



NURSING FACILITIES

This document is subject to change. Please check our web site for updates.

This provider manual outlines policy and claims submission guidelines for claims submitted to the North Dakota Health Enterprise MMIS.

This document covers services provided by nursing facilities (NF) that are certified to participate in the Medicare program, licensed and enrolled with North Dakota (ND) Medicaid.

LEVEL OF CARE

ND Medicaid will not cover nursing facility services unless the individual meets nursing facility level of care criteria.

LIMITS ON LEAVE DAYS

ND Medicaid will cover a maximum of 15 days per occurrence for hospital leave. The purpose of the hospital leave policy is to ensure that a bed is available when a resident returns to the nursing facility. A nursing facility may not bill for hospital leave days if it is known that the resident will not return to the facility.

Once the nursing facility accepts reimbursement for hospital leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for hospital leave days beyond the 15th day that the resident's bed was held but they are non-covered days.

ND Medicaid will cover a maximum of 24 therapeutic leave days per resident per rate year. The rate year begins January 1st for in-state LTC nursing facilities.

Once the nursing facility accepts reimbursement for therapeutic leave on behalf of a Medicaid resident, then the nursing facility must still bill ND Medicaid for therapeutic leave days beyond the 24th day the resident's bed was held but they are non-covered days.

Hospital and therapeutic leave days, occurring immediately following a period when a resident received Medicare Part A benefits in the facility, are non-covered days.

The day of death is paid for in all instances except when a resident is in a Medicare benefit period, in which case the day of death is a non-covered day. The day of discharge to any location for a resident is a non-covered day.

BILLING GUIDELINES

Nursing facilities must bill for services using the North Dakota Web Portal using the electronic claims submission web pages or Electronic Data Exchange transaction. The claim must include a valid National Provider Identification number (NPI) and taxonomy code.

Claims must be submitted to ND Medicaid using the applicable *Bill Type 211-218*.

The bill type frequency must coincide with the status code billed. Claims must be submitted using the following status codes:

- 01** Discharged to Home or Self-Care
- 02** Discharged/Transferred to a Short-Term General Hospital
- 04** Discharged/Transferred to a Facility that Provides Custodial or Supportive Care
- 20** Expired
- 30** Still a Patient
- 40** Expired at Home
- 41** Expired in a Medical Facility
- 42** Expired – Place Unknown
- 50** Hospice - Home
- 51** Hospice – Medical Facility Providing Hospice Level of Care
- 61** Discharged/Transferred to a Hospital-Based Medicare Approved Swing Bed
- 62** Discharged/Transferred to an Inpatient Rehabilitation Facility including Rehabilitation Distinct Part Units of a Hospital
- 63** Discharged/Transferred to a Medicare Certified Long Term Care Hospital
- 65** Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital
- 66** Discharged/Transferred to a Critical Access Hospital
- 70** Discharged/Transferred to another Type of Healthcare Institution

A resident on hospital or therapeutic leave on the last day of the month whose bed is being held by the facility is “Still a Patient”.

The number of units billed must include the date of discharge or death.

A separate claim line must be submitted beginning with the start date of a new MDS classification period whether or not the classification changed.

Claims must be submitted using the following *Revenue* Codes when billing for:

Revenue Code 110	In-House Medicaid Days
Revenue Code 160	Medicare Full Benefit Period Days
Revenue Code 169	Medicare Coinsurance Days
Revenue Code 182	Medicare Non-Covered Leave Days
Revenue Code 183	Therapeutic Leave Days
Revenue Code 185	Hospital Leave Days

A facility must submit a claim for every month a Medicaid eligible resident is in the facility, even if insurance (including Medicare) has paid for the charges. This allows the system to start applying recipient liability towards other claims. The claim should be submitted immediately after the month is over. Do not bill more than one calendar month per claim.

ND Medicaid cannot make any payment for nursing facility services to the nursing facility provider if a resident has elected hospice care. The hospice is paid the rate applicable to the resident and is responsible for paying the nursing facility for services provided to the resident. Recipient liability, if any, is applied to the hospice provider's claim. Once a resident has elected hospice benefits, the LTC nursing facility provider may not submit a claim for services provided while the resident is on hospice.

A hospice provider must submit a revocation of election form to the department before payment can be made to a nursing facility for a resident who no longer is receiving hospice benefits. The facility should contact the hospice provider to ensure that a revocation notice has been filed with the department prior to billing for nursing facility services.

IN-STATE NURSING FACILITIES

The rate established for in-state nursing facilities is an all-inclusive rate for routine services. Routine services include supplies, therapies, nursing facility supplies, equipment, non-emergency transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the in-state nursing facility rate, such as x-ray, lab, drugs, etc. must be billed by the provider furnishing the service.

OUT-OF-STATE NURSING FACILITIES

The rate for out-of-state nursing facilities is an all-inclusive rate and is based on the rate established by the Medicaid agency in the state where the facility is located. The routine

services included in the rate are determined by the rate established by that state's Medicaid agency, such as; supplies, therapies, nursing facility supplies, equipment, non-emergency transportation, and non-legend drugs. Separate billings for these items will not be paid. Ancillary charges that are not included in the out-of-state nursing facility rate must be billed by the provider furnishing the service.

Bill any ancillary charges (example: therapy charges) under the appropriate revenue code.