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Related Clinical Coverage Policies

Refer to http://www.ncdhhs.gov/dma/mp/ for the related coverage policies listed below:
2B-1, *Nursing Facility Services*

1.0 Description of the Procedure, Product, or Service

Units in nursing facilities that provide skilled nursing services for geriatric beneficiaries who are diagnosed with a severe and persistent mental illness (SPMI) are referred to as geropsychiatric units. Such units are comprised of geriatric beneficiaries with long-term psychiatric and behavioral health needs who exhibit challenging and difficult behaviors that are beyond the management capacity of traditional skilled nursing home facilities in community-based facilities. (A more detailed definition appears in **Subsection 3.2, Specific Criteria.**) The service provides both skilled nursing care that has traditionally been provided to geriatric beneficiaries on long-term-care units in psychiatric facilities and enhanced levels of supervision and management for the behavioral and psychiatric needs of persons who have SPMI diagnoses. Beneficiaries of these services exhibit chronic, unsafe behaviors that cannot be managed in a traditional nursing facility but can be managed with reassurance and appropriately trained and enhanced staff.

1.1 Definitions

None Apply.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(*The term "General" found throughout this policy applies to all Medicaid and NCHC policies*)

a. An eligible beneficiary shall be enrolled in either:
   1. the NC Medicaid Program *(Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
   2. the NC Health Choice (*NCHC is NC Health Choice program, unless context clearly indicates otherwise)* Program on the date of service and shall meet the criteria in **Section 3.0 of this policy**.

b. Provider(s) shall verify each Medicaid or NCHC beneficiary's eligibility each time a service is rendered.

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

d. Following is only one of the eligibility and other requirements for participation in the NCHC Program under GS 108A-70.21(a): Children must be between the ages of 6 through 18.

2.1.2 Specific

(***The term "Specific" found throughout this policy only applies to this policy***)

a. Medicaid

Age Restrictions

This service is intended primarily for beneficiaries aged 65 and older.

Financial Eligibility

Medicaid applicants and beneficiaries who meet financial eligibility requirements 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.

b. NCHC

NCHC beneficiaries are not eligible for geropsychiatric nursing facilities.

2.2 Special Provisions

2.2.1 EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

a. **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 beneficiary 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 practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or 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 beneficiary'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 beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

1. that is unsafe, ineffective, or experimental or investigational.

2. 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 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 meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

b. **EPSDT and Prior Approval Requirements**

1. If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does **NOT** eliminate the requirement for prior approval.
2. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below.

NCTracks Provider Claims and Billing Assistance Guide: https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html

EPSDT provider page: http://www.ncdhhs.gov/dma/epsdt/

2.2.2 EPSDT does not apply to NCHC beneficiaries

2.2.3 Health Choice Special Provision for a Health Choice Beneficiary age 6 through 18 years of age

The Division of Medical Assistance (DMA) shall deny the claim for coverage for an NCHC beneficiary who does not meet the criteria within **Section 3.0** of this policy. Only services included under the NCHC State Plan and the DMA clinical coverage policies, service definitions, or billing codes are covered for an NCHC beneficiary.

3.0 When the Procedure, Product, or Service Is Covered

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

3.1 General Criteria Covered

Medicaid and NCHC shall cover the procedure, product, or service related to this policy when 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 beneficiary'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 beneficiary, the beneficiary's caretaker, or the provider.

3.2 Specific Criteria Covered

3.2.1 Specific criteria covered by both Medicaid and NCHC

None Apply.

3.2.2 Medicaid Additional Criteria Covered

Only Medicaid beneficiaries who meet nursing facility level of care criteria and have SPMI diagnoses are eligible for this nursing facility service.

To qualify for placement in a geropsychiatric nursing specialty unit, a beneficiary shall meet **all** of the following criteria.

a. The beneficiary has an SPMI as defined by the following:
   1. The beneficiary has a major mental disorder diagnosable under the Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, schizophrenia, bipolar disorder major depression, schizoaffective disorder, schizophreniform disorders, and psychotic disorder NOS (not otherwise specified).
   2. Prior to admission, the Global Assessment of Functioning (GAF) score is 40 or lower.

b. The level of impairment is confirmed by a level II Pre-Admission Screening and Resident Review (PASRR) evaluation (42 CFR 483.128). PASRR II screening confirms the diagnosis of an SPMI, and recommends additional supportive therapies such as occupational, physical, recreational, and creative expressive arts.

