26

26 Nursing Facility

Medicaid reimburses medically necessary nursing facility services. Nursing facilities must meet the licensure requirements of the Alabama Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act, and must comply with all applicable state and federal laws and regulations.

A nursing facility is an institution that primarily provides one of the following:

- Nursing care and related services for residents who require medical or nursing care
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons
- Health care and services to individuals who require a level of care available only through institutional facilities

A facility may not include any institution for the care and treatment of mental disease except for services furnished to individuals age 65 and over or any institutions for the mentally retarded or persons with related conditions.

The policy provisions for nursing facility providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 10, and Part 483 of the Code of Federal Regulations.

26.1 Enrollment

HP enrolls nursing facility providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as a nursing facility provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for nursing facility-related claims.

NOTE:

The 10-digit NPI is required when filing a claim.

Nursing facility providers are assigned a provider type of 03 (Nursing Facility). The valid specialty for nursing facility providers is Nursing Facility (035).

Enrollment Policy for Nursing Facility Providers

To participate in the Alabama Medicaid Program, nursing facility providers must meet the following requirements:

- Possess certification for Medicare Title XVIII
- Submit a budget to the Provider Reimbursement Section at Medicaid for the purpose of establishing a per diem rate
- Execute a Provider Agreement and a Nursing Facility/Resident Agreement with Medicaid

The Provider Agreement details the requirements imposed on each party to the agreement. It is also the document that requires the execution of the Nursing Facility/Resident Agreement.

The Nursing Facility/Resident Agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. One copy of the agreement is given to the resident/personal representative and a copy is retained by the nursing facility. The completed Nursing Facility/Resident Agreement becomes an audit item by Medicaid.

HP is responsible for enrolling all nursing facility providers including any Medicare certified nursing facilities who wish to enroll as a QMB Medicare only provider.

Renewal Process for Nursing Facilities

The Alabama Department of Public Health conducts annual recertification of all nursing facility providers and provides the recertification information to Medicaid.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Change of Ownership (CHOW) and Closures

Added: **Change of Ownership (CHOW) and Closures** section

Medicaid will mirror Medicare's Change of Ownership (CHOW) policy
Refer to Chapter 19, Hospital for additional information on Change of Ownership

26.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Providers should refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973, and the Disabilities Act of 1990.

Nursing facilities must maintain identical policies and practices regarding transfer, discharge, and covered services for all residents regardless of source of payment.

Nursing facilities must have all beds in operation certified for Medicaid participation.

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

Nursing facilities may require an individual who has legal access to a resident's income or available resources to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

Covered Services

The following services are included in basic covered nursing facility charges:

- All nursing services to meet the total needs of the resident, including treatment and administration of medications ordered by the physician
- Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.
- Room (semiprivate or ward accommodations) and board, including special diets and tube feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.
- All services and supplies for incontinent residents, including diapers and linen savers
- Bed and bath linens
- Nursing and treatment supplies as ordered by the resident’s physician as required, including needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W)

- Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents
- Materials for prevention and treatment of bed sores
- Medically necessary over-the-counter (non-legend) drug products when ordered by a physician. Generic brands are required unless brand name is specified in writing by the physician
- OTC drugs are covered under the nursing facility per diem rate with the exception of insulin covered under the Pharmacy program

Non-covered Services

Special (non-covered) services, drugs, or supplies not ordinarily included in basic nursing facility charges may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility

- Prosthetic devices, splints, crutches, and traction apparatus for individual residents

If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

- Telephone;
- Television/radio for personal use;
- Personal comfort items, including smoking materials, notions and novelties, and confections;
- Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- Personal clothing;
- Personal reading matter;
- Gifts purchased on behalf of a resident;
- Flowers and plants;
- Social events and entertainment offered outside the scope of the required activities program;
- Noncovered special care services such as privately hired nurses or aides;
- Private room, except when therapeutically required (for example: isolation for infection control);
- Specially prepared or alternative foods request instead of the food generally prepared by the facility;
- Beauty and barber services provided by professional barbers and beauticians;
- Services of licensed professional physical therapist;
- Routine dental services and supplies;
- Tanks of oxygen.

Medicaid provides other services under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Payment for Reservation of Beds

Neither Medicaid residents, nor their families, nor their personal representative, may be charged for reservation of a bed for the first four days of any period during which a Medicaid resident is temporarily absent due to admission to a hospital. Prior to discharge of the resident to the hospital, the resident, the family of the resident, or the personal representative of the resident is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the resident beyond the covered four-day hospital reservation period. The covered four-day hospital stay reservation policy does not apply to:

- Medicaid-eligible residents who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
- Any non-Medicaid residents;
- A resident who has applied for Medicaid but has not yet been approved; provided that if such a resident is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the resident, family of the resident, or personal representative of the resident for the period that would have been within the four covered days policy; or
- Medicaid residents who have received a notice of discharge for non-payment of service.

