REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Original Issue Date	Next Annual Review	Effective Date
06/07/2017	06/07/2018	02/01/2018-10/31/2022
Policy Name		**Policy Number**
Nursing Facility Services		PY-0321
Policy Type		
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

Contents of Policy

A. SUBJECT

Nursing Facility Services

B. BACKGROUND

Nursing Facilities are institutions that provide nursing and medical care to patients who no longer require acute care settings, but do require licensed nursing services, rehabilitation services, or other health-related services on a regular basis, that cannot be provided in the home.

C. DEFINITIONS

- **RUG** (Resource Utilization Group) is the system of classifying nursing facility residents into case mix groups.

D. POLICY

I. Prior Authorization is required for all admissions to a Nursing Facility.

II. Admission Criteria

A. Prior to nursing facility admission, all patients must have a Pre-Admission Screening and Resident Review (PASRR) completed.

B. In cases where the patients' primary diagnosis is psychiatric or there is psychiatric care involved, the patient is not considered a candidate for intermediate care services. The individual must also have medical care needs that meet the criteria for intermediate care facility placement.

C. Intermediate care services may be provided to a patient with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician when the following criteria is met.

1. Medical Status

a. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician**. In addition to this criteria, the patient's specific medical condition must require any of the following (b-h) plus one item from 2 or 3.**

b. Nutritional management; which may include therapeutic diets or maintenance of hydration status.

c. Maintenance and preventive skin care and treatment of skin conditions such as cuts, abrasions or healing decubiti.

d. Catheter care such as catheter change and irrigation.

e. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly).

f. Restorative nursing services such as range of motion exercises and bowel and bladder training.

g. Monitoring of vital signs and laboratory studies or weights.

h. Management and administration of medications including injections.

2. Mental Status (**must be such that the cognitive loss is more than occasional forgetfulness**).

a. Documented short or long-term memory deficits with etiologic diagnosis Cognitive loss addressed on MDS/ care plan for continued placement.

b. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/ care plan for continued placement.

c. Problem behavior, i.e., wandering, verbal abuse, physically and /or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention.

d. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia.

3. Functional Status
   a. Transfer and locomotion performance of resident requires limited extensive assistance by staff through help or one-person physical assist.
   b. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals.
   c. Requires direct assistance of another person to maintain continence.
   d. Documented communication deficits in making self-understood or understanding others. Deficits must be addressed in the medical record with etiologic diagnosis address on MDS/ care plan for continued placement.
   e. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (**If this is the only evaluation of care identified, another deficit in functional status is required**).

III. Reimbursement
   A. Reimbursement rates are negotiated at the time of authorization request, upon approval of services and based on an agreed percentage of the RUG score.
   B. For members admitted to a Nursing Facility prior to becoming effective with CareSource the following will apply:
      1. If the member is already admitted to ongoing non acute treatment that has been previously covered prior to the patients effective date with CareSource, services will be covered for at least 30 calendar days to allow time for a clinical review and, if necessary, Transition of Care.
      2. CareSource will not be obligated to cover services beyond 30 calendar days, even if another carriers' authorization was for a period greater than 30 calendar days, if the clinical review determines continued authorization is not medically necessary.
   C. The number of days of care charged for nursing facility services is always in units of full days, beginning at midnight and ends twenty-four hours later. Any part of a day, including the day of admission counts as a full day. However, the day of discharge or death is not counted as a billable day. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one billable day.
   D. Mechanical Ventilation is reimbursed at a per diem rate and is all inclusive for the patients care; no other medical billing is allowed for nursing services.
   E. Nursing Facilities that find, after assessment, that a patient requires a specialized or custom wheelchair in order to maximize independence, are responsible for the expense of that specialized or custom wheelchair and my not bill separately or instruct a Durable Medical Provider to bill CareSource for payment.
   F. The reimbursement rate established is an inclusive payment that covers the cost of the following:
      1. Patients room and board
      2. Special dietary needs
      3. Dietary supplements used for tube or oral feedings, when prescribed by a physician.
      4. Laundry
      5. Nursing and routine services, including the following (this is not an exhaustive list): nursing care (excluding private duty nurse), medical social services, activities program, Physical therapy, Speech therapy, Occupational therapy, specialized rehabilitation services, restorative nursing care, hand feedings, assistance in personal care and grooming, nursing supplies, incontinence care items, routine personal care items and Over the Counter medications.
   G. If the patient is being discharged from the facility with no expectation of return, a discharge status code should be used on the claim form.

H. Appropriate revenue codes must be used when billing patient leave days, whether planned or due to hospitalizations. Providers must only bill the days the patient is in the facility.

IV. In the case that a member will be staying in a Nursing Facility for long term care and does not plan on returning to the community, CareSource will initiate disenrollment back to Medicaid Fee for Service, after 3 months.

E. CONDITIONS OF COVERAGE

HCPCS
CPT

AUTHORIZATION PERIOD

F. RELATED POLICIES/RULES

G. REVIEW/REVISION HISTORY

	DATE	ACTION
Date Issued	06/07/2017	New policy.
Date Revised		
Date Effective	02/01/2018	
Date Archived	10/31/2022	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. REFERENCES

1. Provider Manuals, Nursing Facility Services. (n.d.). Retrieved May 30, 2017, from https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/54/Default.aspx

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.