



MISSISSIPPI DIVISION OF
MEDICAID

Mississippi Medicaid
Provider Reference Guide

For Part 207

Institutional Long Term Care Services

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

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Long Term Care Pre-Admission Screening

The Mississippi Division of Medicaid (DOM) is the state agency responsible for determining clinical eligibility for Medicaid long term care services. DOM administers a Single Point of Entry system for elderly and physically disabled individuals applying or being recertified for clinical eligibility and placement into the following long term care service settings/programs:

- Nursing Facility (NF)
- Assisted Living Waiver (AL)
- Elderly and Disabled Waiver (E&D)
- Independent Living Waiver (IL)
- Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI)

ICF/MR facilities and the ID/DD Waiver program are excluded from this process.

The Single Point of Entry concept is supported through use of a common Pre-Admission Screening Instrument (PAS) designed to fill two primary functions: 1) determine clinical eligibility for Medicaid long term care across both institutional and Home and Community-Based service settings; and 2) facilitate informed choices by individuals applying for services. The Pre-Admission Screening process is intended for use by: hospital discharge planners; nursing facility staff; Mississippi Planning and Development District (PDD) staff; Division of Medicaid staff; the Mississippi Department of Rehabilitation Services (MDRS) staff; and other providers assisting DOM beneficiaries seeking placement in the long term care program.

An individual should be advised of all identified placement options funded by the Division of Medicaid as part of ensuring that an informed choice is made regardless of where an individual applies for services. The PAS-Informed Choice section requires a signature by the applicant or their legal representative. The PAS cannot be processed without the signed Informed Choice section or the signed Physician Certification section.

All Medicaid providers must submit the PAS electronically through the fiscal agent's web portal <https://msmedicaid.acs-inc.com/msenvision/>. Hard copy submission of the PAS will only be accepted in exceptional circumstances and must be approved by DOM.

Refer to the Administrative Code, Part 207, Chapter 1 for specific requirements related to:

- Clinical Eligibility
- Determination (Rule 1.1)
- PAS Exclusions (Rule 1.2) Qualifications (Rule 1.3)
- Documentation of Informed Choice (Rule 1.4)
- Eligibility Period (Rule 1.4)
- Appeals (Rule 1.5)

Guidelines for Submission of PAS for LTC Programs (NF, E&D Waiver, IL Waiver, TBI/SCI Waiver, AL Waiver)

Guide for Submission of PAS for LTC Programs

Current Status/Eligibility	Placement Proposed	PAS Required
Hospital –Medicaid Only eligible	Nursing Facility HCBS Waivers* ID/DD Waiver / ICF/MR	Required Required Not Required
Hospital – Medicare/Medicaid eligible	Skilled Nursing Facility (Medicare only certified bed) Nursing Facility HCBS Waivers* ID/DD Waiver / ICF/MR	Not Required Required Required Not Required
Swing Bed	Nursing Facility HCBS Waivers* ID/DD Waiver / ICF/MR	Required Required Not Required
ICF/MR	Nursing Facility HCBS Waivers* ID/DD Waiver	Required Required Not Required
PRTF and other Institutional Settings	Nursing Facility HCBS Waivers*	Required Required
HCBS Waiver Programs (ID/DD)	Nursing Facility HCBS Waivers*	Required Required
HCBS Waiver Programs (E&D, IL, TBI/SCI, AL)	Nursing Facility ID/DD Waiver / ICF/MR	Required Not Required
Home	Nursing Facility HCBS Waivers* ID/DD Waiver / ICF/MR	Required Required Not Required

*E&D Waiver, IL Waiver, TBI/SCI Waiver, AL Waiver

Responsibilities for PAS Completion

The responsibilities for completing the PAS, including the PASRR Level I, are as follows:

- Conduct face-to-face interview with the applicant/beneficiary or caregiver/designated representative to obtain information.
- Review medical records and other relevant medical documentation to verify major medical conditions and services, to the extent practicable

- Provide information to the applicant/beneficiary and their responsible party/designated representative about available Medicaid program placement options, to facilitate informed decision making.
- Provide information about alternative services/resources for individuals who may not be eligible for Medicaid long term care
- Provide information about the secondary review process and appeal rights for individuals who may not be eligible for Medicaid long term care.

PAS Instrument Components

The PAS consists of ten (10) domains, or sections, most of which have two (2) or more subsections. The table below lists the sections/subsections and identifies the populations for whom each subsection applies.

Section/Subsection	Applies to:
I Intake	All applicants
II Functional Screen	
IIA ADL's & IADL's	All applicants
IIB Communication/Sensory	All applicants
III Cognitive Screen	All applicants (caregiver response component applies only if caregiver is present)
IV Mood/Psychosocial & Behaviors	
IVA Mood/Psychosocial	All applicants
IVB Behaviors	All applicants
V Medical Screen	
VA Medical Conditions	All applicants
VB Health-Related Services	All applicants

VC Medications	All applicants
VD Medical Stability	All applicants
VE Medical Summary	All applicants
VI Social Supports	
VI 1 Primary Caregiver	All applicants except Nursing Home and other institutional residents not seeking community placement
VI 2 Formal Agency Supports	All applicants
VII Home Environment	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII Informed Choice	All applicants
VIII 1 Individual Strengths	All applicants except Nursing Home and other institutional residents not seeking community placement
VIII 2 Program Options & Desired Assistance	All applicants
VIII 3 Individual Choice	All applicants
IX Level II Determination (PASRR)	All applicants considering Nursing Facility placement as an option in Section VIII
X PAS Summary & Physician Certification	All applicants

The Pre-Admission Screening (PAS) Application for Long Term Care may be viewed in its entirety at <https://msmedicaid.acs-inc.com/msenvision/>.

PAS Completion and Submission

All Medicaid providers must submit the PAS electronically through the fiscal agent’s web portal <https://msmedicaid.acs-inc.com/msenvision/>. Hard copy submission of the PAS will only be accepted in exceptional circumstances and must be approved by DOM.

Timeline for review and approval can only be estimated based on the volume of applications received on a daily basis. If a secondary review is required for nursing facility placement (PAS score 45-49), the estimated response is three (3) business days unless exceptional circumstances exist.

Electronic Submission

A face-to-face interview will be conducted with the applicant/beneficiary, and with caregiver(s) and/or the applicant/beneficiary's designated representative, as applicable. Sections I through IX will be completed along with all required signatures/initials from the applicant/beneficiary or their designated representative, including the signed Informed Choice document.

If the PAS is being completed in hard copy format for later electronic entry, all required signatures/initials should be obtained at time of interview. All pertinent documentation should be submitted to DOM. If the PAS is being completed electronically, signatures/initials must be obtained using the separate PAS-Informed Choice document.

Following completion of the electronic version of the PAS, screener(s) must obtain a physician's certification in one of two ways:

- Section X of the PAS can be printed and forwarded to the applicant/beneficiary's physician for signature. The physician must return the certification to the screening organization before the PAS is submitted. The hard copy signature page must be retained by the screening organization for later review by DOM, if requested, and as required by state and federal laws and regulations.
- Alternatively, the physician can provide his/her certification directly on the electronic PAS. This is accomplished by means of an electronic attestation.

Once the physician's certification has been received, either in hard copy or electronically, the PAS will be submitted electronically for adjudication.

- Hospitals discharging to a Nursing Facility must submit to DOM/LTC through the fiscal agent's web portal, and email/fax/mail to the Nursing Facility.
- Nursing Facilities screening a prospective or current resident must submit to DOM/LTC through the fiscal agent's web portal.

PAS Secondary Clinical Reviews

Secondary clinical reviews will be performed in the following circumstances:

- Individual scores below the clinical eligibility numerical threshold, but falls into a DOM-defined “automatic secondary review” range (score of 45 – 49)
- Individual appeals the denial in accordance with Medicaid’s appeal procedures

Secondary reviews will be performed by DOM registered nurses or other designated DOM staff, as deemed by DOM to be clinically appropriate. DOM reviewers may request additional supporting documentation from the screener(s) before making a determination. The screener(s) also may submit additional supporting documentation, in a format specified by DOM, for consideration during the secondary review.

In conducting the secondary review, the reviewer may consider all available information from the PAS as well as any additional documentation provided by the screener or applicant/beneficiary. The reviewer also may consult with the screener(s) and/or the certifying physician.

Once the secondary review is completed, DOM will notify the screening organization of its determination. If the secondary review upholds the finding of clinical ineligibility, the applicant/beneficiary retains the right of appeal.

Notice of LTC Determination

DOM will notify the screening organization of its determination in a manner specified by the Division, in accordance with State and federal noticing requirements. In the event of a denial, the notice will advise the screening organization of the individual’s right to appeal.

PAS Medicaid LTC Expedited Admissions

Nursing Facilities

Expedited admissions to Nursing Facilities may be considered on an individual basis if:

- Determination is made by the physician and documented by physician orders that the patient requires immediate skilled care which cannot be appropriately provided in an alternate health care setting or at home
 - Medicaid bed is available
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- In such cases, a PAS is required to be submitted within 72 hours of admission. The nursing facility must comply with all PAS and PASRR submission requirements.

HCBS Waivers

Expedited admissions to HCBS waiver programs may be considered on an individual basis if:

- There is a slot available in the requested HCBS waiver program
- Level of care required is appropriate to the waiver criteria for admission
- Resources are available in the community to meet the individual's need(s)
- A PAS must be completed and submitted to DOM/LTC for expedited review and approval within 72 hours.

PAS Level II Requirements for Mental Illness (MI) or Mental Retardation (MR)

The purpose of the Pre-Admission Screening and Resident Review (PASRR) is to fulfill the necessary duties required by Medicaid in conducting pre-admission screening and resident review of individuals with mental illness and/or mental retardation seeking admission to a Medicaid-certified nursing facility (NF).

If an indication of mental illness (MI) or mental retardation (MR) is identified during the Pre-Admission Screening (PAS), and the applicant is determined appropriate for admission to a Nursing Facility (NF), a Level II is required. A Level II Evaluation is a further determination of the appropriateness for NF placement and the need for specialized or rehabilitative services.

The goal of Pre-Admission Screening and Resident Review (PASRR) is to insure the provision of appropriate and needed services to individuals who have been diagnosed with mental illness and/or mental retardation per CFR 42, Part 483, and Subpart C.

Refer to the Administrative Code, Part 303, Chapter 1 for specific PASRR/Level II requirements.

Nursing Facility

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and State program of medical assistance to qualified individuals. Each State designates a State agency as the single agency for the administration of the Medicaid program. State law has designated the Division of

Medicaid, Office of the Governor, as the single State agency to administer the Medicaid program in Mississippi.

In order to participate in the Mississippi Medicaid Program, a nursing facility must be licensed and certified for participation by the State survey agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC) or the Centers for Medicare and Medicaid Services (CMS). Any information regarding licensure and/or certification should be obtained from the Director of that agency. In some instances, for State-owned facilities and facilities with validation reviews, the survey and certification function is performed by federal survey staff from CMS.

Medicaid payments may not be made to any nursing facility prior to the date of certification and execution of a valid provider agreement received from the Division of Medicaid (DOM). In general, the certification process is based on an annual survey of the facility through use of federal regulations, and an acceptable plan of correction is required for any deficiencies determined by HFLC. A facility cannot qualify for certification if it is not in substantial compliance with federal survey regulations. Each facility is required to send a copy of each new license issued by the Mississippi State Department of Health to the fiscal agent. Failure to keep licensure information current in the fiscal agent's provider files may result in denial of claims.

A provider agreement with the Division of Medicaid is not valid, even though the facility may be certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84 and 90. In addition, the Division of Medicaid, with adequate documentation showing good cause, may refuse to execute a provider agreement or may cancel an existing agreement with a certified facility.

A nursing facility provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Only services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid is responsible for formulating program policy and directly responsible for the administration of the program. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by the Division of Medicaid.

Provider Agreements

The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification pursuant to federal law and regulation, certifies nursing facilities for participation in the Medicaid program.

When the Division of Medicaid receives the properly executed certification notice from the state or federal survey agency certifying the facility for participation in the Medicaid program, the Division of Medicaid will take the following steps.

1. A Mississippi Medicaid Provider Enrollment application and two (2) Provider Agreements forms will be sent to the facility for completion. All nursing facility provider agreements are open-ended.
2. The Medicaid Provider Enrollment application and a cover letter directs that all forms will be signed and returned to the fiscal agent along with:
 - a copy of the current license of the facility;
 - a certified copy of the minutes or other legally sufficient document authorizing the person who signs the agreements to do so on behalf of the corporation.
3. When the above material is received, it will be reviewed for completeness and, if complete, submitted to the Executive Director of the Division of Medicaid for approval or disapproval.
4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid record. The Medicaid provider Enrollment form will be sent to the fiscal agent so that a Medicaid Provider number may be assigned.

If the Executive Director disapproves, the facility will be notified in writing. The reasons for the disapproval will be clearly stated and information will be given on how to appeal the decision.

For further information on provider agreements, refer to the Title 23 Administrative Code Part 207 Chapter 2 Rule 2.2 and Part 200, Chapter 4, Rules 4.2 and 4.8.

Termination of Agreement

The Division of Medicaid and/or the Centers for Medicare and Medicaid Services (CMS) may terminate any Medicaid participating nursing facility's provider agreement if all participation requirements are not met. Before terminating a provider agreement, CMS and/or the Division of Medicaid must provide written notification to the facility and public notification. When a provider agreement is terminated, federal regulations provide that payments may continue for no

more than thirty (30) days from the date the provider agreement is terminated. For further information on Termination of Agreement refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.3.

Discharge and Relocation of Residents

Within forty-eight (48) hours of receipt of the termination notice, the facility must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising them of the action in process. In addition, the facility must submit the following to the Division of Medicaid and to the State Survey Agency, Mississippi State Department of Health, Division of Health Facilities Licensure and Certification: (1) a current list of Medicaid residents, (2) the name, address and telephone number (when available) of the legal representative and/or responsible party, and (3) the name of the resident's attending physician. The census, including transfer and discharge information, must be updated daily and faxed to the Division of Medicaid.

Medicaid staff will also notify the resident, legal representative and/or responsible party. Medicaid staff can assist both the resident and the facility in making arrangements for relocation to another facility. The resident or the resident's legal representative and/or responsible party must be given opportunity to designate a preference for a specific facility or for other alternative arrangements. A resident's rights/freedom of choice in selecting a facility or alternative to nursing facility placement must be respected. A facility chosen for the relocation of a Medicaid beneficiary must be: (1) Title XIX certified and in good standing under its provider agreement, and (2) able to meet the needs of the resident.

A new Pre-Admission Screening (PAS) application is not required for Medicaid beneficiaries transferred to a new facility. The discharging facility must submit a DOM-317 indicating a transfer to another facility. Include the name and address of the new facility on the 317 form.