NOTE:

HOLDING OF MEDICATIONS FOR LTC RESIDENTS

When a resident leaves a LTC facility and is expected to return, the facility shall hold all medications until the return of the resident. All continued or re-ordered medications will be placed in active medication cycles upon the return of the resident. If the resident does not return to the facility within 30 days, any medications held by the facility shall be placed with other medications for destruction or distribution as permitted by the State Board of Pharmacy regulations. If at the time of discharge it is known that the resident will not return, medications may be destroyed or donated as allowed by State law.

If the medications are not held on accordance with this policy, the facility will be responsible for all costs associated with replacement of the medication.

Therapeutic Visits

Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter. A therapeutic leave visit may not exceed three days per visit. A resident may have a therapeutic visit that is one, two, or three days in duration as long as the visit does not exceed three days per visit or six days per quarter. Visits may not be combined to exceed the three-day limit.

The nursing facility must ensure that each therapeutically indicated visit by a resident to home, relatives, or friends is authorized and certified by a physician.

Payments to ICF/MR facilities for therapeutic visits are limited to 14 days per calendar month.

Medicaid is not responsible for the record-keeping process involving therapeutic leave for the nursing facility. Medicaid will track the use of therapeutic leave through the claims processing system.

The nursing facility must provide written notice to the resident and a family member or legal representative of the resident, specifying the Medicaid policy when a resident takes therapeutic leave and when a resident transfers to a hospital.

The nursing facility or ICF/MR must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave policy is readmitted to the facility. Residents are readmitted immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

Residents with Medicare Part A

Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. Medicaid will make no payment for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

Nursing facilities must ensure that Medicaid recipients eligible for Medicare Part A benefits first use Medicare benefits before accepting a Medicare/Medicaid recipient as a Medicaid resident.

Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Application of Medicare Coverage

Nursing facility residents, either through age or disability may be eligible for Medicare coverage up to 100 days.

Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.

Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

Periods of Entitlement

The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

Individuals with income in excess of the Federal Benefit Rate (FBR) can become eligible for Medicaid after they have been in an approved medical institution for 30 continuous days. After completing 30 continuous days the individual is entitled to retroactive coverage to the first day of the month of entry provided the recipient meets all other points of eligibility.

Individuals entering the nursing facility who are Medicaid eligible through SSI will be eligible for the month in which they enter the nursing facility. Eligibility after the first month must be established through the Medicaid District Office

unless the individual's income is less than $50. An individual with income less than $50 must be certified for SSI by the Social Security Administration.

An applicant must be medically approved by Medicaid or Medicare prior to financial approval.

Financial eligibility will be established in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 25.

Retroactive Medicaid coverage is an exception to the above. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.

For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the Long Term Care Division or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

Nursing Aide Training

A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility for more than four months unless the individual has completed training and a competency evaluation program approved by the state.

The Alabama Department of Public Health is responsible for the certification of the Competency Evaluation programs and maintains a nurse aide registry.

Pre-admission Screening and Resident Review

Prior to admission, all individuals seeking admission into a nursing facility must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition (RC) to determine if the individual's care and treatment needs can most appropriately be met in the nursing facility or in some other setting.

A Level I Screening document (LTC-14) must be completed in its entirety and submitted to the OBRA PASRR Office for a Level I Determination prior to admission. The Level I Screening can be completed by anyone who has access to the medical records excluding family members.

The nursing facility is responsible for ensuring that the applicant is not admitted into the nursing facility without a Level I Screening, Level I Determination and Level II Determination, if applicable, from the Department of Mental Health. The nursing facility is responsible for ensuring that the Level I Determination is signed and dated by the RN indicating that the Level I Screening is accurate based on the available medical records.

The Department of Mental Health is responsible for conducting a Level II Evaluation on all applicants and residents with a suspected diagnosis of MI/ID/RC to determine the individual's need for mental health specialized services and medical eligibility. For all residents with a primary or secondary diagnosis of MI/ID, the Department of Mental Health will make the determination of appropriate placement in a nursing facility, based on the results of the Level II Screening and the application of Medicaid medical criteria.

If the nursing facility fails to obtain the Level I Screening, Level I Determination and Level II Determination, if applicable, made by the Department of Mental Health prior to admitting the resident into their facility, the Alabama Medicaid Agency will recoup all Medicaid payments for nursing facility services from the date of the resident's admission and continuing until the Level I Determination or Level II Determination, if applicable is received.

