

-To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP.

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Related Clinical Coverage Policies

Refer to <https://medicaid.ncdhhs.gov/> for the related coverage policies listed below:

- 3D, *Hospice Services*
- 15, *Ambulance Services*
- 5A-1, *Physical Rehabilitation Equipment and Supplies*
- 5A-2, *Respiratory Equipment and Supplies*
- 5A-3, *Nursing Equipment and Supplies*
- 5B, *Orthotics & Prosthetics*
- 2A-3, *Out-of-State Services*
- 2B-2, *Geropsychiatric Units in Nursing Facilities*

1.0 Description of the Procedure, Product, or Service

A nursing facility is a medical health facility, or a distinct part of a facility (for example, a hospital enrolled by the NC Medicaid (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. Skilled nursing services are those which must be furnished under the direct supervision of licensed nursing personnel and under the general direction of a physician in order to achieve the medically desired results and to assure quality patient care.

Note: An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is not considered to be a nursing facility.

1.1 Definitions

Intermediate Care Facility for Individuals with Intellectual Disabilities: defined in 42 CFR 440.150.

Resident: A Medicaid beneficiary who maintains residency in a nursing facility.

Hospice: defined in 42 CFR 418.3.

Significant Change: A significant change is a major decline or improvement in a resident's status that:

- a. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
- b. Impacts more than one area of the resident's health status; and
- c. Requires interdisciplinary review and revision of the care plan.

2.0 Eligibility Requirements

2.1 Provisions

2.1.1 General

(The term “General” found throughout this policy applies to all Medicaid policies)

- a. An eligible beneficiary shall be enrolled in the NC Medicaid Program (*Medicaid is NC Medicaid program, unless context clearly indicates otherwise*); or
- b. Provider(s) shall verify each Medicaid 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.

2.1.2 Specific

(The term “Specific” found throughout this policy only applies to this policy)

a. Medicaid

Medicaid applicants and beneficiaries who meet financial and medical necessity based on the nursing facility level of care criteria are eligible for Medicaid nursing facility services.

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: <https://medicaid.ncdhhs.gov/>

2.3 Financial Eligibility

Medicaid applicants and beneficiaries 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 (DSS) in the county where the applicant's eligibility is maintained is responsible for determining financial eligibility, and the DHHS utilization review contractor determines medical necessity. The appropriate services are billed initially to Medicare for dually eligible beneficiaries.

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 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 Medicaid

Medicaid shall cover Nursing Facility Services when the beneficiary meets the following specific criteria:

a. Nursing Facility Level of Care Criteria

The following criteria are not intended to be the only determinants of the resident's or beneficiary's need for nursing facility level of care. Professional judgment and a thorough evaluation of the resident's or beneficiary'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 beneficiary to maintain, monitor, or enhance the resident's or beneficiary's level of health must be addressed in the health records and reflected on the medical eligibility assessment form.

b. Qualifying Conditions

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

1. Need for services that, by physician judgment, require:
 - A. A registered nurse for a minimum of 8 hours daily; and
 - B. other personnel working under the supervision of a licensed nurse.
2. Need for 24-hour observation and assessment of resident needs by a registered nurse or a licensed practical nurse.
3. Need for administration and 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 13O.0202, 21 NCAC 36.0401 and 21 NCAC 36.0403, medications may be administered by medication aides with appropriate facility policies and procedures and following the North Carolina board of nursing requirement for teaching, supervision and evaluation).
4. Need for restorative nursing measures to maintain or restore maximum function or to prevent the advancement of progressive disabilities; such measures may include the following:
 - A. Encouraging residents to achieve independence in activities of daily living (such as bathing, eating, toileting, dressing, transferring, and ambulation);
 - B. 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; or
 - C. Training in ambulation and gait, with or without assistive devices.

5. Special therapeutic diets: nutritional needs under the supervision and monitoring by a registered dietician.
6. Nasogastric and gastrostomy tubes: requiring monitoring and observation:
 - A. Tube with flushes;
 - B. Medications administered through the tube;
 - C. Supplemental bolus feedings.
7. 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:
 - A. Nebulizer usage;
 - B. Pulse oximetry;
 - C. Oral suctioning.
8. Wounds and care of decubitus ulcers or open areas.
9. Dialysis: hemodialysis or peritoneal dialysis as part of a maintenance treatment plan.
10. Rehabilitative services by a licensed therapist or assistant as part of a maintenance treatment plan.
11. Diabetes, when daily observation of dietary intake and medication administration is required for proper physiological control.
12. Cognitive disabilities impacting the ability of a resident to independently perform activities of daily living, resulting in the need for hands on assistance.

c. Conditions When in Combination May Justify Nursing Facility Level of Care

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

1. **Need for teaching and counseling** related to a disease process, disability, diet, or medication.
2. **Adaptive programs:** training the resident to reach his or her maximum potential (such as bowel and bladder training or restorative feeding); documentation must incorporate the purpose of the resident's participation in the program and the resident's progress.
3. **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 casts.
4. **Injections:** requiring administration and professional judgment by a licensed nurse.
5. **Treatments:** temporary cast, braces, splint, hot applications, cold applications, or other applications requiring nursing care and direction.
6. **Psychosocial considerations:** psychosocial condition of each resident is 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 are.

- A. Acute psychological symptoms (these symptoms and the need for appropriate services and supervision must have been documented by physician's orders or progress notes or by nursing or therapy notes);
 - B. Age;
 - C. Length of stay in current placement;
 - D. Location and condition of spouse;
 - E. Proximity of social support; and
 - F. 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).
7. **Blindness.**
8. **Cognitive and Behavioral symptoms,**
- A. Wandering;
 - B. Verbal disruptiveness;
 - C. Physical aggression;
 - D. Verbal aggression; or
 - E. Inappropriate behavior (when it can be properly managed at the nursing facility level of care).
9. **Frequent falls.**
10. **Chronic recurrent medical problems** that require daily observation by licensed personnel for prevention and/or treatment.

3.2.2 Medicaid Additional Criteria Covered

In addition to the specific criteria covered in **Subsection 3.2.1** of this policy, Medicaid shall cover:

a. 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 or duration (such as increase in respiratory rate by five breaths per minute, increase in fraction of inspired oxygen (FIO₂) of 25% or more or increase in tidal volume of 200 milliliters or more). Refer to **Subsection 5.2.4 and Attachment F (D.)** for additional information.

b. Non-Emergency Medically Necessary Ambulance Transportation

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 or 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.

c. 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.

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 (such as 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

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 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 Medicaid

Medicaid shall not cover Nursing Facility Services when ONE of the following are met:

- a. the beneficiary (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;
- 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 resident review (PASRR) was not completed prior to admission as required by 42 CFR 483 Subpart C.

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.

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

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

4.2.2 Medicaid Additional Criteria Not Covered

a. Non-Covered Resident Care Items

As indicated in 42 CFR 483.10(f)(11)(ii), the following resident care items are not covered by Medicaid:

1. Telephone, such as a cellular phone;
2. Television, radio, personal computer or other electronic device for personal use;
3. Personal reading matter, such as a newspaper and a magazine;
4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
5. Non-covered special care services such as privately hired nurses or aides;
6. Personal comfort items, including smoking materials, notions, novelties, and confections;
7. Gifts purchased on behalf of a resident;
8. Flowers and plants;
9. Cost to participate in social events and entertainment offered outside the scope of the activities program;
10. Specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, unless ordered by the resident's physician, physician assistant, nurse practitioner or clinical nurse specialist;
11. Personal clothing; or
12. Private rooms, unless the beneficiary's attending physician orders a private room based on medical necessity or when therapeutically required (such as, isolation for infection control) or if the only room available within the facility is a private room.