   The Resource Regulatory Management Section, Program Accountability Team, is responsible for ensuring PASRR compliance. All SPMI persons seeking admission to nursing facilities must be confirmed as mentally ill and have related challenging and difficult psychiatric and behavioral health needs. Beneficiaries must be evaluated to determine whether the nursing facility is the most appropriate placement and whether they require specialized and/or enhanced behavioral health services.

   Note: Refer to Clinical Coverage Policy #2B-1, *Nursing Facility Services* at*:* http://www.ncdhhs.gov/dma/mp for additional information on the PASRR screening process.

c. The beneficiary is currently in a psychiatric hospital; or has had one or more past hospitalizations; or is exhibiting behaviors that place him or her at risk of psychiatric hospitalization in a State, public, or private psychiatric hospital in the State of North Carolina.

d. The beneficiary exhibits chronic, unsafe behaviors that cannot be managed in a traditional nursing facility, including one of the following:
   1. Elopement or wandering.
   2. Combative and assaulting behaviors (physical or verbal abuse toward staff, or self-abuse).
   3. Sexually inappropriate behaviors (touching or grabbing others, for example).

4. Self-endangering behaviors and medicine noncompliance.
5. Other challenging and difficult behaviors related to the beneficiary's psychiatric illness.

e. Alternative services to meet the beneficiary's behavioral health needs are not available, or are not required.

3.2.3 Continued Stay Criteria

Continued stay in a geropsychiatric unit is applicable when the geropsychiatric beneficiary either:

a. exhibits unsafe behaviors in the specialty nursing unit as outlined in **Subsection 3.2d**; or

b. when placed on a regular nursing facility unit, exhibits unsafe behaviors when under observation.

3.2.4 Discharge Criteria

Discharge from a geropsychiatric unit is contingent upon:

a. the consistent **absence** of unsafe behaviors (as outlined in **Subsection 3.2d** in a consistently structured geropsychiatric specialty nursing unit and
b. the anticipation that the beneficiary will not exhibit unsafe behaviors if transitioned from the geropsychiatric unit, as evidenced by trial stays on a regular nursing unit, during which unsafe behaviors are not observed.

In addition to the above criteria, the following must be considered prior to discharge:

a. Monitoring of medication stability and or consistency.
b. Treatment compliance.
c. Appropriate living arrangements upon discharge.
d. Arrangement of aftercare for continued services in the community, with family or legal guardian support and involvement.

Note: These criteria must be closely observed and monitored during a continuous period of at least three months.

3.2.5 NCHC Additional Criteria Covered

None Apply.

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

Note: Refer to Subsection 2.2.1 regarding EPSDT Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age.

4.1 General Criteria Not Covered

Medicaid and NCHC shall not cover the procedure, product, or service related to this policy when:

a. the beneficiary does not meet the eligibility requirements listed in **Section 2.0;**
b. the beneficiary does not meet the criteria listed in **Section 3.0;**
c. the procedure, product, or service 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 Not Covered

4.2.1 Specific Criteria Not Covered by both Medicaid and NCHC

None Apply.

4.2.2 Medicaid Additional Criteria Not Covered

None Apply.

4.2.3 NCHC Additional Criteria Not Covered

a. NCGS § 108A-70.21(b) "Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:
   1. No services for long-term care.
   2. No nonemergency medical transportation.
   3. No EPSDT.
   4. Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection."

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required for all admissions to a nursing facility. Providers seeking Medicaid reimbursement of this service must confirm that the beneficiary:

a. meets the requirements in **Section 2.0, Eligible Beneficiaries,** and

b. meets the requirements in **Section 3.0, When the Service is Covered.**

Note: Refer to the clinical coverage policy 2B, *Nursing Facility Services* at: http://www.ncdhhs.gov/dma/mp for additional information on the prior approval process.

5.2 Preadmission Screening and Resident Review

After a beneficiary receives a Level II evaluation, the beneficiary no longer needs to receive an Annual Resident Review (ARR) to evaluate the beneficiary's continuing need for nursing facility care and or specialized Mental Illness (MI), Intellectual Disability (ID), or Related Conditions (RC) services. Congress repealed the Federal requirement for annual reviews in 1996.

5.3 Significant Change in Mental Health (MH) or ID Beneficiary Condition

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

c. If change is identified then a nursing facility shall be responsible to complete a MDS evaluation for any significant change and shall notify the PASRR contractor within seven (7) calendar days of the significant change so that 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 PASRR evaluation process.
d. Once the PASRR II is completed, communication of changes in service needs must occur with the Department of Mental Health (DMH), since DMH is responsible to arrange and assure MH and ID services for beneficiaries who are appropriate for additional services as defined in 42 CFR §483.114 for a beneficiary with severe mental illness (SMI), ID, or related conditions identified through a Level II screen.