If a resident is discharged into the community for more than 30 days, a new Level I Screening, Level I Determination, and Level II Determination, if applicable, is required before admission.

If the nursing facility's interdisciplinary team identifies a significant change in the condition of a resident with a diagnosis of MI/ID/RC, an updated Level I Screening must be completed and submitted to the Department of Mental Health's PASRR Office within 14 days of the resident's status change to receive an updated Level II Determination to establish continued eligibility. If the nursing facility fails to update the Level I Screening for a significant change in a resident's condition, the Alabama Medicaid Agency may recoup all Medicaid payments for nursing facility services from 14 days of the resident's change in condition and continuing until the updated Level II Determination is received.

Admission Criteria

The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person receives covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for nursing facility care under the following circumstances:

- The physician must certify the need for admission and continuing stay.
- The recipient requires nursing care on a daily basis.
- The recipient requires nursing services that as a practical matter can only be provided in a nursing facility on an inpatient basis.
- Nursing services must be furnished by or under the supervision of a RN and under the general direction of a physician.

A nursing care resident must require **two or more** of the following specific services:

a. Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
b. Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis
c. Nasopharyngeal aspiration required for the maintenance of a clear airway
d. Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created
e. Administration of tube feedings by naso-gastric tube
f. Care of extensive decubitus ulcers or other widespread skin disorders
g. Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse
h. Use of oxygen on a regular or continuing basis
i. Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in non-infected, post-operative, or chronic conditions
j. Comatose resident receiving routine medical treatment
k. Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer - The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

8. Behavior - The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

NOTE:

Admission to a certified nursing facility still requires that the patient meet two or more criteria listed on Form 161 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All applications for admission to a nursing facility must include supporting documentation.

Four exceptions are noted:

- Criterion (a) and criterion (k)-7 are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k)-7 may not be used as the second qualifying criterion.
- Criterion (g) and Criterion (k)-9 are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), Criterion (k)-9 may not be used as the second qualifying criterion.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy, ileostomy or urostomy.

NOTE:

The above criteria will be applied to all initials admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing facility and residents who are re-admitted in less than 30 days after discharge into the community. These residents need to meet only one criteria (a-k) in paragraph two, of the above.

Individuals admitted to a nursing facility as a private pay resident in spend down status with no break in institutional care for more than 30 days and becomes financially eligible for Medicaid, must meet only one of the criteria to transfer from private pay to a Medicaid admission.

Admission to a Nursing Facility from an Inpatient Psychiatric Hospital

A resident may temporarily transfer from an inpatient psychiatric hospital to a nursing facility for a two week trial period. If the resident leaves the nursing facility before the two week period has elapsed, the inpatient psychiatric hospital is responsible for reimbursing the nursing facility. If the resident has a successful trial period with the expectation of remaining in the facility long term, then the inpatient psychiatric facility will discharge the resident so that the nursing facility can admit him/her. The nursing facility must ensure that the resident meets the nursing facility admission criteria. Additionally, the nursing facility must ensure that all required documents, Pre-Admission Screening and Resident Review and the Minimum Data Set are completed for these residents. The nursing facility will be reimbursed by Medicaid if financial eligibility and medical criteria are met.

Medical Director

The nursing facility shall retain a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

- If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.
- A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, or a hospital medical staff, or through another similar arrangement.

The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents.

The medical director is responsible for the development of written by laws, rules, and regulations that are approved by the governing body and include delineation of the responsibilities of attending physicians.

The medical director coordinates medical care by meeting with attending physicians to ensure that they write orders promptly upon admission of a resident, and periodically evaluating the professional and supportive staff and services.

The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The medical director gives the administrator appropriate information to help ensure a safe and sanitary environment for residents and personnel.

The medical director is responsible for the execution of resident care policies.

Conditions Under Which Nursing Facility Is Classified as Mental Disease Facility

If the facility under examination meets one of the following criteria, Medicaid considers the facility to be maintained primarily for the care and treatment of individuals with mental disease:

- It is licensed as a mental institution.
- More than fifty percent (50%) of the residents receive care because of disability in functioning resulting from a mental disease.

Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and *Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases*, adopted for use in the United States, (ICD-10) or its successor, except mental retardation.

Conditions Under Which Nursing Facility Is Not Classified as Mental Disease Facility

Nursing facilities located on grounds of state mental hospitals or in the community must meet specific conditions in order to qualify for federal matching funds for care provided to all individuals eligible under the state plan.