Additionally, the following resident care items are not covered by Medicaid:

1. Guest meal tray; or
2. Morgue boxes, shrouds, or burial wrappings.

Note: This list is not all inclusive.

b. Bed Hold Days

c. According to 42 CFR 483.15(d)(i)-(iv), Medicaid shall not cover bed hold days. Refer to **Subsection 7.4** for additional information on bed holds.

d. Non-Covered Ambulance Transportation Services

e. Medicaid shall not cover the following ambulance transportation services:

1. Non-emergency transportation when it is not medically necessary to transport a resident by ambulance;

2. 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;
3. Transportation of a deceased resident, if the resident was pronounced dead prior to the call for pick-up; or
4. Transportation from a nursing facility to a site for therapeutic leave.

5.0 Requirements for and Limitations on Coverage

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

5.1 Prior Approval

Medicaid shall require prior approval for Nursing Facility Services. The provider shall obtain prior approval before rendering Nursing Facility Services.

5.2 Prior Approval Requirements

5.2.1 General

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the prior approval request; and
- b. all health records and any other records that support the beneficiary has met the specific criteria in subsection 3.2 of this policy.

5.2.2 Specific

Medicaid shall require prior approval 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;
 - a. Ventilator services (refer to **Subsection 5.2.4**);
 - b. Therapeutic leave in excess of 15 consecutive days (refer to **Subsection 5.7**);
 - c. Out-of-state placement to the nursing facility level of care; and
 - d. CAP/DA admissions to a nursing facility.
- e. Current nursing facility residents transitioning from Managed Care to Medicaid Direct.

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

5.2.3 When Prior Approval Is Not Required

Medicaid shall not require prior approval 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; or
- e. Residents whose Medicaid eligibility lapses for no more than 90 calendar days and whose level of care remains the same.

5.2.4 Retroactive Prior Approval

It is the responsibility of the nursing facility to ensure that the initial request for prior approval is on file with DHHS utilization review contractor when a beneficiary 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 or after the prior approval request has been approved.
- a. For retroactive requests exceeding 30 calendar days, health record documentation is required by the DHHS utilization review contractor to support the retroactive request.
- b. Retroactive prior authorization is not applicable to beneficiaries covered under Medicaid Managed Care.

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

5.2.5 Prior Approval for Ventilator Services

Prior approval requests for ventilator services must contain ALL the following:

- a. The Medicaid-designated screening form, with the PASRR number, signed and dated by the attending physician and the National Provider Identifier of the facility that is or will be rendering ventilator services;
- b. Health records documenting the criteria for ventilator level of care listed in **Subsection 3.3.**; and
- 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 beneficiary with ventilator services transfers from the hospital to a nursing facility or to a different nursing facility, the facility shall notify the DHHS utilization review contractor of the transfer. If the DHHS utilization review contractor is not notified within 30 calendar days of the transfer, a new prior approval is required. If the beneficiary 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 F** for additional information on the prior approval process.

5.3 Additional Limitations or Requirements

The provider(s) shall submit to the Department of Health and Human Services (DHHS) Utilization Review Contractor the following:

- a. the accurately completed Medicaid-designated screening FL 2 form DMA 372-124 (refer to the Sample FL 2 in **Attachment G**);
- b. the valid PASRR number must be entered on the FL 2 form;
- c. the attending physician must sign and date the FL 2 form or the Physician's Signature for authorization of LOC form DMA-0100 before submitting the approval request. Family nurse practitioners (FNPs), physicians' assistants (PAs), and surgical assistants (SAs) may sign the FL-2 form DMA 372-124 or the Physician's Signature for authorization of level of care form DMA-0100 **only** if the attending physician co-signs and dates the form; and
- d. if the Medicaid beneficiary is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

5.4 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.

5.4.1 Who Is Subject to PASRR Screens

In accordance with 42 CFR 483.106, all applicants to and residents of Medicaid-certified nursing facilities shall 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.

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

5.4.2 Web-Based Submission

All providers shall submit PASRR screenings through the North Carolina Medicaid Uniform Screening Tool (NC MUST) website located at <https://ncmust.ncdhhs.gov>.

5.4.3 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), intellectual and developmental disabilities (IDD), or a related condition (RC).

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

5.4.4 Level II Screens

Any applicant to a Medicaid-certified nursing facility whose Level I screen indicates the possible presence of SMI, IDD, or RC must undergo a Level II screen. Level II screens are to be performed on-site and prior to admission to the nursing facility.

The results of the Level II determination and summary of findings must be requested from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS).

5.4.5 Annual Resident Review for Level II Screens

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

5.4.6 Significant Change in MH/ IDD Resident Condition

Nursing facilities are responsible for identifying significant changes in the resident's status. In addition to the definition found in section 1.1.d., the following applies:

- a. A significant change shall require referral for a PASRR evaluation if a mental illness, intellectual and developmental disability, or related condition is present or is suspected to be present. Nursing facilities are responsible to notify the DHHS designated contractor for PASRR within seven (7) 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 then follows the same steps as for the initial Level I PASRR evaluation process.
- b. Once the PASRR Level_II evaluation is completed, the results are sent to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) for a determination of specialized service needs.

5.4.7 Level II Screen Postponements

Federal regulations (42 CFR 483.130) allow short-term nursing facility admissions for some applicants with SMI, IDD, or RC. These **time-limited** approvals are authorized during the Level I or Level II (refer to e. and f. below) screen process when any of the following six (6) circumstances are applicable:

- a. **Convalescent care** (30-calendar-day approval): applies to admissions to nursing facilities directly from acute care hospitals;
Note: A beneficiary shall need 30 calendar days or less of nursing facility care for the hospitalization condition for this approval to be granted. The attending physician shall 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 beneficiary needs emergency protective service placement;
- c. **Delirium** (7-calendar day approval): applies to a beneficiary suspected of having SMI, IDD, or RC but whose delirium state prevents accurate completion of the Level I or Level II processes;
- d. **Respite** (7-calendar-day approval): applies to a beneficiary whose in-home caregivers need temporary respite;
- e. **Terminal illness** (1-calendar-year approval): applies to a beneficiary under the care of hospice; or
- f. **Severe physical illness** (1-calendar-year approval): applies when a beneficiary has a diagnosis which results in a level of impairment so severe that the beneficiary could not be expected to benefit from specialized services.

5.4.8 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 resident's date of admission for 7-calendar-day approvals;
- b. within 25 calendar days for 30-calendar-day approvals;
- c. within 55 calendar days for 60-calendar-day approvals; and
- d. within 85 calendar days for 90-calendar-day approvals.

Note: A new prior approval is required if the resident is Medicaid eligible and is approved for continued stay through the updated Level I and Level II process, Medicaid's fiscal agent **must** be contacted for payment to continue.

5.4.9 Documentation

All evaluation results must be kept in the resident's health 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.

5.5 Provision of Services

All services must be provided according to 42 CFR 483 Subpart B. A Medicaid-certified nursing facility shall 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 shall 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.

5.5.1 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, such as therapeutic diets and special dietary supplements used for oral or tube feeding;
- h. Rehabilitative services, such as physical, speech, and occupational therapies;
- i. Social services;
- j. Activity services;
- k. Therapeutic leave (refer to **Subsection 5.7**);
- l. Non-ambulance transportation of Medicaid-eligible residents to receive medical care that cannot be provided in the facility (refer to **Subsection 3.5**); and
- m. Miscellaneous items:
 1. Items furnished on a routine basis to all residents;
 2. Items stocked in gross supply and distributed or used individually in small quantities; and
 3. Items used by individual residents but reusable and expected to be available.

