COVERED SERVICES

NOTE: The covered services, limitations, and exclusions described in this chapter are global in nature and are listed here to offer general guidance to providers. For answers to specific questions regarding covered services, limitations, and exclusions, consult the *AHCCCS Medical Policy Manual* or contact the AHCCCS Office of Office of Special Programs at (602) 417-4053.

Nursing facilities provide care for the chronically ill and for those recuperating from illness who need 24-hour nursing care but not hospitalization. Many nursing facilities offer several levels of care and various specialized services such as therapies. A limited number of facilities provide service to patients with extensive rehabilitation needs, problems due to wandering behavior, or serious respiratory problems.

AHCCCS covers medically necessary nursing facility services for fee-for-service acute care recipients for a period not to exceed 90 days per contract year when the following requirements are met:

- ☑ A physician has ordered nursing facility services in lieu of hospitalization.
- ☑ The medical condition of the recipient is such that, if nursing facility services are not provided, it would result in hospitalization of the individual.
- ☑ Services cannot be effectively provided in the home or in an Indian Health Service (IHS) facility due to lack of appropriate equipment or qualified staff.
- ☑ For recipients enrolled in IHS, an IHS referral has been obtained by the nursing facility documenting the reasons for nursing facility placement.
- ☑ For hospitalized recipients, the hospital personnel have coordinated patient teaching, discharge planning, and transfer in a timely manner.
- ☑ The recipient needs care or constant monitoring by a registered nurse.
- ☑ The recipient requires assistance with care that cannot be self-administered or provided by a caregiver in the home.

Each facility is responsible for coordinating the delivery of ancillary services, including medical services, pharmaceutical services, therapies, diagnostic services, emergency services, and medically necessary transportation.

COVERED SERVICES (CONT.)

The following services are commonly included in the nursing facility per diem rate. The list includes but is not limited to:

- ☑ Nursing services, including rehabilitative and restorative services which include:
  - ✓ Administration of medication
  - ✓ Tube feedings
  - ✓ Personal care services (assistance with bathing, grooming, and laundry)
  - ✓ Routine testing of vital signs
  - ✓ Assistance with eating
  - ✓ Maintenance of catheters
  - ✓ Over the counter medications and laxatives
- ☑ Social services, activity and recreational services, and spiritual services
- ☑ Rehabilitation therapies
- ☑ Nutritional and dietary services including, but not limited to, preparation and administration of special diets and adaptive tools for eating
- ☑ Medical supplies and durable medical equipment
- ☑ Overall management and evaluation of care plan
- ☑ Observation and assessment of a recipient's changing condition
- ☑ Room and board services including, but not limited to, support services such as food, personal laundry, and housekeeping
- ☑ Administrative physician visits solely for the purpose of meeting state licensure
- ☑ Non-prescription, stock pharmaceuticals

The following items are also included in the per diem rate. The list includes but is not limited to:

- ☑ Accucheck monitors
- ☑ Alternating pressure mattress and pump
- ☑ Bedside commode
- ☑ Canes (all types)
- ☑ Crutches
- ☑ Cushions

COVERED SERVICES (CONT.)

Supplies and equipment included in nursing facilities per diem reimbursement (Cont.):

- ☑ Emesis basins
- ☑ Feeding pumps
- ☑ Foot cradles
- ☑ Geri-chairs (all non-customized)
- ☑ Heating pads
- ☑ Hospital beds (electric and manual)
- ☑ Nebulizers
- ☑ Lifts
- ☑ Suction machines
- ☑ IV poles
- ☑ Walker (all non-customized)
- ☑ Water mattress
- ☑ Wheelchairs (all non-customized)

Items included in the per diem rate may not be separately billed. Covered services that are not part of the per diem rate may be billed when ordered by the attending physician and specified in the case management plan.

LIMITATIONS

The following limitations apply to nursing facility services for ALTCS recipients.

- ☑ Private rooms in nursing facilities are limited to medical conditions that require isolation per physician orders.
- ☑ Respite care is limited to 30 days or 720 hours per contract year.
- ☑ Therapeutic leave days are limited to nine days per contract year.
- ☑ Bed hold days for recipients admitted to a hospital for a short stay are limited to 12 days per contract year.
- ☑ Services or items requiring authorization for which authorization has not been obtained are not covered.

LIMITATIONS (CONT.)

