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1.0 Description of the Procedure, Product, or Service

As defined in 42 CFR 440.40, a nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the Medicaid program as a swing-bed provider of nursing facility services), that is licensed and certified by the Division of Health Service Regulation (DHSR) and enrolled with Medicaid to provide nursing facility level of care services.

A nursing facility provides daily licensed nursing care and on-site physician services but does not provide the degree of medical treatment, consultation, or medical support services available in an acute care hospital.

Note: An intermediate care facility for the mentally retarded (ICF/MR) is not considered to be a nursing facility.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Financial Eligibility

Medicaid applicants and recipients who meet financial and medical necessity based on the nursing facility level of care criteria are eligible for Medicaid nursing facility services. The local department of social services in the county where the applicant's eligibility is maintained is responsible for determining financial eligibility, and the designated state contractor determines medical necessity. The appropriate services must have been initially billed to Medicare for dually eligible recipients.

2.3 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the

needed service; and the determination does not limit the recipient's right to a free choice of providers. EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide: <http://www.ncdhhs.gov/dma/basicmed/>
EPSDT provider page: <http://www.ncdhhs.gov/dma/epsdt>

3.0 When the Procedure, Product, or Service Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

3.1 General Criteria

Medicaid covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Nursing Facility Level of Care Criteria

The following criteria are not intended to be the only determinants of the resident's or recipient's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or recipient's medical condition and psychosocial needs are necessary, as well as an understanding of and the ability to differentiate between the need for nursing facility care and other health care alternatives. All professional services that are provided to the resident or recipient to maintain, monitor, and/or enhance the resident's or recipient's level of health must be addressed in the medical records and reflected on the medical eligibility assessment form.

3.2.1 Qualifying Conditions

Conditions that are considered when assessing a recipient for nursing facility level of care include the following:

- a. Need for services that, by physician judgment, require
 1. a registered nurse for a minimum of 8 hours daily and
 2. other personnel working under the supervision of a licensed nurse
- b. Need for daily licensed nurse observation and assessment of resident needs
- c. Need for administration and/or control of medications that, according to state law, are to be the exclusive responsibility of licensed nurses, requiring daily observation for drug effectiveness and side effects (as defined in 10A NCAC 130.0202, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for supervision)
- d. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities as much as possible; such measures may include, but are not limited to, the following:
 1. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transfer/ambulation)
 2. Using preventive measures and devices, such as positioning and alignment, range of motion, handrolls, and positioning pillows, to prevent or retard the development of contractures
 3. Training in ambulation and gait, with or without assistive devices
- e. Special therapeutic diets: nutritional needs under the supervision and monitoring of a registered dietician
- f. Nasogastric/gastrostomy tubes: requiring supervision and observation by licensed nurses
 1. Tube with flushes
 2. Medications administered through the tube
 3. Supplemental bolus feedings
- g. Respiratory therapy: oxygen as a temporary or intermittent therapy or for residents who receive oxygen therapy continuously as a component of a stable treatment plan
 1. Nebulizer usage

2. Pulse oximetry
3. Oral suctioning
- h. Wounds and care of decubitus ulcers or open areas
- i. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan
- j. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan
- k. Diabetes, when daily observation of dietary intake and/or medication administration is required for proper physiological control

3.2.2 Conditions That Must be Present in Combination to Justify Nursing Facility Level of Care

The following conditions when in combination may justify nursing facility level of care placement:

- a. **Need for teaching and counseling** related to a disease process, disability, diet, or medication
- b. **Adaptive programs:** training the resident to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must include the purpose of the resident's participation in the program and the resident's progress
- c. **Ancillary therapies:** supervision of resident performance of procedures taught by a physical, occupational, or speech therapist, including care of braces or prostheses and general care of plaster casts
- d. **Injections:** requiring administration and/or professional judgment by a licensed nurse
- e. **Treatments:** temporary cast, braces, splint, hot or cold applications, or other applications requiring nursing care and direction
- f. **Psychosocial considerations:** psychosocial condition of each resident will be evaluated in relation to his or her medical condition when determining the need for nursing facility level of care; factors to consider along with the resident's medical needs include
 1. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes and/or by nursing or therapy notes)
 2. Age
 3. Length of stay in current placement
 4. Location and condition of spouse
 5. Proximity of social support
 6. Effect of transfer on resident, understanding that there can always be, to a greater or lesser degree, some trauma with transfer (proper and timely discharge planning will help alleviate the fear and worry of transfer)
- g. **Blindness**
- h. **Behavioral problems** such as
 1. Wandering

2. Verbal disruptiveness
 3. Combativeness
 4. Verbal or physical abusiveness
 5. Inappropriate behavior (when it can be properly managed at the nursing facility level of care)
- i. **Frequent falls**
 - j. **Chronic recurrent medical problems** that require daily observation by licensed personnel for prevention and/or treatment

3.3 Ventilator Level of Care

To qualify as ventilator level of care, a resident must be dependent upon mechanical ventilation at least **10** hours per day and in stable condition without unstable or progressive infections or extreme changes in ventilator settings and/or duration (such as increase in respiratory rate by five breaths per minute, increase in fraction of inspired oxygen (FIO₂) of 25% or more and/or increase in tidal volume of 200 milliliters or more). Refer to **Subsection 5.2.4 and Attachment D (E.)** for additional information.

3.4 Non-Emergency Medically Necessary Ambulance Transportation

In accordance with 10A NCAC 22O.0110, Medicaid covers non-emergency medically necessary ambulance transportation to receive medical services that cannot be provided in the nursing facility when any other means of transportation would endanger the resident's health and it is medically necessary that the resident be transported via stretcher due to a medical/physical condition. Medicaid covers ambulance services only if they are furnished to a resident whose medical condition is such that other means of transportation would be contraindicated.

3.5 Non-Ambulance Transportation

Non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility is covered in the per diem that is reimbursed to the facility as documented in 10A NCAC 22G.0104(d)(7).

Note: The facility cannot charge the family or the resident's funds for the cost of this transportation. The facility may contract with a service (including county-coordinated transportation systems) to provide transportation or may provide transportation services using its own vehicles if this is more cost effective.

4.0 When the Procedure, Product, or Service Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

4.2 Specific Criteria

Nursing facility services are not covered when

- a. the recipient (age 65 and older) is entitled to Medicare benefits and does not apply for Medicare;
- b. the services are denied by private health plans due to non-compliance with those plan requirements

(Note: If the provider's service would have been covered and payable by the private plan, but some requirement of the plan was not met, Medicaid does not pay for the service.);

- c. the insurance payment amount is more than the Medicaid-allowed amount;
- d. the resident's monthly liability equals or exceeds the Medicaid reimbursement rate for the facility; or
- e. a preadmission screening (PASRR) was not completed prior to admission as required by 42 CFR 483 Subpart C.

Note: Once the Level I (and, if appropriate, the Level II) screen is completed, Medicaid reimbursement will resume.

Refer to **Subsection 5.1** for additional information regarding PASRR.

4.3 Non-Covered Patient Care Items and Services

4.3.1 Non-Covered Patient Care Items

As indicated in 42 CFR 483.10(c)(8)(ii), the following patient care items are not covered by Medicaid:

- a. Telephones
- b. Televisions or radios
- c. Newspapers
- d. Magazines
- e. Private duty nurses and sitters
- f. Tobacco products
- g. Medical photography

Additionally, as indicated in 10A NCAC 22G.0103 and 22O.0403, the following patient care items are also not covered by Medicaid:

- a. Guest meal tray
- b. Personal clothing
- c. Morgue boxes, shrouds, or burial wrappings
- d. Private rooms, unless the recipient's attending physician orders a private room based on medical necessity or if the only room available within the facility is a private room.

Note: This list is not all inclusive.

4.3.2 Bed Hold Days

In accordance with 42 CFR 483.12(a)(8)(b), Medicaid does not cover bed hold days. Refer to **Subsection 7.4** for additional information on bed holds.

4.3.3 Non-Covered Ambulance Transportation Services

As indicated in 10A NCAC 22O.0110 and .0409, the following ambulance transportation services are not covered by Medicaid:

- a. Non-emergency transportation when it is not medically necessary to transport a resident by ambulance
- b. Transportation from the nursing facility to the emergency room or to the outpatient department of a hospital for medical services that can be rendered at the nursing facility
- c. Transportation of a deceased resident, if s/he was pronounced dead prior to the call for pick-up
- d. Transportation from a nursing facility to a site for therapeutic leave

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

5.1 Preadmission Screening Resident Review

The Preadmission Screening Resident Review (PASRR) program is a federal statutory requirement (refer to 42 CFR 483 Subpart C) that mandates the review of every individual who applies to or resides in a Medicaid-certified nursing facility, regardless of the source of payment for nursing facility services.

5.1.1 Who Is Subject to PASRR Screens

In accordance with 42 CFR 483.106, all applicants to and residents of Medicaid-certified nursing facilities must be screened through the Level I and, if appropriate, the Level II process.

Note: Hospital swing beds, Community Alternatives Program services, and nursing facilities that are **not** Medicaid certified are exempt from Level I and Level II PASRR screens. A small number of nursing facilities in North Carolina have a distinct part that participates in the Medicaid program as a nursing facility and another distinct part that participates in the Medicare program as a skilled nursing facility. Persons seeking admission to the **Medicare** distinct part, as long as that part is not Medicaid certified, are also exempt from the Level I and Level II processes.

An individual who is transferred from any of these placements into a Medicaid-certified nursing facility bed (or Medicaid-certified part of a nursing facility) must have a Level I and, if applicable, a Level II screen before that transfer can occur.

5.1.2 Web-Based Submission

All providers will be required to submit PASRR screenings or Tracking forms through the Division of Medical Assistance's (DMA) web-based tool or through a third-party vendor with interface capabilities into DMA's web-based tool.

Note: Organizations currently submitting PASRR screenings and Tracking forms through a third-party vendor with interface capabilities into DMA's web-based tool can continue to use this method.

5.1.3 Level I Screens

Federal law (42 CFR 483.128) mandates that states provide a Level I screen for all applicants to Medicaid-certified nursing facilities to identify residents with serious mental illness (SMI), mental retardation (MR), or a related condition (RC).

For residents with no evidence or diagnosis of SMI, MR, or RC, the initial Level I screen remains valid unless there is a significant change in status.

5.1.4 Level II Screens

Any applicant to a Medicaid-certified nursing facility whose Level I screen indicates the possible presence of SMI, MR, or RC must undergo a Level II screen. Level II screens are federally mandated (42 CFR 483.128) to be performed on-site and prior to admission to the nursing facility.

The results of the Level II screens can be seen on the NCMUST.com website.

5.1.5 Annual Resident Review for Level II Screens

After an individual receives a Level II evaluation, s/he no longer needs to receive an Annual Resident Review (ARR) to evaluate the individual's continuing need for nursing facility care and/or specialized MI, MR, or RC services. Congress repealed the Federal requirement for annual reviews in 1996.

5.1.6 Significant Change in MH/MR Resident Condition

Nursing facilities will have greater responsibility for identifying significant changes in the resident's status. A significant change is defined as a major change in the resident's status that results either in an improvement or deterioration in at least two (2) or more areas of the resident's physical or mental functioning, which has an impact on his/her specialized needs.