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

5.6 Transfer and Discharge

Transfers and discharges must be provided according to 42 CFR 483.15(c). Transfer and discharge can refer to 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 shall permit each resident to remain in the nursing facility and shall 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 due to the clinical or behavioral status of the resident;
- 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; or
- f. The facility ceases to operate.

A nursing facility shall not transfer or discharge a resident while an appeal is pending, according to 42 CFR 431.230, when a resident exercises his or her right to appeal a transfer or discharge notice from a nursing facility according to 42 CFR 431.220(a)(3), unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

When a nursing facility transfers or discharges a resident for any of the above reasons, those reasons must be documented in the resident's health record. A transfer or discharge of a resident requires a physician's order.

When a nursing facility decides to transfer or discharge a resident, the resident or the responsible party has the right to an appeal. A state-approved Notice of Transfer or Discharge (DMA-9050) (**Attachment I**), including a Hearing Request form (DMA-9051) (**Attachment J**), 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 must be made as soon as practicable 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.

5.7 Readmissions

Readmissions must be provided according to 42 CFR 483.15(e)(1). A nursing facility resident who has been hospitalized and is ready for readmission to the nursing facility shall be readmitted to their previous room if available or 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.

5.8 Therapeutic Leave

Therapeutic leave must be provided as follows:

- 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 health record.
- c. Facilities shall 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 NC Medicaid.

Note: The facility shall request prior approval on behalf of the beneficiary through the DHHS utilization review contractor for therapeutic leave that exceeds 15 consecutive days.

- e. The therapeutic justification for such absence is subject to review by the State or its agent during scheduled on-site medical reviews.
- f. For reference and audit purposes, facilities shall 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 must 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 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 is not reimbursed by Medicaid.

5.9 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 shall refer the resident to the Local Contact Agency Call Center.

In 2010 with a change to the MDS 3.0, CMS revised section Q of the MDS assessment to identify beneficiaries residing in nursing facilities who may be interested in talking with someone about moving back into the community.

North Carolina Division of Health Benefits' Money Follows the Person (NCMFP) and the Division of Health Service Regulation shall coordinate to manage a referral process using a central call center and Transition Coordination Contact (TCC). The TCC functions as a Local Contact Agency to receive referrals generated by Section Q of the MDS.

The TCC is an independent third party responsible to contact and provide information about available supports and services in the community to beneficiaries in nursing facilities who are interested in making the transition back to the community. The nursing facility shall make a referral for supports and services in the community at the request of a beneficiary.

6.0 Provider(s) 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 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 Provider Qualifications and Occupational Licensing Entity Regulations

- a. Nursing facilities shall be licensed and certified by the DHSR as a nursing facility according to 42 CFR 483.70(a).
- b. Nursing facilities receiving Medicaid funding must be enrolled for participation in Medicare and Medicaid.
- c. Refer to clinical coverage policy 2A-3, *Out-of-State Services*, at <https://medicaid.ncdhhs.gov/>.

Note: Prior approval must be obtained for any Medicaid beneficiary to be admitted to an out-of-state nursing facility.

6.2 Provider Certifications

6.2.1 Nursing Facility Providers

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

- a. Employing staff who are licensed, certified, or registered according to applicable federal and state laws 42 CFR 483.70(f)(1)(2).
- b. Obtaining training and competency evaluations through DHSR for nurse aides employed in the nursing facility [42 CFR 483.35(d)(4)].
- 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 483.70(h)(2)(i)].
- 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 K** 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 483.30(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 483.30(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 483.30(e)(1)(i)-(iii)).
- 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 483.35(b)].
- g. Providing appropriate methods and procedures for dispensing and administering drugs and biologicals (42 CFR 483.45).
- 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 483.70(j)].
- 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.

- j. A nursing facility shall comply with all applicable Federal, State and local emergency preparedness requirements to include establishing and maintaining an emergency preparedness program as required in 42 CFR 483.73.
- k. Conducting a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies with an effective date of November 28, 2017. The facility shall review and update the assessment as necessary, and, at least annually (42 CFR 483.70(e)).

Additionally, nursing facilities shall:

- a. participate in the MDS validation program if they are participating in the Medicaid Case Mix Reimbursement System;
- b. provide evidence (written documentation, facility staff interviews, or onsite reviews) that the facility is actively participating in quality improvement initiatives. (Refer to **Attachment L** for additional information.); and
- c. conduct at least annually a resident satisfaction survey for a resident or their legally responsible person.

Note: NC Medicaid 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 NC Tracks Provider Claims and Billing Assistance Guide:

<https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html>.

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. Any provider who is sanctioned by CMS must notify NC Medicaid immediately.

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; or
- d. A resident return to the nursing facility from therapeutic leave after the sanction date.

7.0 Additional Requirements

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

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 NC Medicaid'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 Residents' Rights

- a. 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 beneficiaries, regardless of a resident's payment source.
- b. As required by 42 CFR 483.10(g)(17), the nursing facility shall 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:
 1. 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.
 2. 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.
 3. Changes that are made to items or services listed in a or b above.
- c. At any time, the facility intends to alter or temporarily restrict resident's rights, the facility must provide notice to the residents and their responsible party. The notice shall include the contact information for the regional and state Long-term Care Ombudsman and the Division of Health Service Regulation Complaint Hotline.

7.2.1 Payments for Services

Payment for services must comply with federal regulations in 42 CFR 483.15(a)(2)-(4) as follows:

- a. A nursing facility shall not request or 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 request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

- b. A nursing facility shall not request or 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 must 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 must 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))
- d. A nursing facility shall not request or require a resident or potential resident to waive potential facility liability for losses of personal property.

7.2.2 Payments for Services for Beneficiaries with Medicare Part A

For a Medicare Part A covered stay, Medicaid payments cannot be made for the first 20 days of care for a beneficiary who is also eligible for Medicare Part A. Payments for co-insurance will begin for the subsequent 21st through 100th days of care. "The Division of Medical Assistance shall co-insurance, the total of which must 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 pays straight Medicaid reimbursement if all Medicaid requirements are met. Refer to **Subsection 4.1 and 4.2** for reasons that Medicaid does not pay for nursing facility services.

7.2.3 Married Residents

As indicated in 42 CFR 483.10(e)(4), each nursing facility resident has the right to share a room with his or her spouse when both residents live in the same facility, 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(f)(10)(vi), the facility shall 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 for each resident for clothing and personal needs while residing in the nursing facility. This allowance is \$70.00 per month for an aged, blind, or disabled individual.

7.3.3 Personal Funds

According to 42 CFR 483.10(f)(10)(iii), the nursing facility shall 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.

According to 42 CFR 483.10(f)(10)(ii)(B), residents whose care is funded by Medicaid: the facility shall deposit the 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 shall 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

According to 42 CFR 483.10(f)(10)(iv)(A)-(B), 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, Eviction, or Death

According to 42 CFR 483.10(f)(10)(v), upon the discharge or eviction of a resident with a personal fund deposited with the facility, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the resident. In the case of death, the facility shall convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate, according to State law.