When a resident is transferred, all of the following reports, records, and supplies must be transmitted to the receiving facility:

- A copy of the current physician's orders for medication, treatment, diet, and special services required.
 - Personal information such as: (1) name and address of next of kin, legal representative, or party responsible for the resident, (2) attending physician, (3) Medicare and Medicaid identification number, (4) social security number, and (5) other identification information as deemed necessary and available.
 - All medication dispensed in the name of the resident for which a physician's orders are current. The medications must be inventoried and transferred with the resident. Medications past the expiration date and/or discontinued by physician order must be inventoried for disposition in accordance with state law.
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- The residents' personal belongings, clothing, and toilet articles. An inventory of personal property and valuables must be made by the closing facility.
- Resident trust fund accounts maintained by the closing facility.

Resident Trust Fund Accounts

Resident trust fund accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by the Division of Medicaid. All documentation needed to perform an audit of the residents' trust fund account must be maintained and available for review. This includes, but is not limited to, residents' trial balances, residents' transactions histories, bank statements, vouchers, receipts of purchases, etc. In addition, the facility must maintain a current surety bond to cover the total amount of funds in the trust fund account.

Reinstatement after Termination

To be considered for re-instatement in the Medicaid program, the Division of Medicaid must receive: (1) a notification of re-instatement from the appropriate entity, and (2) an application for re-instatement to participate in the Medicaid program. The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date. For further information on Reinstatement after Termination refer to the Title 23 Administrative Code Part 207 Chapter 2, Rule 2.3.

Admission Requirements

A Pre-Admission Screening (PAS) application must be completed to determine clinical eligibility for individuals seeking admission to Medicaid certified nursing facilities. The PAS must be submitted within thirty (30) days of the physician's certification. An individual seeking Medicaid eligibility for nursing home placement must receive a PAS score of fifty (50) or greater. For further information on Admission Requirements refer to the Title 23 Administrative Code Part 207, Chapter, 2 Rule 2.7 and Part 303, Chapter 1 Rules 1.1 - 1.4. For additional information on Long Term Care/Pre-Admission Screening refer to the Title 23 Administrative Code Part 207, Chapter 1, Rule 1.1.

If an individual with an indication of mental illness and/or mental retardation is determined during the Pre- Admission Screening (PAS) to be appropriate for admission to a Nursing Facility (NF), a Level II is required. A Level II Evaluation is a further determination of the appropriateness for NF and the need for specialized or rehabilitative services. The goal of Pre-Admission Screening and Resident Review (PASRR) is to insure the provision of appropriate and needed services to individuals who have been diagnosed with mental illness and/or mental retardation per CFR 42, Part 483, and Subpart C.

The State mental health authority is responsible for providing specialized services to residents with mental illness or mental retardation residing in Medicaid-certified facilities. The facility is

required to provide all other care and services appropriate to the resident’s condition including resident rights, quality of life and quality of care.

Additional requirements for admission to a Private Nursing Facility for the Severely Disabled (PNF-SD) include:

- The beneficiary’s diagnosis must include at a minimum: Spinal Cord Injury, Closed Head Injury, or Long-Term Ventilator dependency. Other diagnoses allowed should be similar or closely related to severity and involvement of care.
- The MDS classification must be one of the following categories, as defined in the Title 23 Administrative Code Part 207 Chapter 2 Rule 2.10, Case Mix Submission and Documentation Requirements of this guide, and in the State Operations MDS Manual for Resident Assessment Instrument:

SE1	SSC
SE2	SSB
SE3	SSA

Any beneficiary whose classification falls into a lower classification category will be considered to require a less specialized level of care than that available through a Private Nursing Facility for the Severely Disabled.

- The extent of care medically necessary cannot be provided in a traditional nursing facility in Mississippi.
- The Division of Medicaid will deny payment for beneficiary admissions by PNF-SD that do not fall within the parameters of this policy section.

Eligibility

The nursing facility receiving the individual for admission must complete a Form DOM-317 to determine Medicaid eligibility for individuals in long term care. The Medicaid Regional Office of the individual’s county of residence is responsible for authorizing Medicaid reimbursement payments via Form DOM-317 for each Medicaid beneficiary, including SSI beneficiaries. This form can be obtained from any Medicaid Regional Office.

The Form DOM-317 documents the most recent date of Medicaid eligibility and the amount of Medicaid income due from the beneficiary each month. Medicaid income is the amount of money the resident in the nursing facility must pay toward the cost of his/her care.

The completion of the Form DOM-317 is used by the nursing facility or hospital and Medicaid Regional Office as an exchange of information form regarding applicants for and beneficiaries of Medicaid. It must be completed as follows:

1. The nursing facility/hospital initiates the form at the time a Medicaid applicant/beneficiary enters, transfers in or out, is discharged, or expires in the facility.
2. The Medicaid Regional Office completes the form at the time an application has been approved for Medicaid and will notify the facility and the fiscal agent of the effective date of Medicaid eligibility and the amount of the individual's Medicaid income. Form DOM-317 is used to notify the nursing facility/hospital and the fiscal agent of any change in Medicaid income and to report when Medicaid eligibility is denied or terminated.
3. The form is also used to notify the fiscal agent of the date a vendor payment is to begin and the amount the beneficiary must pay toward the cost of care (Medicaid income).

The nursing facility/hospital originating the form will prepare an original and one (1) copy. The original is to be mailed to the appropriate Medicaid Regional Office while the copy is retained by the facility.

When the Medicaid regional office receives a DOM-317 form from the nursing facility or hospital, the information is entered into their computer, and it generates a DOM-317 form. This form is sent back to the nursing facility or hospital by the fiscal agent to inform them of the Medicaid eligibility status, Medicaid income, and other optional information necessary to complete the exchange of information from the regional office. This form should be kept in the beneficiary's file.

DOM-317 forms completed by the regional office to report rejected applications, approvals of yearly reviews with no change in previously reported Medicaid income amounts, or closures with no change in Medicaid income will not be submitted to the fiscal agent for billing purposes. In these instances, the original is returned to the nursing facility or hospital and one copy (1) is retained in the case record.

MEDICAID INSTRUCTIONS FOR COMPLETING THE DOM-317

Items 1-16 are identifying information about the Medicaid beneficiary and are completed by the facility originating the form.

1. Name of Nursing Facility/Hospital
Enter the name of the nursing facility/hospital in which the beneficiary resides.
 2. Provider Number
Enter the provider's Medicaid ID number.
 3. Address
Enter the complete street address or post office box of the medical facility.
 4. City
Enter the city of the medical facility.
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5. State
Enter the state of the medical facility.
 6. ZIP
Enter the zip code of the medical facility.
 7. Client's Name
Enter the name of the beneficiary.
 8. Medicaid ID
Enter the beneficiary's Medicaid ID number, if known.
 9. Social Security Number
Enter the beneficiary's Social Security number.
 10. Name of Responsible Relative
Enter the name of the relative(s) authorized to act in the beneficiary's behalf.
 11. Address of Relative
Enter the responsible relative's address
 12. Client's County of Residence Before Entering Facility
Enter the name of the county where the beneficiary lived or maintained a home before entering the medical facility.
 13. Does This Beneficiary Receive SSI?
Mark whether or not the beneficiary is a recipient of SSI. If the beneficiary receives an SSI check, enter the amount of the SSI check, if known.
 14. Notice of Action Taken
This portion of the form is completed by the nursing facility or hospital at the time the following occur:
 - A. Client Entered Facility
Enter the month, day, and year the beneficiary entered the facility.

Family or Beneficiary Has Been Given An Application Form
Enter "X" in appropriate place.
 - B. Client Has Been Discharged to Another Medical Facility as of -
Enter the date the beneficiary was discharged to another medical facility.

Name/Address of New Facility Is -
Enter complete name and address of new facility.
-

- C. Client Has Been Transferred to another Medical Facility as of -
Enter the date the beneficiary was transferred to another medical facility.
- Name/Address of New Facility Is -
Enter complete name and address of new facility.
- D. Client Has Been Discharged to Hospice Care within same facility effective -
Enter the date the beneficiary was enrolled into hospice care provided the beneficiary remains in the same nursing facility.
- E. Client Has Been Discharged to a Private Living Arrangement
Enter date beneficiary was discharged.
- F. Client is Deceased. Date of Death
Enter beneficiary's date of death.
15. Signature
The nursing facility administrator should sign the form.
16. Date
Enter the date the form is completed.

For more information on Eligibility refer to the Title 23 Administrative Code Part 101.

Reimbursement

Cost Reports

Participating Mississippi facilities must prepare and submit a Medicaid cost report following the close of their standard reporting year of January 1st through December 31st, except for state and county operated facilities, which must report on their statutory fiscal years ending June 30th and September 30th, respectively. A facility may elect to change their cost reporting period to match the Medicare or home office period. When the due date of the cost report falls on a Saturday, Sunday, state or federal holiday, the cost report is due on the following business day. Cost reports must be prepared in accordance with the State Plan for reimbursement of long-term care facilities. A copy of the Plan is available upon written request and on the website at www.dom.state.ms.us.

For additional information on Cost Reports refer to the Title 23 Administrative Code Part 207, Chapter 2, and Rule 2.5.

Per Diem Covered Services

Each Long Term Care facility, Nursing Facility (NF), and Private Nursing Facility for the Severely Disabled (PNF-SD) must provide and pay for all services and supplies covered in the Medicaid per diem rate required to meet the needs of the resident.

Services and items which can be billed outside the Medicaid per diem rate include:

1. Items and services covered by Medicare Part B or any other third party must be billed to Medicare Part B or the other third party. Applicable crossover claims should also be filed with Medicaid.
2. Any services or supplies that may be billed directly to Medicaid for facility residents are not allowable costs on the cost report and must be billed directly. These providers must have a separate provider number from that of the facility. These include
 - a) Laboratory services,
 - b) X-rays,
 - c) Drugs covered by the Medicaid drug program, and
 - d) DME supplies. Refer to the Title 23 Administrative Code Part 209, Chapter 1, Rule 1.4 J (1) (2), K.

For further information on Per Diem Covered services refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.5.

Resident Assessments Minimum Data Set (MDS)

Case mix roster reports are provided electronically according to the following schedule:

<u>First Quarter</u>	<u>January 1 – March 31</u>
March 15	1st Quarter 1st Interim Roster
April 15	1st Quarter 2nd Interim Roster
May 5	1st Quarter Close Date
<u>Second Quarter</u>	<u>April 1 – June 30</u>
June 15	2nd Quarter 1st Interim Roster
July 15	2nd Quarter 2nd Interim Roster
August 5	2nd Quarter Close Date
<u>Third Quarter</u>	<u>July 1 – September 30</u>
September 15	3rd Quarter 1st Interim Roster
October 15	3rd Quarter 2nd Interim Roster
November 5	3rd Quarter Close Date

<u>Fourth Quarter</u>	<u>October 1 – December 31</u>
December 15	4th Quarter 1st Interim Roster
January 15	4th Quarter 2nd Interim Roster
February 5	4th Quarter Close Date

Minimum Data Set 3.0 Assessment Schedule

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT
Admission (Comprehensive)	Must be completed by the 14 th day of the resident’s stay.
Annual (Comprehensive)	Must be completed within 366 days of the most recent comprehensive assessment
Significant Change in Status (Comprehensive)	Must be completed by the end of the 14 th calendar day following determination that a significant change has occurred.
Quarterly or Nursing Home PPS(NP)(Non Comprehensive)	Set of MDS items, mandated by State (contains at least CMS established subset of MDS RUGs III items). The quarterly assessment reference date should not be less than eighty (80) days and not more than ninety (90) days from the previous assessment reference date.
Significant Correction to prior Comprehensive Assessment	Completed no later than 14 days following determination that a significant error in a prior full assessment has occurred.
Significant Correction to prior Quarterly Assessment (Non-Comprehensive)	Completed no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred.

Mississippi Division of Medicaid utilizes all assessment types in calculating the facility case mix average used for reimbursement, including Other Medicare Reasons for Assessment (OMRA). Some MDS 3.0 item sets do not contain all items necessary to calculate a RUGS III, 34 grouper payment classification. Use of these assessment combinations will result in a default classification (BC1).

Case Mix Submission and Documentation Requirements

All federal requirements must be met. In addition, sections contained herein may be more stringent and will supersede the federal requirements for the Resident Assessment Instrument. It is the responsibility of the provider to be in compliance with both the federal and State requirements.

One of the primary aims of the Division of Medicaid (~~DOM~~) is the provision of an equitable payment system based on consistent data. At the core of this system are the Minimum Data Set (MDS 3.0) resident assessment instrument and its accurate completion.

Mississippi Division of Medicaid utilizes a RUGs-III *modified* 34 grouper model for case mix calculation.

The Mississippi M³PI uses the same grouper logic as the CMS RUGS-III, 34 grouper model (mapping Specifications, version 1.00.4) with the exceptions of MDS 3.0., Sections K0510, Nutritional Approaches, and O0100, Special Treatments and Programs. For Mississippi M³PI payment calculation the resulting answers for the following items should be substituted for the grouper logic only when **K0510A or K0510B was received or O0100A, B, C, D, E, F, H, I, &/or J was performed after admission/entry or reentry into the facility, Column 2 (While a Resident):**

K0510A2	Parenteral/IV feeding
K0510B2	Feeding Tube
K0510A2	Parenteral/IV feeding
K0510B2	Feeding Tube
O0100A2	Chemotherapy
O0100B2	Radiation
O0100C2	Oxygen Therapy
O0100D2	Suctioning
O0100E2	Tracheostomy Care
O0100F2	Ventilator or Respirator
O0100H2	IV Medications
O0100I2	Transfusions
O0100J2	Dialysis

The RUGS-III Crosswalk Logic v1.00.4 (Appendix A), provided by CMS, should be utilized for all other reimbursement items that are not a direct match from MDS 2.0 to MDS 3.0 (Example: impaired cognition and indicators of depression which now include a resident interview). Concurrent therapy minutes and the “look-back” revisions will be applied to all MDS 3.0 items used in the Mississippi M³PI.

Please note that numerical values, **not dashes**, should be used for Section O0400 A—D.

MDS Item Sets Mandated by the State

Mississippi Division of Medicaid supports the OBRA regulations for completion and submission of the initial and other periodic resident assessments and utilizes all assessment types in calculating the facility case mix average used for reimbursement, including PPS and Other Medicare Reasons for Assessment, (OMRA). Some MDS 3.0 item sets do not contain all items necessary to calculate a RUGS III, 34 grouper payment classification. Use of these assessment combinations will result in a default classification (BC1).

The MDS 3.0 Item Sets required by Mississippi must contain, at least, the CMS established RUGSIII items. The approved item sets for Mississippi are: Nursing Home Comprehensive (NC), Nursing Home Quarterly (NQ), Nursing Home PPS (NP), Nursing Home Discharge (ND) and Nursing Home Tracking (NT).

Mississippi's CMI calculation begins with the day of admission and ends with the date prior to a final discharge date. The MDS Assessment Reference Date (ARD), A2300, drives the CMI calculation. Assessments greater than 90 days between ARDs are considered past due for Medicaid and will calculate at the default rate (i.e.: ARD to ARD > 90days = BC1).