- a. Nursing facilities shall be responsible to complete an MDS evaluation for any significant change and must notify the PASRR contractor within seven business days of the significant change so that either a PASRR I or PASRR II evaluation can be arranged, whichever is indicated by the change. The process will then follow the same steps as for the initial Level I PASRR evaluation process.
- b. Once the PASRR II is completed, communication of changes in service needs must occur with the Department of Mental Health, who is responsible to arrange and assure MH and MR services for individuals who are appropriate for additional services.

5.1.7 Level II Screen Postponements

Federal regulations (42 CFR 483.130) allow short-term nursing facility admissions for some applicants with SMI, MR, or RC. These **time-limited** approvals are authorized during the Level I screen process when any of the following four circumstances are applicable:

- a. **Convalescent care** (30-calendar-day approval): applies to admissions to nursing facilities directly from acute care hospitals
Note: An individual must need 30 calendar days or less of nursing facility care for the hospitalization condition for this approval to be granted. The attending physician must provide certification that the nursing facility stay is not expected to exceed 30 calendar days. (42 CFR 483.106)
- b. **Emergency** (7-calendar-day approval): applies when the individual needs emergency protective service placement
- c. **Delirium** (7-calendar-day approval): applies to individuals suspected of having SMI, MR, or RC but whose delirium state prevents accurate completion of the Level I and/or Level II processes
- d. **Respite** (7-calendar-day approval): applies to individuals whose in-home caregivers need temporary respite

5.1.8 Continued Stays

If residence in the facility is expected to extend beyond the end date shown on the initial Level I screen, further approval and evaluation, as authorized by 42 CFR 483.130(e), must be obtained before the authorized period ends. The admitting facility is responsible for initiating further assessment through an updated Level I evaluation.

- a. within 5 calendar days of the individual's date of admission for 7-calendar-day approvals,
- b. within 25 calendar days for 30-calendar-day approvals, and
- c. within 50 calendar days for 60-calendar-day approvals.

Note: If the individual is Medicaid eligible and is approved for continued stay through the updated Level I/II process, Medicaid's fiscal agent **must** be contacted for payment to continue.

5.1.9 Documentation

All evaluation results must be kept in the resident's medical record to allow availability to the facility's care planning team and to federal and state auditors (Refer to **Subsection 7.6** for additional information on documentation).

Refer to **Attachment C** for additional information about the PASRR process.

5.2 Prior Approval

5.2.1 When Prior Approval Is Required

As indicated in 10A NCAC 22O.0116, prior approval is required for the following:

- a. All new Medicaid admissions to a nursing facility
- b. Current nursing facility residents who are private payers or insured with a third-party insurance carrier who now seek Medicaid assistance
- c. A resident discharged home or to an adult care home who later returns to the nursing facility
- d. Ventilator services (refer to **Subsection 5.2.4**)
- e. Therapeutic leave in excess of 15 consecutive days (refer to **Subsection 5.6**)
- f. Out-of-state placement to the nursing facility level of care
- g. CAP/DA client admissions to a nursing facility

Note: Prior approval does not guarantee financial eligibility or Medicaid payment. Nursing facilities are responsible for verifying Medicaid eligibility when a recipient presents for services.

5.2.2 When Prior Approval Is Not Required

Prior approval is not required for the following:

- a. Residents returning from a hospital to the nursing facility
- b. Residents transferring from one nursing facility to another (except for residents approved for ventilator level of care) (refer to **Subsection 5.2.4**)
- c. The admission of a resident to an acute care hospital
- d. Residents returning from therapeutic leave of 15 calendar days or less
- e. Residents whose Medicaid eligibility lapses for no more than 90 calendar days and whose level of care remains the same

Note: Prior approval requests must be submitted using the Medicaid-designated screening form.

- a. The PASRR number must be entered on the form.
- b. The attending physician must sign and date the form before submitting the approval request.

5.2.3 Retroactive Prior Approval

It is the responsibility of the nursing facility to ensure that the initial request for prior approval is on file with Medicaid's fiscal agent when a recipient is admitted to the facility.

- a. Retroactive prior approval for nursing facility level of care, back to 90 calendar days, may be approved when the initial authorization is requested.

- b. For retroactive requests exceeding 30 calendar days, medical record documentation is required by the fiscal agent to support the retroactive request.
- c. The fiscal agent will review retroactive requests back to 180 calendar days only when eligibility is an issue.

Note: When the nursing facility level of care is denied, residents/responsible parties must be notified that they have the right to an appeal of the denial in accordance with Medicaid's recipient notices procedures.

5.2.4 Prior Approval for Ventilator Services

Prior approval requests for ventilator services must include the following:

- a. The Medicaid-designated screening form, with the PASRR number, signed and dated by the attending physician
- b. Medical records documenting the criteria for ventilator level of care listed in **Subsection 3.3**
- c. A ventilator addendum form, signed and dated by the attending physician within 45 calendar days of the authorization for ventilator level of care

Note: If the recipient with ventilator services transfers from the hospital to a nursing facility or to a different nursing facility, the facility must notify Medicaid's fiscal agent of the transfer. If Medicaid's fiscal agent is not notified within 30 calendar days of the transfer, a new prior approval is required. If the recipient is in the hospital and placement has yet to be determined, the hospital's provider number must be entered on the authorization request.

Refer to **Attachment D** for additional information on the prior approval process.

5.3 Provision of Services

All services must be provided in accordance with 42 CFR 483 Subpart B. A Medicaid-certified nursing facility must provide or arrange for the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with the comprehensive assessment and plan of care. A licensed nurse must provide daily observation and assess the total needs of the resident, plan and manage treatment according to the plan of care approved by the physician, and render direct services to the resident.

5.3.1 Services and Items Covered in the Per Diem

The following items and services must be provided by a nursing facility as part of the per diem that is reimbursed to the facility. This list is not all inclusive.

- a. Room and board
- b. All general nursing services, including restorative nursing
- c. Personal hygiene and laundry care items (refer to **Attachment B**)
- d. Dressing and skin care items (refer to **Attachment B**)
- e. Medical supplies and equipment (refer to **Attachment B**)
- f. Non-prescription (over-the-counter) drugs, biologicals, and emergency drugs
- g. Dietary services, including therapeutic diets and special dietary supplements used for oral or tube feeding

- h. Rehabilitative services, including physical, speech, and occupational therapies
- i. Social services
- j. Activity services
- k. Therapeutic leave (refer to **Subsection 5.6**)
- l. Non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility (refer to **Subsection 3.5**)
- m. Miscellaneous items
 - 1. Items furnished on a routine basis to all patients
 - 2. Items stocked in gross supply and distributed or used individually in small quantities
 - 3. Items used by individual residents but reusable and expected to be available

Refer to **Subsection 7.3.7** for information on items and services that residents may pay for from their personal funds.

5.4 Transfer and Discharge

Transfers and discharges must be provided in accordance with 42 CFR 483.12(a). Transfer and discharge includes movement of a resident to a bed outside of the certified facility, whether or not that bed is in the same physical plant. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

A nursing facility must permit each resident to remain in the nursing facility and must not transfer or discharge a resident from the facility unless at least one of the following is true:

- a. The resident's welfare and needs cannot be met in the facility.
- b. The resident's health has improved sufficiently so that the facility's services are no longer needed.
- c. The safety of individuals in the facility is endangered.
- d. The health of individuals in the facility would be endangered.
- e. The resident has failed, after reasonable and appropriate notice, to pay (or have paid under Medicare or Medicaid) for a stay at the facility.
- f. The facility ceases to operate.

When a nursing facility transfers or discharges a resident for any of the above reasons, those reasons must be documented in the resident's clinical record.

When a nursing facility decides to transfer or discharge a resident, the resident and/or responsible party has the right to an appeal. A state-approved Notice of Transfer or Discharge (DMA-9050) (**Attachment E**), including a Hearing Request form (DMA-9051) (**Attachment F**), must be issued 30 calendar days prior to discharge. This applies to every individual in a Medicaid-certified nursing facility, regardless of pay source, and to all instances in which the resident is transferred or discharged from the facility. This does not, however, apply to situations in which a resident and/or the responsible party choose to move to another placement.

The notice may be made as soon as practicable before the transfer or discharge when

- a. the safety of individuals in the facility is endangered;
- b. the health of individuals in the facility is endangered;
- c. the resident's health has improved sufficiently so that the facility's services are no longer needed;
- d. an immediate transfer or discharge is required by the resident's urgent medical needs; or
- e. the resident has not resided in the facility for 30 calendar days.

5.5 Readmissions

Readmissions must be provided in accordance with 42 CFR 483.12(b)(3). A nursing facility resident who has been hospitalized and is ready for readmission to the nursing facility must be readmitted immediately to the first available bed in a semiprivate room if the resident requires the services provided by the facility and is eligible for Medicaid nursing facility services.

5.6 Therapeutic Leave

Therapeutic leave must be provided in accordance with 10A NCAC 22O.0409.

- a. Each Medicaid eligible resident who is occupying a nursing facility bed for which the N.C. Medicaid program is then paying reimbursement shall be entitled to take up to 60 days of therapeutic leave in any calendar year from any such bed, without the facility's suffering any loss of reimbursement during the period of leave.
- b. The taking of such leave must be for therapeutic purposes only, and must be ordered by the resident's attending physician. The necessity for such leave shall be documented in the resident's plan of care and therapeutic justification for each instance of such leave shall be entered into the resident's medical record.
- c. Facilities must reserve a therapeutically absent resident's bed for him or her, and are prohibited from deriving any Medicaid revenue for that resident other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken that exceed the legal limit.
- d. No more than 15 consecutive therapeutic leave days may be taken without approval of the Division of Medical Assistance (DMA).
Note: The facility must request prior approval on behalf of the recipient through DMA's fiscal agent for therapeutic leave that exceeds 15 consecutive days.
- e. The therapeutic justification for such absence shall be subject to review by the State or its agent during scheduled on-site medical reviews.
- f. For reference and audit purposes, facilities must keep a cumulative record of therapeutic leave days taken by each resident. In addition, residents on therapeutic leave must be noted as such on the facility's midnight census. Facilities bill Medicaid for approved therapeutic leave days as regular residence days.
- g. The official record of therapeutic leave days taken for each resident shall be maintained by the State or its agent.
- h. Entitlement to therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving either inpatient or nursing services provided

either elsewhere or at a different level of care in the current facility when such services are or will be paid for by Medicaid.

- i. Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed by Medicaid.

5.7 Nursing Facility Transitions Program

The Olmstead Act mandates that if a nursing facility resident requests transition to a community level of care, and this is a viable option, the nursing facility must refer the resident to the Division of Vocational Rehabilitation Independent Living Services Transition Program.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid's qualifications for participation;
- b. be currently enrolled with N.C. Medicaid; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

6.1 Qualifications for Enrollment

- a. Nursing facilities must be licensed and certified by the DHSR as a nursing facility in accordance with 42 CFR 483.75 and 42 CFR 483.5.
- b. Nursing facilities receiving Medicaid funding must be enrolled for participation in Medicare and Medicaid in accordance with 10A NCAC 220.0116.
- c. Nursing facilities that are located 40 miles or fewer outside of North Carolina's borders may enroll as N.C. Medicaid providers. Nursing facilities beyond 40 miles of North Carolina's borders may also enroll in the N.C. Medicaid program, but *only* to provide emergency or prior approved services. Nursing facilities outside of North Carolina borders must be licensed and certified in their respective states of practice by the state agency that is charged with licensure.

