First Health Services Corporation
A Magellan Health Company

Billing Guidelines for Provider Type 19

Nursing Facility

A nursing facility provides 24-hour skilled and intermediate nursing services to individuals who, due to medical disorders, injuries, developmental disabilities and/or related cognitive and behavioral impairments, exhibit the need for medical, nursing, rehabilitative and psychosocial management above the level of room and board.

State policy for nursing facilities is in Medicaid Services Manual (MSM) Chapter 500 at http://dhcfp.nv.gov.

Please contact the Division of Health Care Financing and Policy (DHCFP) Continuum of Care Unit at (775) 684-3759 with any questions regarding Nevada Medicaid nursing facility policy.

Billing Authorization

All nursing facilities must submit the Nursing Facility Tracking Form to DHCFP in order to receive a billing authorization. This form is on the DHCFP web site at http://dhcfp.nv.gov/nursing.htm.

This form is required for all:

- Admissions
- Discharges - **Note:** Failure to immediately report discharge information may prevent the recipient from receiving other necessary services and/or prevent other providers from receiving payment.
- Deaths
- Hospice enrollments or disenrollments
- Level of Care changes
- Medicaid Managed Care disenrollments
- New or retro eligibility determinations
- Payment continuations

After DHCFP processes the Nursing Facility Tracking Form, a billing authorization letter is mailed to the provider showing the authorized dates. Authorized dates may also be viewed on the Electronic Verification System (EVS). See the EVS User Manual for instruction on viewing the EVS eligibility screens.

Out-of-State Requirements

Out-of-state nursing facilities must obtain an authorization number when billing for a differential rate. The authorization number must be entered into Field 63 of the UB-04 claim form. Claim form instructions are on First Health Services' website (select "Billing Information" from the "Providers" menu).

A claim must reflect authorized dates of service from one prior authorization only. For example, if the date range on one prior authorization ends on the 15th of the month and the date range on a second prior authorization begins on the 16th of that month, two separate claims are required–one claim for each date range during the month.

Special Billing Instructions

Leave of Absence (LOA) days

Use revenue code 0183 to bill for up to 24 LOA days per calendar year. On the first claim line, enter revenue code 0101 or 0123 and the number of days the recipient spent in the nursing facility. On the second claim line, enter revenue code 0183 and the number of LOA days for the billing period.

Free-standing Nursing Facility

Use the following revenue codes for the recipient's specific level of care:

- Revenue code 0101: NF Standard or NF Ventilator Dependent
- Revenue code 0123: NF Pediatric Specialty Care I or NF Pediatric Specialty Care II
- Revenue code 0183: LOA days

Hospital-based Nursing Facility, Out-of-state Nursing Facility and Veteran's Nursing Home

Use revenue code 0101 exclusively for the recipient's room and board charges.

Hospital-based Nursing Facility

List and use the appropriate revenue codes to bill for ancillary services/items (excluding pharmacy).

Additional Notes

The UB-04 claim form instructions are available on First Health Services' website (select "Billing Information" from the "Providers" menu).

All recipients must receive a **Level of Care (LOC)** and **Pre-Admission Screening and Resident Review (PASRR)** prior to nursing facility admission. See MSM Chapter 500, for requirements.

If a recipient in a nursing facility is enrolled in the Medicaid **hospice program**, the hospice provider is responsible for billing Medicaid for the nursing facility services.

If a recipient was enrolled in a **Managed Care Organization (MCO)** upon admission, that MCO is responsible for the first 45 days of nursing facility payment before the recipient converts to the Medicaid Fee For Service (FFS) benefit plan.

Patient Liability (PL) does not apply during the first 20 days of a nursing facility stay when the recipient is also eligible for Medicare benefits. Medicare coinsurance and deductibles are not to exceed the Medicaid maximum allowable amount.