Mississippi Section

Submission of Section S is required with all MDS 3.0 Item Sets (NC, NQ, NT, & ND).

Mississippi Section S includes one (1) item **S6250**—Alzheimer/Dementia Special Care Unit. The intent of **S6250** is to capture the care provided to the resident inside a **designated** Alzheimer/Dementia special care unit during the specified time period. **S6250** should only be coded if care is received by the resident **after** admission/entry re-entry to the facility and within the 14-day look-back period.

Submission of Hospital and Therapeutic Leave Periods

Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing forms. Hospital and therapeutic leave periods are also used in determining staff resources in the case mix facility average. All resident hospital and therapeutic leave periods, **regardless of payment source**, must be submitted to the Division of Medicaid electronically through the Mississippi Envision Web Portal prior to the close of the quarter in which it occurred. To complete this task a user ID and password are required (may be obtained through Web Registration on the Envision web site (<https://msmedicaid.acs-inc.com/msenvision/>)).

Final Discharge Date Submission Requirements

When the resident is discharged from the nursing home, return anticipated, but does not return to the facility within 15 days, the facility must submit the final discharge date

electronically through the Mississippi Envision Web Portal. A final discharge date is necessary to end the calculation of patient days on facility case mix roster reports and must be submitted prior to the close of the quarter in which it occurred. The only residents that should calculate on the Medicaid Case-Mix Roster are:

1. Residents that are physically inside the facility, or
2. Residents on a **paid** bed-hold stay (Medicaid or private pay).

This policy applies to *all* nursing facility residents, *regardless of payment source*.

Final discharge dates should not be submitted via the web portal system prior to the submission of the resident’s initial MDS entry record and/or an assessment.

For further information on Hospital/Therapeutic Leave and Discharge Requirements refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.8.

M³PI RUG-III Classification

The RUG-III classification system has seven major classification groups: Rehabilitation, Extensive Services, Special Care, Clinically Complex, Impaired Cognition, Behavioral Problems, and Reduced Physical Function. The seven groups are further divided by the intensity of the resident’s activities of daily living (ADL) needs and, in the Clinically Complex category, by the presence of depression; and in the Impaired Cognition, Behavioral and Physical Functioning categories, by the provision of restorative nursing services.

A calculation worksheet was developed in order to provide clinical staff with a better understanding of how the RUG-III classification system works. The worksheet translates the software programming into plain language to assist staff in understanding the logic behind the classification system. A copy of the calculation worksheet for the Mississippi RUG-III Classification system for nursing facilities can be found at the end of this section.

SEVEN MAJOR M³PI RUG-III CLASSIFICATION GROUPS	
MAJOR RUG-III GROUP	CHARACTERISTICS ASSOCIATED WITH MAJOR RUG-III GROUP
Rehabilitation	Residents receiving physical, speech or occupational therapy.
Extensive Services	Residents receiving complex clinical care or with complex clinical needs such as IV feeding or medications, suctioning, tracheostomy care, ventilator/respirator and co morbidities that make the resident eligible for other RUG categories.
Special Care	Residents receiving complex clinical care or with serious medical conditions such as multiple sclerosis, quadriplegia, cerebral palsy, respiratory therapy, multiple ulcers, stage 3 or 4 pressure ulcers, radiation, surgical wounds or open lesions, tube feeding and aphasia, fever with dehydration, pneumonia, vomiting, weight loss or tube feeding.

Clinically Complex	Residents receiving complex clinical care or with conditions requiring skilled nursing management and interventions for conditions and treatments such as burns, coma, septicemia, pneumonia, foot problems/wounds, internal bleeding, dehydration, tube feeding, oxygen, transfusions, hemiplegia, chemotherapy, dialysis, physician visits/order changes.
Impaired Cognition	Residents having cognitive impairment in decision-making, temporal orientation, recall and short-term memory.
Behavioral Problems	Residents who experience hallucinations or delusions, display physical, verbal or other behavioral symptoms, wandering and/or rejection of care.
Reduced Physical Function	Residents whose needs are primarily for activities of daily living and general supervision.

M³PI-Mississippi Case Mix Categories (5.20)

Major Categories

MDS 3.0 Item

Extensive Care (One or More) ADL Score >6 (See ADL Index)

Parenteral/IV Feeding

K0510A2

Suctioning

O0100D2

Tracheostomy Care

O0100E2

Ventilator or Respirator

O0100F2

IV Medications

O0100H2

Rehabilitation (One or More) ADL Score 4-18

Speech Therapy (minutes and days)

O0400A1, 2, 3 & 4;

Occupational Therapy (minutes and days)

O0400B1, 2, 3 & 4;

Physical Therapy (minutes and days)

O0400C1, 2, 3 & 4;

A. Received 150 minutes or more of therapy on at least 5 days of the 7 day observation period

(Any combination of the three disciplines)

or

B. Received 45 minutes or more of therapy on at least 3 days of the 7 day observation period

(Any combination of the disciplines)

and 2 or more *Nursing Rehabilitation/Restorative care practices, each for at least 15 minutes daily and **each for at least 6 days of the 7 day observation period.

Refer to Rehabilitation/Restorative Nursing Criteria (*) (**).

Special Care (One or More) and an ADL Score > 6 (See ADL index)

Residents who meet the criteria for Extensive Care category and an ADL score of 6 or less.

or

Ulcers; 2 or more of ANY type ulcer	M0300A, B1-F1≥ 1 M1030≥1
with Selected Skin Care Treatment (2 or more)	M1200A-E, G-H=1
or	
Stage 3 or 4 Pressure Ulcer with Selected Skin Care Treatment (2 or More)	M0300C1, D1, 1≥1 M1200A-E, G-H=1
or	
Feeding Tube	<u>K0510B2</u> =1
and Aphasia	I4300=1
and Parenteral/Enteral Intake* (K0700A=3) or (K0700A=2 and K0700B=2)	K0700A=2,3 K0700B=2
or	
Surgical Wounds	M1040E=1
and Surgical Wound Care	M1200F=1
or	
or Application of non-surgical dressings (with or without medications) other than to feet	M1200G=1
or Application of Ointments	M1200H=1
or	
Open Lesions (other than ulcers, rashes and/or cuts)	M1040D=1
and Surgical Wound Care	M1200F=1
or Application of non-surgical dressings(with or without medications) other than to feet	M1200G=1
or Application of Ointments	M1200H=1
or	
Respiratory Therapy x 7 days	O0400D2=7
or	
Cerebral Palsy with ADL >9	I4400=1
or	
Fever	J1550A=1
and Vomiting	J1550B=1
or Weight Loss	K0300=1,2
or Pneumonia	I2000=1
or Dehydration	J1550C=1
or Feeding Tube	K0510B2=1
and Parenteral/Enteral Intake* (K0700A=3) or (K0700A=2 and K0700B=2)	K0700A=2,3 K0700B=2
or	
Multiple Sclerosis with ADL >9	I5200=1
or	

Quadriplegia with ADL >9	I5100=1
or	
Radiation Therapy	O0100B2=1
*51% + calories or 26%+ calories and 501+cc per day intake	
Clinically Complex (One or More)	
Residents who meet the criteria for Special Care category	
and an ADL score of 6 or less.	
or	
Dehydration	J1550C=1
or	
Hemiplegia/Hemiparesis and ADL>9	I4900=1
or	
Internal Bleeding	J1550D=1
or	
Pneumonia	I2000=1
or	
Chemotherapy	O0100A2=1
or	
Dialysis	O0100J2=1
or	
Transfusions	O0100I2=1
or	
Oxygen Therapy	O0100C2=1
or	
Physician Order changes on 4 or more days	O0700=4-14
and Physician Examinations on 1 or more days	O0600=1-14
or	
Physician Order changes on 2 or more days	O0700=2-14
and Physician Examinations on 2 or more days	O0600=2-14
or	
Diabetes	I2900=1
and Injections on 7 Days	N0300=7
and Physician Order changes on 2 or more days	O0700=2-14
or	
Feeding Tube	K0510B_=1
and Parenteral/Enteral Intake*	K0700A=2,3
(K0700A=3) or (K0700A=2 and K0700B=2)	K0700B=2

***51%+ calories or 26%+ calories and 501+ cc per day intake**

or

Comatose/Persistent Vegetative State	B0100=1
and Totally Dependent in Bed Mobility	G0110A1=4,8
and Totally Dependent in Transferring	G0110B1=4,8
and Totally Dependent in Eating	G0110H1=4,8
and Totally Dependent in Toilet Use	G0110I1 =4,8
or	
Septicemia	I2100=1
or	
Burns (Second or Third Degree)	M1040F=1
or	
Infection of Foot	M1040A=1
and Foot Dressing	M1200I=1
or	
Diabetic Foot Ulcer	M1040B=1
and Foot Dressing	M1200I=1
or	
Open Lesion on Foot	M1040C=1
and Foot Dressing	M1200I=1
Impaired Cognition (ADL sum of 10 or less)	
Combination of the Following Items:	
Short Term Memory Problem	C0700=1
Cognitive Skills for Daily Decision Making	C1000=1,2,3
Making Self Understood	B0700=1,2,3
Combinations include;	
C0700=1 and C1000=1 and B0700=2	
C0700=1 and C1000=1 and B0700=3	
C0700=1 and C1000=2	
C0700=1 and B0700=2	
C0700=1 and B0700=3	
C1000=1 and B0700=2	
C1000=1 and B0700=3	
C1000=2 and B0700=1	
C1000=2 and B0700=2	
C1000=2 and B0700=3	
C1000=3	
or	
Brief Interview for Mental Status (BIMS) Summary Score	C0500 ≤9
BIMS Summary Score is derived from the values of the following items:	
C0200 Repetition of Three Words	

- C0300A Able to report correct year
- C0300B Able to report correct month
- C0300C Able to report correct day of week
- C0400A Able to recall “sock”
- C0400B Able to recall “blue”
- C0400C Able to recall “bed”

Behavioral Problems (one or more) ADL sum of 10 or less

- Hallucinations E0100A=1
- or**
- Delusions E0100B=1
- or**
- Physical Behavior on 4 or more days E0200A≥2
- or**
- Verbal Behavior on 4 or more days E0200B≥2
- or**
- Other Behavior on 4 or more days E0200C≥2
- or**
- Rejection of Care 4 or more days E0800≥2
- or**
- Wandering on 4 or more days E0900≥2

Physical Functioning (reduced function) ADL sum of 4-18

Resident assessments that do not meet the criteria for any of the categories previously described shall be classified in the Physical Functioning categories. Additional splits are established for resident assessments coded as receiving Nursing Rehabilitation/Restorative care practices. ADL scores determine final category.

Extensive Category Splits

Once the resident assessment qualifies for the Extensive category by having O0100D2 or O0100H2 or O0100E2 or O0100F2 or K0510A2 coded and with an ADL score equal to or greater than 7, the following counter is used to determine the splits:

- Start the counter at zero 0
- If the resident assessment qualifies for Special Care Add 1
- If the resident assessment qualifies for Clinically Complex Add 1
- If the resident assessment qualifies for Impaired Cognition Add 1

If the resident assessment has Parenteral/IV Feeding coded

(K0510A2=1) Add 1

If the resident assessment has IV Medications coded (O0100H2=1) Add 1

The counter can be zero (0) to five (5).

A count of zero (0) or one (1) puts the resident assessment in SE1.

A count of two (2) or three (3) puts the resident assessment in SE2.

A count of four (4) or five (5) puts the resident assessment in SE3.

Please note that O0100D2, O0100E2 and O0100F2 will qualify the resident assessment for an Extensive Care category; however, none of these items are used in determining the category splits. Also, if the ADL score is 4-6, the resident assessment will classify into a Special Care category (this is the only case where a resident assessment with an ADL score of 4-6 will qualify for the Special Care category.)

Depression Criteria

Resident Mood Interview (PHQ-9[®] *)

PHQ-9[®] Total Severity Score D0300 \geq 9.5

PHQ-9[®] Total Severity Score is derived from the values of the following items:

D0200A2 Little interest or pleasure in doing things.

D0200B2 Feeling down, depressed, or hopeless.

D0200C2 Trouble falling or staying asleep or sleeping too much.

D0200D2 Feeling tired or having little energy.

D0200E2 Poor appetite or overeating.

D0200F2 Feeling bad about yourself-or that you are a failure or have let yourself your family down.

D0200G2 Trouble concentrating on things, such as reading the newspaper watching television.

D0200H2 Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.

D0200I2 Thoughts that you would be better off dead, or of hurting yourself in some way.

or

Staff Assessment of Resident Mood (PHQ-9-OV^{®*})

PHQ-9-OV[®] Total Severity Score D0600 \geq 9.5

PHQ-9-OV[®] Total Severity Score is derived from the values of the following items:

- D0500A2 Little interest or pleasure in doing things
- D0500B2 Feeling or appearing down, depressed, or hopeless
- D0500C2 Trouble falling or staying asleep, or sleeping too much
- D0500D2 Feeling tired or having little energy
- D0500E2 Poor appetite or overeating
- D0500F2 Indicating that s/he feels bad about self, is a failure, or has let self or family down.
- D0500G2 Trouble concentrating on things, such as reading the newspaper or watching television.

D0500H2 Moving or speaking so slowly that other people have noticed. Or the opposite- being so fidgety or restless that s/he has been moving around a lot more than usual.

D0500I2 States that life isn't worth living, wishes for death, or attempts to harm self

D0500J2 Being short-tempered, easily annoyed

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Rehabilitation/Restorative Nursing Criteria

Techniques/Practices (**2 or more** provided)

Range of Motion - Passive*	O0500A≥6
or	
Range of Motion - Active*	O0500B≥6
or	
Splint or Brace Assistance*	O0500C≥6
or	
Training/Skill Practice in Bed Mobility*	O0500D≥6
or	
Training/Skill Practice in Transfers*	O0500E≥6
or	
Training/Skill Practice in Walking*	O0500F≥6
or	
Training/Skill Practice in Dressing/Grooming*	O0500G≥6
or	
Training/Skill Practice in Eating/Swallowing*	O0500H≥6
or	
Amputation/Prosthesis Care*	O0500I≥6
or	
Communication*	O0500J≥6

or	
Toileting Program**	H0200C=1
or	
Bowel Toileting Program**	H0500=1

***Each must be provided for at least 15 minutes daily on at least 6 of the past 7 days.**

**** Combinations of O0500A and O0500B; or O0500D and O0500F; or H0200C and H0500 count as one service, even if both are provided.**

ADL Dependency Index

Determining ADL Scores

Bed Mobility Coding	ADL Score
G0110A1=-,0,1,7	1
G0110A1=2	3
G0110A1=3,4,8 AND G0110A2=-,0,1,2	4
G0110A1=3,4,8 AND G0110A2=3,8	5
Transfer Coding	ADL Score
G0110B1=-,0,1,7	1
G0110B1=2	3
G0110B1=3,4,8 AND G0110B2=-,0,1,2	4
G0110B1=3,4,8 AND G0110B2=3,8	5
Toileting Coding	ADL Score
G0110I1=-,0,1,7	1
G0110I1=2	3
G0110I1=3,4,8 AND G0110I2=-,0,1,2	4
G0110I1=3,4,8 AND G0110I2=3,8	5
Eating Coding	ADL Score
G0110H1=-,0,1,7	1
G0110H1=2	2
G0110H1=3,4,8	3
K0510A=1	3
K0510B2=1 and (K0700A=3)	3
K0510B2=1 and (K0700A=2 and K0700B=2)	3

Scores from each of the four areas are summed for the total ADL score.