- ☑ Services rendered in institutions for the treatment of tuberculosis for individuals ages 21 – 64 are not covered.
- ☑ Services rendered in institutions for the treatment of mental disease for individuals ages 21 – 64 are limited to 30 days per admission and no more than 60 days per year.
- ☑ Services provided in a facility or area of a facility not certified for such services are not covered.
- ☑ Services provided to individuals in a facility who require a level of care (as determined by the PAS and reassessment process) below the level of care they are receiving are not covered.

SHARE OF COST

ALTCS recipients are required to contribute toward the cost of their care. This share of cost (SOC) is calculated by subtracting certain expenses and deductions from the recipient's gross income. Recipients in nursing facilities have a deduction for personal needs equal to 15 per cent of the SSI federal benefit rate (which changes each January) and frequently have a SOC.

When a recipient's eligibility for ALTCS is approved, a notice is generated which identifies the amount of SOC the recipient owes. SOC change notices are sent to nursing facilities for any changes to the SOC amount.

BILLING FOR SERVICES

Prior authorization must be obtained from the AHCCCS PA Unit before admission of an acute care recipient unless the recipient becomes retroactively eligible for AHCCCS. Initial authorization will not exceed the recipient’s anticipated fee-for-service enrollment period or a medically necessary length of stay, whichever is shorter. Reauthorization for continued stay is subject to concurrent utilization review by AHCCCS or its designee.

Facilities must obtain initial authorization from the ALTCS case manager before admission of an ALTCS recipient unless the recipient becomes retroactively eligible. Ongoing authorization for services must be obtained from the ALTCS case manager.

Long term care facilities cannot submit claims that overlap months. The recipient's SOC is calculated on a monthly basis, and claims that overlap two or more calendar months cannot be processed accurately.

BILLING FOR SERVICES (CONT.)

AHCCCS only pays for the date of admission up to, but not including, the date of discharge, unless the patient expires.

Long term care facilities must bill for room and board services on the UB-92 claim form. The table below summarizes the allowable revenue codes and bill types, effective with dates of service on and after October 1, 2003.

Revenue Codes		Allowable Bill Types
190	Subacute General	86X
191	Subacute Care Level I	110 – 179, 211 – 228, 611 - 628
192	Subacute Care Level II	110 – 179, 211 – 228, 611 - 628
193	Subacute Care Level III	110 – 179, 211 – 228, 611 - 628
194	Subacute Care Level IV	110 – 179, 211 – 228, 611 - 628
199	Other Subacute Care	651 - 678
183	LOA – Therapeutic (For home visit by recipient)	211 – 228, 611 - 628
185	LOA – Bed hold (For short-term hospitalization)	211 – 228, 611 - 628

When billing revenue codes 183 and 185, providers must split bill and submit claims on separate UB-92 claim forms using the appropriate bill types and patient status codes.

Example 1:

A recipient residing in a skilled nursing facility is hospitalized on April 11. The recipient is discharged from the hospital on April 14 and returns to the nursing facility that day. The recipient remains in the nursing facility through April 30. When billing for the month of April, the nursing facility would submit the following three claims to AHCCCS:

First claim

Dates: 04/01 - 04/10 Bill Type: 212
Revenue code: 192 Patient status: 30

Second claim

Dates: 04/11 - 04/13 Bill Type: 213
Revenue code: 185 Patient status: 02

Third claim

Dates: 04/14 - 04/30 Bill Type: 214
Revenue code: 192 Patient status: 30

BILLING FOR SERVICES (CONT.)

The AHCCCS allowed amount is the lesser of:

Nursing facility per diem X number of days billed – SOC

or

Billed charges - SOC

Facilities must bill AHCCCS for the entire amount due for care for the month or partial month, including SOC. AHCCCS will automatically subtract the SOC from the AHCCCS allowed amount and pay the balance. If the facility bills for the care minus the required SOC collection, AHCCCS will still deduct the SOC amount, creating a double deduction for the month.

Example 2:

Provider incorrectly submits claim with SOC deducted from billed charges.

Dates of service:	June 1 – 30	Total charges:	$2,405
Recipient's SOC:	$878	Billed charges:	$1,527 ($2,405 - $878)

AHCCCS allowed amount	$1,527
SOC deducted by AHCCCS	- 878
Payment to provider	$ 649

When Medicare is the primary payer, AHCCCS will pay the full Medicare coinsurance amount minus any other third party payment and share of cost (SOC). Payment will equal the full Medicare coinsurance amount for the covered days.

The Medicare allowed amount includes all ancillary services covered under the Medicare per diem. Providers should not bill separately for those ancillary services.

NOTE: See Chapter 9, Medicare/Other Insurance Liability, for detailed information on billing nursing facility claims with Medicare.