Note: If an administrator has not been appointed, the balance must be paid to the Clerk of the Superior Court within 30 calendar days after death. The funds and personal property are disbursed by the Clerk of the Superior Court. Funds must be sent to the Clerk of the Superior Court of the county providing the Medicaid assistance. The letter remitting the funds must 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

According to 42 CFR 483.10(f)(11)(iii), the facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident. The facility shall 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

According to 42 CFR 483.10(f)(11)(ii), if requested by the resident and the resident or the resident's representative is informed of the charge, a resident's personal funds **may** be used for the following items and services:

- a. Telephones, such as a cellular phone;
- b. Television, radio, personal computer or other electronic device for personal use;
- c. Personal reading matter, such as a newspaper and a magazine;
- d. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
- e. Non-covered special care services such as privately hired nurses or aides;
- f. Personal comfort items, including smoking materials, notions, novelties and confections;
- g. Gifts purchased on behalf of a resident;
- h. Flowers and plants;
- i. Cost to participate in social events and entertainment offered outside the scope of the activities program;
- j. Specially prepared or alternative food requested instead of the food and meals generally prepared by the facility, unless ordered by the resident's physician, physician assistant, nurse practitioner or clinical nurse specialist;
- k. Personal clothing; or
- l. Private room, unless the beneficiary's attending physician orders a private room based on medical necessity or when therapeutically required (e.g. isolation for infection control) (refer to **Subsection 7.5**).

Additionally, 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, such as patient liability to hospitals and nursing facilities.
- b. Medical and health care not covered by Medicaid.
- c. Personal needs such as, the following:
 1. Beauty shop and barber shop services.

Note: The nursing facility shall 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.

7.3.8 Restrictions on Use of Residents' Funds

- a. According to 42 CFR 483.10(f)(11), a resident's personal funds **must not** be used for the following:

1. Items and services that are furnished as part of Medicaid-covered nursing facility care; or
 2. Services covered by Medicaid and furnished by other participating Medicaid providers.
- b. Additionally, a resident's personal funds must not be used for the following:
1. Transportation to and from other participating Medicaid providers;
 2. Operating costs of the facility;
 3. Collateral for a loan for facility operating expenses;
 4. Items included in the per diem for nursing facilities (refer to **Attachment B**); or
 5. Commingling with facility funds (refer to **Subsection 7.3.3**).

7.4 Bed Holds

According to 42 CFR 483.15(d), 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

According to 42 CFR 483.10(f)(11)(ii)(k), a resident or his or her family may pay for a private room, unless the beneficiary's attending physician orders a private room based on medical necessity or when therapeutically required (such as, isolation for infection control) 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 or private room if the facility chooses to place a resident in a private room for clinical reasons or if the only room available is private. The Medicaid payment plus any third-party insurance payment and beneficiary liability is payment in full.

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 shall 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 must be informed of the limited number of days those assets will cover.

7.6 Record Retention

The nursing facility shall comply with 42 CFR 483.70(i)(4)(i)-(iii) for record retention.

- a. These records must be furnished upon request to the appropriate federal or state authorities, such as the DHHS utilization review contractor.
- 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 to file annual Medicaid cost reports with NC Medicaid in order to ensure that allowable costs have been identified according to 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 K** 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 beneficiary'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 must specify payment arrangements and must 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 contained in the agreement.

Refer to clinical coverage policy 3D, *Hospice Services*, at <https://medicaid.ncdhhs.gov/> for additional information on hospice services.

7.10 Continuity of Service during an Appeal

As indicated in NCGS 108A-70.9A, 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 Revised	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
12/05/11	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
3/12/12	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy.
3/12/12	Level I PASRR screening form Attachment E & F	Replaced with updated forms.
3/12/12	Subsection 5.2.3(c) Attachment D(D)(7)	Deleted to match eligibility requirements.
06/01/12	Subsection 5.3	Added for clarification of prior approval requirements
06/01/12	Subsection 5.8	Added information regarding transitioning back to the community
06/01/12	Subsection 7.6	Language change
06/21/13	All sections and attachments	Corrected revision date in header of policy
10/01/2015	All Sections and Attachments	Updated policy template language and added ICD-10 codes to comply with federally

Date	Section Revised	Change
		mandated 10/1/2015 implementation where applicable.
10/01/2017	All Sections and Attachments	Policy title changed from Nursing Facilities to Nursing Facility Services
10/01/2017	All Sections and Attachments	Updated policy to comply with 42 CFR
10/01/2017	All Sections and Attachments	Removed expired NC Administrative Codes
10/01/2017	All Sections and Attachments	Clarified wording with no change to scope of coverage
10/01/2017	Subsections 5.2.3, 5.2.4, 5.3 and Attachment D	Updated Prior Approval (PA) requirements to comply with current PA process
10/01/2017	Subsection 5.8	Updated Nursing Facility Transitions Program to comply with current referral process
10/01/2017	Attachments D, E, G, H, I, J	Updated forms
06/01/2018	All Sections and Attachments	Policy posted on this date, with an Amended Date of October 1, 2017
03/15/2019	Table of Contents	Added, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after November 1, 2019, please contact your PHP."
03/15/2019	All Sections and Attachments	Updated policy template language.
01/10/2020	Table of Contents	Updated policy template language, "To all beneficiaries enrolled in a Prepaid Health Plan (PHP): for questions about benefits and services available on or after implementation, please contact your PHP."
01/10/2020	Attachment A	Added, "Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines".
12/15/2021	7.2 Resident Rights	Added language to require nursing homes to notify beneficiaries and/or their responsible party of any changes to resident's rights and to include contact information for regional Ombudsman.
04/15/2022	Attachment K	Added language to allow the MDS Validation reviews to be conducted on-site or remotely.
04/15/2022	All Sections and Attachments	Policy posted 04/19/2022 with an amended date of 04/15/2022
12/15/2022	Attachment A	Removed Revenue Code(s) 100 and 183
08/01/2024	Attachment K	Updated Nursing Facility Quality Initiatives to comply with 42 CFR 483.

Date	Section Revised	Change
08/01/2024	Attachment J	Updated Medicaid Minimum Data Set Validation Program to comply with current review process and of the federally required Optional State Assessment (OSA) effective October 1, 2023.
08/01/2024	Subsection 5.1.2, 5.1.4, 5.1.6, 5.1.8 and Attachment C	Updated Preadmission Screening and Resident Review to comply with current process.
08/01/2024	Section 5.8	Updated Nursing Facility Transitions Program to comply with current process.
08/01/2024	Attachment B. C.	Added “Orthotics”, “Prosthetics” and the word “Manual” to Wheelchairs.
08/01/2024	Attachment F	Added PASRR timeline requirements to Prior Approval Process.
08/01/2024	Attachment D	Update North Carolina Level I Screening Form.
08/01/2024	Attachment E	Delete North Carolina Nursing Facilities Tracking Form.
08/01/2024	Attachment G and H	Update the FL-2 Form and the Physician’s Signature for Authorization Form.
08/01/2024	Section 7.3.2	Deleted 10ANCAC23E.0204. Was repealed on May 1, 2019. Deleted \$30.00 and added \$70.00.
08/01/2024	Section 4.2.2	Added acronym PASRR before Level I and Level II in second Note.
08/01/2024		Policy posted 08/07/2024 with an amended date of 08/01/2024

Attachment A: Claims-Related Information

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

A. Claim Type

Institutional (UB-04/837I transaction)

Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.

B. International Classification of Diseases and Related Health Problems, 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.

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 facilities and Hospital swing beds.

G. Co-payments

For Medicaid refer to the NC Medicaid State Plan:

<https://medicaid.ncdhhs.gov/meetings-notice/medicaid-state-plan-public-notice>

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

Provider(s) shall bill their usual and customary charges.