Note: As indicated in 10A NCAC 220.0119, prior approval must be obtained for any N.C. Medicaid recipient to be admitted to an out-of-state nursing facility.

6.2 Conditions of Participation

6.2.1 Nursing Facility Providers

To qualify for participation with the N.C. Medicaid Program, nursing facilities must meet the requirements defined in 42 CFR 483 Subpart B and all other applicable federal, state, and local laws and regulations, including the following.

- a. Employing staff who are licensed, certified, or registered in accordance with applicable federal and state laws (42 CFR 483.75)
- b. Obtaining training and competency evaluations through DHSR for nurse aides employed in the nursing facility [42 CFR 483.75(e)]
- c. Establishing and implementing policies (developed with the advice and periodic review of a professional group, including one or more physicians and one or more registered nurses) to govern the skilled nursing care and

- related medical or other services it provides. There must be a physician responsible for the implementation of such policies [42 CFR 483.75(d)].
- d. Conducting initial and periodic comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Minimum Data Set (MDS) assessment tool according to federal requirements for resident assessment (42 CFR 483.20). (Refer to **Attachment G** for additional information on MDS.)
 - e. Ensuring that each resident is under the care and supervision of a physician and providing or arranging for physician services 24 hours a day in the case of an emergency [42 CFR 483.40(a)(1)(d)] (After the initial visit, at the option of the physician, required physician visits may alternate between personal visits by the physician and visits by a nurse practitioner or physician assistant. (42 CFR 483.40(c)(4)) Any required physician task in a nursing facility may be satisfied when performed by a nurse practitioner or physician assistant who is acting within their scope of practice as defined by State law and is not an employee of the facility but is working in collaboration with a physician. (42 CFR 483.40(e)(f))
 - f. Ensuring the 24-hour availability of licensed nursing care, with the services of a registered nurse available for at least eight consecutive hours a day, seven days a week [42 CFR 483.30(a)(1)(b)]
 - g. Providing appropriate methods and procedures for dispensing and administering drugs and biologicals (42 CFR 483.60)
 - h. Implementing a written transfer agreement with one or more participating hospitals providing for the transfer of patients between the hospital and the nursing facility and the interchange of medical and other information [42 CFR 483.75(n)]
 - i. Meeting all the requirements of the Patient Self Determination Act, including
 1. giving patients age 18 and older (at the time of admission) written information of their rights to make decisions about their medical care and to complete advance directives;
 2. conducting staff and community education on advance directives; and
 3. documenting in the resident's medical record whether or not he or she had executed an advance directive.

Additionally, nursing facilities must

- a. participate in the MDS validation program if they are participating in the Medicaid Case Mix Reimbursement System and
- b. provide evidence (written documentation, facility staff interviews, or onsite reviews) that the facility is actively participating in quality improvement initiatives. (Refer to **Attachment H** for additional information.)

Note: DMA may review the facility's quality initiative(s) every 12 to 15 months.

6.2.2 Swing Bed Providers

Any hospital enrolled as a swing-bed provider of nursing facility services must meet all state and federal requirements (42 CFR 482.66) governing swing beds.

Refer to the *Basic Medicaid Billing Guide* for additional information on conditions of participation.

6.3 Sanctions

A nursing facility may be sanctioned by the Centers for Medicare and Medicaid Services (CMS) for failure to comply with federal regulations for long-term care facilities or for repeated citations for substandard quality of care. Providers who receive sanctions from CMS may become ineligible for Medicaid payments and are ineligible for payment for new admissions.

Note: Medicaid does not consider a nursing facility resident to be a new admission in the following situations:

- a. Medicare was the primary payer, but benefits were exhausted after the sanction date and Medicaid becomes the primary payer.
- b. A resident was a private payer prior to the sanction date and becomes eligible for Medicaid after the sanction date.
- c. A resident was hospitalized prior to the sanction date and re-admitted to the nursing facility after the sanction date.
- d. A resident returns to the nursing facility from therapeutic leave after the sanction date.

Any provider who is sanctioned by CMS must notify DMA immediately.

7.0 Additional Requirements

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, refer to **Subsection 2.3** of this policy.

7.1 Compliance

Providers shall comply with all applicable federal, state, and local laws and regulations, including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

7.2 Residents' Rights

Nursing facilities in North Carolina are subject to reviews by the DHSR to evaluate compliance with requirements and regulations regarding residents' rights (10A NCAC 13D.2109). Residents' rights apply to all residents of a nursing facility that accepts Medicaid recipients, regardless of a resident's payment source.

As required by 42 CFR 483.10(b)(6), the nursing facility must inform each resident who is entitled to Medicaid benefits, **in writing**, at the time of admission to the nursing facility, when the resident becomes eligible for Medicaid, and periodically throughout the stay, of the following:

- a. The items and services that are included in the nursing facility services under the State plan and for which the resident may not be charged
- b. The items and services that the nursing facility offers for which the resident may be charged and the amount of the charges for those services
- c. Changes that are made to items or services listed in a or b above

7.2.1 Payments for Services

Payment for services must comply with federal regulations in 42 CFR 483.12(d) as follows:

- a. A nursing facility must not require a third-party guarantee of payment to the facility as a condition of admission or expedited admission to, or continued stay in, the facility.

Note: The nursing facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring financial liability, to provide facility payment from the resident's income or resources.

- b. A nursing facility must not require residents or potential residents to waive their rights to Medicare or Medicaid, nor require written or oral assurance that they are not eligible for, or will not apply for, Medicare or Medicaid benefits.
- c. A nursing facility may not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State Plan, any gift, money, donation, or other consideration as a pre-condition of admission, expedited admission, or continued stay for Medicaid-eligible residents in the facility. Furthermore, the provider may not charge a resident for failure to remain an inpatient for any agreed-upon length of time or for failure to give advance notice of departure from the provider's facilities.
(42 CFR 489.22(d))

7.2.2 Payments for Services for Recipients with Medicare Part A

In accordance with 10A NCAC 22G.0107(c), Medicaid payments for recipients who are also eligible for Medicare Part A cannot be made for the first 20 days of care. Payments for co-insurance will begin for the subsequent 21st through 100th days of care. "The Division of Medical Assistance shall pay an amount for each day of Medicare Part A inpatient co-insurance, the total of which shall equal the facility's Medicaid per diem rate less any Medicare Part A payment, but no more than the Medicare co-insurance amount."

Note: If Medicare is not involved, then Medicaid will pay straight Medicaid reimbursement if all Medicaid requirements are met. Refer to **Subsection 4.1 and 4.2** for reasons that Medicaid will not pay for nursing facility services.

7.2.3 Married Residents

As indicated in 42 CFR 483.10(m), each nursing facility resident has the right to share a room with his or her spouse when both residents require nursing facility care and both consent to the arrangement.

7.3 Residents' Funds and Property

7.3.1 Surety Bond

As required by 42 CFR 483.10(c)(7), the facility must purchase a surety bond or otherwise provide assurance to the Secretary of the United States Department of Health and Human Services that all personal funds of residents deposited with the facility are secure.

7.3.2 Personal Needs Allowance

A protected personal needs allowance fund must be established in accordance with 10A NCAC 21B.0313 for each resident for clothing and personal needs while residing in the nursing facility. This allowance is \$30.00 per month for an aged, blind, or disabled individual.

7.3.3 Personal Funds

In accordance with 42 CFR 483.10(c)(4), the nursing facility must establish and maintain a system that ensures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility on the resident's behalf. The system must preclude any commingling of resident funds with nursing facility funds or with the funds of any person other than the resident. The individual financial record must be available to the resident or his or her legal guardian through quarterly statements and upon request.

In accordance with 42 CFR 483.10(c)(3), the facility must deposit any resident's personal funds in excess of \$50.00 in an interest-bearing account(s) that is separate from any of the facility's operating accounts and must credit all interest earned on the resident's funds to his or her account. In pooled accounts, there must be a separate accounting for each resident's share. The facility must maintain a resident's personal funds not exceeding \$50.00 in a non-interest-bearing account, an interest-bearing account, or petty cash fund. It is acceptable to charge the bank service fee on the interest-bearing account against the interest earned and apply the net amount to each resident's account. Facilities are required to keep sufficient cash on hand to furnish residents convenient access to cash when needed.

7.3.4 Notice of Balances

In accordance with 42 CFR 483.10(c)(5), the facility is required to notify each resident who receives Medicaid benefits

- a. when the amount in the resident's account reaches \$200 less than the supplemental security income (SSI) resource limit for one person and
- b. that the resident may lose eligibility for Medicaid or SSI if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person.

7.3.5 Disposition of Funds upon Discharge or Death

In accordance with 42 CFR 483.10(c)(6), upon the death of a Medicaid resident, his or her balance in the personal needs fund must be accounted for and turned over to the administrator of the estate within 30 calendar days after death.

Note: If an administrator has not been appointed, the balance should be paid to the Clerk of the Superior Court within 30 calendar days after death. The funds and personal property will be disbursed by the Clerk of the Superior Court. Funds should be sent to the Clerk of the Superior Court of the county providing the Medicaid assistance. The letter remitting the funds should state the resident's full name, date of death, Medicaid identification (MID) number, and the name of the county department of social services (DSS) that provided medical assistance.

7.3.6 Request for Items and Services

In accordance with 42 CFR 483.10(c)(8)(iii), the facility must not charge a resident or the resident's representative for any item or service not requested by the resident. The facility must not require a resident or the resident's representative to request any item or service as a condition of admission or continued stay. The resident or the resident's representative requesting an item or service for which a charge will be made must be informed what the charge will be prior to the resident's receiving the item or service.

7.3.7 Use of Residents' Personal Funds

In accordance with 42 CFR 483.10(c)(8), a resident's personal funds **may** be used for the following items and services if requested by the resident and the resident or the resident's representative is informed of the charge:

- a. Authorized cost-sharing in Medicaid-covered services, including patient liability to hospitals and nursing facilities
- b. Medical and health care not covered by Medicaid
- c. Personal needs including, but not limited to, the following:
 1. Beauty shop and barber shop services

Note: The nursing facility must provide or arrange for (with no charge to resident) shampooing, conditioning, and routine hair trimming as part of basic hygiene service rendered to residents. The resident, family member, or representative must be informed upon admission and periodically thereafter of the method and schedule by which these services are provided. **If the resident elects** to use the service of a barber or beautician, and such services are outside the facility's method or schedule, then the services may be charged to the resident's funds.

