



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) 684-3757 with any questions regarding Nevada Medicaid nursing facility policy.

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DIVISION OF HEALTH CARE FINANCING AND POLICY	Section: 503
MEDICAID SERVICES MANUAL	Subject: POLICY

503 POLICY

503.1 PROGRAM PARTICIPATION

503.1A COVERAGE AND LIMITATIONS

A nursing facility (NF) must comply with the following requirements in order to be eligible to participate in the Nevada Medicaid program. All in-state nursing facilities must:

1. Be licensed by the Nevada State Health Division, Bureau of Licensure and Certification in accordance with the Nevada Revised Statute (NRS) and the Nevada Administrative Code (NAC).
2. Be certified by the Nevada State Health Division, Bureau of Licensure and Certification (BLC) and the Centers for Medicare and Medicaid Services (CMS) which assures that the nursing facility meets the federal requirements for participation in Medicaid and Medicare per 42 CFR 483.
3. Be approved to participate as a nursing facility provider in the Nevada Medicaid program as described in Chapter 100 of the Medicaid Services Manual.

Continued participation as a Nevada Medicaid provider will be subject to recertification and compliance with all Federal and State laws, rules and regulations.

Billing authorization

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.

The Nursing Facility Tracking Form must be submitted through the Long-Term Care (LTC)/PASRR system. The LTC/PASRR system is accessed through the Electronic Verification System (EVS). Do not submit the form to DHCFP. For additional information, see the [Nevada Medicaid Nursing Facility and ICF/IID Tracking Process Training](#) presentation.

Once the tracking form has been completed and approved in the Long-Term Care/PASRR system and the provider has verified the NF benefit line has been entered in EVS, the facility will then be able to bill for services. Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

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 on the claim. Claim form instructions are on the Nevada Medicaid website



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www.medicaid.nv.gov (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.

Eligibility

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.

Special billing instructions

Admit date must identify most recent episode of care

Nursing Facility claims must reflect the recipient's *most recent* admission date. See [Electronic Verification System \(EVS\) Chapter 3 Claims](#) for billing instructions.

For example, if a recipient is admitted on Jan. 1, discharged on Jan. 15 and then re-admitted on Jan. 18, the admission date for the first episode of care must be Jan. 1 and the admission date for the second episode of care must be Jan. 18.

Entering an admission date on the claim for a previous episode of care wrongfully signifies that the recipient has been in the Nursing Facility the entire date span with no discharge days (e.g., using the Jan. 1 admission date for services rendered on the episode of care beginning Jan. 18). Entering the wrong date causes payment delays for hospitals and other acute care facilities that provided service on the days the recipient was not in the Nursing Facility.

Room and board

Use code 0120 for room and board charges instead of code 0101.

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 0120 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:



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- Revenue code 0120: 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 0120 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).