Lowest score = 4 (1+1+1+1), Highest score = 18 (5+5+5+3)

Mississippi Case Mix Index for M3PI					
Version 5.20---10/01/10					
RUG Group	Description	Base Index	Access Incentive Index	Alzheimer's Regular Index	Alzheimer's Access Incentive Index
SE3	Extensive Special Care 3 / ADL>6	2.839	2.896	2.839	2.896
SE2	Extensive Special Care 2 / ADL>6	2.316	2.362	2.316	2.362
SE1	Extensive Special Care 1 / ADL>6	1.943	1.982	1.943	1.982
RAD	Rehab. All Levels / ADL 17-18	2.284	2.330	2.284	2.330
RAC	Rehab. All Levels / ADL 14-16	1.936	1.975	1.936	1.975
RAB	Rehab. All Levels / ADL 10-13	1.772	1.807	1.772	1.807
RAA	Rehab. All Levels / ADL 4-9	1.472	1.501	1.472	1.501
SSC	Special Care / ADL 17-18	1.877	1.915	1.877	1.915
SSB	Special Care / ADL 15-16	1.736	1.771	1.736	1.771
SSA	Special Care / ADL 7-14 (Extensive 4-6)	1.709	1.743	1.709	1.743
CC2	Clinically Complex w/Depression/ ADL 17-18	1.425	1.454	1.824	1.860
CC1	Clinically Complex / ADL 17-18	1.311	1.337	1.678	1.712
CB2	Clinically Complex w/Depression / ADL 12-16	1.247	1.272	1.596	1.628
CB1	Clinically Complex / ADL 12-16	1.154	1.177	1.477	1.507
CA2	Clinically Complex w/Depression / ADL 4-11	1.043	1.064	1.335	1.362
CA1	Clinically Complex / ADL 4-11	0.934	0.953	1.196	1.219
IB2	Cognitively Impaired w/Nursing Rehab./ ADL 6-10	1.061	1.082	1.825	1.861
IB1	Cognitively Impaired / ADL 6-10	0.938	0.957	1.613	1.646
IA2	Cognitively Impaired w/Nursing Rehab. / ADL 4-5	0.777	0.777	1.336	1.336
IA1	Cognitively Impaired / ADL 4-5	0.703	0.703	1.209	1.209
BB2	Behavioral Problems w/ Nursing Rehab. / ADL 6-10	1.021	1.041	1.756	1.791
BB1	Behavioral Prob. / ADL 6-10	0.866	0.883	1.490	1.519
BA2	Behavioral Prob. w/ Nursing Rehab. / ADL 4-5	0.750	0.750	1.290	1.290
BA1	Behavioral Prob. / ADL 4-5	0.612	0.612	1.053	1.053
PE2	Physical Functioning w/ Nursing Rehab. / ADL 16-18	1.188	1.212	1.521	1.551
PE1	Physical Functioning / ADL 16-18	1.077	1.077	1.379	1.379
PD2	Physical Functioning w/ Nursing Rehab. / ADL 11-15	1.095	1.117	1.402	1.430
PD1	Physical Functioning / ADL 11-15	0.990	0.990	1.267	1.267
PC2	Physical Functioning w/ Nursing Rehab. / ADL 9-10	0.937	0.956	1.199	1.223
PC1	Physical Functioning / ADL 9-10	0.865	0.865	1.107	1.107

PB2	Physical Functioning w/ Nursing Rehab. / ADL 6-8	0.824	0.841	1.055	1.076
PB1	Physical Functioning / ADL 6-8	0.749	0.749	0.959	0.959
PA2	Physical Functioning. w/ Nursing Rehab. / ADL 4-5	0.637	0.637	0.815	0.815
PA1	Physical Functioning. / ADL 4-5	0.575	0.575	0.736	0.736
BC1	RUG3/M3PI not calculated due to errors	0.575	0.575	0.575	0.575

For more information on documentation requirements refer to the Title 23 Administrative Code Part 200, Chapter 1, Rule 1.3.

<p>B0100</p>	<p>Comatose/ Persistent Vegetative State</p>	<p>This item is coded to record whether the resident’s clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.</p> <p>COMATOSE (coma): A pathological state in which neither arousal (wakefulness, alertness) nor awareness exists. The person is unresponsive and cannot be aroused; he/she does not open his/her eyes, does not speak and does not move his/her extremities on command or in response to noxious stimuli (e.g., pain).</p> <p>PERSISTENT VEGETATIVE STATE: Sometimes residents, who were comatose after an anoxic-ischemic injury (i.e., not enough oxygen to the brain) from a cardiac arrest, head trauma, or massive stroke, regain wakefulness but do not evidence any purposeful behavior or cognition. Their eyes are open, and they may grunt, yawn, pick with their fingers, and have random body movements. Neurological exam shows extensive damage to both cerebral hemispheres.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Indicate that a physician or other licensed, authorized staff as permitted by state Law has a documented physician’s diagnosis of coma or persistent vegetative state that is applicable during the observation period. • Have a relationship to the resident’s current functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
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B0700	Makes Self Understood	<p>This item is coded to record the resident’s ability to express or communicate requests, needs, and opinions and to conduct social conversation in his or her primary language, whether in speech, writing, sign language, gestures or a combination of these.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Include a description of the resident’s ability to make self understood. • Be consistent with physician and interdisciplinary notes, interventions and the plan of care.
<p>C0100</p> <p>C0200</p> <p>C0300</p> <p>C0400</p> <p>C0500</p>	<p>Brief Interview for Mental Status (BIMS)</p> <p>Repetition of Three Words</p> <p>Temporal Orientation</p> <p>Recall</p> <p>Summary Score</p>	<p>This item is coded to determine the resident’s attention and ability to register and recall new information.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Include an exact description of the resident’s responses. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. <p>Records the maximum number of words that the resident correctly repeated on the first attempt.</p> <p>Records the resident’s response to year, month and day of the week.</p> <p>Records the resident’s ability to recall the three words that were initially presented.</p> <p>Total score reflects cognitive status:</p> <ul style="list-style-type: none"> • 13—15 Cognitively intact • 08—12 Moderately impaired • 00—07 Severe impairment
C0700	Short Term Memory	<p>This item is coded to determine the functional capacity to remember recent events and assess the mental state of residents who cannot be interviewed.</p> <p>Documentation in the clinical record, within the observation</p>

		<p>period, must:</p> <ul style="list-style-type: none"> • Include an exact description of the resident’s responses. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
C1000	Cognitive Skills for Daily Decision Making	<p>This item is coded to record the actual performance in making everyday decisions about tasks or activities of daily living. Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A description of the resident’s ability to make everyday decisions about the tasks or activities of daily living. • The supervision or assistance required to make decisions. • The frequency of the impaired decision making process. • The resident’s documented performance must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
D0200	Resident Mood Interview (PHQ-9[®]) Copyright © Pfizer Inc. All rights reserved.	<p>Items contained in this section are coded to record the presence and frequency of symptoms of depression. The PHQ-9[®] provides a standardized severity score and a rating for evidence of a depressive disorder. Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Have an exact description of the resident’s responses and symptom frequency. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and mood/behavior records. • Have a plan of care in place for each mood coded with specific interventions addressing each symptom(s).
D02001	Symptom Presence	<p>This item is coded to record the resident’s stated response to the presence of mood symptoms (D0200A—D0200I).</p>
D02002	Symptom	<p>This item is coded to record the resident’s stated frequency of the mood symptoms (D0200A—D0200I).</p>

<p>D0200A-D0200I</p>	<p>Frequency</p> <p>Symptom(s)</p>	<p>A. Little interest or pleasure in doing things. B. Feeling down, depressed, or hopeless. C. Trouble falling or staying asleep or sleeping too much. D. Feeling tired or having little energy. E. Poor appetite or overeating. F. Feeling bad about yourself-or that you are a failure or have let yourself or your family down. G. Trouble concentrating on things, such as reading the newspaper or watching television. H. Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual. I. Thoughts that you would be better off dead, or of hurting yourself in some way.</p>
<p>D0300</p> <p>D0500</p>	<p>Total Severity Score</p> <p>Staff Assessment of Resident Mood (PHQ-9-OV[®]) Copyright[®] Pfizer Inc. All rights reserved.</p>	<p>Records the total frequency score for questions D0200A2—D0200I2.</p> <p>Responses to PHQ-9[®] can indicate possible depression. Total Severity Score can be interpreted as follows:</p> <p>A. 01—04 Minimal depression B. 05—09 Mild depression C. 10—14 Moderate depression D. 15—19 Moderately severe depression E. 20—27 Severe depression</p> <p>The PHQ-9-OV[®] Staff Assessment of Mood is completed so that any behaviors, signs, or symptoms of mood distress are identified and treated.</p> <p>Documentation in the clinical record, within the observation period, must:</p> <ul style="list-style-type: none"> • Have an exact description of the resident’s responses, staff observations and symptom frequency. • Be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and mood/behavior records.

<p>D05001</p>	<p>Symptom Presence</p>	<ul style="list-style-type: none"> • Have a plan of care in place for each mood coded with specific interventions addressing each symptom(s). <p>This item is coded to record the staff’s assessment of the resident for the presence of mood symptoms (D0500A—D0500J).</p>
<p>D05002</p>	<p>Symptom Frequency</p>	<p>This item is coded to record the staff’s assessment for the frequency of occurrence of the resident’s mood symptoms (D0500A—D0500J).</p>
<p>D0500A- D0500J</p>	<p>Symptom(s)</p>	<p>A. Little interest or pleasure in doing things. B. Feeling or appearing down, depressed, or hopeless. C. Trouble falling or staying asleep, or sleeping too much. D. Feeling tired or having little energy. E. Poor appetite or overeating. F. Indicating that s/he feels bad about self, is a failure, or has let self or family down. G. Trouble concentrating on things, such as reading the newspaper or watching television. H. Moving or speaking so slowly that other people have noticed; or the opposite- being so fidgety or restless that s/he has been moving around a lot more than usual. I. States that life isn’t worth living, wishes for death, or attempts to harm self. J. Being short-tempered, easily annoyed.</p>
<p>D0600</p>	<p>Total Severity Score</p>	<p>Records the total frequency score for questions D0500A2—D0500J2.</p> <p>Responses to PHQ-9-OV® can indicate possible depression. The Total Severity Score can be interpreted as follows:</p> <p>A. 01—04 Minimal depression B. 05—09 Mild depression C. 10—14 Moderate depression D. 15—19 Moderately severe depression E. 20—30 Severe depression</p>

Section E	Psychosis and Behavioral Symptoms	<p>These items are coded to identify behavioral symptoms in the last seven days that cause distress to the resident, or are distressing or disruptive to facility residents, staff members or the care environment. This section focuses on the resident’s actions, not the intent of his or her behavior.</p> <p>These documentation requirements apply to items E0100A—E0900.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A specific description, frequency and impact of the hallucination/delusion experienced by the resident. • Follow-up evaluation and care plan interventions developed to improve behavioral symptoms and/or reduce their impact. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records, mood/ behavior records and the plan of care.
E0100A	Hallucinations	The perception of the presence of something that is not actually there. It may be auditory or visual or involve smells, tastes or touch.
E0100B	Delusions	A fixed, false belief not shared by others that the resident holds even in the face of evidence to the contrary.
E0200A	Physical behavioral symptoms directed toward others	This includes, but not limited to: hitting, kicking, pushing, scratching, grabbing, and/or abusing others sexually.
E0200B	Verbal behavioral symptoms directed toward others	This includes, but not limited to: threatening, screaming and/or cursing at others.
E0200C	Other behavioral symptoms not directed toward others	This includes, but not limited to: physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, verbal/vocal symptoms like screaming, and/or disruptive sounds.

E0800	Rejection of care—Presence & Frequency	<p>This includes potential behavioral problems that interrupts or interferes with the delivery or receipt of care by disrupting the usual routines or processes by which care is given, or by exceeding the level or intensity of resources that are usually available for the provision of care.</p> <ul style="list-style-type: none"> • Does not include behaviors that have already been addressed (e.g., by discussion or care planning with the resident or family), and/or determined to be consistent with resident values, preferences, or goals.
E0900	Wandering—Presence & Frequency	<p>Wandering is the act of moving (walking or locomotion in a wheelchair) from place to place without a specified course or known direction.</p> <ul style="list-style-type: none"> • Wandering may be aimless. The wandering resident may be oblivious to his or her physical or safety needs. Alternatively, the resident may have a purpose such as searching to find something, but he or she persists without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas (e.g., when a resident believes she must find her mother, who staff knows is deceased). • Does not include pacing.
G01101	ADL Self-Performance	<p>These items are coded to record the resident’s self-care performance for bed mobility, transfers, eating, and toileting activities of daily living during the last seven days. This is a measure of what the resident actually did, not what he or she might be capable of doing.</p> <ul style="list-style-type: none"> • Code for resident’s performance over all shifts. • A description of each ADL aspect, as applicable to the individual resident, must be documented in the clinical record within the observation period. • The resident’s participation in any ADL aspects, as applicable to the individual resident, must be documented. • Although it is not necessary to document the actual number of times the activity occurred, it is necessary to

		<p>document whether or not the activity occurred three or more times within the last 7 days.</p> <ul style="list-style-type: none"> • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
G01102	ADL Support	<p>These items are coded to measure the type and highest level of support, provided by staff, for bed mobility, transfers, eating, and toileting activities of daily living over the last seven days, even if that level of support only occurred once.</p> <ul style="list-style-type: none"> • Code for the most support provided over all shifts. • A description of the support provided (no help, set-up help, one person physical assist, two+ persons physical assist and/or did not occur) for each of the ADL aspects, as applicable to the individual resident, must be documented in the clinical record within the observation period. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
H0200C	Current toileting program or trial	<p>This item is coded to gather information on the use of and response to urinary training programs. “Program” refers to a specific approach that is organized, planned, documented, monitored and evaluated and is consistent with the nursing homes’ policies and procedures and current standards of practice.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • Implementation of an individualized, resident-specific toileting program that is based on an assessment of the resident’s unique voiding pattern; and • Evidence that the individualized program is communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and • Notation of the resident’s response to the toileting