Note: Refer to clinical coverage policy 2B-1, *Nursing Facility Services* at: http://www.ncdhhs.gov/dma/mp for additional information on the Level II screens.

5.4 Service Provisions

Refer to clinical coverage policy 2B-1, *Nursing Facility Services* at: http://www.ncdhhs.gov/dma/mp for additional information on requirements for and limitations to services provided in nursing facilities.

5.4.1 Therapeutic Environment

Geropsychiatric units must provide a therapeutic environment using the least restrictive alternatives (10A NCAC 27E.0101) that promote the maintenance and enhancement of the beneficiary's quality of life. These therapeutic elements are provided through:

a. Enhanced nursing services to meet both the nursing care and behavioral care needs of the beneficiaries.

   Note: Refer to **Subsection 6.4, Staff Training Requirements,** for the initial and ongoing training required of nursing staff.
b. Psychiatric services to address the beneficiary's needs related to the management of symptoms and medications for severe and persistent mental illness.
c. Psychological services to develop and implement behavior management plans, including training nursing staff in ongoing implementation of the plan.
d. Social work services to coordinate the enhanced behavioral health care services provided to the beneficiaries.
e. Licensed psychiatric nursing services to supervise and coordinate the nursing and medical services being provided to the beneficiaries.
f. Programming that is focused on maintaining previously learned psychosocial and recreational skills.

5.4.2 Staffing Levels

This skilled nursing unit requires more nursing staff than in a traditional nursing facility unit. A 20-bed geropsychiatric specialty unit must be staffed by both a standard team of nursing staff (10A NCAC 13D.2303) and enhanced levels of staffing including all of the following:

a. 10 full-time-equivalent (FTE) nursing staff [Registered Nurse (RN), Licensed Practical nurse (LPN), Certified Nursing Assistant (CNA)]
b. 0.2 FTE psychiatrist

c. 0.2 FTE licensed psychologist
d. 0.5 FTE Licensed Clinical Social Worker (LCSW)
e. 0.5 FTE social work assistant (Bachelor in Social Work (BSW) or Bachelor's related to field with 1 year's experience)

The psychiatrist and the psychologist will be a part of the ongoing treatment, assessment and treatment planning of the beneficiary.

The qualifying nursing facility has the option to contract with a private group to provide the enhanced staffing (except nursing staff, who must be employees of the nursing facility).

The qualifying providers are responsible for working closely with the Local Management Entity's (LME) geropsychiatric teams located in each region.

5.4.3 Beneficiary's Safety

The facility shall provide consistent staff monitoring of beneficiaries to ensure safety and security, address the behaviors exhibited by the beneficiaries, and plan appropriately when significant medical and behavioral changes occur. The facility shall provide services by maintaining sufficient numbers of personnel, on a 24-hour basis, to provide nursing care to all beneficiaries in accordance with person-centered care plans. This staffing level consists of the following ratio of staff to beneficiaries:

a. First shift: 1 CNA for every 3 beneficiaries, 1 LPN for every 12 beneficiaries, and 4 hours of RN coverage. For every 20 beneficiaries there must be 0.2 FTE psychiatrist; 0.2 FTE licensed psychologist; 0.5 FTE social services assistant; and 0.5 FTE LCSW.
b. Second shift: 1 CNA/3 beneficiaries, 1 LPN/12 beneficiaries, and 4 hours of RN coverage.
c. Third shift: 1 CNA/7 beneficiaries and 1 LPN/20 beneficiaries.

5.5 Therapeutic Leave

Refer to clinical coverage policy 2B-1, *Nursing Facility Services* at: http://www.ncdhhs.gov/dma/mp for additional information on therapeutic leave.

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

To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

a. meet Medicaid or NCHC qualifications for participation;
b. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; 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 Establishing Units

The enhanced skilled nursing units shall be an on-site geropsychiatric component of a licensed nursing facility and shall be certified (42 CFR 483) to receive Medicaid and Medicare reimbursements.

There are two options for establishing a geropsychiatric unit in a nursing facility:

a. A nursing facility may use no more than 20 currently certified nursing beds to create the geropsychiatric services unit. There must be clinical documentation to ensure that existing beneficiaries meet criteria for the geropsychiatric unit and that the geropsychiatric unit is the most appropriate placement for beneficiaries who would otherwise be displaced. The nursing facility must also provide a transition plan for any beneficiaries who will be displaced by the creation of the geropsychiatric unit.
b. A nursing facility may expand its current number of certified beds by converting existing beds that are not currently certified beds or by developing new certified nursing beds. If this option is selected, the Certificate of Need (CON) requirements apply and the facility must meet and follow all CON requirements. The CON must be approved prior to the final approval of a proposal to develop a geropsychiatric unit in the nursing facility.