Medicaid is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet any of the following criteria:

- The facility is established under state law as a separate institution organized to provide general medical care, and provides such care.
- The facility is licensed separately under state law governing licensing of medical institutions other than mental institutions.
- The facility is operated under standards that meet those for nursing facilities established by the responsible State authority.
- The facility is dually certified under Title XVIII and XIX.
- The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- The facility is operated under policies that are clearly distinct and different from those of the mental institutions, and the policies require admission of residents from the community who need the care it provides.

Nursing facilities in the community must meet all but the last of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

Nursing facilities on the grounds of mental hospitals must meet all of the preceding policy conditions in order to provide care to eligible individuals under the state plan.

The facilities that do not meet the conditions listed above are classified as institutions for mental diseases for Medicaid payment purposes. In such facilities, unless the facility is JCAHO-accredited as an inpatient psychiatric facility, payments are limited to Medicaid residents who are 65 years of age and older. If the facility is JCAHO-accredited as an inpatient psychiatric facility, payments may be made on behalf of the individuals who are under age 21 or are 65 years of age and older.

Medicaid Per Diem Rate Computation

The Medicaid per diem rate is determined under reimbursement methodology contained in the *Alabama Medicaid Agency Administrative Code*, Chapter 22. The rates are based on the cost data contained in cost reports (normally covering the period July 1 through June 30).

Reimbursement and Payment Limitations

Reimbursement is made in accordance with the *Alabama Medicaid Agency Administrative Code,* Chapter 22.

Each nursing facility has a payment rate assigned by Medicaid. The resident's available monthly income minus an amount designated for personal maintenance (and in some cases, amounts for needy dependents and health insurance premiums) is first applied against this payment rate, and then Medicaid pays the balance.

- The nursing facility may bill the resident for services not included in the per diem rate (non-covered charges) as explained in this section.
- The monthly income is prorated if the resident is not in the facility for the entire month.
- Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

Medicaid defines a ceiling for operating costs for nursing facilities. Refer to the *Alabama Medicaid Agency Administrative Code,* Chapter 22, or contact the Provider Audit Division at the Agency for more details.

Nursing Facility Records

Nursing facilities are required to keep the following minimum records:

- Midnight census by resident name at least one time per calendar month (more frequent census taking is recommended)
- Ledger of all admissions, discharges, and deaths
- Complete therapeutic leave records
- A monthly analysis sheet that summarizes all admissions and discharges, paid hold bed days, and therapeutic leave days

Cost Reports

Each provider is required to file a complete uniform cost report for each fiscal year ending June 30. Medicaid must receive the complete uniform cost report on or before September 15. Should September 15 fall on a state holiday or weekend, the complete uniform cost report is due the next working day. Please prepare cost reports carefully and accurately to prevent later corrections or the need for additional information.

Review of Medicaid Residents

Medicaid or its designated agent will perform a review of Medicaid nursing facility/ICF/MR facility residents' records to determine appropriateness of admission.

Medicaid or its designee will conduct a retrospective review on a monthly basis of 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Agency or its designee within ten working days from receipt of the faxed letters shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Agency may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.

Electronic Upload and Submission of Medical Records

When submitting records the LTC HP Cover Sheet from the web portal must accompany the medical record. LTC records for approval may be uploaded two different ways:

- Medicaid Interactive Web Portal (preferred)

  https://www.medicaid.alabamaservices.org/AL Portal/Account/Secure 20Site/tabld/66/Default.aspx

- Fax information in for processing (bar coded cover sheet required)

Documents must be in a Portable Document Format (PDF) for upload through the Medicaid web portal. If you do not currently have the ability to create PDF versions of medical records, you may perform an internet search and find free downloadable utilities that can be installed to create a PDF. For your convenience, a list of three PDF creation utilities that can be installed to create PDF documents at no charge.

- PrimoPDF – http://www.primopdf.com/
- Solid PDF – http://www.freepdcreator.org/
- PDF24 – http://en.pdf.24.org/creator.html

Once a PDF utility has been successfully downloaded and the PDF document created, providers should follow these steps to upload documentation for review:

1. Log on to Medical Interactive Web portal:

   https://www.medicaid.alabamaservices.org/ALPortal/Account/Secure %20-Site/tabld/66/Default.aspx

2. Select Trade Files/Forms.

Forms Name field – select LTC Records from the drop down list and click on “Search”.

3. Complete all fields (record ID field will auto populate). Required
4. Click on ‘Browse’ and select the required medical records documentation from your network drive or PC and select ‘Submit’.
5. A message will be generated that states ‘your form was submitted successfully’ at the top of the page.
6. A barcode coversheet is generated and will be displayed.
7. Select the ‘Print Friendly View’ button to print the barcode coversheet or to save as a PDF. A copy of this barcode coversheet should be saved in the event additional documentation is required.