		<p>program and subsequent evaluations as needed.</p> <p>Toileting program (or trial toileting) does not refer to:</p> <ul style="list-style-type: none"> • Simply tracking continence status. • Changing the resident’s pads or wet garments. • Random assistance with toileting or hygiene.
H0500	Bowel Toileting Program	<p>This item is coded to gather information on the use of and response to a bowel toileting program. “Program” refers to a specific approach that is organized, planned, documented, monitored and evaluated and is consistent with the nursing homes’ policies and procedures and current standards of practice.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • Implementation of an individualized, resident-specific toileting program that is based on an assessment of the resident’s unique bowel function pattern; and • Evidence that the individualized program is communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; and • Notation of the resident’s response to the toileting program and subsequent evaluations as needed. <p>Toileting program does not refer to:</p> <ul style="list-style-type: none"> • Simply tracking continence status. • Changing the resident’s pads or soiled garments. • Random assistance with toileting or hygiene.
Section I	Active Diagnoses	<p>Diagnoses that have a direct relationship to the resident’s functional status, cognitive status, mood or behavior status, medical treatments, nursing monitoring, or risk of death during the observation period.</p> <p>These documentation requirements apply to items I2000— I5200.</p> <p>Documentation in the clinical record must include:</p> <ul style="list-style-type: none"> • A current physician diagnosis. • Signs and symptoms specific to the diagnosis and/or

		<p>problem.</p> <ul style="list-style-type: none"> • Treatment and interventions • Documentation must also be consistent with radiological reports, laboratory reports, positive study, tests or procedures, physician orders, progress notes, interdisciplinary notes, treatment records, mood/behavior records and the plan of care.
I2000	Pneumonia	A disease of the lungs characterized by inflammation and consolidation followed by resolution and caused by infection or irritants.
I2100	Septicemia	Invasion of the bloodstream by virulent microorganisms from a focus of infection that is accompanied by chills, fever, and prostration and often by the formation of secondary abscesses in various organs.
I2900	Diabetes Mellitus	A variable disorder of carbohydrate metabolism caused by a combination of hereditary and environmental factors and usually characterized by inadequate secretion or utilization of insulin, by excessive urine production, by excessive amounts of sugar in the blood and urine, and by thirst, hunger, and loss of weight.
I4300	Aphasia	Loss or impairment of the power to use or comprehend words usually resulting from brain damage.
I4400	Cerebral Palsy	A disability resulting from damage to the brain before, during, or shortly after birth and outwardly manifested by muscular incoordination and speech disturbances.
I4900	Hemiplegia or Hemiparesis	Total or partial paralysis of one side of the body that results from disease of or injury to the motor centers of the brain.
I5100	Quadriplegia	An abnormal condition characterized by paralysis of both arms and legs and the trunk of the body below the level of the associated injury to the spinal cord. This disorder is usually caused by a spinal cord injury in the area of the fifth to seventh cervical vertebrae. Automobile accidents and sporting mishaps are common causes.
I5200	Multiple Sclerosis	A demyelinating disease marked by patches of hardened tissue in the brain or the spinal cord and associated especially with partial or complete paralysis and jerking muscle tremor.
	Diagnoses Reference:	Merriam Webster Medical Dictionary website http://www.intelihealth.com/IH/ihtIH/WSIH/9276/9276.html

<p>J1550A</p>	<p>Fever</p>	<p>This item is coded to record a fever which is defined as a temperature of 2.4 degrees F higher than the baseline. The resident’s baseline temperature should be established prior to the Assessment Reference Date.</p> <ul style="list-style-type: none"> • Documented temperatures must be utilized when identifying a baseline temperature. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
<p>J1550B</p>	<p>Vomiting</p>	<p>This item is coded to record the regurgitation of stomach contents; may be caused by many factors (e.g., drug toxicity, infection, psychogenic).</p> <ul style="list-style-type: none"> • Frequency of episodes and accompanying symptoms must be documented. • Description of the vomitus must be documented. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
<p>J1550C</p>	<p>Dehydration</p>	<p>This is a condition that occurs when fluid output exceeds fluid intake. Code this item if the resident has two or more of the following indicators over the last 7 days.</p> <ul style="list-style-type: none"> • Resident usually takes in less than the recommended 1,500 ml. of fluids daily (water or liquids in beverages and water in high fluid content foods such as gelatin and soups). • Resident has one or more clinical signs of dehydration, including but not limited to dry mucous membranes, poor skin turgor, cracked lips, thirst, sunken eyes, dark urine, new onset of confusion, fever, or abnormal laboratory values (e.g. elevated hemoglobin and hematocrit, potassium chloride, sodium, albumin, blood urea nitrogen, or urine specific gravity). • Resident’s fluid loss exceeds the amount of fluids he/she takes in (e.g. loss from vomiting, fever, diarrhea

		<p>that exceeds fluid replacement).</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • Clinical signs and symptoms of the illness. • Interventions and treatments. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
J1550D	Internal Bleeding	<p>This item is coded to record bleeding that may appear as frank (such as bright red blood) or occult (such as guaiac positive stools). Clinical indicators include black, tarry stools, vomiting “coffee grounds”, hematuria (blood in urine), hemoptysis (coughing up blood), and severe epistaxis (nosebleed) that requires packing. However, nose bleeds that are easily controlled should not be coded in internal bleeding.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • The source and characteristics/description of the bleeding. • Treatment and interventions. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
K0300	Weight Loss	<p>This item is coded to record a 5% or more weight loss in the past 30 days or a 10% or more weight loss in the past 180 days.</p> <ul style="list-style-type: none"> • Weight loss should be monitored and recorded at least monthly. • Percentages of weight loss during the past 30 and past 180 days must be documented. • Weight loss should be assessed and care planned at the time of detection and not delayed until the next MDS assessment. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes,

		treatment records and the plan of care.
K0510A2	Parenteral/IV Feeding (While a Resident)	<p>This item is coded to record the introduction of a nutritive substance into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous) during the last 7 days.</p> <ul style="list-style-type: none"> • Code fluids received by the nursing home resident after admission/entry or reentry to the facility • Includes only substances administered for nutrition or hydration. • Documentation in the clinical record must include physician’s order, time, type, amount, and rate of administration. • Code fluids used for the reconstitution of medications for IV administration unless there is a documented need for additional fluid intake for nutrition and/or hydration. • Do not include fluids administered as a routine part of an operative or diagnostic procedure or recovery room stay. • Do not include fluids administered in conjunction with chemotherapy or dialysis. • Do not include additives, such as electrolytes and insulin that are added to TPN or IV fluids. • Documentation in the clinical record must reflect that alternative nutritional approaches are monitored to validate effectiveness. • Care planning must include periodic reevaluation of the appropriateness of the approach.
K0510B2	Feeding Tube (While a Resident)	<p>This item is coded to record the presence of any type of tube that can deliver food, nutritional substances, fluids <u>or</u> medications directly into the gastrointestinal system during the last 7 days after admission/entry or reentry to the facility.</p> <p>Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, and percutaneous endoscopic gastrotomy (PEG) tubes.</p>

		<ul style="list-style-type: none"> • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Documentation in the clinical record must include time, type, amount, and rate of administration. • Documentation in the clinical record must reflect that alternative nutritional approaches are monitored to validate effectiveness. • Care planning must include periodic reevaluation of the appropriateness of the approach.
K0700A	Percent Intake by Artificial Route—Calories	<p>This item is coded to record the proportion of total calories the resident received through parenteral or tube feeding during the last 7 days.</p> <ul style="list-style-type: none"> • Documentation in the clinical record must include intake records to determine actual caloric intake through parenteral or tube feeding routes. • Proportion of calories received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and hydration. • Oral intake must be documented. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
K0700B	Percent Intake by Artificial Route—Fluids	<p>This item is coded to record the average fluid intake the resident received through parenteral or tube feeding during the last 7 days.</p> <ul style="list-style-type: none"> • Documentation in the clinical record must include intake records to determine actual fluid intake through parenteral or tube feeding routes. • Fluid intake received through artificial routes should be monitored with periodic reassessment to ensure adequate nutrition and/or hydration. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes,

		treatment records and the plan of care.
M0300	Unhealed Pressure Ulcers	<p>A pressure ulcer is defined as a lesion(s) caused by unrelieved pressure that result(s) in damage to the underlying tissues. Pressure ulcers occur when tissue is compressed between a bony prominence and an external surface.</p> <p>These documentation requirements apply to items M0300A—M0300F1:</p> <ul style="list-style-type: none"> • Ulcer staging should be based on the ulcer’s deepest visible anatomical level. Review the history of each pressure ulcer in the medical record. If the pressure ulcer has ever been classified at a deeper stage than what is observed now, it should continue to be classified at the deeper stage. A detailed historical description (length, depth, width, stage) of the ulcer at the deeper stage must be included in the clinical record. • A detailed current description that includes, but is not limited to, the size (length, width, and depth), stage and the location must be documented in the clinical record within the observation period. • The care plan should include individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident’s clinical record are not acceptable for reimbursement.
M0300A	Number of Stage 1 Pressure Ulcers	This item is coded to record the number of unhealed stage 1 pressure ulcers. A stage 1 ulcer is defined as: intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues.
M0300B1	Number of	This item is coded to record the number of unhealed stage 2

	Stage 2 Pressure Ulcers	pressure ulcers. A stage 2 ulcer is defined as: partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or opened/ruptured blister.
M0300C1	Number of Stage 3 Pressure Ulcers	This item is coded to record the number of unhealed stage 3 pressure ulcers. A stage 3 ulcer is defined as: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
M0300D1	Number of Stage 4 Pressure Ulcers	This item is coded to record the number of unhealed stage 4 pressure ulcers. A stage 4 ulcer is defined as: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may present on some parts of the wound bed. Often includes undermining and tunneling.
M0300F1	Number of Unstageable Pressure Ulcers—Slough and/or Eschar	This item is coded to record the number of known pressure ulcers that are not stageable due to coverage of wound bed by slough and/or eschar. Staging should be determined once enough slough and/or eschar are removed to expose the base of the wound and the true depth/stage.
M1030	Number of Venous and Arterial Ulcers	This item is coded to record the number of venous and arterial ulcers. Venous ulcers are caused by peripheral venous disease, which most often commonly occur proximal to the medial or lateral malleolus, above the inner or outer ankle, or on the lower calf area of the leg. Arterial ulcers are caused by peripheral arterial disease, which commonly occur on the tips of toes, top of the foot, or distal to the medial malleolus. The wound does not typically occur over a bony prominence, and pressure forces play virtually no role in the development

		<p>or these ulcers. Lower extremity and foot pulses may be diminished or absent.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A detailed description that includes, but is not limited to, the stage of the ulcer, the size (length, width, and depth), and the location. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident’s clinical record are not acceptable for reimbursement.
M1040	Other Ulcers, Wounds and Skin Problems	<p>These items are coded to record other ulcers, wounds and skin problems present during the last 7 days. (Pressure ulcers coded in M0200 through M0900 should not be coded here.)</p> <p>These documentation requirements apply to items M1040A—M1040F.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> • A detailed description of the skin impairment (infection, ulcer, surgical wound, lesion or burn) that includes, but is not limited to, the type, location, size, depth, appearance, etc. • A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. • Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care. • Facility wound reports that are not part of the resident’s clinical record are not acceptable for reimbursement.
M1040A	Infection of the	Includes but is not limited to cellulitis and/or purulent

	foot	<p>drainage.</p> <ul style="list-style-type: none"> Do not code infections located on the ankle. The ankle is not part of the foot.
M1040B	Diabetic foot ulcer	<p>Diabetic foot ulcers are caused by the neuropathic and small blood vessel complications of diabetes. These ulcers typically occur over the planter (bottom) surface of the foot on load bearing areas such as the ball of the foot. Ulcers are usually deep, with necrotic tissue, moderate amounts of exudates, and callused wound edges.</p> <ul style="list-style-type: none"> Do not code ulcers located on the ankle. The ankle is not part of the foot.
M1040C	Other open lesion(s) on the foot	<p>Includes but is not limited to cuts, ulcers and/or fissures.</p> <ul style="list-style-type: none"> Does not include an open lesion on the ankle.
M1040D	Open lesion(s) other than ulcers, rashes and/or cuts	<p>Typically skin ulcers that develop as a result of diseases and conditions such as syphilis and cancer.</p> <ul style="list-style-type: none"> Does not include pressure ulcers, diabetic foot ulcers, venous ulcers, arterial ulcers, rashes or cuts. Documentation must reflect the wound is “open” during the observation period.
M1040E	Surgical Wounds	<p>Any healing or non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body.</p> <ul style="list-style-type: none"> This category does not include healed surgical sites, stomas or lacerations that require suturing or butterfly closure as surgical wounds. PICC sites, central line sites, and peripheral IV sites are not coded as surgical wounds. Do not code pressure ulcers that have been surgically debrided as surgical wounds. This coding is appropriate for pressure ulcers that are surgically repaired with grafts and/or flap procedures.

<p>M1040F</p>	<p>Burn(s)</p>	<p>Second or third degree burn(s) are defined as skin and tissue injury caused by heat or chemicals and may be in any stage of healing.</p> <ul style="list-style-type: none"> Type, cause, detailed description and tissue involvement must be documented in the clinical record within the observation period.
<p>M1200</p>	<p>Skin and Ulcer Treatments</p>	<p>These items are coded to record general skin treatment, basic pressure ulcer prevention and skin health interventions that were provided during the last 7 days.</p> <p>These documentation requirements apply to items M1200A—M1200I.</p> <p>Documentation in the clinical record, within the observation period, must include:</p> <ul style="list-style-type: none"> A description and the frequency of the specific care/treatment provided. A care plan with individualized interventions and evidence that the interventions have been monitored and modified as appropriate. Documentation must also be consistent with physician orders, progress notes, interdisciplinary notes, treatment records and the plan of care.
<p>M1200A M1200B</p>	<p>Pressure Reducing Device for Chair Pressure Reducing Device for Bed</p>	<p>Equipment that aims to relieve pressure away from areas of high risk. May include foam, air, water gel, or other cushioning placed on a chair, wheelchair or bed.</p> <ul style="list-style-type: none"> Does not include egg crate cushions of any type. Do not include doughnut or ring devices in chairs.
<p>M1200C</p>	<p>Turning/ Repositioning Program</p>	<p>A consistent program for changing the resident’s position and realigning the body.</p> <ul style="list-style-type: none"> “Program” is defined as a specific approach that is organized, planned, documented, monitored, and evaluated based on an assessment of the resident’s needs. The program should specify the intervention (e.g.