2. Cigarettes, cigars, pipes, and tobacco
3. Clothing
4. Cosmetics; grooming items, and services in excess of those covered by Medicaid or Medicare
5. Telephone
6. Television/Radio
7. Personal comfort items, such as notions, novelties, confections
8. Reading matter, flowers, plants, gifts to the resident
9. Social events and entertainment offered outside the scope of the activities program
10. Non-covered special care services, such as privately hired nurses and/or aides

11. Specially prepared or alternative food requested instead of the regular and medically necessary food prepared by the facility
12. Private room, except when therapeutically required (e.g., isolation for infection control) (refer to **Subsection 7.5**)

7.3.8 Restrictions on Use of Residents' Funds

In accordance with 42 CFR 483.10(c)(8), a resident's personal funds **must not** be used for the following:

- a. Items and services that are furnished as part of Medicaid-covered nursing facility care
- b. Services covered by Medicaid and furnished by other participating Medicaid providers
- c. Transportation to and from other participating Medicaid providers
- d. Operating costs of the facility
- e. Collateral for a loan for facility operating expenses
- f. Items included in the per diem for nursing facilities (refer to **Attachment B**)
- g. Commingling with facility funds (refer to **Subsection 7.3.3**)

7.4 Bed Holds

In accordance with 42 CFR 483.12(b), when a resident must be hospitalized, the resident or responsible party may arrange to reserve the resident's bed in the nursing facility. Medicaid has no provision for bed-hold; it is a private agreement between the resident or responsible party and the nursing facility. The admission contract must state the charge for bed-hold and the resident must be notified of any changes as they are made.

7.5 Private Rooms

In accordance with 42 CFR 483.10(c)(8)(ii)(k), a resident or his or her family may pay for a private room, provided that the resident's physician has not ordered private accommodations and that such arrangements are not a condition of admission to or continued stay in the facility.

The Medicaid per diem rate is for a semiprivate room, unless the recipient's attending physician orders a private room or if the only room available is private. The Medicaid payment plus any third-party insurance payment and patient liability is payment in full under these circumstances (10A NCAC 22O.0403 and 22G.0107).

Note: When private accommodations are requested for the convenience and comfort of the resident and his or her family, the facility may charge the difference between the facility's private patient rates for semiprivate and private rooms, because Medicaid is paying for semiprivate accommodations.

Medicaid must get credit for all third-party insurance payments up to the amount of the Medicaid payment. Third-party payments cannot be used to pay the difference between the semiprivate and private rates until after Medicaid has been reimbursed in full.

Residents may use their own assets (not income) to pay the private room charge; however, the resident should be informed of the limited number of days those assets will cover.

7.6 Medical Record Documentation and Records Retention

As a condition of participation, each nursing facility must retain any records necessary to disclose the extent of services provided to residents and any information regarding claim payments [42 CFR 483.75(l)]. Records must be retained for a period of not less than five years from the date of service, unless a longer retention period is required by applicable federal or state law, regulations, or agreements (10A NCAC 22F.0107), except for an individual who is a minor at the time of discharge. For a minor recipient, records shall be kept on file until his or her 19th birthday, and then for an additional five years. Refer to 10A NCAC 13D .2402.

- a. These records must be furnished upon request to the appropriate federal or state authorities, including the fiscal agent. The Health Insurance Portability and Accountability Act (HIPAA) does not prohibit the release of records to Medicaid (45 CFR 164.502).
- b. Failure to submit the requested records results in recoupment of all payments for the services.

7.7 Cost Reporting

Nursing facilities are mandated by federal and state regulations (10A NCAC 22G.0104) to file annual Medicaid cost reports with DMA in order to ensure that allowable costs have been identified in accordance with Medicaid regulations.

7.8 Minimum Data Set Validation Program

Nursing facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program. Refer to **Attachment G** for additional information about the MDS Program.

7.9 Hospice Services for Residents in Nursing Facilities

Hospice services may be provided to a nursing facility resident if a contractual agreement has been made between the hospice agency and the facility. The contract must specify that the hospice agency is responsible for the professional management of the recipient's care and that the facility agrees to provide room and board. Medicaid reimbursement for room and board costs is made to the hospice. The agreement between the hospice and the nursing facility shall specify payment arrangements and shall comply with 10A NCAC 13K, which documents current rules governing the licensure of hospices. Hospice is responsible for medications and durable medical equipment directly related to the terminal illness, with the exclusion of those outlined in the reference above. All other details related to the provision of care are included in the agreement.

Refer to Clinical Coverage Policy 3D, *Hospice Services*, on DMA's Web site at <http://www.ncdhhs.gov/dma/mp/> for additional information on hospice services.

7.10 Continuity of Service during an Appeal

As indicated in 10A NCAC 22H.0104, Medicaid covers services in a nursing facility at the existing level of care for an authorized Medicaid resident while an informal or formal appeal is in process.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 1991

Revision Information:

Date	Section Updated	Change
1/1/09	Throughout	Initial promulgation of current coverage, with change from 16 hours of ventilator care to 10 hours
11/01/09	5.2 & Attachment C	PASRR no longer requires Annual Resident Review
11/01/09	3.2.2	Language change: criteria that in combination may justify admission
9/1/11	Table of Contents	Edited to match the changes in PASRR and MDS
9/1/11	Throughout	“PASARR” changed to “PASRR”
9/1/11	Throughout	Corrections to formatting issues that occurred during the last publication
9/1/11	Throughout	“Calendar” or “business” added where needed to clarify type of “days”
9/1/11	5.1	Language changes for clarification
9/1/11	7.2.1(c)	42 CFR site added
9/1/11	Attachment C Sections C & G	Language changes for clarification
9/1/11	Attachment G Section C (5)	Language changes for clarification “Hearing unit” changed to “Office of Administrative Hearings (OAH)” to match new due process changes
12/1/11	Subsection 6.2.1(e)	Clarified, according to 42 CFR, which visits and tasks can be performed by a nurse practitioner or physician assistant in a nursing facility

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers shall bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Codes

Revenue Code	Description
100	All-inclusive room and board plus ancillary
183	Therapeutic leave

D. Modifiers

Providers are required to follow applicable modifier guidelines

E. Billing Units

The appropriate RC code determines the billing unit

F. Place of service

Nursing facilities and hospital swing beds

G. Co-Payments

Residents of a nursing facility are exempt from a co-payment for the following:

1. The facility
2. Any services rendered by practitioners at the facility or at another location
3. Prescription drugs

H. Reimbursement

Providers shall bill their usual and customary charges.

When Medicaid payment is received, the provider is paid in full and there is no outstanding balance on that claim.

I. Third-Party Payers/Recovery

The collection of any and all third-party benefits is mandatory. Medicaid reimburses only after all third parties—including Medicare, CHAMPUS, Workers' Compensation liability carriers, and private health insurance carriers—have paid on claims.

J. First Billable Day

Medicaid payment is based on the facility's midnight census; therefore, the date of admission is counted as the first billable day. The discharge date or date of death is not billable to

Medicaid. The only exception is when the date of admission and the date of discharge or death occur on the same day.

Attachment B: Items Included in Per Diem Rate

A. Dressing and Skin Care Items Included in Nursing Facility Per Diem

(Not all inclusive)

ABD pads	Disposable underpads
Applicators, cotton-tipped	Eye pads
Arm slings	Finger cots
Bandages, elastic or cohesive	Gauze
Band-aids	Lotions
Bath soap	Nonprescription creams
Body oil	Nonprescription medicated powder
Composite pads	Ointments
Corn starch	Petroleum jelly
Cotton balls	Powder
Decubitus ulcer pads	Shampoo
Deodorant	Sponges
Disposable diapers or reusable diapers, as required for individual patients	Sterile pads
Disposable ulcer pads	Surgical dressing
	Surgical pads
	Underpads

B. Personal Hygiene and Laundry Included in Nursing Facility Per Diem

(Not all inclusive)

Bath soap	Patient gowns
Brush	Personal laundry (no dry cleaning)
Comb	Razors
Cotton balls	Sanitary napkins and related supplies
Cotton swabs	Shampoo
Dental floss	Shaving cream
Denture adhesive	Specialized cleansing agents (skin)
Denture cleaner	Tissues
Deodorant	Toothbrush
Disinfecting soaps	Toothpaste
Hair conditioner	Towels
Hair cuts	Washcloths
Moisturizing lotion	
Nail care	

C. Medical Supplies and Equipment Included in Nursing Facility Per Diem

(Not all inclusive)(List continues through p. 25)

Ace bandages	Asepto-syringes
Adhesive and adhesive removal	Aspirating catheters
Adhesive tape	Basins
Air mattress, disposable	Bed frame equipment—turning frames, bedrails, trapeze bars, foot cradles
Airway (oral, reusable)	
Airway, disposable	
Anti-embolic hose	Bed pans, fracture and regular

Bedside utensils	Needles, all types and sizes
Bibs	Oxygen
Bottles, specimen	Oxygen mask
Brown paper bags (isolation only)	Oxygen nebulizer and regulator
Buck extension	Pad, eye
Canes, regular and customized	Pad, foam
Cannula	Pad, foam, self-adhering
Catheter, 3-way	Pads, flotation
Catheter, aspirating	Pads, non-stick
Catheters, disposable	Paper mask (isolation only)
Clysis set	Paper tape
Colostomy bags, belt, gasket, irrigation syringe	Patient lift
Crutches, regular and customized	Pharmaline
Douche bags	Pillowcase (disposable, isolation only)
Drainable stoma bags	Pilo pump
Drainage bags	Pitchers
Enema cans and supplies	Pressure pads, donut
Flex trach tube	Pumps, aspiration and suction
Furacin gauze	Restraints
Gloves, sterile and unsterile	Roller gauze
Gowns (isolation only)	Saline, sterile (30 cc)
Gowns, patient	Sandbags
Heat cradle	Scales suitable for NF purposes
Heating pads	Scalp vein set
Heel protectors	Scalpels, blades, disposable scalpels
I.V. solutions	Sheepskin
Ice bags	Sheets, disposable (isolation only)
Incontinency pads and pants, disposable or reusable	Sheets, half, disposable (isolation only)
Infusion arm boards	Sitz bath, disposable
Inhalation therapy supplies (aerosol inhalators, nebulizer and replacement kits, steam vaporizers, IPPB-intermittent positive pressures breathing machine, oxygen tents and masks)	Skin closures
Invalid rings, all sizes	Skin gel
IPPB	Solutions, sterile, irrigating
Irrigation syringes or bulbs	Specimen cups
K pads, water-heated	Speculum, vaginal, disposable
Lemon-glycerine swabs	Splint, finger or wrist
Levine tubes	Suction equipment
Linens	Suture and needle, sterile
Mattresses (air, air p.r., alternative pressure, flotation water)	Syringes, all types and sizes, disposable and reusable
Nasal catheter	Tape-butterfly; for lab tests; non- allergenic, surgical and adhesive
Nebulizer for moist nebulization	Tissue wipes
	Tissue, bedside
	Tongue depressors
	Trach soap
	Tracheostomy brush
	Tracheostomy mask

Tracheostomy tubes	Tubing, catheter, all types, including plugs, clamps and drainage bags
Tray, catheter (disposable)	Tubing, drainage, all types
Tray, I.V. set	Tubing, I.V.
Tray, irrigation (disposable)	Tubing, oxygen
Tray, service	Tubing, suction (large bubble)
Tray, suture	Urinals, male and female
Tray, suture removal	Urine, leg bath (disposable)
Tray, tracheostomy	Uro sheath catheter
Tray, urethral catheter	Urostomy bags
Tube, stomach	Vaseline gauze
Tube, urinary drainage	Walkcane
Tubes, nasogastric, NG feeding and stomach	Walkers
Tubing, cannula, nasal	Water, sterile (quart, gallon, etc.)
	Wheelchairs

Attachment C: Preadmission Screening Resident Review Process

A. The PASRR Process

Before the PASRR contractor can approve a nursing facility level of care, a Level I or, if appropriate, Level II PASRR number must be obtained for all new admissions. A PASRR number must also be obtained for residents who were admitted prior to February 1994 who have a change in financial, medical, or mental status. The PASRR number can be found on the NCMUST.com website.

