system and the provider has verified the NF benefit line has been entered in the Electronic Verification System (EVS), the facility will then be able to bill for services. Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Out-of-State Requirements

To request approval of an Out-of-State (OOS) placement, the in-state provider such as a hospital or nursing facility must complete the FA-30 Out-of-State Nursing Facility Placement Packet, and submit all documentation outlined in Nevada Medicaid Services Manual Chapter 500 Section 503.22 to Long Term Services and Supports (ltss@dhcfp.nv.gov).

A claim must reflect authorized dates of service from one prior authorization only. For example, if the date range on one

prior authorization ends on the 15th of the month and the date range on a second prior authorization begins on the 16th of that month, two separate claims are required–one claim for each date range during the month.

Eligibility

If a recipient in a NF is enrolled in the Medicaid **hospice program**, the hospice provider is responsible for billing Medicaid for the nursing facility services.

If a recipient was enrolled in a **Managed Care Organization (MCO)** upon admission, that MCO is responsible for the first 180 days of NF payment before the recipient converts to the Medicaid Fee-For-Service (FFS) benefit plan on the 181st day.

Patient Liability (PL) does not apply during the first 20 days of a nursing facility stay whe n the recipient is also eligible for Medicare benefits. Medicare coinsurance and deductibles are not to exceed the Medicaid maximum allowable amount.

Special Billing Instructions

Admit date must identify most recent episode of care.

Submit claims monthly.

NF claims must reflect the recipient's *most recent* admission date. See Electronic Verification System (EVS) Chapter 3 Claims for billing instructions.

For example, if a recipient is admitted on Jan. 1, discharged on Jan. 15 and then re-admitted on Jan. 18, the admission date for the first episode of care must be Jan. 1 and the admission date for the second episode of care must be Jan. 18.

Entering an admission date on the claim for a previous episode of care wrongfully signifies that the recipient has been in the Nursing Facility the entire date span with no discharge days (e.g., using the Jan. 1 admission date for services rendered on the episode of care beginning Jan. 18). Entering the wrong date causes payment delays for hospitals and other acute care facilities that provided service on the days the recipient was not in the Nursing Facility.

Room and Board

Use code 0120 for room and board charges.

Leave of Absence (LOA) Days:

Use revenue code 0183 to bill for up to 24 LOA days per calendar year. On the first claim line, enter revenue code 0120 or 0123 and the number of days the recipient spent in the nursing facility. On the second claim line, enter revenue code 0183 and the number of LOA days for the billing period.

Free-Standing Nursing Facility:

Use the following revenue codes for the recipient's specific level of care:

- Revenue code 0120: NF Standard or NF Ventilator Dependent
- Revenue code 0123: NF Pediatric Specialty Care I or NF Pediatric Specialty Care II
- Revenue code 0183: LOA days

Hospital-based Nursing Facility, Out-of-state Nursing Facility and Veteran's Nursing Home

Use revenue code 0120 exclusively for the recipient's room and board charges.

Hospital-based nursing facilities must list and use the appropriate revenue codes to bill for ancillary services/items (excluding pharmacy).

Nursing Facility

Ordering, Prescribing or Referring (OPR) Provider Requirements

The Patient Protection and Affordable Care Act and the Centers for Medicare & Medicaid Services (CMS) require all ordering, prescribing and referring physicians to be enrolled in the state Medicaid program (§455.410 Enrollment and Screening of Providers). The Affordable Care Act (ACA) requires physicians or other eligible practitioners to enroll in the Medicaid program to order, prescribe and refer items or services for Medicaid recipients, even when they do not submit claims to Medicaid. Physicians or other eligible professionals who are already enrolled in Medicaid as participating providers and who submit claims to Medicaid are not required to enroll separately as OPR providers.

For any services or supplies that are ordered, prescribed or referred, the National Provider Identifier (NPI) of the Nevada Medicaid-enrolled Ordering, Prescribing or Referring (OPR) provider must be included on Nevada Medicaid/Nevada Check Up claims or those claims will be denied. To prevent claim denials for this reason, please confirm that the OPR provider is enrolled with Nevada Medicaid; this can be done on the Provider Web Portal by using the Search Providers feature: https://www.medicaid.nv.gov/hcp/provider/Resources/SearchProviders/tabid/220/Default.aspx

Reminders for providers who submit institutional claims:

- If your provider type requires the attending physician to be listed on the Institutional claim, that attending physician must be enrolled with Nevada Medicaid.
- If the service was ordered, prescribed or referred by another provider, the NPI of the OPR provider is required to be listed on the claim form. The OPR provider must be enrolled in Nevada Medicaid.
- If the attending physician is the same as the OPR provider, leave the OPR field blank.
- The attending and OPR NPI must be for an individual provider (not an organization or group).
- For detailed claim completion information, refer to the 837I FFS Companion Guide located at: https://www.medicaid.nv.gov/providers/edi.aspx and the Electronic Verification System (EVS) User Manual Chapter 3 located at: https://www.medicaid.nv.gov/providers/evsusermanual.aspx