		<p>reposition on side, pillows between knees) and frequency (e.g. every 2 hours).</p> <ul style="list-style-type: none"> Progress notes, assessments and other documentation (as directed by facility policy) should support that the turning/repositioning program is monitored and reassessed to determine the effectiveness of the intervention.
M1200D	Nutrition/ Hydration Interventions	<p>Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions, e.g., wheat free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing.</p>
M1200E	Ulcer Care	<p>Interventions for treating pressure ulcers.</p> <ul style="list-style-type: none"> May include the use of topical dressings, chemical or surgical debridement, wound irrigations, <u>negative pressure wound therapy (NPWT)</u> wound vacuum assisted closure (VAC), and/or hydrotherapy.
M1200F	Surgical Wound Care	<p>Surgical wound care may include any intervention for treating or protecting any type of surgical wound.</p> <ul style="list-style-type: none"> Includes topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture/staple removal, and warm soaks or heat application.
M1200G	Application of non-surgical dressings (with or without medications) other than to feet	<p>Dressings do not have to be applied daily in order to be coded on the MDS assessment. Code any dressing meeting the MDS definitions, if applied even once during the last 7 days.</p> <ul style="list-style-type: none"> Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles. Do NOT code dressings for pressure ulcers in this item; use Pressure Ulcer Care item (M1200E). Application of a dressing to the ankle <i>should</i> be

		included in this item.
M1200H	Application of ointments/ Medications (other than to feet)	<p>Ointments or medications used to treat a skin condition.</p> <ul style="list-style-type: none"> • Includes topical creams, powders, and liquid sealants used to treat or prevent skin conditions. • This does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain). • Do NOT code application of ointments/medications (e.g. chemical or enzymatic debridement) for pressure ulcers here; use Ulcer Care, item (M1200E).
M1200I	Application of dressings to feet, with or without topical medications	<p>Interventions to treat any foot wound or ulcer other than a pressure ulcer.</p> <ul style="list-style-type: none"> • For pressure ulcers on the foot, use Ulcer Care item (M1200E). • Do not code application of dressings to the ankle. The ankle is not part of the foot.
N0300	Injections	<p>This item is coded to record the number of days during the last 7 days (or since admission/reentry if less than 7 days) that the resident received any type of medication, antigen, vaccine, etc., by subcutaneous, intramuscular, or intradermal injection.</p> <ul style="list-style-type: none"> • A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record for each day administered. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the plan of care.
O01002	Special Treatments, Procedures and Programs (While a Resident)	<p>These items are coded to record any special treatments, procedures and programs that the resident received during the specified time periods.</p> <p>These documentation requirements apply to items O0100A2—O0100J2 and must be part of the clinical record:</p> <ul style="list-style-type: none"> • All treatments, procedures and programs received by

		<p>the resident after admission/entry or re-entry to the facility and within the 14-day observation period.</p> <ul style="list-style-type: none"> • Do not include services that were provided solely in conjunction with a surgical procedure, such as IV medications or ventilators. Surgical procedures include pre- and post-operative procedures. • A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record within the observation period. • Documentation must be consistent with physician orders, progress notes, interdisciplinary notes, treatment/medication administration records and the plan of care.
00100A2	Chemotherapy	<p>Any type of chemotherapy agent administered as an antineoplastic given by any route during the last 14 days.</p> <ul style="list-style-type: none"> • The chemotherapy must be given for the treatment of cancer. Does not include chemotherapy that is given for reasons other than the treatment of cancer (e.g., Megace for appetite stimulation). • A description that includes the name of the drug, amount given, route, and time must be documented in the clinical record within the observation period. • Documentation must also include the monitoring of the side effects associated with the chemotherapy.
00100B2	Radiation Therapy	<p>Intermittent radiation therapy, as well as, radiation administered via radiation implant during the last 14 days.</p> <ul style="list-style-type: none"> • Documentation within the observation period must include the type, method of administration and time.
00100C2	Oxygen Therapy	<p>Continuous or intermittent oxygen administered via mask, cannula, etc., delivered to a resident to relieve hypoxia during the last 14 days. Code oxygen used in Bi-level Positive Airway Pressure/Continuous Positive Airway Pressure (BiPAP/CPAP) here.</p> <ul style="list-style-type: none"> • Do not code hyperbaric oxygen for wound therapy in

		<p>this item.</p> <ul style="list-style-type: none"> Documentation within the observation period must include the method of administration, time, and amount.
O0100D2	Suctioning	<p>Only tracheal and or nasopharyngeal suctioning that occurred during the last 14 days.</p> <ul style="list-style-type: none"> Does not include suctioning of the oral cavity. The type, frequency, and results of the suctioning must be documented.
O0100E2	Tracheostomy Care	<p>Code cleansing of the tracheostomy site, cannula and/or dressings to the site.</p> <ul style="list-style-type: none"> Documentation must include the specific type and description of the tracheostomy care.
O0100F2	Ventilator or Respirator	<p>Code any type of electrically or pneumatically powered closed-system mechanical ventilator support device that ensure adequate ventilation in the resident who is unable to support his/her own respiration. A resident who is being weaned off of a respirator or ventilator during the last 14 days should also be coded here.</p> <ul style="list-style-type: none"> Do not code this item when the ventilator or respirator is used only as a substitute for BiPAP or CPAP. Documentation must include the type of ventilatory device used and the frequency of use.
O0100H2	IV Medications	<p>Code any drug or biological (e.g., contrast material) given by intravenous push, epidural pump, or drip through a central or peripheral port during the last 14 days.</p> <ul style="list-style-type: none"> Epidural, intrathecal, and baclofen pumps may be coded. Do not code subcutaneous pumps in this item. Do not include IV medications of any kind that were administered during dialysis or chemotherapy. Do not code saline or heparin flushes to keep a heparin lock patent, or IV fluids without medication here. Documentation must include the time, type, frequency and method of administration.

<p>O0100I2</p>	<p>Transfusions</p>	<p>Code transfusions of blood or any blood products (e.g., platelets, synthetic blood products), which are administered directly into the bloodstream during the last 14 days.</p> <ul style="list-style-type: none"> • Do not include transfusions that were administered during dialysis or chemotherapy. • Documentation must include time, type, amount, and the monitoring of side effects.
<p>O0100J2</p>	<p>Dialysis</p>	<p>Code renal dialysis which was administered at the nursing home or at another facility, since admission/entry or re-entry, during the last 14 days.</p> <ul style="list-style-type: none"> • Documentation must include the monitoring of side effects as well as the time and type of dialysis (e.g., hemodialysis, peritoneal dialysis).
<p>O0400</p>	<p>Therapies</p>	<p>These items are coded to record specialized therapies (Speech, Occupational, Physical and Respiratory) received during the last 7 days.</p> <p>The qualified therapist, in conjunction with the physician and nursing administration, is responsible for determining the necessity for, and the frequency and duration of, the therapy services provided to residents.</p> <p>These documentation requirements apply to items O0400A—O0400D:</p> <ul style="list-style-type: none"> • Code only medically necessary therapies that occurred after admission/entry or re-entry to the nursing home. • Must be ordered by a physician or nurse practitioner based on a qualified therapist’s assessment (i.e., one who meets Medicare requirements or, in some instances, under such person’s direct supervision) and treatment plan. • Must be performed by a qualified therapist, (e.g. one who meets State credentialing requirements or, in some instances under such a person’s supervision.) • Must be documented in the resident’s medical record. • Must be care planned and periodically evaluated to ensure that the resident receives needed therapies and that current treatment plans are effective.

		<ul style="list-style-type: none"> • Therapy treatment may occur either inside or outside of the facility. • The therapist’s time spent on documentation or on an initial evaluation is not included. • When a resident returns from a hospital stay, an initial evaluation MUST be performed after entry to the facility, and only those therapies that occurred since readmission/re-entry to the facility and after the initial evaluation may be counted. • The therapists time spent on subsequent reevaluations, conducted as part of the treatment process should be counted. • Therapy aides cannot provide skilled services. Only the time an aide spends on set-up for skilled services may be coded on the MDS (e.g., set up the treatment area for wound therapy). • Record only the actual minutes of therapy. The conversion of units to minutes or minutes to units is not appropriate. Please note that therapy logs are not an MDS requirement, but reflect a standard clinical practice expected of all therapy professionals. These therapy logs may be used to verify the provision of therapy services in accordance with the plan of care and to validate information reported on the MDS assessment.
<p>O0400A</p>	<p>Speech- Language Pathology/ Audiology</p>	<p>This item is coded to record services that are provided by a licensed speech-language pathologist and/or audiologist.</p> <ul style="list-style-type: none"> • Rehabilitative treatment addresses physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing (dysphagia). • Communication includes speech, language (both receptive and expressive) and non-verbal communication such as facial expression and gesture. • Swallowing problems managed under speech therapy are problems in the oral, laryngeal, and/or pharyngeal stages of swallowing. • Common treatments may range from physical strengthening exercises, instructive or repetitive

		<p>practice and drilling, to the use of audio-visual aids and introduction of strategies to facilitate functional communication. Speech therapy may also include sign language and the use of picture symbols.</p> <ul style="list-style-type: none"> • Speech-language pathology assistants are not recognized therefore should not provide services and should not be coded on the MDS.
O0400B	Occupational Therapy	<p>This item is coded to record services that are provided or directly supervised by a licensed occupational therapist.</p> <ul style="list-style-type: none"> • A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed occupational therapist. • Occupational therapy interventions address deficits in physical, cognitive, psychosocial, sensory, and other aspects of performance in order to support engagement in everyday life activities that affect health, well-being, and quality of life.
O0400C	Physical Therapy	<p>This item is code to record services that are provided or directly supervised by a licensed physical therapist.</p> <ul style="list-style-type: none"> • A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. • Include services provided by a qualified physical therapy assistant who is employed by (or under contract to) the nursing home only if he or she is under the direction of a licensed physical therapist. • Interventions may include therapeutic exercise, functional training, manual therapy techniques, assistive and adaptive devices and equipment, physical agents, and electrotherapeutic modalities.
O0400D	Respiratory	<p>This item is coded to record services that are provided by a</p>

	Therapy	<p>qualified professional (respiratory therapists, respiratory nurse). Respiratory therapy services are for the assessment, treatment, and monitoring of patients with deficiencies or abnormalities of pulmonary function.</p> <ul style="list-style-type: none"> • Respiratory therapy services include coughing, deep breathing, heated nebulizers, aerosol treatments, assessing breath sounds and mechanical ventilation, etc. • A trained respiratory nurse is one who has received specific training on the administration of respiratory treatments and procedures when permitted by the state Nurse Practice Act. This training may have been provided at a hospital or nursing facility as part of work experience or as part of an academic program. Nurses do not necessarily learn these procedures as part of their formal nurse training programs. • Does not include hand-held medication dispensers. • Count only the time that a qualified professional spends with the resident. • Respiratory therapy must meet all of the requirements of other specialized therapies. • Documentation must include a respiratory assessment pre and post treatment that includes but is not limited to the following: heart rate, respiratory rates, breath sounds, direct care minutes and toleration.
<p>O0400A1 O0400B1 O0400C1 O0400D1</p>	<p>Individual Therapy Minutes</p>	<p>These items are coded to record the total number of minutes of therapy provided on an individual basis during the 7 day observation period.</p> <p>Individual therapy is the treatment of one resident at a time. The resident is receiving the therapist’s or the assistant’s full attention.</p>
<p>O0400A2 O0400B2 O0400C2</p>	<p>Concurrent Therapy Minutes</p>	<p>These items are coded to record the total number of minutes of therapy provided on a concurrent basis during the 7 day observation period.</p>

		<p>Concurrent therapy is the treatment of 2 residents at the same time, regardless of payer source, both of whom must be in line-of-sight of the treating therapist or assistant.</p>
<p>O0400A3 O0400B3 O0400C3</p>	<p>Group Therapy Minutes</p>	<p>These items are coded to record the total number of minutes of therapy that was provided in a group during the 7 day observation period.</p> <p>Group therapy is the treatment of 2 to 4 residents, regardless of payer source, who are performing similar activities, and are supervised, by a therapist or assistant who is not supervising any other individuals.</p>
<p>O0400A4 O0400B4 O0400C4 O0400D2</p>	<p>Days</p>	<p>These items are coded to record the total number of days that therapy services were provided during the 7 day observation period.</p> <p>A day of therapy is defined as treatment for 15 minutes or more during a day.</p>
<p>O0500</p>	<p>Restorative Nursing Programs</p>	<p>Restorative nursing program refers to nursing interventions that promote the resident’s ability to adapt and adjust to living as independently and safely as possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.</p> <p>These documentation requirements apply to items O0500A—O0500J and must meet the following criteria for restorative care:</p> <ul style="list-style-type: none"> • Measureable objectives and interventions must be documented in the care plan and in the medical record. • If a restorative nursing program is in place when a care plan is being revised, it is appropriate to reassess progress, goals, and duration/frequency as part of the care planning process. Good clinical practice would indicate that the results of this reassessment should be documented in the record. • “Program” is defined as a specific approach that is organized, planned, documented, monitored, and evaluated on an assessment of the resident’s needs. • Evidence of periodic evaluation by the licensed nurse

		<p>must be present in the medical record.</p> <ul style="list-style-type: none"> • Nursing assistants/aides must be skilled in the techniques that promote resident involvement in the activity. • A registered nurse or a licensed practical (vocational) nurse must supervise the activities in a nursing restorative program. • This category does not include groups with more than four residents per supervising helper or caregiver. • Training and skill practice are activities including repetition, physical or verbal cueing, and/or task segmentation provided by any staff member under the supervision of a licensed nurse. • These exercises must be planned, scheduled, and documented in the clinical record. • Each restorative technique must be provided for at least 15 minutes during a day to be counted as a “day”; however, the 15 minutes of time in a day may be totaled across 24 hours
O0500A	Range of Motion (Passive) Number of Days	<p>The provision of passive movements in order to maintain flexibility and useful motion in the joints of the body.</p> <ul style="list-style-type: none"> • The resident provides no assistance • Does not include passive movement by the resident that is incidental to dressing, bathing, etc. <p>This item is coded to record the total number of days (during the 7 day observation period) on which passive range of motion was received.</p>
O0500B	Range of Motion (Active) Number of Days	<p>Exercises performed by the resident, with cueing, supervision, or physical assist by staff.</p> <ul style="list-style-type: none"> • Includes active ROM and active-assisted ROM. • Does not include active movement by the resident that is incidental to dressing, bathing, etc. <p>This item is coded to record the total number of days (during the 7 day observation period) on which active range of motion was received.</p>

<p>O0500C</p>	<p>Splint or Brace Assistance</p>	<p>The provision of:</p> <ol style="list-style-type: none"> (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. <ul style="list-style-type: none"> • For splint and/or brace assistance: assess the resident’s skin and circulation under the device, and reposition the limb in correct alignment periodically and document in the clinical record. <p>This item is coded to record the total number of days (during the 7 day observation period) on which splint or brace assistance was received.</p>
<p>O0500D</p>	<p>Bed Mobility</p>	<p>Activities provided to improve or maintain the resident’s self-performance in moving to and from a lying position, turning side to side and positioning himself or herself in bed.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which bed mobility training and skill practice was received.</p>
<p>O0500E</p>	<p>Transfer</p>	<p>Activities provided to improve or maintain the resident’s self-performance in moving between surfaces or planes either with or without assistive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which transfer training and skill practice was received.</p>
<p>O0500F</p>	<p>Walking</p>	<p>Activities provided to improve or maintain the resident’s self-performance in walking, with or without assistive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which training and skill practice for walking was received.</p>
<p>O0500G</p>	<p>Dressing and/or Grooming</p>	<p>Activities provided to improve or maintain the resident’s self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.</p>

