

## **Instructions and Detail to Accompany the North Carolina Nursing Home Monthly Assessment Fee Statement**

These expanded instructions and explanations should be used to assist in the accurate completion of the Monthly Assessment Fee Statement.

- Report all nursing facility bed days. Do not include independent living, assisted living, adult care home or rest home bed days in these amounts.
  - Provider's Month End and Year End Totals (patient days) must agree with the provider's midnight census.
1. Nursing Facility Name: Enter the Nursing Facility Name as it appears on the Nursing Home License. Enter the name consistently on each month's report.
  2. Provider Number: Enter the facility's skilled provider number.
  3. Federal Tax ID Number: Enter the Federal Tax Identification number.
  4. Total Medicaid Patient Days, Current Month Ended Total: Enter the number of nursing facility days paid or payable by North Carolina Medicaid through the nursing facility reimbursement program for the current month based on dates of service. This number should include any Medicaid pending days as well as Therapeutic Leave days. Certified Medicaid Ventilator Bed Days with negotiated rates and Certified Medicaid Head Injury Program Days are not considered nursing program days for this assessment and should not be included in this total.
  5. Total Private/Other Non-Medicare Days, Current Month Ended Total: Enter the number of any nursing facility patient days not paid or payable by either Medicare or Medicaid as a nursing facility day for the current month based on dates of service. This includes all nursing days that are paid for privately by the patients through cash or private long-term care insurance. Hospice, VA, Bed Hold days and all other facility days that are not expressly paid for as a nursing facility day through North Carolina Medicaid or Medicare as the primary payer source should also be included in this total.
  6. Total Non-Medicare Days, Current Month Ended Total: Add items 4 and 5 and enter the result here.
  7. Total Medicare Patient Days, Current Month Ended Total: Enter the number of any nursing facility patient days for the current month based on dates of service paid or payable by Medicare Part A under the traditional fee for service agreement or under a Medicare Health Maintenance Organization (HMO) Contract.
  8. Total Patient Days, Current Month Ended Total: Add items 6 and 7 and enter the result here.
  9. Total Medicaid Patient Days, Documented Prior Period Adjustments: Enter the net number of previously unreported Medicaid patient day adjustments from prior periods. These adjustments would include patient days classified as Medicaid days that have been reclassified to non-Medicaid days as well as days that were previously classified as non-Medicaid days that were reclassified to Medicaid days.

## **Instructions and Detail to Accompany the North Carolina Nursing Home Monthly Assessment Fee Statement**

**Example:**

Patient A was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient A was actually private pay. These 10 days should be reclassified from Medicaid to Private/Other Non-Medicare days. The Medicaid days impact for this would be a decrease of 10 days (-10).

Patient B was originally classified as Medicare for 2 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days should be reclassified from Medicare to Medicaid. The Medicaid days impact for this would be an increase of 2 days (+2).

The net number of previously unreported Medicaid patient day adjustments from prior periods would be -8 (-10 plus +2).

A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

10. Total Private/Other Non-Medicare Days, Documented Prior Period Adjustments: Enter the number of previously unreported Private/Other Non-Medicare patient day adjustments from prior periods. These adjustments would include patient days classified as Private/Other Non-Medicare days that have been reclassified to either Medicare or Medicaid as well as days that were previously classified as Medicare or Medicaid days that were reclassified to Private/Other Non-Medicare days.

**Example:**

Patient A was originally classified as Medicaid for 10 days in the previous month. A determination has been made that Patient A was actually private pay. These 10 days should be reclassified from Medicaid to Private/Other Non-Medicare days. The Private/Other Non-Medicare days impact for this would be an increase of 10 days (+10).

Patient C was originally classified as Private/Other Non-Medicare for 4 days in the previous month. A determination has been made that those days should have been classified as Medicare. These 4 days will be reclassified from Private/Other Non-Medicare to Medicare. The Private/Other Non-Medicare days impact for this would be a decrease of 4 days (-4).

