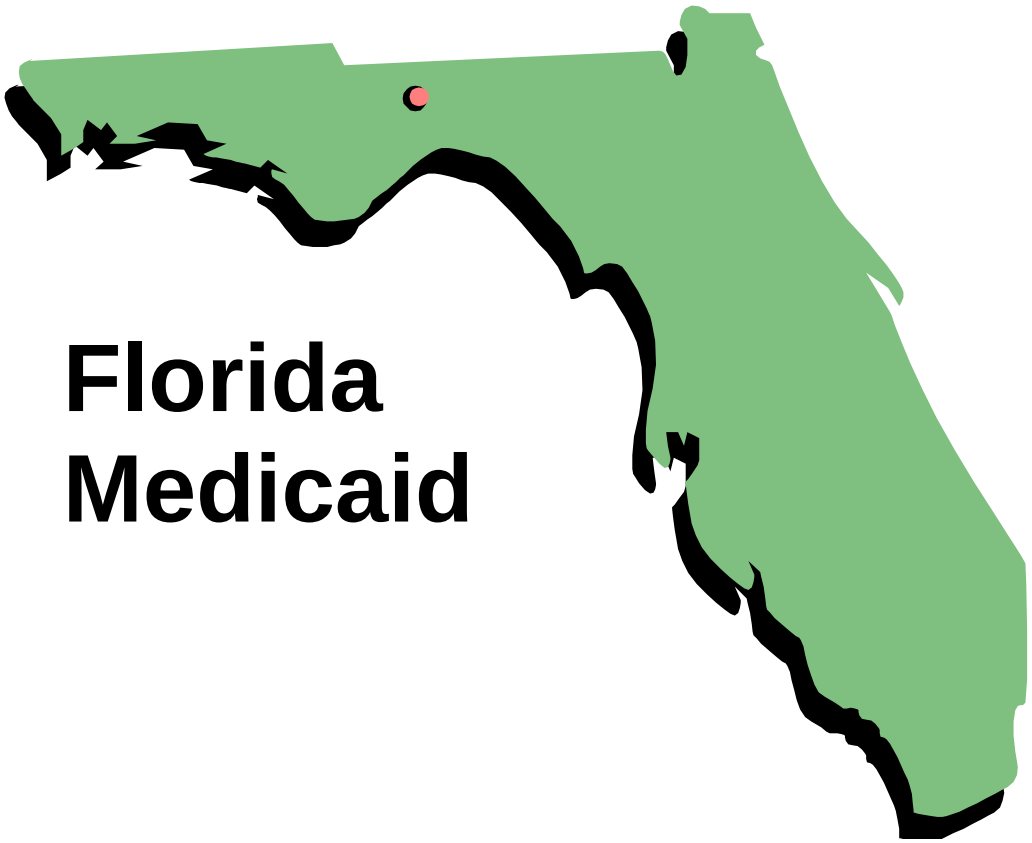

Florida Medicaid

Nursing Facility Services Coverage Policy

Agency for Health Care Administration

May 2016

Table of Contents

1.0 Introduction

1.1 Description

Nursing facility services provide 24-hour medical and nursing care in a residential setting, institution, or a distinct part of an institution.

1.1.1 Florida Medicaid Policies

This policy is intended for use by nursing facility providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of nursing facility services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the Agency for Health Care Administration's (AHCA) contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Nursing facility services are authorized by the following:

- Title 42, Code of Federal Regulations (CFR), Chapter IV, Subpart B, Part 483
- Sections 409.905 and 409.908, Florida Statutes (F.S.)
- Rule 59G-4.200, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Institutional Care Program

The Institutional Care Program (ICP) is an eligibility category that covers individuals who meet the eligibility requirements for Florida Medicaid services in a skilled nursing facility or swing bed, intermediate care facility (ICF), state mental health hospital, or hospice.

1.3.5 Leave Days
When a recipient leaves the facility overnight for hospitalization or therapeutic leave.

1.3.6 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.3.7 Patient Responsibility
The portion of a Florida Medicaid recipient's monthly income, as determined by the Department of Children and Families (DCF), that the recipient is responsible to pay an ICF, nursing facility, state mental health hospital, or hospice.

1.3.8 Provider
The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.9 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.10 Resident Rights
Additional rights afforded to nursing facility residents in accordance with section 400.022, F.S.