		<p>This item is coded to record the total number of days (during the 7 day observation period) on which training and skill practice in dressing and grooming activities was received.</p>
O0500H	Eating and/or Swallowing	<p>Activities provided to improve or maintain the resident’s self-performance in feeding oneself food and fluids, or activities used to improve or maintain the resident’s ability to ingest nutrition and hydration by mouth.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which eating and swallowing training and skill practice was received.</p>
O0500I	Amputation/ Prosthesis Care	<p>Activities provided to improve or maintain the resident’s self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (e.g., leg stump or eye socket).</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which amputation/prosthesis care training and skill practice was received.</p>
O0500J	Communication	<p>Activities provided to improve or maintain the resident’s self-performance in functional communication skills or assisting the resident in using residual communication skills and adaptive devices.</p> <p>This item is coded to record the total number of days (during the 7 day observation period) on which communication training and skill practice was received.</p>
O0600	Physician Examinations	<p>This item is coded to record the number of days over the last 14 days, when the physician (or nurse practitioner) examined the resident.</p> <ul style="list-style-type: none"> • Include medical doctors, doctors of osteopathy, podiatrists, dentists and authorized physician assistants, nurse practitioners or clinical nurse specialists working in collaboration with the physician. • Examination (partial or full) can occur in the facility or in the physician’s office. • Documentation of the physician’s visit and examination/evaluation must be included in the clinical

		<p>record.</p> <ul style="list-style-type: none"> • Do not include exams conducted in the Emergency Room as part of an unscheduled emergency room visit or hospital observation stay. • Do not count examinations done prior to the date of admission/entry or re-entry. • Off-site evaluations by a physician (e.g. while undergoing dialysis or radiation therapy), can be coded as a physician examination as long as documentation of the physician’s evaluation is included in the medical record. • Examination by a Psychologist (PhD) should be recorded in O0400E, Psychological Therapy. • Does not include visits made by Medicine Men.
<p>O0700</p>	<p>Physician Orders</p>	<p>This item is coded to record the number of days over the last 14 days, when the physician (or nurse practitioner) changed the resident’s orders.</p> <ul style="list-style-type: none"> • Do not include standard admission orders, return admission orders, renewal orders, or clarifying orders without changes. • Do not count orders prior to the date of <u>admission/entry</u> or re-entry. • Orders written on the day of admission as a result for an unexpected change/deterioration in condition or injury are considered as new or altered treatment orders and should be counted as a day with order changes. • Includes written, telephone, fax or consultation orders for new or altered treatment. • Notification of the physician that the PRN order was activated does not constitute a new or changed order and may not be counted when coding this item. • Orders written to increase the resident’s RUG classification and facility payment are not acceptable. • Orders for transfer of care to another physician may not be counted. • Do not count orders written by a pharmacist.

Resident Funds

Basic Requirements

All nursing facilities are required to maintain resident fund accounts, if requested by a resident. For further information on Resident Funds refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.11 A - M.

Individual Records:

The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. Proper bookkeeping techniques may include a computer software package for the accounting of resident trust funds and/or, an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained.

Resident fund records must:

- include the resident's name;
 - identify the resident's representative, if any;
 - include the resident's admission date;
 - show the actual transaction date and amount of each deposit and withdrawal;
 - reflect the actual date of an adjusting or correcting entry;
 - state the name of the person who accepted the withdrawn funds;
 - show the balance after each transaction (i.e., maintain a running balance);
 - provide the appropriate signatures for all disbursements of funds, such as:
 - resident's signature, or
 - resident's mark, or "x", with two witnesses, or
 - power of attorney's signature, or
 - resident's responsible party (amount disbursed must be supported by appropriate documentation, e.g., receipts, invoices, etc.), or
 - two signatures of facility personnel (amount disbursed must be supported by appropriate documentation, e.g., receipts, invoices, etc.);
 - document transactions with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, other than the residents
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and powers of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. (*Note: The facility must reimburse the resident's account for any undocumented transactions.*)

For powers of attorney, the provider must maintain a copy of the power of attorney in the resident's file, and before the provider allows withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them. This power is normally designated as a "General Power of Attorney" and not as "Limited or Special" power;

- reflect the resident's earned interest, if any;
- be reconcilable, at all times, with the current bank statement and/or petty cash;
- not include, as an outstanding item, any check written on a resident's account that has not been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 2 Rule 2.11 J.

Resident's Access to Financial Records and Quarterly Statements

The facility must provide each resident, responsible party, or legal representative of each resident a statement that must include at least the following:

- balance at the beginning of the statement period;
- total deposits and withdrawals;
- interest earned, if any;
- identification number and location of any account in which that resident's personal funds have been deposited;
- ending balance

Nurse Aid Training

Services and Items Covered for In-House Training

Reasonable cost of training and competency testing of nurse aides in order to meet the requirements necessary for the nurse aide to be certified in accordance with the Omnibus Budget Reconciliation Act of 1987 are to be billed directly to the Division of Medicaid. The nursing facility will be directly reimbursed by the Division of Medicaid for covered services, equipment and supplies as set forth in this manual. For further information on Nurse Aide Training and Testing Reimbursement refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.12 A - G.

The Division of Medicaid will reimburse the nursing facilities or related training centers for the minimum required services and supplies in accordance with provisions of this manual.

The following services and supplies are covered for reimbursement to in-house training programs:

1. **Salary Expense** - Allowable salaries include those for the training instructor and coordinator. The salaries expense is allowable to the extent that the employee was actually involved in nurse aide training and preparation for class and nurse aide testing. Program coordinators and training instructors must be approved in advance by the MSDH. All salary expenses billed for a facility's nurse aide training program must report the following information for each billing submitted:
 - Name of the person and their position that worked the hours billed,
 - The actual days being billed,
 - The corresponding number of hours worked each day billed (time must be in either quarter, half or whole hours),
 - A detailed description of the duties and/or tasks performed to match the hours billed, and
 - The hourly salary amount for the person billed.

Overtime will be reimbursed at the rate of cost to the facility for time actually spent on nurse aide training or testing. Salary for a secretary will be reimbursed for a training center only. Approved instruction time will be limited to the seventy-five (75) hours required for program approval by the Mississippi State Department of Health.

2. **Fringe Benefits** - The fringe benefits directly related to approved salaries for nurse aide training staff will be approved for reimbursement. Fringe benefits may be billed as a percent of salary or may be billed by listing the separate amounts. The fringe benefits included in the percent of salary must be noted on the billing.

Allowable fringe benefits include:

- FICA (7.65%),
 - Health insurance premium paid by employer,
 - Pension contributions,
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- Unemployment tax, and
- Worker's compensation insurance premiums

Salaries and related fringe benefits for holiday, sick, and vacation days are not allowable for payment through direct reimbursement.

3. **Training Manuals** - Training manuals are an allowable expense for each nurse aide trained through the program.
 4. **Training Program System** - The Division of Medicaid will reimburse each facility the cost of one (1) training program for each 120 certified beds. Included in the reimbursement is the cost of sales tax and shipping. The Division of Medicaid will also approve for direct reimbursement the maintenance contract paid for by the facility. Facilities that have previously been reimbursed for a training system will not be reimbursed for a new or replacement system. However, facilities that were reimbursed for a TV/VCR, may request to purchase replacements with justification and prior approval by Medicaid.
 4. **Instructor Training Classes** - The Division of Medicaid will approve for payment facility costs incurred for the instructor training classes.
 6. **Travel Cost** - (a) For the facilities that do not have an approved training program at the nursing facility (in-house), allowable travel costs include those for nurse aides to attend training and written and skills testing at an off-site location. (b) For the facilities with an approved training program, allowable travel costs include those for nurse aides to travel to another site for clinical skills evaluation. The limits for travel reimbursement will be at the same rate federal employees are reimbursed for the use of personal vehicles for federal business. Meal reimbursement is limited to the maximum allowable amount as mandated by the Department of Finance and Administration. The actual cost of overnight lodging will be reimbursed. Receipts must be submitted for overnight lodging costs but are not required for meal costs. Meal costs are reimbursed only for overnight stays. Meal costs are not reimbursed for day trips. Direct reimbursement will not be made for the use of the facility's vehicle(s) to transport nurse aides or nurses to the training program or testing site.
 7. **Mannequin** – The base cost for reimbursement for a mannequin is limited to \$900.00. This limitation amount does not include shipping and handling charges and enhancements such as removable mouthpieces and a bedsore dressing model. Shipping and handling charges and mannequin enhancements will be reimbursed in addition to the “base” cost of the mannequin.
 8. **Equipment and Supplies** - This listing is based on a facility training ratio of 1:5 (i.e., one instructor for every five students). The items listed here are the minimum equipment and supplies that are required for the approval of a nurse aide training program. For consumable supply items (ex. shaving cream, toothpaste, mouth wash, etc.), a facility will
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be reimbursed for the initial supply of these items. However, a facility may request to purchase an additional supply of these items after seven (7) years.

Antiemboli Hose	1
Bath Basin	6
Bath Blanket	2
Bed (Standard, not electrical)	1
Bed Pan (standard) (FX)	4
Bed Rails set	1
Bed Spread	2
Blanket	2
Blood Pressure Cuff	3
Bottle of Lotion	6
Box of Alcohol wipes (or cotton balls & alcohol)	6
Box of Cotton Swabs (or cotton tip applicators)	2
Box of Disposable Diapers	2
Box of Gloves (medium & large)	1
Box of Lemon/Glycerin Swabs	6
Box of Polident	6
Box of Straws	1
Box of Tissues	6
Box of Tongue Blades	1
Box of Trash Bags	1
Brush and Comb Set	2
Call Light (Does not have to be working)	1
Cart or Table for IVD/TV/VCR	1
Case of Toothettes	1
Catheter (Regular) with anchoring straps	3
Catheter Bag	3
Commode Chair (portable bedside toilet)	1
Condom Catheter	3
Container of Powder/Cornstarch	6
Dental Brush	12
Dental Cup	12
Dental Floss	12
Denture Cream	12
Deodorant	2
Dietary Set-Up (Includes trays, covers, dishes, and silverware)	1
Douche Bag	2
Draw Sheet	2
Dual Stethoscope	3
Emesis Basin	12
Enema (fleet type)	2
Enema Bag	2
Feeding Bag	3
Feeding Syringe	1

Folding Table	1
Fracture Bed Pan	4
Gait Belt	3
Goose Neck Lamp	1
Hospital gown	2
Isolation gown/cap/mask	3
IV Pole	1
Laundry Hamper or Bag (for wet or soiled linens)	1
Lubricating Jelly	3
Mannequin (anatomically appropriate with interchangeable gender-specific parts)	1
Mattress	1
Mirror	1
Mouthwash	12
N/G Tube	3
Nail Care Equipment Set	3
Night Stand	1
Nurse Aide Manual for each Student	N/A
Oral Thermometer (Glass)	12
Over Bed Table	1
Oxygen Mask/Cannula/Humidifier	2
Pillow	4
Positioning Devices (wedges, roll pillows, etc.)	3
Privacy Curtain or Screen	1
Razor	6
Rectal Thermometer (Glass)	12
Restraint - Chest (vest)	2
Restraint - Limb	2
Restraint - Mittens	2
Restraint - Waist (roll belt) (lap buddy)	2
Rubber Sheets sets	2
Scales - weighted (preferably non-digital stand-up, with height measuring device)	1
Set containing a Water Pitcher, Glasses, and Tray	2
Shaving Cream	6
Sheets set	2
Shelves for Supplies (Only if storage cabinet is not purchased)	1
Soap Dish with Soap (or skin cleaner)	2
Spec-pan/or Specimen Containers	12
Stacking Chair	6
Stethoscopes	3
Storage Cabinet for Supplies	1
Television (Only if Training Program System was not purchased)	1
Thermometer Covers/Sheaths	12
Toilet Tissue	12
Toothbrush	12

Toothpaste	12
Towel Set (Includes wash cloth)	6
Under pads	1 Dozen
Urinal	4
VCR (Only if Training Program System was not purchased)	1
Walker	1
Walking Cane	1
Water Thermometer	3
Wheelchair (with footrest & wheel brakes)	1

9. **Rent for Training Center Space** - A reasonable rent will be reimbursed for training center space and for training space used in an in-house training program located in an area remote from the facility due to facility space restrictions. Related party transactions will be reimbursed at an amount not to exceed the cost to the related party. Prior approval must be obtained from The Division of Medicaid, before any reimbursement will be considered. Any changes in a rent or lease agreement must be approved in advance.

10. **Training Area Utilities** - Utilities directly related to the training facility or the training space within a facility is allowable. Utilities represent water, phone, natural gas, electricity, janitorial services and pest control. Initial installation charges for utilities are also included in this category (deposits for utility services are excluded). All utility costs for direct reimbursement are limited to the extent that the facility or floor space is used for nurse aide competency training and testing.

11. **Office Furniture** - Office furniture costs are allowable only for a training center. Office furniture including a desk, desk chair, bookcase, and filing cabinet purchased to provide a work area for the nurse aide training coordinator, the instructor and the secretary is an allowable cost.

Non-Covered Services and Items for In-House Training

1. **Office and Cleaning Supplies** - Office and cleaning supplies that are used in a nurse aide training program should be included in the facility's cost report.

2. **Utilities' Deposits and Late Payment Penalties**

3. **Office Equipment** - Office equipment purchased for the use of the training facility is not allowable for direct reimbursement. This includes, but is not limited to, copy machines, typewriters, calculators, computers, and fax machines. The cost of these items should be included in the facility's cost report.

4. **Enhancement Items** - Items purchased to enhance the items required to set-up the training facility. This includes, for example, the items necessary to conduct the Red Cross training program for nurse aides which are not a minimum requirement for nurse aide training.

