NURSING FACILITIES

ND Medicaid covers services provided by nursing facilities (NF) that are certified to participate in the Medicare program, licensed, and enrolled with North Dakota (ND) Medicaid.

LEVEL OF CARE

ND Medicaid will not cover nursing facility services unless the member meets nursing facility level of care criteria.
Nursing facility level of care means services provided by a facility that meets:

- the standards for nursing facility licensing established by the Division of Public Health, and
- all requirements for nursing facilities per federal law and regulations governing the Medicaid program and Children's Health Insurance Program (CHIP).
- *See* N.D. Admin. Code § 75-02-02-09.

A. Nursing Facility level of care criteria (meeting one satisfies medically necessary standard)
   - The individual's nursing facility stay is, or is anticipated to be, temporary for receipt of Medicare part A benefits. A nursing facility stay may be based on this criterion for no more than fourteen days after termination of Medicare part A benefits.
   - The individual is in a comatose state.
   - The individual requires the use of a ventilator at least six hours per day, seven days a week.
   - The individual has respiratory problems that require regular treatment, observation, or monitoring that may only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse, and is incapable of self-care.
   - The individual requires constant help sixty percent or more of the time with at least two of the activities of daily living of toileting, eating, transferring, and locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.
   - The individual requires aspiration for maintenance of a clear airway.
   - The individual has dementia, physician-diagnosed or supported with corroborative evidence, for at least six months, and as a direct result of that dementia, the individual's condition has deteriorated to the point when a structured, professionally staffed environment is needed to monitor, evaluate, and accommodate the individual's changing needs.

B. If none of the criteria from section A are met, an individual who applies for care in a nursing facility or who resides in a nursing facility may demonstrate that a nursing facility level of care is medically necessary if any 2 of the criteria below are met:
   - The individual requires administration of prescribed:
     1. Injectable medication;
     2. Intravenous medication or solutions on a daily basis; or
     3. Routine oral medications, eye drops, or ointments on a daily basis.
   - The individual has one or more unstable medical conditions requiring specific and individual services on a regular and continuing basis that can only be provided by or under the direction of a registered nurse or, in the case of a facility which has secured a waiver of the requirements of 42 CFR 483.30(b), a licensed practical nurse.
   - The individual is determined to have restorative potential and can benefit from restorative nursing or therapy treatments, such as gait training or bowel and bladder training, which are provided at least five days per week.
   - The individual requires administration of feedings by nasogastric tube, gastrostomy, jejunostomy, or parenteral route.
   - The individual requires care of decubitus ulcers, stasis ulcers, or other widespread skin disorders.
   - The individual requires constant help sixty percent or more of the time with any one of the activities of daily living of toileting, eating, transferring, or locomotion. For purposes of this subdivision, constant help is required if the individual requires a caregiver's continual presence or help without which the activity would not be completed.

C. If nursing level of care criteria at above Sections A or B is not satisfied, an individual who applies to or resides in a nursing facility designated as a facility for nongeriatric individuals with physical disabilities may show that a nursing facility level of care is medically necessary if the individual is determined to have restorative potential.

D. If nursing level of care criteria at above Sections A, B, or C is not satisfied, an individual who applies for care in a nursing facility may demonstrate a nursing level of care is medically necessary if:
   - The individual has an acquired brain injury, including anoxia, cerebral vascular accident, brain tumor, infection, or traumatic brain injury; and
   - As a result of the brain injury, the individual requires direct supervision at least four hours a day, five days a week.

LIMITS ON LEAVE DAYS

The hospital leave policy ensures that a bed is available when a resident returns to the nursing facility. ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. A nursing facility may not bill for hospital leave days if it is known that the resident will not return to the facility.

Once the nursing facility accepts payment for hospital leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for hospital leave days

beyond the 15th day that the resident's bed was held. Any days exceeding the 15-day limit are noncovered days.

ND Medicaid will cover a maximum of 24 therapeutic leave days per resident per rate year. The rate year begins January 1st for in-state long term care (LTC) nursing facilities.

Once the nursing facility accepts payment for therapeutic leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for therapeutic leave days beyond the 24th day that the resident's bed was held. Any days exceeding the 24-day limit are noncovered days.

Hospital and therapeutic leave days, occurring immediately following a period when a resident received Medicare Part A benefits in the facility, are noncovered days.

The day of death is paid for in all instances except when a resident is in a Medicare benefit period, in which case the day of death is a noncovered day. The day of a resident’s discharge to any location is a noncovered day.

BILLING GUIDELINES

A resident on hospital or therapeutic leave on the last day of the month whose bed is being held by the facility is “Still a Patient”.

The number of billed units must include the date of discharge or death.

A separate claim line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed.

Claims must be submitted using the following Revenue Codes when billing for:

Revenue Code **0110**	In-House Medicaid Days (private)
Revenue Code **0120**	In-House Medicaid Days (semiprivate)
Revenue Code **0160**	Medicare Full Benefit Period Days
Revenue Code **0169**	Medicare Coinsurance Days
Revenue Code **0182**	Medicare Noncovered Leave Days
Revenue Code **0183**	Therapeutic Leave Days
Revenue Code **0185**	Hospital Leave Days

A facility must submit a claim for every month a member is in the facility, even if insurance has paid for the services. This allows the system to apply recipient liability

towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make payment for nursing facility services to the nursing facility provider if a resident has elected hospice care. The hospice is paid the rate applicable to the resident and is responsible for paying the nursing facility for services provided to the resident. Recipient liability, if any, is applied to the hospice provider's claim. Once a resident has elected hospice benefits, the LTC nursing facility provider may not submit a claim for services provided while the resident is on hospice.

A hospice provider must submit a revocation of election form to ND Medicaid before payment can be made to a nursing facility for a resident who no longer is receiving hospice benefits. The facility should contact the hospice provider to ensure that a revocation notice has been filed with ND Medicaid prior to billing for nursing facility services.

IN-STATE NURSING FACILITIES

The rate established for in-state nursing facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the in-state nursing facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

OUT OF STATE NURSING FACILITIES

The rate for out of state nursing facilities is based on the rate established by the Medicaid agency in the state where the facility is located. Included routine services are determined by the rate established by that state's Medicaid agency, such as; supplies, therapies, nursing facility supplies, equipment, nonemergency transportation, and non-legend drugs. Ancillary charges not included in the out of state nursing facility rate must be billed by the provider furnishing the service.