1.3.11 Therapeutic Leave
A non-medical visit outside the facility, used for overnight visits with family or friends.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary nursing facility services who:

- Have a level of care determined by the Comprehensive Assessment and Review for Long-Term Care Services (CARES) if ages 21 years and older, or the Children's Multidisciplinary Assessment Team (CMAT), if under the age of 21 years
- Meet the requirements for the ICP
- Have a Pre-Admission Screening and Resident Review completed in accordance with Rule 59G-1.040, F.A.C.
- Have a completed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form, as incorporated by reference in Rule 59G-1.045, F.A.C.

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

2.4 Patient Responsibility
Providers may not change a recipient's patient responsibility without DCF approval.

3.0 Eligible Provider

3.1 General Criteria
Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

- Nursing facilities licensed in accordance with Chapter 400, Part II, F.S.
- Rural hospital swing bed facilities licensed in accordance with Chapter 395, Part I, F.S.
- Hospital-based skilled nursing facilities licensed in accordance with Chapter 395, Part I, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for 365/6 days of all-inclusive nursing facility services, per year, per recipient when the following occurs in accordance with 42 CFR 483.440:

- Services are prescribed by a physician licensed in the state of Florida
- Recipient occupies a Medicaid-certified bed (unless the recipient is covered by Medicare Part B, in which case, a Medicare-certified bed is allowable)

Providers must provide or arrange for the provision of necessary care and services required for each recipient to attain, or maintain, the highest practicable physical, mental, and psychosocial well-being, in accordance with 42 CFR 483, Subpart B and section 400.022, F.S. Services include the following as applicable:

- On-site physician services
- Person-centered care planning
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care
- Personal hygiene items, including incontinence supplies
- Laundry services
- Dressing and skin care items
- Medical supplies and equipment
- Non-prescription (over-the-counter) drugs, biologicals, and emergency drugs
- Dietary services, including therapeutic diets and special dietary supplements used for oral or tube feeding
- Rehabilitative services, including physical, speech, and occupational therapies
- Social services
- Activity services

4.2.1 Leave Days

Florida Medicaid reimburses for leave days when the recipient is expected to return to the facility, as follows:

- Hospitalization – 8 days per medically necessary hospital stay
- Therapeutic leave – 16 days per state fiscal year

Providers must notify recipients and their representatives of the leave policy in writing upon admission and upon a recipient leaving the facility on hospital or therapeutic leave.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0.
- The recipient does not meet the eligibility requirements listed in section 2.0.
- The service unnecessarily duplicates another provider's service.

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Services when a recipient is enrolled in a Home Community-Based Service Waiver (except for recipients enrolled in the Statewide Medicaid Managed Care Long-term Care program)
- Leave days once a facility receives notice that a recipient will not return to the facility
- Leave days when at least 95 percent (raw number, cannot be rounded up) of the facility's Medicaid-certified beds were not filled during the previous quarter. This is calculated using the occupancy rate that is sent monthly to AHCA, Division of Health Quality Assurance. Providers may use the average occupancy of the last calendar, fiscal, or rolling quarter to calculate the occupancy rate

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

Providers must maintain a completed Medical Certification for Medicaid Long-term Care Services and Patient Transfer Form in the recipient's file, as incorporated by reference in Rule 59G-1.045, F.A.C.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

8.2.1 Billing During Emergencies or Disasters
If a provider evacuates a recipient to another facility without discharging the recipient, the originating facility may continue to claim for reimbursement and must pay the receiving facility for its services.

8.2.2 Certified Nursing Assistant Training Expenses Reimbursement
Medicare and Medicaid-certified providers may submit the completed Nurse Aide Training and Competency Evaluation Program Invoice to the following address to request reimbursement for allowable certified nursing assistant training expenses in accordance with 42 CFR 483.152:

Agency for Health Care Administration
Field Office 7
400 W. Robinson Street, Suite S309
Orlando, FL 32801

Note: The invoice is available on the AHCA Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.2.3 Discharge Claims
Providers must include the date of discharge and the patient discharge code on the claim form when a recipient is formally discharged to the community.

8.3 Claim Type
Institutional (837I/UB-04)

8.4 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.5 Diagnosis Codes
There are no specific diagnosis codes for this service.

8.6 Rate
For per diem rates, see http://ahca.myflorida.com/Medicaid/Finance/finance/index.shtml.

8.6.1 Supplemental Payment of Recipients Under the Age of 21 Years
Florida Medicaid reimburses providers at an enhanced rate for recipients under the age of 21 years who are determined by the CMAT to meet the criteria to receive supplemental payment in accordance with Rule 59G-4.290, F.A.C.