If a PDF document of the medical records cannot be created, information may also be faxed for review. A fax cover sheet will be required with each submission; providers should follow the instructions below to fax documentation:

1. Follow steps 1-7 documented above.
2. Fax the required medical records documentation with the barcode coversheet on top of the documentation to 334-215-7146.Include the bar coded cover sheet with each submission for the same recipient.
3. Do not fax double sided pages.
4. Do not fax multiple sets of records at the same time, each fax should be sent separately.

NOTE:
The bar code cover sheet is required for each fax submission for the same recipient. A fax submission cannot be processed without the bar coded cover sheet. DO NOT place anything on the bar code on the cover sheet or alter it any manner.

26.3 Establishment of Medical Need

The Medicaid Agency has delegated authority for the initial and subsequent level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

The process to establish medical need includes medical and financial eligibility determination.

- The determination of level of care will be made by an RN of the nursing facility staff.
- Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.

All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

- New Admissions

  XIX LTC-9 Form 161. If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.

PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

Readmissions

XIX-LTC-9 Form 161

Updated PASRR screening information as required.

All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

- New Admissions

  Medicaid Patient Status Notification (Form 199).

  Form XIX LTC-9 Form 161

  PASRR screening information, including the Level I Screening and Level I Determination and Level II Screening and Level II Determination if applicable.

All Medicaid certified ICF/MR facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/MR level of care needs.

- New Admissions

  A fully completed Medicaid Patient Status Notification (Form 199).

  A fully completed ICF/MR Admission and Evaluation Data (Form XIX-LTC-18-22).

  The resident's physical history.

  The resident's psychological history.

  The resident's interim rehabilitation plan.

  A social evaluation of the resident.

- Readmissions

  Medicaid Patient Status Notification (Form 199).

  ICF/MR Admission and Evaluation Form.

A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings: (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and

a plan of rehabilitation where applicable. The assessment document will be submitted with the LTC-9 on new admissions.

- Authorization of eligibility by Medicaid physician

For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Clinical Services & Support Division, Medical & Quality Review Unit. The nurse reviewer will review and assess the documentation submitted and make a determination based on the total condition of the applicant. If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency physician will approve or deny medical eligibility.

Application Denials

On each denied admission application, Medicaid advises the resident and/or personal representative, the attending physician, and the facility of the resident's opportunity to request a reconsideration of the decision and that they may present further information to establish medical eligibility.

If the reconsideration results in an adverse decision, the resident and/or personal representatives are advised of the resident's right to a fair hearing. If the reconsideration results in a favorable decision, normal admitting procedures are followed.

Signature Requirement

For information regarding electronic signature refer to Chapter 1-General Section of the Administrative Code Rule No. 560-X-.18.

26.4 Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents

Ventilator-dependents and qualified tracheostomy residents recipients can choose any Medicaid nursing facility that has been approved to provide services to ventilator-dependent recipients.

Information regarding the required medical eligibility and documentation for the nursing facility and the resident is included in Alabama Medicaid Administrative Code Chapter 63. Refer to the **Electronic Upload and Submission of Medical Records** section of this chapter for more information.

26.5 Cost Sharing (Copayment)

Copayment does not apply to services provided by nursing facility providers.

26.6 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers are encouraged to bill Medicaid claims electronically.

Nursing facility providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

➢ Electronic claims submission can save you time and money. The system alerts you to common errors and allows you to correct and resubmit claims online.

NOTE:

When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Institutional Medicaid/Medicare-related Claim Form.

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

26.6.1 Time Limit for Filing Claims

Medicaid requires all claims for nursing facilities to be filed within one year of the date of service. Refer to Section 5.1.5, Filing Limits and Approved Exceptions, for more information regarding timely filing limits and exceptions.

26.6.2 Diagnosis Codes

Deleted: ~~9th~~
Added: 10th

Added: (ICD-10-CM)

Added: American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335

Deleted: ~~American Medical Association, P. O. Box 10950, Chicago, IL 60610~~

Added: **NOTE**

The International Classification of Diseases - Current 10th Edition - Clinical Modification (ICD-10-CM) manual or its successor, lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

Added: or ICD-10

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

26.6.3 Covered Revenue Codes

The type of bill for nursing facilities is 21X.

Nursing facilities are limited to the following revenue codes:

Code	*Description*
101	All-inclusive room & board
183	Therapeutic leave
947	Nursing Home Ventilator

26.6.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

26.6.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to claims with third party denials.

NOTE:
When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

26.7 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Chapter 5
Institutional Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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