B. Completing the North Carolina Level I Screening Form

The county department of social services or appropriate clinical staff from the referral source completes the North Carolina Level I Screening Form. The individual performing the evaluation must be familiar enough with the applicant or recipient to respond to clinical and/or medical status questions.

If there is clearly no evidence of SMI, MR, or RC (as defined in **Subsection 5.1.3**), complete the Level I form through Section III. If there is evidence or suspicion of one or more of these conditions, complete every section of the Level I form.

C. Submitting the North Carolina Level I Screening Form

Agencies will submit PASRR screenings and Tracking forms through the Division of Medical Assistance's (DMA) web-based tool or through a third-party vendor with interface capabilities into DMA's web-based tool. In most cases a PASRR number will be noted at the NCMUST.com site within approximately 30 minutes unless it is flagged for manual nurse review for out of state providers, out of state residents, or a Level II evaluation. The website will automatically refer the patients needing a Level II evaluation to the appropriate provider.

The receiving nursing facility submits the North Carolina Nursing Facilities Tracking Form to the PASRR contractor, who forwards the North Carolina Level I Screening Form to the nursing facility for the resident's file.

Refer to **Attachment D** for additional information on the prior approval process.

D. Completing the North Carolina Level II Screening Form

If a Level II evaluation is needed, the PASRR contractor notifies the referral source that a Level II PASRR evaluation is required and requests that medical records be available for the on-site evaluation by a qualified mental health professional.

1. A face-to-face, in-depth assessment is performed by the field assessor.
2. When the Division of Mental Health, Developmental Disabilities and Substance Abuse Services makes the final determination for placement and services, a PASRR number is assigned, if appropriate, and sent to the referral source.
3. A letter is mailed by the PASRR contractor to the resident or responsible party, informing them of the final decision and their appeal rights.

If the Level II individual is a Medicaid recipient, the referral source contacts the PASRR contractor (1-800-688-6696 or 1-919-851-8888) and proceeds with the Medicaid nursing facility prior approval process (refer to **Attachment D**).

The receiving nursing facility submits the North Carolina Nursing Facilities Tracking Form via the web portal, the web portal then triggers an action from the website to send the North Carolina PASRR determination notice to the nursing facility, via e-mail, for the resident's file.

E. The North Carolina Nursing Facilities Tracking Form

The North Carolina Nursing Facilities Tracking Form indicates to the PASRR contractor that an applicant has been admitted to a Medicaid-certified nursing facility. The nursing facility must complete and submit this form via the web portal for all new admissions in order to obtain a copy of the Level I evaluation and, if appropriate, the Level II evaluation results. These results **must be kept in the individual's medical records** so they are available to the facility's care planning team and to state or federal auditors.

F. Transfers

1. Level I: Level I information must be transferred with the resident upon transfer to another Medicaid-certified nursing facility. Unless there is a change in mental status, no further contact with the PASRR contractor is required for residents who are not subject to the PASRR Level II process.
2. Level II: Level II information must also be transferred with the resident upon transfer to another Medicaid-certified nursing facility. Receiving facilities must immediately report admission of a resident who has been evaluated by the Level II process to the PASRR contractor.

The North Carolina Nursing Facilities Tracking Form is also the mechanism used to monitor location for persons with SMI, MR, or RC. It must be submitted via the web portal for these Level II residents if any of the following occur:

1. A Level II resident transfers to another Medicaid-certified facility
2. A Level II resident expires
3. A Level II resident is discharged from the nursing facility system

Note: Discharge means either that the resident has been placed in a less restrictive setting than the nursing facility or that the resident no longer resides in a Medicaid-certified nursing facility.

For example, if a nursing facility has adult care home beds and the Level II resident transfers to the adult care home level of care, he or she is no longer subject to PASRR, and the PASRR contractor should be notified of that discharge. The adult care home level of care, even if the adult care home beds are part of a Medicaid-certified nursing facility, is not subject to PASRR requirements.

G. Time Limited Stays

The referral source completes the North Carolina Level I Screening Form and contacts the PASRR contractor for a PASRR number.

1. If a Level II evaluation is not needed, a time limit and a PASRR number is assigned by the PASRR contractor. The PASRR number will end with one of the following letters:
 - D—represents a 7-calendar-day approval
 - E—represents a 30-calendar-day approval
 - F—represents a 60-calendar-day approval

2. If the individual is a Medicaid recipient, the referral source submits the PASRR form via the web portal and then proceeds with the Medicaid nursing facility prior approval process (refer to **Attachment D**). If needed, assistance can be requested at (1-800-688-6696 or 1-919-851-8888).

The receiving nursing facility submits the North Carolina Nursing Facilities Tracking Form to the PASRR web portal.

1. If the resident is to remain beyond the authorized time frame, the receiving facility contacts the PASRR contractor prior to the end-date to update the Level I information (contact within 5 calendar days for a 7-calendar-day authorization; within 25 calendar days for a 30-calendar-day authorization; or within 50 calendar days for a 60-calendar-day authorization).
2. If approved, the PASRR contractor issues the new PASRR number.
3. If a Level II evaluation is needed, the PASRR contractor completes the Level II evaluation.
4. If approved through the Level II process, the facility contacts the PASRR contractor to update the nursing facility prior approval.

H. Significant Change (New Level I Required)

To request a significant change review, the nursing facility staff completes the North Carolina Level I Screening Form and submits it via the DMA web portal or through a third-party vendor with interface capabilities into DMA's web-based tool, to re-evaluate the resident.

The same process is followed as with the Preadmission Level I or Level II, except that a North Carolina Nursing Facilities Tracking Form is not required regarding admission.

Sample of the North Carolina Level I Screening Form

Please Print	NORTH CAROLINA LEVEL I SCREENING FORM	CONFIDENTIAL
THIS MUST REMAIN IN THE INDIVIDUAL'S RECORD		
Patient Name: _____		SS #: _____
Mailing Address: _____		Medicaid # _____ Sex _____
Referring Facility: _____		DOB: _____ Pmt. Status: _____ Marital Status: _____
Facility Address: _____		Admit Date to Nursing Facility: _____
Telephone: _____		Admitting Facility: _____
Submitted By: _____		Address: _____
Submitter's Signature & Title: _____		Contact Person: _____
		Telephone: _____
		Patient's Current Location: _____
		Address: _____
		County: _____
Does the individual desire NF services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
SECTION I: MENTAL ILLNESS SCREEN		
1.A. Psychiatric Diagnoses <u>excluding</u> Dementia, Alzheimer's, and/or Organic Brain Disorders <input type="checkbox"/> Anxiety/panic disorder <input type="checkbox"/> Psychotic disorder <input type="checkbox"/> Bipolar Disorder <input type="checkbox"/> Somatoform disorder <input type="checkbox"/> Delusional Disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Schizoaffective disorder <input type="checkbox"/> Major Depression <input type="checkbox"/> Eating disorder (specify) _____ <input type="checkbox"/> Personality disorder (specify) _____ <input type="checkbox"/> Other: _____		
1.B. Psychiatric Medication Diagnosis / Purpose _____ _____		
3.C. Significant problems adapting to typical changes within 6 months due to MI (<u>excluding</u> medical problems, Dementia Alzheimer's, and/or Organic Brain D/Os) Y N Requires mental health intervention due to increased symptoms Y N Requires judicial intervention due to symptoms Y N Symptoms have increased as a result of adaptation difficulties Y N Serious agitation and/or withdrawal due to adaptation difficulties Y N Other _____ Notes: _____		
NC Medicaid USE ONLY: Meets diagnosis criteria for diagnosis/chronicity? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD Meets criteria for stability? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD MI Decision: Meets criteria for SMI? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD		
SECTION II: MENTAL RETARDATION SCREEN		
2.A. Psychiatric treatment received in past 2 years (<u>excluding</u> treatment for Dementia, Alzheimer's and/or Organic Brain D/O's) Include dates of the hospitalization(s) <input type="checkbox"/> Inpatient psych. hosp. _____ <input type="checkbox"/> Partial hosp./day treatment _____ <input type="checkbox"/> Outpatient treatment _____		
2.B. Intervention(s) to prevent hospitalization(s). Include date(s) <input type="checkbox"/> Supportive living (due to MI) _____ <input type="checkbox"/> Housing intervention (due to MI) _____ <input type="checkbox"/> Legal intervention (due to MI) _____ <input type="checkbox"/> Other: _____		
NC Medicaid USE ONLY: Meets criteria for MR? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD Meets criteria for MR? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD MR diagnosis: _____ Mild _____ Moderate _____ Severe _____ Profound _____ 1. Diagnosed but suspected MR: _____ N _____ Y _____ N/A 2. History of receipt of MR services: _____ N _____ Y _____ 3. (specify): _____ D. Onset before age 18: _____ N _____ Y (if yes, specify age): _____ Education Level _____ History of gainful employment? _____ N _____ Y Ability to handle finances? _____ N _____ Y		
NC Medicaid USE ONLY: Meets criteria for MR? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD Meets criteria for MR? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD		
SECTION III: RELATED CONDITIONS SCREEN		
3.A. Interpersonal Functioning (<u>excluding</u> medical problems, Dementia, Alzheimer's and/or Organic Brain D/O) Indicate: "F" Frequently, "O" Occasionally, "N" Never <input type="checkbox"/> Alterations <input type="checkbox"/> Social isolation/avoidance <input type="checkbox"/> Evictions <input type="checkbox"/> Excessive irritability <input type="checkbox"/> Fear of strangers <input type="checkbox"/> Easily upset/anxious <input type="checkbox"/> Illogical comments <input type="checkbox"/> Hallucinations <input type="checkbox"/> Other _____ <input type="checkbox"/> Serious communication difficulties <input type="checkbox"/> Suicide attempt/ideations _____ Please note dates: _____		
3.B. Concentration/Task limitations within past 6 months due to MI (<u>excluding</u> medical problems, Dementia, Alzheimer's and/or Organic Brain D/O) <input type="checkbox"/> Serious difficulty completing age related tasks <input type="checkbox"/> Serious loss of interest in things <input type="checkbox"/> Serious difficulty maintaining concentration/attention <input type="checkbox"/> Numerous errors in completing tasks which she/he should be physically capable <input type="checkbox"/> Requires assistance with tasks for which she/he should be physically capable of accomplishing <input type="checkbox"/> Other _____		
1.A. Related Condition diagnosis which impairs intellectual functioning or adaptive behavior: _____ Blindness _____ Cerebral Palsy _____ Autism _____ Epilepsy _____ Deafness _____ Closed Head Injury _____ Other _____		
1.B. Substantial functional limitations 3 or more of the following secondary to Related Condition and not a medical condition: <input type="checkbox"/> Self-care <input type="checkbox"/> Mobility <input type="checkbox"/> Learning <input type="checkbox"/> Self-direction <input type="checkbox"/> Capability for independent living Understanding/use of language? _____ N _____ Y specify if yes: _____		
1.C. Was the condition manifested prior to the age 22? _____ N _____ Y		
NC Medicaid USE ONLY: Meets criteria for Related Condition? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UTD		
Comments related to applicant's MI, MR, and/or RC: _____ _____ _____		