6.2 Facility Requirements

The facility shall meet nursing facility requirements as well as an enhanced level of nursing care to meet the special nursing and behavioral health needs of the beneficiaries. The facility must be certified and monitored by the Division of Health Service Regulation (DHSR) for compliance with nursing facility rules. This compliance is to ensure that the facility is designed, constructed, equipped, and maintained to protect the health and safety of beneficiaries, personnel, and the public.

The facility shall provide a therapeutic environment with enhanced and trained staff as identified in **Subsection 5.3, Service Provisions.** The Program Accountability Team from Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SAS) monitors all specialty training for the enhanced nursing staff in a therapeutic environment to ensure that it is timely maintained and documented. If training requirements are not met, the nursing facility does not qualify for the nursing specialty services, geropsychiatry. MH/DD/SAS Program Accountability shall monitor all geropsychiatric units for the following through its annual program of assessments and reviews:

a. Therapeutic environment.
b. Staffing.
c. Staff training.

All nursing facilities shall provide separate and sufficient space on the geropsychiatric unit. They shall provide equipment in dining, medical health services, recreation, and program areas to enable staff to provide beneficiaries with needed behavioral health services.

6.3 Staff Training Requirements

All nursing staff (RNs, LPNs, and CNAs) shall (10A NCAC 27E.0107) complete no fewer than 40 initial hours of staff training (20 hours annually thereafter) on behavioral health management issues for challenging and difficult behaviors, and additional training

as professionally required. The staff training calendar and schedule are planned by the Staff Development Coordinator with approval of DMH. All nurses and CNAs are required to participate in this training. The facility orientation will include additional training for all nursing facility staff assigned to the geropsychiatric unit.

The training curriculum is defined by the MH/DD/SAS training guidelines. Training includes the mental health, nursing, and medical guidelines for treating the geropsychiatric beneficiary population to ensure employee skilled competencies in the following areas:

a. Person-Centered Thinking and Person-Centered Care planning.
b. Assessment of mental status.
c. Documentation of behaviors.
d. Loss and grief.
e. Establishment of a therapeutic environment.
f. Effective communication with families.
g. Effective communication with persons with cognitive deficits.
h. Physical, social, and emotional self-awareness.
i. Recognition of symptoms of mental illness.
j. Sexuality and aging.
k. Mental illness and the aging population.
l. Crisis prevention and intervention.
m. Relocation trauma; psychological aspects of change.
n. Stress management and impact on caregivers.
o. Psychotropic medications and side effects and adverse reactions in the elderly.
p. Reality orientation.
q. Problem solving: bathing.
r. Problem solving: incontinence.
s. Therapeutic approaches and interventions for problem behaviors.
t. Elopement precautions.
u. Working with aggressive, assaulting, and sexual behaviors.
v. Training for staff self-protection.

7.0 Additional Requirements

7.1 Compliance

Provider(s) shall comply with the following in effect at the time the service is rendered:

a. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
b. All DMA's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s.

7.2 Nursing Facility Service Requirements

Provider shall comply with all of the requirements and limitations documented in clinical coverage policy 2B-1, *Nursing Facility Services* at: http://www.ncdhhs.gov/dma/mp.

7.3 Reporting Requirements

The operation of a geropsychiatric specialty unit in a nursing facility requires the collection and reporting (10A NCAC 27A.0103) of North Carolina Treatment Outcomes and Programs Performance System (NC-TOPPS) data for each beneficiary in accordance with MH/DD/SAS policy. Refer to the MH/DD/SAS website: http://nctopps.ncdmh.net/ for more information.

8.0 Policy Implementation/Revision Information

Original Effective Date: April 1, 2009

Revision Information:

Date	Section Revised	Change
04/01/2009	All sections and attachment(s)	Initial promulgation of new coverage
12/01/2009	Header	New revised date December 1, 2009 added
12/01/2009	3.2 , 5.2	PASRR removal of annual reviews
12/01/2009	3.2, 5.2,5.3, 5.4, 7.2	Deleted “forthcoming policy” wording in reference to 2B-1, Nursing Facility Services
12/01/2009	5.2	Information on PASRR responsibilities added
03/12/2012	All sections and attachment(s)	Merge Medicaid and NCHC current coverage into one policy.
01/01/2013	All sections and attachment(s)	Replaced “recipient” with “beneficiary.”
01/01/2013	All sections and attachment(s)	Replaced “patient” with “beneficiary” when applicable.
01/01/2013	All sections and attachment(s)	Replaced “resident” with “beneficiary” when applicable.
01/01/2013	All sections and attachment(s)	Replaced “individual” with “beneficiary” when applicable.
01/01/2013	All sections and attachment(s)	Replaced “mental retardation” with “intellectual disability”
01/01/2013	Subsection 3.3b.	Deleted “if moved from the enhanced services available in the geropsychiatric unit, as evidenced by exploratory visits in the regular nursing facility unit, during which unsafe behaviors are observed” and replaced text with “when placed on a regular nursing facility unit, exhibits unsafe behaviors when under observation on a regular facility unit.”
01/01/2013	Subsection 3.4	Replaced “Additional determining criteria for discharge include the following:” with “In addition to the above criteria, the following must be considered prior to discharge:”
01/01/2013	Subsection 3.4d.	Replaced “with family/guardian” with “family or legal guardian”
01/01/2013	Subsection 5.1	Deleted “10A NCAC 22O.0166(a)

Date	Section Revised	Change
01/01/2013	Subsection 5.2	Deleted "Significant Change in MH/MR Resident Condition"
01/01/2013	Subsection 5.2.1	Items c.d. and e. from Subsection 5.2 were placed under Subsection 5.2.1 "Significant Change in Mental Health (MH) or ID Beneficiary Condition"
01/01/2013	Subsection 5.2.1.d.	Clarified "they" with "DMH"
01/01/2013	Subsection 5.3.1	Subsection 5.3.1 Medical Care was deleted due to Congress repealing the requirement for PASRR level II annual reviews.
01/01/2013	Subsection 5.3.2	Subsection 5.3.2 Therapeutic Environment was renumbered as 5.3.1 Therapeutic Environment
01/01/2013	Subsection 5.3.1	Deleted text: "b. Psychiatric services to address the recipients' needs related to the management of symptoms and medications for severe and persistent mental illness (that is, the psychiatrist will be part of the ongoing treatment assessment and treatment planning of the recipient) c. Psychological services to develop and implement behavior management plans, including training nursing staff in ongoing implementation of the plan (that is, the psychiatrist will be part of the ongoing treatment assessment and treatment planning of the recipient)"
01/01/2013	Subsection 5.3.2	Staffing Levels added text: "The psychiatrist and the psychologist will be a part of the ongoing treatment, assessment and treatment planning of the beneficiary."
01/01/2013	Subsection 5.3.4	Subsection 5.3.4 "Client Safety" was renumbered and changed to 5.3.3 "Beneficiary's Safety"
01/01/2013	Subsection 5.4	Deleted "Therapeutic leave must be provided (10A NCAC 22O.0409)"
01/01/2013	Subsection 6.3	Subsection 6.3 Provider Agreement was deleted as no longer applicable.
01/01/2013	Subsection 6.4	Subsection 6.4 was renumbered to 6.3
01/01/2013	Subsection 7.4	This subsection was deleted because requirements are included in Subsection 7.1
01/01/2013	Attachment A. Section E	This entire "Section E. Third-Party Payers/Recovery" with was deleted because it does not apply
01/03/2013	Subsection 5.2.1.a	"A nursing facility has a greater responsibility for identifying.." corrected to read "A nursing facility shall have a greater responsibility …"
01/03/2013	Section 8.0	Clarified revisions made 01/01/2013
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally mandated 10/1/2015 implementation where applicable.

Attachment A: Claims-Related Information

Reimbursement Provider(s) shall comply with the, *NCTracks Provider Claims and Billing Assistance Guide*, Medicaid bulletins, fee schedules, DMA's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid and NCHC:

A. Claim Type

Institutional (UB-04/837I transaction)

B. International Classification of Diseases, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS)

Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

C. Code(s)

Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy.

If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.

Revenue Code(s)
100
183

Unlisted Procedure or Service
CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.

HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service.

D. Modifiers

Provider(s) shall follow applicable modifier guidelines.

E. Billing Units

Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).

F. Place of Service

Nursing Facility.

G. Co-payments

For Medicaid refer to Medicaid State Plan, Attachment 4.18-A, page 1, located at http://www.ncdhhs.gov/dma/plan/sp.pdf.
For NCHC refer to G.S. 108A-70.21(d), located at http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_108A/GS_108A-70.21.html.

Beneficiaries of a nursing facility are exempt from co-payments for the following:

1. Facility room and board.
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.
For a schedule of rates, see: http://www.ncdhhs.gov/dma/fee/

I. 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.