For a schedule of rates, refer to: <https://medicaid.ncdhhs.gov/>

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

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

(Not all inclusive)

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

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

(Not all inclusive)(List continues through p. 31)

Ace bandages	Bibs
Adhesive and adhesive removal	Bottles, specimen
Adhesive tape	Brown paper bags (isolation only)
Air mattress, disposable	Buck extension
Airway (oral, reusable)	Canes, regular and customized
Airway, disposable	Cannula
Anti-embolic hose	Catheter, 3-way
Asepto-syringes	Catheter, aspirating
Aspirating catheters	Catheters, disposable
Basins	Clysis set
Bed frame equipment—turning frames, bedrails, trapeze bars, foot cradles	Colostomy bags, belt, gasket, irrigation syringe
Bed pans, fracture and regular	Crutches, regular and customized
Bedside utensils	Douche bags

Drainable stoma bags	Roller gauze
Drainage bags	Saline, sterile (30 cc)
Enema cans and supplies	Sandbags
Flex trach tube	Scales suitable for NF purposes
Furacin gauze	Scalp vein set
Gloves, sterile and unsterile	Scalpels, blades, disposable scalpels
Gowns (isolation only)	Sheepskin
Gowns, patient	Sheets, disposable (isolation only)
Heat cradle	Sheets, half, disposable (isolation only)
Heating pads	Sitz bath, disposable
Heel protectors	Skin closures
I.V. solutions	Skin gel
Ice bags	Solutions, sterile, irrigating
Incontinency pads and pants, disposable or reusable	Specimen cups
Infusion arm boards	Speculum, vaginal, disposable
Inhalation therapy supplies (aerosol inhalators, nebulizer and replacement kits, steam vaporizers, IPPB-intermittent positive pressures breathing machine, oxygen tents and masks)	Splint, finger or wrist
Invalid rings, all sizes	Suction equipment
IPPB	Suture and needle, sterile
Irrigation syringes or bulbs	Syringes, all types and sizes, disposable and reusable
K pads, water-heated	Tape–butterfly; for lab tests; non- allergenic, surgical and adhesive
Lemon-glycerine swabs	Tissue wipes
Levine tubes	Tissue, bedside
Linens	Tongue depressors
Mattresses (air, air p.r., alternative pressure, flotation water)	Trach soap
Nasal catheter	Tracheostomy brush
Nebulizer for moist nebulization	Tracheostomy mask
Needles, all types and sizes	Tracheostomy tubes
Orthotics	Tray, catheter (disposable)
Oxygen	Tray, I.V. set
Oxygen mask	Tray, irrigation (disposable)
Oxygen nebulizer and regulator	Tray, service
Pad, eye	Tray, suture
Pad, foam	Tray, suture removal
Pad, foam, self-adhering	Tray, tracheostomy
Pads, flotation	Tray, urethral catheter
Pads, non-stick	Tube, stomach
Paper mask (isolation only)	Tube, urinary drainage
Paper tape	Tubes, nasogastric, NG feeding and stomach
Patient lift	Tubing, cannula, nasal
Pharmadine	Tubing, catheter, all types, including plugs, clamps and drainage bags
Pillowcase (disposable, isolation only)	Tubing, drainage, all types
Pilo pump	Tubing, I.V.
Pitchers	Tubing, oxygen
Pressure pads, donut	Tubing, suction (large bubble)
Prosthetics	Urinals, male and female
Pumps, aspiration and suction	Urine, leg bath (disposable)
Restraints	Uro sheath catheter
	Urostomy bags
	Vaseline gauze
	Walkcane

Walkers
Water, sterile (quart, gallon, etc.)

Manual Wheelchairs

Attachment C: Preadmission Screening Resident Review Process

A. The PASRR Process

Before the DHHS designated contractor for PASRR 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 NC MUST 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 beneficiary to respond to clinical and medical status questions. All sections of the Level I Screening Form must be completed.

C. Submitting the North Carolina Level I Screening Form

Agencies shall submit PASRR screenings through the NC MUST website. In most cases a PASRR number is noted at the NC MUST website 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. Referrals are made to the DHHS designated contractor for the beneficiary needing a Level II evaluation.

The receiving nursing facility enters the admission data into the NC MUST Tracking Module located within the NC MUST website.

Refer to **Attachment F** 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 DHHS designated contractor for PASRR notifies the referral source that a Level II PASRR evaluation is required and requests that health 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 NC Medicaid to the resident or responsible party, informing them of the final decision and their appeal rights.

If the Level II individual is a Medicaid beneficiary, the referral source contacts the DHHS utilization review contractor and proceeds with the Medicaid nursing facility prior approval process (refer to **Attachment F**).

The receiving nursing facility enters the admission data into the NC MUST Tracking Module located within the NC MUST website

E. The NC MUST Tracking Module

The nursing facility shall enter the admission data into the Tracking Module located within the NC MUST website for all new admissions to obtain the Level I evaluation. A request must be made to DMH/DD/SAS to obtain the Level II final determination and

summary of findings These results **must be kept in the individual's health record** 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 significant change in the beneficiary's status, no further contact with the DHHS designated contractor for PASRR 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 shall immediately report admission of a resident who has been evaluated by the Level II process to the DHHS designated contractor for PASRR.

The NC MUST Tracking Module is also the mechanism used to monitor location for persons with SMI, IDD, or RC. Information must be submitted via the NC MUST website 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.

G. Time Limited Stays

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

1. If a Level II evaluation is not needed, a time limit and a PASRR number is assigned by the DHHS designated contractor for PASRR. The PASRR number ends with one of the following letters:

D-represents a 7-calendar-day approval

E-represents a 30-calendar-day approval

If a Level II evaluation is needed, a time limit is assigned by the DMH/DD/SAS and a PASRR number is assigned by NC Medicaid. The PASRR number ends with the following letter:

F-represents a 30-60-90-calendar-day approval

2. If the individual is a Medicaid beneficiary, the referral source submits the PASRR form via the NC MUST website and then proceeds with the Medicaid nursing facility prior approval process (refer to **Attachment F**). If needed, assistance can be requested at (1-800-688-6696).

The receiving nursing facility shall enter the admission data into the Tracking Module located within the NC MUST website.

1. If the resident is to remain beyond the authorized time frame, the receiving facility contacts the DHHS designated contractor for PASRR prior to the end-date to update the Level I information (contact within five (5) calendar days for a 7-calendar-day authorization; within 25 calendar days for a 30-calendar-day authorization; or within 55

calendar days for a 60-calendar-day authorization; or within 85 calendar days for a 90-calendar-day authorization).

2. If approved, the DHHS designated contractor for PASRR issues the new PASRR number.
3. If a Level II evaluation is needed, the DHHS designated contractor for PASRR completes the Level II evaluation.
4. If approved through the Level II process, the facility contacts the DHHS utilization review 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 via the NC MUST website, to re-evaluate the resident.

The same process is followed as with the Preadmission Level I or Level II, except that the NC MUST Tracking Module does not require updating regarding admission.