Please Print North Carolina Level I Screening Form Confidential
Page Two

Patient Name: _____ Patient Social Security Number: _____

<p>STOP HERE IF THERE IS NO EVIDENCE OF MI, MR, and/or RC. OTHERWISE, CONTINUE.</p> <p>SECTION IV: DEMENTIA (complete for both MI & MR)</p> <p>1.A. Does the individual have a primary diagnosis of Dementia or Alzheimer's? <input type="checkbox"/> N <input type="checkbox"/> Y (specify) _____</p> <p>1.B. Does the individual have any other organic disorders? <input type="checkbox"/> N <input type="checkbox"/> Y (specify) _____</p> <p>1.C. Is there evidence of undiagnosed Dementia or other organic mental disorders? <input type="checkbox"/> Y <input type="checkbox"/> N disoriented to time <input type="checkbox"/> Y <input type="checkbox"/> N disoriented to situation <input type="checkbox"/> Y <input type="checkbox"/> N disoriented to place <input type="checkbox"/> Y <input type="checkbox"/> N paranoid ideation <input type="checkbox"/> Y <input type="checkbox"/> N severe ST memory deficit</p> <p>1.D. Is there evidence of affective symptoms which might be confused with Dementia? <input type="checkbox"/> Y <input type="checkbox"/> N frequent tearfulness <input type="checkbox"/> Y <input type="checkbox"/> N severe sleep disturbance <input type="checkbox"/> Y <input type="checkbox"/> N frequent anxiety <input type="checkbox"/> Y <input type="checkbox"/> N severe appetite disturbance</p> <p>1.E. Can the facility supply any corroborative information to affirm that the dementing condition exists and is the primary diagnosis? <input type="checkbox"/> Dementia work-up <input type="checkbox"/> Thorough mental status exam <input type="checkbox"/> Medical / functional history prior to onset of dementia <input type="checkbox"/> Other _____</p> <p>Documentation must be provided to support diagnosis of Primary Dementia</p> <p>NC Medicaid USE ONLY: Does the individual have a primary dementia diagnosis? Dementia decision: <input type="checkbox"/> Y <input type="checkbox"/> N</p>	<p>If the individual chooses admission to a NF, she/he meets the North Carolina Level of Care criteria for placement. *Further evaluation requirements are specified below:</p> <p>3.A. _____ Terminal illness with life expectancy of 6 months or less (Level II evaluation will be completed via paper based review)</p> <p>3.B. _____ Coma or persistent vegetative state (Level II evaluation will be completed via paper based review)</p> <p>NC Medicaid USE ONLY: Approval for Categorical/Exempted Admission: <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>Mailing Information - Please Print: Legal representative's name and address: Name: _____ Street Address: _____ City: _____ State & Zip Code: _____</p> <p>Primary physician name and address: Name: _____ Address: _____ State & Zip Code: _____</p>
<p>SECTION V: CATEGORICALS</p> <p>Convascent Care Exemption</p> <p>1. Does the admission meet all of the following criteria? <input type="checkbox"/> Admission to a NF directly from a hospital after receiving appropriate medical care in the hospital; and <input type="checkbox"/> Need for NF care is required for the condition for which provided in the hospital; and <input type="checkbox"/> The attending physician has certified prior to admission that the individual will require less than 30 calendar days of care.</p> <p>*Individuals meeting all criteria are exempt for Level I care for 30 calendar days. The receiving facility must update Level I care at such time that it appears the individual will exceed 30 calendar days and no later than the 25th calendar day.</p> <p>NC Medicaid USE ONLY: Meets convalescent exemption? <input type="checkbox"/> Y <input type="checkbox"/> N Expiration Date: _____</p> <p>The following decision _____ the individual does meet NF eligibility and does not require services for the time limit specified. Screen is required if the stay is expected to exceed _____ calendar days & no later than the 5th calendar day.</p> <p>2.A. _____ Emergency protective situation for MI/MR/RC individual needing 7 calendar day NF placement</p> <p>2.B. _____ Delirium precludes the ability to accurately diagnose. An updated Level I is required at such time that the delirium clears and/or no later than 5 calendar days from admission</p> <p>2.C. _____ Respite is needed for in-home caregivers to whom the MI/MR/RC individual will return within 7 calendar days</p> <p>NC Medicaid USE ONLY: Meets categorical determination? <input type="checkbox"/> Y <input type="checkbox"/> N Expiration Date: _____</p>	<p style="text-align: center;">NC MEDICAID SUMMARY - OFFICE USE ONLY</p> <p>Date and Time Received: _____</p> <p><input type="checkbox"/> Level I approved <input type="checkbox"/> Requires Level II MI evaluation <input type="checkbox"/> Requires Level II MR/RC evaluation <input type="checkbox"/> Requires paper review <input type="checkbox"/> Time limited approval Expiration Date: _____ <input type="checkbox"/> Status Change <input type="checkbox"/> Early ARR required <input type="checkbox"/> Categorical ARR</p> <p>NC Medicaid Reviewer _____ Date _____</p>

Sample of the North Carolina Nursing Facilities Tracking Form

NORTH CAROLINA NURSING FACILITIES TRACKING FORM		EDS P.O. Box 300015, Raleigh, NC 27622-0015 Phone: 1-800-688-6696 / Fax: 1-866-216-3424
<i>(Please Print)</i>		
Resident/Applicant Demographic Information		
Last name _____	First name _____	Middle Initial _____
Social Security Number _____	Date of Birth _____	PASARR Number (if applicable) _____
Immediate Response!! Complete This Section for Call Back of Existing Patient PASARR #:		
Requestors Name: _____ Requestor (to receive #): _____		
Call Back Phone #: _____ <i>(You still must complete Tracking Section below)</i>		
Section I: NEW ADMISSIONS (Transfer/Tracking) Complete for NF admissions to receive screen result (Level I, Level II via mail; Facility EDS)		
Admitting Facility: _____ Admission Date: _____		
Address: _____ Contact Person: _____		
Telephone: _____		
Section II: Purpose of Tracking Form Submission		
<input type="checkbox"/> Request for copy of Level II Screening Information (Mailed PASARR number)		
<input type="checkbox"/> Notifying EDS of a change in the patient's location or status		
Section III: TRANSFERRED, DISCHARGED OR DECEASED INDIVIDUALS Complete for individuals who have received previous Level II screens.		
A. TRANSFER (Tracking) (Patient location changes within one or higher Level of Care retains PASARR #):		
<input type="checkbox"/> Hospital/General <input type="checkbox"/> Medical Unit <input type="checkbox"/> Psychiatric Unit <input type="checkbox"/> State Hospital/Acute <input type="checkbox"/> Nursing Facility		
Admitting Facility: _____ Admission Date: _____		
Address: _____ Contact Person: _____		
Telephone: _____		
NOTE: A) "Transfer" updates the patient's location to a facility in NF Level of Care or higher. B) "Discharge" updates patient's location move to Lower LOC and results in cancellation of the PSAARR #.		
B. DISCHARGE (Tracking to Lower LOC, may result in expiration of PASARR #):		
Discharge date: // .		
Discharged to: <input type="checkbox"/> Group Home <input type="checkbox"/> Other Setting <input type="checkbox"/> Rest Home		
<input type="checkbox"/> Adult Care Home/Domiciliary Care <input type="checkbox"/> Home: _____		
C. DECEASED*: Date: _____ Facility notifying EDS: _____		
Staff submitting this info: _____ Phone: _____		
<i>*Note: Deceased Status Results in PASARR # expiration.</i>		

NC Medicaid Rev: 11/2005

Attachment D: Prior Approval Process

A. Requesting Prior Approval

Prior approval requests for nursing facility level of care (LOC) can be initiated by any of the following routes:

1. calling in the paper FL-2 by telephone and then mailing the three-part paper FL-2
2. submitting the paper FL-2 by mail only
3. submitting the FL-2e electronically through the identified Web access

Records may also be sent to justify the LOC.

The FL-2 must be current, with a physician's signature dated within 30 calendar days of receipt by Medicaid's fiscal agent.

If approval is requested by telephone, the person calling must be a nursing facility administrator, social worker, registered nurse (RN), licensed practical nurse (LPN), a case manager, or a case worker. If the nursing facility designates other staff to phone in requests, the administrator or director of nursing must submit the request in writing to Medicaid's fiscal agent with their qualifications and title indicated on the request. To preclude problems in telephone approvals, information should be read directly from the FL-2.

The attending physician must always **sign** and **date** the form **prior to** submitting the approval request.

When using the paper FL-2, the completed three-part original FL-2 **must** be forwarded and received by Medicaid's fiscal agent within 10 business days of the review decision.

Note: A Level I PASRR evaluation must be performed before anyone, regardless of pay source, can be admitted to any Medicaid-certified nursing facility.

A request for prior approval does not guarantee claims payment. Services cannot be reimbursed until the FL-2 is submitted for final review and approval.

B. Processing Steps for a Paper FL-2

The following procedure is used to process the paper FL-2 for prior approval:

1. The paper FL-2 must be accurately completed, **signed, and dated by the attending physician**, and a PASRR number must be obtained, before it can be called or mailed in for prior approval. After the FL-2 is called in, the **entire FL-2 (3 carbon copies)** must then be mailed to Medicaid's fiscal agent's Long Term Care Prior Approval Unit.
2. The fiscal agent's nurse analyst, applying the N.C. Medicaid nursing facility LOC criteria, reviews the FL-2.
3. If the documentation on the FL-2 supports the nursing facility LOC, the fiscal agent assigns a service review number (SRN), which is written on the FL-2 along with the date approved. The white copy of the FL-2 is retained by the fiscal agent, and the pink and blue copies are forwarded to the recipient's county DSS. The county DSS retains the blue copy and forwards the pink copy to the receiving facility.
4. If the nursing facility LOC is not evident upon review of the FL-2, all three copies will be returned to the sender (if the facility's full name and address is on the FL-2) or the

appropriate county DSS with a letter indicating the need for additional information. The FL-2 may be resubmitted with additional information/medical records for re-evaluation.

Note: Medicaid's fiscal agent will re-evaluate the additional information if it is received within 15 business days of the date of return.

5. If the FL-2 and medical records do not meet the nursing facility LOC criteria, they are forwarded to the fiscal agent's medical director to review. If the medical director agrees that the FL-2 and medical records do not meet the nursing facility LOC criteria, the nursing facility LOC is denied. The white copy of the FL-2 is retained by the fiscal agent and the pink and blue copies are forwarded to the recipient's county DSS along with a denial letter and an appeal form. The county DSS retains the blue copy and forwards the pink copy to the nursing facility. A denial letter and appeal form are also sent to the recipient.