The net number of previously unreported Private/Other Non-Medicare patient day adjustments from prior periods would be +6 (+10 plus -4).

A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

11. Total Non-Medicare Days, Documented Prior Period Adjustments: Add items 9 and 10 and enter the result here.

## **Instructions and Detail to Accompany the North Carolina Nursing Home Monthly Assessment Fee Statement**

12. Total Medicare Patient Days, Documented Prior Period Adjustments: Enter the number of previously unreported Medicare patient day adjustments from prior periods. These adjustments would include patient days classified as Medicare days that have been reclassified to either Medicaid or Private/Other Non-Medicare as well as days that were previously classified as Medicaid or Private/Other Non-Medicare days that were reclassified to Medicare days.

**Example:**

Patient B was originally classified as Medicare for 2 days in the previous month. A determination has been made that those days should have been covered by Medicaid. These 2 days will be reclassified from Medicare to Medicaid. The Medicare days impact for this would be a decrease of 2 days (-2).

Patient C was originally classified as Private/Other Non-Medicare for 4 days in the previous month. A determination has been made that those days should have been classified as Medicare. These 4 days will be reclassified from Private/Other Non-Medicare to Medicare. The Medicare days impact for this would be an increase of 4 days (+4).

The net number of previously unreported Medicare patient day adjustments from prior periods would be +2 (-2 plus +4).

A sample worksheet showing this example and a blank sample worksheet are attached. This worksheet is not required, but is merely a sample that you may use if you desire. All prior period adjustments must be supported with documentation. The attached sample worksheet is not considered supporting documentation. Supporting documentation may include and FL-2, Medicaid Remittance Advice, or other official documentation.

13. Total Patient Days, Documented Prior Period Adjustments: Add items 11 and 12 and enter the result here. A result of zero indicates that days were only reclassified. A positive number would indicate that adjustments have resulted in an increase in total days. A negative number would indicate that adjustments have resulted in a decrease in total days.
14. Total Medicaid Patient Days, Adjusted Monthly Total: Add items 4 and 9 and enter the result here.
15. Total Private/Other Non-Medicare Days, Adjusted Monthly Total: Add items 5 and 10 and enter the result here.
16. Total Non-Medicare Days, Adjusted Monthly Total: Add items 14 and 15 and enter the result here.
17. Provider Assessment Daily Rate: This is the assessment rate as indicated on the cover letter that accompanied the reporting packet.
18. Monthly Provider Fee Due: Multiply item 16 by item 17 and enter the result here. This is the amount of assessment due on or before the 15<sup>th</sup> of the month following the reporting period. Failure to submit the completed provider fee report and full payment by the due date shall result in penalties and interest as stated in the North Carolina Provider Agreement and Controller Cash Management Plan.

**Instructions and Detail to Accompany the  
North Carolina Nursing Home Monthly Assessment Fee Statement**

19. Total Medicare Patient Days, Adjusted Monthly Total: Add items 7 and 12 and enter the result here.
20. Total Patient Days, Adjusted Monthly Total: Add items 16 and 19 and enter the result here.
21. Total Medicaid Patient Days, Year to Date Cumulative: Add item 14 from the current period report to item 14 from the previous period report and enter the result here.
22. Total Private/Other Non-Medicare Days, Year to Date Cumulative: Add item 15 from the current period report to item 15 from the previous period report and enter the result here.
23. Total Non-Medicare Days, Year to Date Cumulative: Add items 21 and 22 and enter the result here.
24. Total Medicare Patient Days, Year to Date Cumulative: Add item 19 from the current period report to item 19 from the previous period report.
25. Total Patient Days, Year to Date Cumulative: Add items 23 and 24 and enter the result here.
26. Signed by: Upon completion, this form must be signed by an Owner, Partner, Officer or Administrator of the reporting facility. If not signed, the form will be considered incomplete.
27. Title: Title of the individual who signed the form.
28. Print Name: Legibly print the name of the individual who signed the form.
29. Telephone/E-mail: Enter the Telephone number and the e-mail address of the individual who signed the form.