Attachment D: North Carolina Level I Screening Form

< First Page	<< Previous	Next >>	Last Page >	North Carolina PASRR Level I Screen	Print Form
 PASRR Level I <small>NC Department of Health and Human Services home page</small> Rev March 22, 2013		<input type="button" value="Validate Entries"/>			
Screening Type					
Please Enter the Type of Screening				Date	
Screener Information					
Last Name	First Name	Telephone	Fax	Email	
Organization ID	Organization Name		Submitted On Behalf Of		Email(Behalf Of)
Organization ID (Behalf Of)	Organization Name(Behalf Of)		Fax(Behalf Of)	Phone(Behalf Of)	
Applicant Information					
Applicant					
Last Name		First Name		Middle Name	
Permanent Mailing Address (where does applicant receive their mail?)					
Street Address			City	State	Zip Code
Patients Current Location (where does applicant physically reside?)					
Specify Location Type : <input checked="" type="radio"/> Same As Screeners Organization <input type="radio"/> Same As Permanent Mailing Address <input type="radio"/> Other(enter below)					
Personal Details					
Social Security Number		Date of Birth		Applicant's Home or Cell Phone Number	
Medicare Number		Medicaid ID Number		Applicant's Preferred Setting of Care	
		Medicaid Status		Medicaid County of Residence	
Legally Responsible Person					
Who Has Legal Responsibility for this Applicant?		Name		Street Address	
City		State		Zip	
		Home or Cell Phone Number (999-999-9999)		Work Phone Number (999-999-9999)	
Other Contact Person					
Name		Type of Contact		Home/Cell Number (999-999-9999)	
				Work Phone Number (999-999-9999)	
Street Address			City		State
					Zip Code
Attending/ Primary Physician					
Physician Name					
Street Address			Mailing Address (if Different from Street Address)		
City		State		Zip Code	
				Telephone Number (999-999-9999)	

Physical Health Diagnoses			
Substance Abuse			
Has History Of, or Currently has a Substance Abuse Problem <input type="radio"/> Yes <input type="radio"/> No		Date of Last Use (MM/DD/YYYY)	
Terminal Prognosis			
Is there a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No	Has a Doctor Certified a Terminal Prognosis? <input type="radio"/> Yes <input type="radio"/> No	Name of Physician	Date of Physician Certification
Cognitive Impairment			
Is there a Cognitive Impairment Diagnosis? <input type="radio"/> Yes <input type="radio"/> No			
Cognitive Impairment Diagnoses <div style="background-color: #ccccff; height: 20px; width: 100%;"></div>	If Other Cognitive Impairment Diagnosis, Specify		Is Dementia the Primary Diagnosis? <input type="radio"/> Yes <input type="radio"/> No
Current Psychiatric Medications			
		<input type="button" value="Add Additional Medication"/>	
Medication Name	Type of Medication	<input type="button" value="Delete"/>	
If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication			
Mental Health			
Mental Health (MH) Diagnoses			
Is there an MH Diagnosis? <input type="radio"/> Yes <input type="radio"/> No	Disorders/Diagnoses <div style="background-color: #ccccff; height: 20px; width: 100%;"></div>	If Other MH Diagnosis, Specify	
Intellectual/Developmental Disability (I/DD) Diagnosis			
Is there an I/DD Diagnosis? <input type="radio"/> Yes <input type="radio"/> No	If I/DD Diagnosis is Present/Suspected, Indicate the Severity Level	Age at Onset (years)	Are I/DD Services Being Provided? <input type="radio"/> Yes <input type="radio"/> No
Conditions Related to Intellectual/Developmental Disability (I/DD) Diagnoses			
Is there a RC Diagnosis? <input type="radio"/> Yes <input type="radio"/> No			
Select All RC Diagnoses <div style="background-color: #ccccff; height: 20px; width: 100%;"></div>	If Other RC Diagnoses, Specify		Did the Condition Manifest Prior to Age 22? <input type="radio"/> Yes <input type="radio"/> No

Mental Health Behavioral Profile		
Concentration / Task Limitations within the Past 6 Months	Adapting To Changes within the Past 6 Months	
(Other) Concentration / Task Limitations within the Past 6 Months	(Other) Adapting To Changes within the Past 6 Months	
Mental Health Treatments		
<input style="border: 1px solid black;" type="button" value=" Add Additional Treatment "/>		
Treatments Received within the Past 2 Years	Date Treatment was Received (MM/DD/YYYY)	<input style="border: 1px solid black;" type="button" value=" Delete "/>
Mental Illness Interventions		
<input style="border: 1px solid black;" type="button" value=" Add Additional Intervention "/>		
Interventions to Prevent Hospitalization	Intervention Treatment Date (MM/DD/YYYY)	<input style="border: 1px solid black;" type="button" value=" Delete "/>
If Other MI Intervention, Specify		
Orientation		
Oriented to Time <input type="radio"/> Yes <input type="radio"/> No	Oriented to Person <input type="radio"/> Yes <input type="radio"/> No	Oriented to Place <input type="radio"/> Yes <input type="radio"/> No
Mood and Behavior		
<input type="checkbox"/> Socially Inappropriate/Disruptive Behavioral Symptoms	<input type="checkbox"/> Wandering	<input type="checkbox"/> Physically Abusive
<input type="checkbox"/> Resists Care	<input type="checkbox"/> Verbal Expressions of Distress	<input type="checkbox"/> Self Deprecation
<input type="checkbox"/> Anxious Non-Health Complaints Concerns	<input type="checkbox"/> Persistent Anger	<input type="checkbox"/> Repetitive Verbalizations
<input type="checkbox"/> Sad, Pained, Worried, Facial Expressions	<input type="checkbox"/> Crying/Tearfulness	<input type="checkbox"/> Unpleasant Mood In Morning
<input type="checkbox"/> Reduced Social Interaction/Isolation	<input type="checkbox"/> Repetitive Physical Movements	<input type="checkbox"/> Withdrawal From Activities Of Interest
Interpersonal Functioning		
<input type="checkbox"/> Combative	<input type="checkbox"/> Dangerous to Self, Others, or Property ?	<input type="checkbox"/> Altercations
<input type="checkbox"/> Evictions Due To Socially Inappropriate Behavior	<input type="checkbox"/> Fear of Strangers	<input type="checkbox"/> Illogical Comments
<input type="checkbox"/> Suicide Attempts/Ideation	<input type="checkbox"/> Social Isolation	<input type="checkbox"/> Excessive Irritability
<input type="checkbox"/> Hallucinations	<input type="checkbox"/> Paranoid Ideation	<input type="checkbox"/> Homicidal
Other Conditions		
Categoricals		
Is this a Request for a Short Term Nursing Facility Stay? <input type="radio"/> Yes <input type="radio"/> No	If Yes Then Indicate the Duration of the Nursing Facility Stay	
Communication		
Makes Self Understood	Understand/Use Of Language	

< First Page << Previous Next >> Last Page >| **North Carolina PASRR Level I Screen** Print Form

Functional Limitations	
Does the applicant have any functional limitations? <input type="radio"/> Yes <input type="radio"/> No	Select All That Apply <div style="border: 1px solid black; height: 20px; background-color: #e0f0ff;"></div>

Screener Certification	
Supplier Of Information <div style="border: 1px solid black; height: 20px; background-color: #e0f0ff;"></div>	Please select the most appropriate option below: <input type="radio"/> Yes I am legal representative of the individual being screened or paid by or affiliated with a Licensed Adult Care Home. As per the aforementioned process, I have received the paper form by an approved referring agency and will upload a scanned copy upon request. <input type="radio"/> No I am not legal representative of the individual being screened, and I am not paid by, or affiliated with a Licensed ACH.

By checking the box below, I certify that I have completed the above screening of the applicant to the best of my knowledge.
I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation.
This screening is NOT physician's orders. There is no physician's signature on the form

<input type="checkbox"/> Screener Certification
<div style="border: 1px solid black; height: 40px;"></div>

Attachment E: Prior Approval Process

A. Requesting Prior Approval

Prior approval (PA) requests for nursing facility level of care (LOC) are initiated by submitting the FL-2 form DMA 372-124 electronically through the website of the DHHS utilization review contractor.

Records may also be sent to justify the LOC.

The FL-2 form DMA 372-124 or the Physician's Signature for authorization of LOC form DMA-0100 must be current, with a physician's signature dated within 30 calendar days of receipt by the DHHS utilization review contractor.

The attending physician shall **sign and date** the FL-2 form DMA 372-124 or the Physician's Signature for authorization of LOC form DMA-0100 **prior to** submitting the approval request.

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

The prior approval timelines are based on the PASRR authorization timeframes and restrictions. Nursing facility services must not be authorized prior to or past the PASRR authorization timeframes.