C. Processing Steps for an Electronic FL-2

The following procedure is used to process the electronic FL-2 (FL-2e) for prior approval:

1. The FL-2e must be accurately completed, **signed, and dated by the attending physician**, and a PASRR number must be obtained, before submission for prior approval. The FL-2e is then submitted via the identified Web access to the fiscal agent's Long Term Care Prior Approval Unit.
2. The fiscal agent's nurse analyst, following the N.C. Medicaid nursing facility LOC criteria, reviews the FL-2e.
3. If the documentation on the FL-2e supports the nursing facility LOC, the fiscal agent assigns an SRN. The FL-2e, along with a cover sheet indicating the approval, is faxed to the initiator of the prior approval request (hospital, nursing facility, recipient's county DSS) and the county DSS office within 24 hours of receipt. The county DSS will fax the FL-2e and cover sheet to the receiving facility.
4. If the nursing facility LOC is not evident upon review of the FL-2e, the FL-2e is returned to the sender with an e-mail indicating the need for additional information. A copy of the FL-2e with medical records may be submitted to the fiscal agent by mail for re-evaluation.

Note: Medicaid's fiscal agent will re-evaluate the additional information if it is received within 15 business days of the date of return.

5. If the FL-2e and medical records do not meet the nursing facility LOC criteria, they are forwarded to the fiscal agent's medical director to review. If the medical director agrees that the FL-2e and medical records do not meet the nursing facility LOC criteria, the nursing facility LOC is denied. The FL-2e, along with a cover sheet indicating the denial and an appeal form, is sent to the recipient's county DSS the same day the decision is made. The county DSS faxes the FL-2e and cover sheet to the receiving facility. A denial letter and appeal form is also sent to the recipient.

Note: If the nursing facility level of care is denied, residents/responsible parties must be notified that they have the right to an appeal of the denial in accordance with Medicaid's recipient notices procedures. If the nursing facility LOC denial is appealed, the Office of Administrative Hearings (OAH) must receive the completed appeal form within 30 calendar days after the date of the denial letter.

D. Retroactive Prior Approval

It is the responsibility of the nursing facility to ensure that the initial request for prior approval is on file with Medicaid's fiscal agent when a recipient is admitted to their facility.

1. Requests for retroactive approval for nursing facility services may be approved when the initial authorization is requested.
2. Medicaid's fiscal agent may approve only up to 30 calendar days of retroactive coverage by telephone.
3. Retroactive coverage requests exceeding 30 calendar days, but less than 90 calendar days, must be made in writing and include all pertinent medical records for the dates of service requested.
4. Submit a completed FL-2, copies of nursing notes, physician progress notes, and any other pertinent information that justifies the nursing facility LOC.
5. The medical records submitted **must** date back to the requested date for retroactive coverage.
6. A cover letter must be attached requesting retroactive coverage indicating the "from" and "to" dates, along with a contact person's name and telephone number.
7. Medicaid's fiscal agent will review retroactive requests back to 180 calendar days only when eligibility is an issue.

E. Prior Approval for Ventilator Services

Requests for prior approval for ventilator services must include the following:

1. An FL-2 form with
 - a. PASRR number
 - b. Current physician's signature and date
 - c. Provider number of the facility that is or will be rendering ventilator services
2. Medical records
3. A ventilator addendum form signed and dated by the physician within 45 calendar days of the authorization for ventilator LOC.

The FL-2 and addendum must be forwarded to the fiscal agent's Prior Approval Unit for review based on the N.C. Medicaid LOC criteria for ventilator care.

When the recipient transfers from the hospital to a nursing facility or to a different nursing facility, the facility must notify the fiscal agent's Prior Approval Unit of the transfer. If the fiscal agent is not notified within 30 calendar days of the transfer, a new prior approval is required. If the recipient is in the hospital and placement has yet to be determined, the hospital's provider number must be entered on the authorization request.

F. Physician Signature

Prior approval request forms require a valid physician signature and date. Medicaid's fiscal agent will accept these forms with corrected dates if the physician who makes the error draws a single line through the incorrect date, writes the correct date above or next to the incorrect date, and initials the correction. Family nurse practitioners (FNPs), physicians' assistants (PAs), and surgical assistants (SAs) may sign the FL-2 **only** if the attending physician co-signs and dates the form. **The corrected signature/date is not for the purpose of updating an expired FL-2.**

Example of Altered Physician Signature Date

			<i>SJ</i>
Acceptable	<i>S. Jones MD</i>	<i>7/22/05</i>	<i>7/23/05</i>
			<i>SJ</i>
Not Acceptable	<i>S. Jones MD</i>	<i>3/28/05</i>	<i>7/28/05</i>

Sample of the FL-2 Form

FL-2 (86)		NORTH CAROLINA MEDICAID PROGRAM	
INSTRUCTIONS ON REVERSE SIDE		LONG TERM CARE SERVICES	
<input type="checkbox"/> PRIOR APPROVAL		<input type="checkbox"/> UTILIZATION REVIEW	
<input type="checkbox"/> ON-SITE REVIEW			
IDENTIFICATION			
1. PATIENT'S LAST NAME	FIRST	MIDDLE	2. BIRTHDATE (M/D/Y)
3. SEX		4. ADMISSION DATE (CURRENT LOCATION)	
5. COUNTY AND MEDICAID NUMBER		6. FACILITY	ADDRESS
			7. PROVIDER NUMBER
8. ATTENDING PHYSICIAN NAME AND ADDRESS		9. RELATIVE NAME AND ADDRESS	
10. CURRENT LEVEL OF CARE		11. RECOMMENDED LEVEL OF CARE	
<input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF <input type="checkbox"/> (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER <input type="checkbox"/> HOSPITAL		<input type="checkbox"/> HOME <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> SNF <input type="checkbox"/> (REST HOME) <input type="checkbox"/> ICF <input type="checkbox"/> OTHER	
		12. PRIOR APPROVAL NUMBER	
		13. DATE APPROVED/DENIED	
14. DISCHARGE PLAN			
<input type="checkbox"/> SNF <input type="checkbox"/> HOME <input type="checkbox"/> ICF <input type="checkbox"/> DOMICILIARY (REST HOME) <input type="checkbox"/> OTHER			
15. ADMITTING DIAGNOSES, PRIMARY, SECONDARY, DATES OF ONSET			
1.			5.
2.			6.
3.			7.
4.			8.
16. PATIENT INFORMATION			
DISORIENTED		AMBULATORY STATUS	
<input type="checkbox"/> CONSTANTLY <input type="checkbox"/> INTERMITTENTLY		<input type="checkbox"/> AMBULATORY <input type="checkbox"/> SEMI-AMBULATORY <input type="checkbox"/> NON-AMBULATORY	
INAPPROPRIATE BEHAVIOR		FUNCTIONAL LIMITATIONS	
<input type="checkbox"/> WANDERER <input type="checkbox"/> VERBALLY ABUSIVE <input type="checkbox"/> INJURIOUS TO SELF <input type="checkbox"/> INJURIOUS TO OTHERS <input type="checkbox"/> INJURIOUS TO PROPERTY <input type="checkbox"/> OTHER:		<input type="checkbox"/> SIGHT <input type="checkbox"/> HEARING <input type="checkbox"/> SPEECH <input type="checkbox"/> CONTRACTURES <input type="checkbox"/> ACTIVITIES SOCIAL	
PERSONAL CARE ASSISTANCE		BLADDER	
<input type="checkbox"/> BATHING <input type="checkbox"/> FEEDING <input type="checkbox"/> DRESSING <input type="checkbox"/> TOTAL CARE		<input type="checkbox"/> CONTINENT <input type="checkbox"/> INCONTINENT <input type="checkbox"/> INDWELLING CATHETER <input type="checkbox"/> EXTERNAL CATHETER	
PHYSICIAN VISITS		COMMUNICATION NEEDS	
<input type="checkbox"/> 30 DAYS <input type="checkbox"/> 60 DAYS <input type="checkbox"/> OVER 180 DAYS		<input type="checkbox"/> VERBALLY <input type="checkbox"/> WRITTEN <input type="checkbox"/> BOTH	
NEUROLOGICAL		RESPIRATION	
<input type="checkbox"/> CONVULSIONS <input type="checkbox"/> GRAND MAL <input type="checkbox"/> PETIT MAL		<input type="checkbox"/> NORMAL <input type="checkbox"/> TRACHEOSTOMY <input type="checkbox"/> OTHER:	
17. SPECIAL CARE FACTORS		NUTRITION STATUS	
<input type="checkbox"/> BLOOD PRESSURE <input type="checkbox"/> DIABETIC URINE TESTING <input type="checkbox"/> PT (BY LICENSED PT) <input type="checkbox"/> RANGE OF MOTION EXERCISE		<input type="checkbox"/> DIET <input type="checkbox"/> SUPPLEMENTAL <input type="checkbox"/> SPOON <input type="checkbox"/> PARENTERAL <input type="checkbox"/> NASOGASTRIC <input type="checkbox"/> GASTROSTOMY <input type="checkbox"/> INTAKE AND OUTPUT <input type="checkbox"/> FORCE FLUIDS <input type="checkbox"/> WEIGHT <input type="checkbox"/> HEIGHT	
		DRESSINGS:	
		FREQUENCY	
18. MEDICATIONS NAME & STRENGTHS, DOSAGE & ROUTE			
1.			7.
2.			8.
3.			9.
4.			10.
5.			11.
6.			12.
19. X-RAY AND LABORATORY FINDINGS / DATE:			
20. ADDITIONAL INFORMATION:			
21. PHYSICIAN'S SIGNATURE			22. DATE

Attachment E: Sample Notice of Transfer/Discharge

NURSING HOME NOTICE OF TRANSFER/DISCHARGE

- 1) DATE OF NOTICE: _____
- 2) RESIDENT: _____
FACILITY: _____
ADDRESS: _____
ADMINISTRATOR: _____ PHONE: _____

- 3) DATE OF TRANSFER/DISCHARGE: _____

Under federal law (42 U.S.C 1396r(c)(2)(A); 42 CFR 483.12), you may only be transferred or discharged from this nursing facility for one of the following reasons:

- It is necessary for your welfare and your needs cannot be met in this facility;
- Your health has improved sufficiently so that you no longer need the services provided by this facility;
- The safety of individuals in this facility is endangered;
- The health of individuals in this facility would otherwise be endangered;
- You have failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility; or
- The facility ceases to operate.

- 4) THE REASON FOR THIS NOTICE OF YOUR TRANSFER/DISCHARGE IS: _____

- 5) In addition to notifying you (i.e. the resident) of this transfer/discharge, _____ has also been notified.
(family member/legal representative)

- 6) Check **ONE** and **INDICATE LOCATION** below:
{ } THIS FACILITY PLANS TO **TRANSFER** YOU TO:
{ } THIS FACILITY PLANS TO **DISCHARGE** YOU TO:

NAME OF FACILITY/LOCATION: _____
ADDRESS: _____ PHONE: _____

You have the **RIGHT TO APPEAL** this transfer/discharge to the DHHS Hearing Office **WITHIN 11 DAYS** of the date of this notice if you want to continue to stay at this facility. The appeal will be at no cost to you or your representative. The request for an appeal (see attached form) must be received by the hearing officer no later than the 11th day or your right to appeal is waived. If you wish to review your medical record, we must allow you to see it no later than five working days prior to the hearing.