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 an Electronic FL-2

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

1. The FL-2 form DMA 372-124 or the Physician's Signature for authorization of LOC form DMA-0100 must be accurately completed, **signed, and dated by the attending physician**. A PASRR number must be obtained, before submission for prior approval. The FL-2 is then submitted via the identified Web access to the DHHS utilization review contractor's Long Term Care Prior Approval Unit.
2. The DHHS utilization review contractor's nurse analyst, following 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 (refer to **Subsection 3.2.2**), the DHHS utilization review contractor assigns a prior approval number. An approval notice is sent to the Office Administrator inbox assigned to the provider who submitted the prior approval request, (hospital, nursing facility, beneficiary's county DSS). The provider who submitted the prior approval request shall notify the county DSS when the request is approved.
4. If the nursing facility LOC is not evident upon review of the FL-2, a denial letter or a request for additional information is sent by mail (certified mail if the request is denied) to the provider who submitted the prior approval request and to the Office Administrator inbox assigned to the provider. A copy of the FL-2 with medical records may be submitted to the DHHS utilization review contractor by mail, upload, or faxed along with a system generated cover sheet printed from the website of the DHHS utilization review contractor for re-evaluation.

Note: The DHHS utilization review contractor will re-evaluate the additional information if it is received within 10 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 DHHS utilization review contractor'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. A denial letter is sent to the provider who submitted the prior approval request. A denial letter and appeal form is also sent to the beneficiary.

Note: Information on an appeal of denial of nursing facility level of care is located at <http://www.oah.state.nc.us/hearings/medicaid.html>.

C. Retroactive Prior Approval

It is the responsibility of the nursing facility to ensure that an approved prior approval is on file with the DHHS utilization review contractor when a beneficiary is admitted to their facility.

1. Requests for retroactive approval for nursing facility services may be approved when the initial authorization is requested or after the prior approval request has been approved.
2. The DHHS utilization review contractor shall approve up to 30 calendar days of retroactive coverage during the initial authorization if the admission date is on the FL-2 form DMA 372-124 or the Physician's Signature for authorization of level of care form DMA-0100.
3. Retroactive coverage requests exceeding 30 calendar days, but less than 90 calendar days, must be made in writing and contain all pertinent health records for the dates of service requested. Requests for retroactive coverage can be made during the initial request for prior approval or after the prior approval request has been submitted and approved.
4. Submit copies of pertinent nurses' notes, a history and physical, therapy notes, therapy evaluations, signed medication administration records, activity of daily living sheets and any other pertinent information that justifies the nursing facility LOC.
5. The health records submitted **must** date back to the requested date for retroactive coverage.
6. A cover letter requesting retroactive coverage indicating the "from" and "to" dates, along with a contact person's name and telephone number must be attached to the prior approval or the information may be documented in the Additional Information section of the prior approval.
7. Request for retroactive approval on an authorized prior approval must be initiated through the call center of the DHHS utilization review contractor.
8. Retroactive prior authorization is not applicable to beneficiaries covered under Medicaid Managed Care.

Note: The prior approval timelines are based on the PASRR authorization timeframes and restrictions. Nursing facility services must not be authorized prior to or past the PASRR authorization timeframes.

D. Prior Approval for Ventilator Services

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

1. An FL-2 form with:
 - a. PASRR number.
 - b. Current physician’s signature and date.
 - c. National Provider Identifier of the facility that is or will be rendering ventilator services.
2. Health records, documenting the number of hours of ventilator use and the ventilator settings.
3. A completed 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 submitted electronically to the DHHS utilization review contractor’s Prior Approval Unit for review based on the N.C. Medicaid LOC criteria for ventilator care.

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

E. Physician Signature

The FL-2 form DMA 372-124 and the Physician’s Signature for authorization of level of care form DMA-0100 require a valid physician signature and date. Medicaid’s DHHS utilization review contractor shall 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 form DMA 372-124 or the Physician’s Signature for authorization of level of care form DMA-0100 **only** if the attending physician co-signs and dates the form. **The corrected signature and date is not for the purpose of updating an expired FL-2.**

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>

Attachment F: FL-2 Form



NC Medicaid Long Term Care FL2 Form



Recipient Information

NC Medicaid-372-124

1. Recipient Last Name: _____ 2. First Name: _____ 3. Recipient DOB: _____
 4. Recipient ID #: _____ 5. Recipient Gender: _____ 6. SSN: _____
 7. Admission Date (current location): _____ 8. Facility Name: _____ 9. PASRR #: _____
 10. Facility Address: _____ 11. Provider Number: _____
 12. Attending Physician Name/Address: _____
 13. Relative Name/Address: _____
 14. Current Level of Care: Home SNF ICF Hospital Dom Other: _____
 15. Requested Level of Care: Vent Care Nursing Facility NF Rehab Spec. Hosp Rehab Extended Care
 OOS NF OOS Vent CAP/CH SNF CAP/CH Hosp CAP/DA SNF CAP/DA ICF Other: _____
 16. Discharge Plan: Home SNF ICF Dom Other: _____

Diagnosis Information

	Admitting Diagnosis (code AND description)	Date of Onset	Primary <input checked="" type="checkbox"/>
1			
2			
3			
4			
5			

Patient Information

Disoriented		Ambulatory Status		Bladder		Bowel	
<input type="checkbox"/> Constantly	<input type="checkbox"/> Intermittently	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Semi-Ambulatory	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Continent	<input type="checkbox"/> Incontinent
Inappropriate Behavior		<input type="checkbox"/> Non-Ambulatory		<input type="checkbox"/> Indwelling Catheter		<input type="checkbox"/> Colostomy	
<input type="checkbox"/> Wanderer	Functional Limitations		<input type="checkbox"/> External Catheter		Respiration		
<input type="checkbox"/> Verbally Abusive	<input type="checkbox"/> Sight		Communication of Needs		<input type="checkbox"/> Normal		
<input type="checkbox"/> Injurious to Self	<input type="checkbox"/> Hearing		<input type="checkbox"/> Verbally		<input type="checkbox"/> Tracheostomy		
<input type="checkbox"/> Injurious to Others	<input type="checkbox"/> Speech		<input type="checkbox"/> Non-Verbally		<input type="checkbox"/> Other:		
<input type="checkbox"/> Injurious to Property	<input type="checkbox"/> Contractures		<input type="checkbox"/> Does Not Communicate		<input type="checkbox"/> O2	<input type="checkbox"/> PRN:	<input type="checkbox"/> Cont:
<input type="checkbox"/> Other:	Activities Social		Skin		Nutrition Status		
Personal Care Assistance		<input type="checkbox"/> Passive		<input type="checkbox"/> Normal		<input type="checkbox"/> Diet	
<input type="checkbox"/> Bathing	<input type="checkbox"/> Active		<input type="checkbox"/> Other:		<input type="checkbox"/> Supplemental		
<input type="checkbox"/> Feeding	<input type="checkbox"/> Group Participation		<input type="checkbox"/> Decubiti - Describe:		<input type="checkbox"/> Spoon		
<input type="checkbox"/> Dressing	<input type="checkbox"/> Re-Socialization				<input type="checkbox"/> Parenteral		
<input type="checkbox"/> Total Care	<input type="checkbox"/> Family Supportive				<input type="checkbox"/> Nasogastric		
Physician Visits		Neurological		<input type="checkbox"/> Dressings:		<input type="checkbox"/> Intake and Output	
<input type="checkbox"/> 30 Days	<input type="checkbox"/> Convulsions/Seizures				<input type="checkbox"/> Force Fluids		
<input type="checkbox"/> 90 Days	<input type="checkbox"/> Grand Mal				<input type="checkbox"/> Weight		
<input type="checkbox"/> Over 180 Days	<input type="checkbox"/> Petit Mal				<input type="checkbox"/> Height		
	<input type="checkbox"/> Frequency						
Special Care Factors		Frequency		Special Care Factors		Frequency	
<input type="checkbox"/> Blood Pressure				<input type="checkbox"/> Bowel & Bladder Program			
<input type="checkbox"/> Diabetic Urine Testing				<input type="checkbox"/> Restorative Feeding Program			
<input type="checkbox"/> PT (by licensed PT)				<input type="checkbox"/> Speech Therapy			
<input type="checkbox"/> Range of Motion Exercises				<input type="checkbox"/> Restraints			
Medications - Name & Strength, Dosage and Route							
1.		7.					
2.		8.					
3.		9.					
4.		10.					
5.		11.					
6.		12.					
X-ray and Laboratory Findings/Date:							
Additional Information:							