You may wish to contact your regional **LONG TERM CARE OMBUDSMAN** for help in mediation with the facility or for assistance in obtaining free legal services, if qualified. The ombudsman's name, address and phone number is:

- 7) NAME: _____
ADDRESS: _____ PHONE: _____

If mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact:
DISABILITY RIGHTS NORTH CAROLINA, 2626 Glenwood Avenue, Suite 550, Raleigh, NC 27608.
Telephone number: (919) 856-2195 or 1-800-821-6922 or TTY 1-877-235-4210

- 8) _____
Signature of Administrator Date

DMA-9050 (11/07)

Instructions For Completing The Transfer/Discharge Notice

- 1) Enter the date the notice is served upon the resident and representative.
- 2) Resident: Enter the resident's complete name.
Facility: Enter the name of your facility.
Address: Enter your facility's complete mailing address.
Administrator: Enter the name of your facility's administrator.
Phone: Enter your facility's area code and telephone number.
- 3) Enter the date on which you intend to transfer or discharge the resident.
- 4) Enter the reason your facility is transferring or discharging this resident. If necessary to provide a full explanation, additional information may be attached.
- 5) Enter the name of the family member or legal representative upon whom this notice has been served. If the facility has been made unable to ascertain the name of a family member or legal representative, indicate "unknown" in the space provided.
- 6) Enter a mark {X} in the appropriate space for either Transfer or Discharge, **AND** enter the name of the facility or other location to which the resident is being transferred or discharged. Enter the address and telephone number of the intended location.
- 7) Enter the name, address and telephone number of the appropriate Long Term Care Ombudsman for your region.
- 8) Administrator signs and dates the form as your facility's representative.

Attachment F: Sample Hearing Request Form

**NURSING HOME
HEARING REQUEST FORM**

TO BE COMPLETED BY NURSING FACILITY

Resident _____

Facility _____

Date of Transfer/Discharge Notice: _____

Date of Scheduled Transfer/Discharge: _____

Dear Hearing Officer:

I would like to request a hearing to appeal the above resident's notice of transfer/discharge. I would like for the hearing to be held (please check one):

By telephone

In person in Raleigh, NC

Name of Person Requesting Hearing: _____

Address: _____

Telephone Number: _____ Date: _____

Signature: _____

(The signature of resident or family member or legal representative authorizes release of medical records)

If you have questions, you may contact the DHHS Hearing Office by calling (919) 647-8200 or by calling the CARELINE (Monday-Friday, 8:00 AM – 5:00 PM) at 1-800-662-7030 and asking for the Hearing Office.

PLEASE COMPLETE THE ABOVE INFORMATION AND ATTACH A COPY OF THE NOTICE OF TRANSFER OR DISCHARGE THAT WAS ISSUED TO YOU BY THE NURSING FACILITY. YOUR REQUEST MUST BE RECEIVED NO LATER THAN ELEVEN DAYS FROM THE DATE OF THE NOTICE OF TRANSFER/DISCHARGE. YOUR REQUEST FORM MAY BE SUBMITTED BY MAIL OR FACSIMILE TO:

DHHS Hearing Office
2501 Mail Service Center
Raleigh NC 27699-2501
Fax (919) 715-6394

DMA-9051 (11/07)

Attachment G: Medicaid Minimum Data Set Validation Program

A. Background

On October 1, 2004, DMA began the Medicaid MDS Validation Program as a component of the Medicaid Case Mix Reimbursement System. All facilities participating in the Medicaid Case Mix Reimbursement System are required to participate in the MDS Validation Program. The overall goal of the Case Mix Reimbursement System is to align payments to the facility based on the resources utilized by the residents in the facility. Accurate completion of the MDS assessment is a very important function of the nursing facility staff and ensures that the nursing facility receives correct payments from N.C. Medicaid.

The MDS Validation Program provides DMA and the nursing facility with assurance that Medicaid payments are accurately based on the recorded medical and functional needs of the nursing facility resident as documented in the medical record. The MDS Validation Program replaces the FL-2 utilization review program performed by the facility staff and contract physicians. The Utilization Review Program was discontinued as of September 30, 2003.

The MDS contractor provides registered nurse reviewers certified in the MDS to conduct annual onsite MDS reviews at each nursing facility in North Carolina.

B. Resource Utilization Group Reimbursement System

N.C. Medicaid uses the 34 Grouper Resource Utilization Group (RUG) system to assign the facility Case Mix Index (CMI) rate. The residents in the facility are classified into one of 34 groups based on the quantities of resources utilized. Resources are defined as nursing time, therapy time, and nursing assistant time. The RUG classification is based on information from the MDS.

C. Case Mix

Case Mix refers to the combination of different resident profiles seen in a nursing facility.

D. Case Mix Index

The CMI is the weighted numeric score assigned to each RUG group. The weight is assigned based on the resources used to provide care to the resident. The higher the CMI, the greater the resource needs of the resident.

E. Resident Roster

The Resident Roster is a list of all non-discharged residents as of the snapshot date that includes information on the RUG group transmitted to the state. It also provides the number of residents in each RUG category.

F. Case Mix Supportive Documentation Guidelines

The Case Mix Supportive Documentation Guidelines approved by DMA identify the documentation that is necessary to support the resident's assessment.

G. Protocols

1. The resident roster is produced on the CMI Report every quarter on the snapshot date and sent to the facility. The snapshot dates are March 31, June 30, September 30, and December 31. The review sample is drawn from the CMI report two quarters prior to

the date of the review. For a facility review occurring in October, the review sample is drawn from the CMI report dated June 30. For a facility review occurring in February, the review sample is drawn from the CMI report dated September 30.

2. The sample is drawn from all residents listed on the final CMI report to include a minimum of 90% Medicaid residents and 10% other.
3. An expanded review is done when the primary assessment sample results are greater than the state threshold for unsupported assessments. The expanded review includes an additional 10% of the residents on the final CMI report or an additional 10 assessments, whichever is greater.
4. If the findings of the MDS Validation Review result in recalculating the RUG scores, a change in the CMI rate for the nursing facility may occur. If the CMI differs from the value transmitted for N.C. Medicaid payment, a retrospective rate adjustment may be applied.

H. MDS Review Process

1. Nursing facilities are notified by the nurse reviewer by phone and by fax three business days prior to the scheduled review.
2. An entrance conference is held with the nursing facility administrator, the MDS coordinator, and any other facility personnel the administrator selects to present the MDS review process.
3. The nurse reviewer provides a list of the resident records selected for review. Facility personnel pull the records immediately. If possible, the primary sample contains at least one assessment from each of the seven RUG classification groups.
4. The review begins immediately after the entrance conference. The reviewers use the most current version of the Case Mix Supportive Documentation Guidelines to support the transmitted MDS values.
5. The reviewer verifies the supportive documentation to determine if the RUG category assigned on the Final Case Mix Report is supported with documentation.
6. Documentation for the Activities of Daily Living (ADLs) must reflect 24 hours of the observation periods to verify the submitted values on the MDS.
7. After the review of the supportive documentation, the nurse reviewers hold an exit interview with the facility staff to go over preliminary results. Any unresolved issues or trends are identified and discussed.
8. No supporting documentation is accepted after the close of the exit conference.
9. A case mix review summary letter is mailed to the provider indicating any changes to the RUG category and CMI that were made as a result of the review. If the facility disagrees with the findings of the review, a reconsideration of the review findings may be requested to DMA.
10. DMA reserves the right to conduct follow-up reviews as needed. A follow-up review occurs no earlier than 120 calendar days following the exit interview.

I. Delinquent Minimum Data Set Assessments

Any assessment with an assessment reference date (ARD A2300) greater than 121 calendar days from the previous ARD (A2300) is deemed delinquent and assigned a RUG code of BC1 with the lowest case mix index.

J. Unsupported Minimum Data Set Assessments

The MDS is unsupported when the RN reviewer does not find adequate documentation in the resident's record as defined by the guidelines issued by DMA to support the RUG classification level. An unsupported MDS assessment may result in a different RUG classification from the one submitted by the facility. The CMI will also change.

K. Effect of Unsupported Thresholds

1. First year of program – October 1, 2004, through September 30, 2005 – No penalties for unsupported MDS items.
2. Second year of program – October 1, 2005, through September 30, 2006 – 40% unsupported MDS values will result in a recalculated RUG category for all unsupported MDS assessments and a recalculation of the direct rate. There may also be a retrospective rate adjustment.
3. Third year of program – October 1, 2006, through September 30, 2007 – 35% unsupported MDS values will result in a recalculated RUG category for all MDS assessments and a recalculation of the direct rate. A retrospective rate adjustment may also be applied.
4. Fourth year of program – October 1, 2007, through September 30, 2008 – 25% unsupported MDS values will result in the recalculation as indicated above.

Since September 30, 2008 facilities are required to maintain no more than 25% unsupported MDS values. Failure to do so will result in a recalculated RUG category for all MDS assessments and a recalculation of the direct rate. A retrospective rate adjustment may also be applied.

L. Minimum Data Set Validation Review Reconsideration

If the facility disagrees with the onsite Medicaid MDS Validation review findings, the facility may request an informal reconsideration. The procedure is as follows:

1. A summary letter of the review findings is sent to the facility within 10 business days of the exit conference date.
2. If the facility disagrees with the findings, a written request for an informal reconsideration is sent to DMA within 15 business days of the receipt of the MDS validation findings letter. The request is sent to the DMA Facility Services Unit Manager, 2501 Mail Service Center, Raleigh, N.C. 27699-2501. The letter to DMA must describe in detail the reason a reconsideration has been requested.
3. DMA reviews the findings in question and renders a decision. This decision is sent in writing from DMA to the facility within 20 business days of the request for reconsideration.
4. If the facility disagrees with this decision, the facility should notify the DMA Facility Services Unit Manager within 10 calendar days of receipt of the decision. The information will be reviewed again by a neutral DMA staff member. A final decision is rendered in writing to the facility within 30 calendar days.

Attachment H: Nursing Facility Quality Initiatives

N.C. Medicaid Case Mix reimbursement to nursing facilities began in October 2003. As a condition of receiving case mix reimbursement, nursing facilities are required to participate in quality improvement initiatives.

1. A quality improvement initiative is a facility-wide program that has an impact on the quality of care or the quality of life for the residents.
2. The impact of the facility's chosen initiative should be supported by research or statistical data.
3. A quality improvement initiative could potentially span years. The initiative should be evaluated and updated by the facility at least annually and whenever necessary.
4. Examples of quality initiatives that a facility might adopt include programs aimed at direct care worker retention and stability, incentive programs aimed at direct care worker retention, long-term-care staff mentoring, educational programs for staff, enhanced services for residents, adoption of Best Practices Guidelines, care issues, or pieces of the facility's existing quality assurance program.
5. The facility must provide evidence that a program is in place. Evidence may include written documentation, facility staff interviews (written, phone, or face-to-face), or an on-site review of the program.
6. DMA may review the facility's quality initiative(s) every 12 to 15 months.