Physician's Signature _____

Date _____

Attachment G: Physician's Signature for Authorization

NC DHB Physician's Signature for authorization of level of care

This form is to verify that I have provided the information submitted on the State Approved Level Of Care Form on the NCTracks website on behalf of the recipient. I have assessed the following level of care to be appropriate for this individual:

NF ____ NF Rehab ____ Vent ____ Specialty Hospital Rehab ____ Extended Care

CAP/DA Intermediate ____ CAP/DA Skilled ____

CAP/C Skilled ____ CAP/C Hospital PACE ____

Recipient Information:

Name: _____ Recipient ID: _____

Receiving Facility Name (if known): _____

Date LOC/ determination made: _____

Date of Move to facility (if known) _____

I verify that the information on the state approved level of care form is accurate and reflects the needs of the recipient regarding the above-named individual.

MD Signature

Date Signed

Fax this form to NCTracks at: (855) 710-1964

DMA-0100

Attachment H: 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: _____
- 4) REASON(S) FOR TRANSFER/DISCHARGE:
Under federal law 42 CFR §483.15, 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 due to the clinical or behavioral status of the resident;
 - 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.
- 5) In addition to notifying you (i.e. the resident) of this transfer/discharge, _____ has also been notified.
[Resident's representative(s)]
- 6) THIS FACILITY PLANS TO TRANSFER OR DISCHARGE YOU TO:

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

APPEAL RIGHTS

You have the right to appeal this transfer/discharge to the DHHS Hearing Office **WITHIN 11 CALENDAR 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 calendar day or your right to appeal is waived. If you wish to review your medical record, the facility must allow you to see it no later than five working days prior to the hearing.

LONG TERM CARE OMBUDSMAN

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 contact information is below:

NAME: _____ EMAIL: _____

ADDRESS: _____ PHONE: _____

Facility sent Ombudsman a copy of the Notice: Yes No

If mentally ill or developmentally disabled, you or your family member or legal representative may wish to contact: DISABILITY RIGHTS NORTH CAROLINA, 3724 National Drive, Suite 100, Raleigh, NC 27612. Telephone number: (919) 856-2195 or 1-877-235-4210 or TTY 1-888-268-5535

Signature of Administrator

Date

NC Medicaid-9050 (8/2019)

Attachment I: 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: _____

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) 814-0090.

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 (11) CALENDAR 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) 882-1179

Email: Medicaid.Hearings@dhhs.nc.gov

Informational webinars regarding the Transfer/Discharge hearing process can be found at <http://www.ncdhhs.gov/dma/ahearings.htm>

NC Medicaid-9051 (8/2019)

Attachment J: Medicaid Minimum Data Set Validation Program

A. Background

On October 1, 2004, NC Medicaid 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 NC Medicaid 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 health 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 or remote MDS reviews at each nursing facility in North Carolina.

B. Resource Utilization Group Reimbursement System (RUG)

N.C. Medicaid uses the 34 Grouper RUG system or a subsequent reimbursement 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. To maintain the RUG case mix reimbursement system, an OSA must be submitted with all federally required MDS assessments with an assessment reference date (ARD) of October 1, 2023 or later. The OSA must have the same ARD as the MDS assessment.

C. Case Mix

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

D. Case Mix Index

The Case Mix Index (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 contains 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 NC Medicaid 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 (2) 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 contain 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 contains 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 support staff by phone and email three (3) 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 (1) 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 conference 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 NC Medicaid.
10. NC Medicaid 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.

Effective for MDS assessments with an ARD date of October 1, 2023, and after, the determination of delinquent MDS assessments will be as follows:

a. Federally required MDS assessment records without a concurrent OSA will be delinquent for all days assigned to the assessment record (beginning on the ARD, entry date or quarter start date.)

1. Delinquent assessment records with a Medicare or other payor source will be assigned a RUG code of SE3 with the highest case mix index.
2. Delinquent assessment records with a Medicaid payor source will be assigned a RUG code of AAA with the lowest case mix index.
3. OSA submissions with an ARD (A2300) that do not match a federally required assessment will be excluded from the quarterly MDS processing and case mix index calculation, which may result in delinquent record determinations.

J. Unsupported Minimum Data Set Assessments

The MDS is unsupported when the RN reviewer does not find adequate documentation in the resident's health record as defined by the guidelines issued by NC Medicaid to support the RUG classification level. An unsupported MDS assessment may result in a different RUG classification from the one submitted by the facility. When unsupported MDS assessments result in a changed RUG classification and the unsupported cases exceed the established limit, the CMI will also change.

K. Effect of Unsupported Thresholds

Facilities are required to maintain no more than 25 percent unsupported MDS values.

Failure to do so results in a recalculated RUG category for all MDS assessments and a recalculation of the direct rate. A retrospective rate adjustment may also be applied.

Facilities with 26 percent to 39 percent unsupported MDS values must have an on-site MDS review the following year. Facilities with 40 percent or greater unsupported MDS values must have a follow-up on-site MDS review no earlier than 180 calendar days following the exit interview.

L. Minimum Data Set Validation Review Reconsideration

If the facility disagrees with the 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 NC Medicaid within 15 business days of the receipt of the MDS validation findings letter. The request is sent to the NC Medicaid Facility Services Unit Manager, 2501 Mail Service Center, Raleigh, N.C. 27699-2501 or email the Nurse Consultant for Long-Term Care. The letter to NC Medicaid must describe in detail the reason a reconsideration has been requested.

3. NC Medicaid reviews the findings in question and renders a decision. This decision is sent in writing from NC Medicaid 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 NC Medicaid Facility Services Unit Manager within 10 calendar days of receipt of the decision. The information will be reviewed again by a neutral NC Medicaid staff member. A final decision is rendered in writing to the facility within 30 calendar days.

Attachment K: 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 must be evaluated and updated by the facility at least annually and whenever necessary.
4. Quality initiatives that a facility might adopt are 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 shall provide evidence that a program is in place. Evidence may include written documentation, interviews with facility staff and residents or their legally responsible person (written, phone, or face-to-face), or an on-site review of the program.
6. NC Medicaid may review the facility's quality initiative(s) every 12 to 15 months.

According to 42 CFR 483.75(g),(1) a facility shall maintain a quality assessment and assurance committee.

- a. The committee shall consist, at a minimum, of:
 1. The Director of nursing services.
 2. The Medical Director or his or her designee.
 3. At least three (3) other members of the facility's staff, at least one (1) of whom must be the administrator, owner, a board member or other individual in a leadership role.
 4. The infection preventionist.
- b. The quality assessment and assurance committee shall comply with 42 CFR 483.75(g)(2)(i), (ii), (iii).