5. **Miscellaneous Excess Services and Supplies** - Aprons, pins, federal express shipping charges, and landscaping have been determined to exceed the minimum needs of a nurse aide training program and are not allowable for direct reimbursement.
6. **Excess Costs as Defined by Federal Regulations** - This includes costs associated with training that exceed the minimum required standards for nurse aide training as stated in the federal regulations including CPR training and in-service training costs.
7. **Repairs and Renovations to Space** - Repairs and renovations that are made so that leased floor space may be made suitable as a training facility as well as repairs and renovations that are made to floor space within a nursing facility are not directly reimbursable and should be included in the facility's cost report.
8. **Holiday, Sick and Vacation Pay** - Salaries and related fringe benefits for holiday, sick, and vacation days are not allowable nurse aide training program costs.
9. **Staff Costs Incurred for Training at Another Facility's Training Site** - The training facility where training is held must bill for incurred expenses.
10. **Nurse Aides Salaries** - Salaries incurred for nurse aides while they are attending either a training program or the competency test and the cost of replacement aides working while the nurse aides attend either a training program or the competency test are not allowable for direct reimbursement.
11. **Travel to Train at Another Facility** - The instructor salary and travel cost incurred for time spent traveling to train at another facility's training site is not an allowable cost. In cases where an instructor travels to a site other than her permanent employer to conduct training, the training program receiving her services must bill for the instructor's training time. Neither the permanent employer nor the training program receiving temporary services is allowed to receive reimbursement for the instructor's travel time and travel costs.
12. **Instructor Travel Cost for Testing** - Travel cost for a nurse aide instructor to attend students at an off-site testing site is not allowable.
13. **Interviewing Costs** - Costs incurred to interview prospective nurse aides are not allowed. This includes, but is not limited to, coordinator or instructor time to set up and conduct interviews.
14. **Equipment Repairs, Service, and Maintenance** - Costs incurred to repair, service and maintain equipment are not allowed for direct reimbursement. One exception exists for the maintenance agreement of the training program system.

Out of Facility Training

Costs are determined allowable following the guidelines stated for approved training centers. The following additional guidelines apply to related party out-of-facility training.

The following costs will be considered allowable for determining monthly costs:

1. The monthly cost related to the nurse aide training and testing program for salary and allowable fringe benefits of the training coordinator, training instructor and secretary.
2. The cost of one manual for each student.
3. The rent and utilities of the training space.
4. The cost of fixed equipment will be included in the tuition to the extent that depreciation would be allowed under the straight-line method over the period of time indicated below:

Training Program system 5 years

Mannequin 5 years

Bed and bed rails 5 years

TV/VCR 5 years

Wheelchair 5 years

Desk (up to three) 5 years

Desk Chair (up to three) 5 years

Bookcase (up to three) 5 years

Filing cabinet (up to three) 5 years

Equipment and Supplies list (reminder) 3 years

5. Instructor training should be included with the billing of training for the month paid for direct reimbursement. These costs will not be made a part of monthly costs for determining the allowable tuition.
6. Actual testing fees incurred should not be included in the tuition for related parties but should be billed on the testing form with the required pass/fail results.

Billing Procedures

Training and testing billings should be submitted to the following address:

Division of Medicaid

Bureau of Reimbursement
Walter Sillers Building
550 High Street, Suite 1000
Jackson, MS 39201

Training and testing billings received at The Division of Medicaid will be verified before the reimbursement request is processed. Failure of a facility to submit billings timely will result in denial of direct reimbursement of the billing. Billings submitted without proper documentation or proper signature or with improper amounts, will result in a written request for more information. Failure to comply with the request will result in denial of direct reimbursement.

Due Dates

The Division of Medicaid requires that all nurse aide billings be submitted monthly. Training expenses must be submitted within thirty (30) days of the incurred expense. Testing expenses must be billed within thirty (30) days of the test date. Failure to comply with these requirements will result in denial of expenses.

Nurse Assistant Training Expenses - Billing Procedures

The billing form for nurse assistant training expenses is used by nursing facilities and training centers to bill training expenses associated with the training of nurse aides.

Instructions for completing the billing form for nurse assistant training expenses are as follows:

1. Type or print legibly the facility name at the top of the form in the space provided.
2. Indicate below the facility name the Medicaid provider number that was assigned by the fiscal agent.
3. Indicate to the right of the provider number the training program approval number that was assigned by the MSDH to the facility, if applicable.
4. Indicate below the provider number the mailing address of the facility.
5. Training centers must indicate below the mailing address the facility name payment is to be made under. A training center is an area set up for nurse aide training which serves more than one facility and is located in an area remote from any of the associated facilities.
6. Each column must be appropriately completed for each item billed before reimbursement will be considered.

Instructions: Billing Form for Nurse Assistant Training Expenses

1. **Invoice Date**
-

List the date of the invoice for each item billed. List the date of payroll for salaries billed.

2. **Vendor Name**

List the company or individual paid for the item.

3. **Description**

Briefly describe the purpose of the expense (i.e., instructor salary, rent, tuition, etc.).

4. **Amount**

List the amount of allowable costs for which reimbursement is requested.

5. **For Medicaid Use Only (Approved)**

The Division of Medicaid will fill in the approved amount for each item.

6. **Total Amount of this Billing**

Add the dollar amounts listed on the billing form and insert the sum on this line. In cases where the billing is more than one page, the total for all pages should be filled in only on the last page.

7. **Attach Copies of Invoices for the Expenses Listed Above**

Each item submitted for reimbursement must be supported by documentation which is adequate for Medicaid to determine allowability of the item. For guidance on salary documentation refer to the "salary documentation" subheading in this policy or contact The Division of Medicaid.

8. **Certification**

Each billing form must be dated and signed by the current administrator of the facility or by a prior approved designated employee of the facility to certify that the billing includes only costs actually incurred for the training of nurse assistants. In cases where the billing is more than one page, the certification is required only on the last page which includes the "total amount of the billing".

9. **For Medicaid Use Only - Amount Approved for Reimbursement**

The Division of Medicaid will determine the amount approved for reimbursement by applying the facility's or center's Medicaid utilization percent to the approved gross amount of the billing.

Salary Documentation

In order to simplify the billing for salary expenses, Medicaid has included some examples of documentation needed to comply with our guidelines. Sample forms may be found at the end of this policy section. NOTE: These are only some of the examples of forms allowed. Facilities are not limited to these examples. Other forms for salary documentation, created by the facility may be submitted.

TABLE 1 Chart of Training Progress of Topic

TABLE 2 Basic Curriculum
TABLE 3 Planner

When using these forms or any other form as documentation, the facility must include the following:

1. Instructor's and/or coordinator's name.
2. The actual date each topic was covered or task performed.
3. The amount of time spent on each topic or task. Time must be reported in quarter, half or whole hours.
4. If using TABLE 3, or a schedule created by your facility, the description of duties or tasks performed must be detailed.
5. Submit only one (1) of the above types of schedules, or a schedule created by your facility. Do not submit one (1) of each type of these schedules.

This information should be submitted for the instructor's and coordinator's time only. If billing for more than one (1) Instructor or both the instructor and coordinator at the same time, a separate form must be included for each. Do not submit a schedule for each nurse aide taught.

Nurse Assistant Testing Fees - Billing Procedures

The billing form for nurse assistant testing fees is used by nursing facilities for billing nurse assistant testing fees each month.

Instructions for completing the billing form for nurse assistant testing fees are as follows:

1. Type or print legibly the facility name at the top of the form in the space provided.
2. Indicate below the facility name the Medicaid provider number which was assigned by the fiscal agent.
3. Indicate to the right of the provider number the page number of the billing form and the number of pages included in the billing.
4. Indicate below the provider number the facility mailing address.
5. All columns of the billing form must be appropriately completed before reimbursement will be considered.

Instructions: Billing Form for Nurse Assistant Testing Fees

1. **Name of Nursing Assistant**
-

List the name of the nursing assistant for whom testing fees are being billed. Each name must be listed on a separate line. Full names must be used.

2. **Social Security Number**

List the social security number of each nursing assistant. This must be completed.

3. **Date Employed**

Enter in this column the nurse assistant's first day of employment at your facility.

4. **Date Tested**

Enter in this column the date that the nurse assistant took the test being billed.

5. **Type of Test**

Columns "Written", "Clinical" and "Oral", indicate which type of test was taken. Place a check mark in the appropriate column. If a test type is being taken for the second (2nd) or third (3rd) time put a corresponding "2" or "3" in the appropriate column. A facility may bill a nurse assistant's clinical and written test fees on the same line of the billing form. This should be indicated by putting a check mark in both columns.

6. **Cost of Test**

Enter the fee paid for the test(s) being billed. The current fees as assigned by the contracted testing service will be reimbursed.

7. **For Medicaid Use Only**

The Division of Medicaid will use this area to determine the approved fees.

8. **Total Amount of this Billing**

Add the dollar amounts listed on the billing form and insert the sum on this line. In cases where the billing is more than one page, the total for all pages should be filled in only on the last page.

9. **Attach Copies of the Pass/Fail Results**

Each testing fee which is billed must be supported by the pass/fail results issued from the testing service, or the actual results given to the aides at the time of the tests.

10. **Certification**

Each billing form must be dated and signed by the current administrator of the facility or by a prior approved designated employee of the facility, in order to certify that all of the persons listed are employees of the facility and that all of the fees were incurred as indicated on the billing form.

11. **For Medicaid Use Only**

The Division of Medicaid will use this area to determine the amount to be reimbursed by applying the Medicaid utilization percent of the nursing facility to the approved gross amount of the billing.

In-Service Training

The cost of in-service training (other than for certification) of nurse aides (nurse assistants) are a nursing facility cost and are an allowable cost to be included on the facility's cost report.

Program Approval

MSDH will review and approve or disapprove nurse aide training and testing programs upon request. MSDH in accordance with federal regulations sets the requirements for approval of programs. In determining whether or not the program will be approved, MSDH will ascertain that the program meets the set course requirements. MSDH will determine that all necessary equipment and training staff are available to the program. MSDH will also visit the entity providing the program. If the training site is within a facility, MSDH will ensure that the facility meets the requirements for approval stated in the department policies and federal regulations.

Withdrawal of Program Approval

MSDH will withdraw approval of a program if it is determined that any of the minimum requirements are not met by the program or if it is determined that the entity has not shown evidence of its intention to activate the program. Withdrawal of approval is required by federal regulation under the following circumstances:

1. If the entity providing the program refuses to permit unannounced visits by MSDH,
2. If the facility receives an extended or partial extended survey,
3. If the facility is assessed a civil money penalty of not less than \$5,000 as described in CFR 42, part 483.151 (b)(2)(iv), or
4. If the facility is subject to a remedy as described in CFR 42, part 483.151 (b)(2)(v).

Upon withdrawal of approval, MSDH will notify the entity in writing and will explain the reason(s) for the withdrawal of the approval. Students who have started a program from which approval has been withdrawn must be allowed to complete the course.

MSDH will notify the Division of Medicaid in writing when program approval is withdrawn. As a result, reimbursement from Medicaid will be stopped as of the date of withdrawal of program approval. Exception: the Division of Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval. If it is determined by the MSDH that the equipment and supplies purchased for the nurse aide training program were never used for nurse aide training, the Division of Medicaid will require reimbursement from the facility for all costs incurred by Medicaid. Where possible used training equipment should be transferred to another approved training site. Any funds received from the sale of nurse aide training equipment, which was paid for by Medicaid, must be refunded to the Division of Medicaid at the Medicaid utilization percent in effect at the time of original reimbursement.

Waivers

Concurrent with Public Law 105-15, which was signed into law May 15, 1997, and which revises specific provisions of the Social Security Act, MSDH is permitted to waive the two (2) year prohibition of a Nurse Aide Training and Competency Evaluation Program (NATCEP) based on the following criteria:

- Determines that there is no other such program offered within a reasonable distance of the facility;
- Assures, through an oversight effort, that an adequate environment exists for operating the program in the facility; and,
- Provides notice of such determination and assurances to the State long term care ombudsman.

After consideration of a request for a waiver, MSDH will notify the entity and DOM, in writing, of approval or disapproval. MSDH will also ascertain that any facility with a waiver meets all set course requirements. They will then determine that all necessary equipment and training staff are available to the program.

Sample forms may be found on the following pages of this document. Providers may access the Nurse Assistant Training Expenses and Nurse Assistant Testing Fees billing forms at <http://www.medicaid.ms.gov/providerforms.aspx>.

Pharmacy

Return of Unused Medications

Refer to the Title 23 Administrative Code Part 207, Chapter 2, Rule 2.14 and current Mississippi Medicaid Bulletins for the most current requirements regarding return of unused medications.

Feeding Assistant Program

Services and Items Covered

The following services and supplies are covered for reimbursement:

1. **Salary Expense** – Allowable salaries include those for the training instructor. The salary expense is allowable to the extent that the employee was actually involved in feeding
-

assistant training and will be limited to the sixteen (16) hours required for program approval by MSDH. Training instructors must be approved in advance by MSDH. For each billing submitted, the following information must be reported:

- Name of the person that worked the hours billed and their position;
 - Actual days being billed;
 - Corresponding number of hours worked each day billed (time must be in either quarter, half or whole hours);
 - Detailed description of the duties and/or tasks performed to match the hours billed; and
 - Hourly salary amount for the person billed.
2. **Fringe Benefits** – The fringe benefits directly related to approved salaries for feeding assistant training staff will be approved for reimbursement. Fringe benefits may be billed as a percent of salary or may be billed by listing the separate amounts. The fringe benefits included in the percent of salary must be noted on the billing.

Allowable fringe benefits include:

- FICA (7.65%);
 - Health insurance premium paid by employer;
 - Pension contributions;
 - Unemployment tax; and
 - Worker's compensation insurance premiums.
3. **Training Manuals** – MSDH approved training manuals are an allowable expense for each feeding assistant trained through the program.

Billing Procedures

Training billings should be submitted to the following address:

Division of Medicaid
Attention: Reimbursement
Suite 1000, Walter Sillers Building

550 High Street
Jackson, Mississippi 39201

Training billings received by the Division of Medicaid will be verified before the requested reimbursement is processed. Billings submitted without proper documentation or proper signature, or with improper amounts, will result in a written request for more information. Failure to comply with the request will result in denial of direct reimbursement.

Due Dates

The Division of Medicaid requires that all feeding assistant billings be submitted within thirty (30) days of the incurred expense. Failure of a facility to submit billings in a timely manner will result in denial of direct reimbursement of the billing.

Feeding Assistant Training Expenses- Billing Procedures

The billing form for feeding assistant training expenses is used by nursing facilities and training centers to bill training expenses associated with the training of feeding assistants. A sample of the billing form can be found on page five (5) of this policy.

Instructions for completing the billing form for feeding assistant training expenses are as follows:

1. Type or print legibly the facility name at the top of the form in the space provided.
2. Below the facility name, indicate the Medicaid provider number which was assigned by the fiscal agent.
3. To the right of the provider number, indicate the training program approval number which was assigned by MSDH to the facility, if applicable.
4. Below the provider number, indicate the Mailing Address of the facility.
5. Below the mailing address, indicate the facility name that payment is to be made under. A training center is an area set up for feeding assistant training which serves more than one (1) facility and is located in an area remote from any of the associated facilities.
6. Complete each column. Each column must be appropriately completed for each item billed before reimbursement will be considered.

Explanation of the Billing Form for Feeding Assistant Training Expenses

1. **Date of Class**
List the date (s) of the class. List the date of payroll for salaries billed.
 2. **Instructor and/or Vendor Names**
-

List the company or instructor name for the item being billed.

3. Hours Being Billed

Indicate the total number of hours being billed (limited to a total of sixteen (16) hours).

4. Salary Per Hour

List how much the instructor makes per hour.

5. Amount

List the amount of allowable costs for which reimbursement is requested.

6. For Medicaid Use Only (Approval)

The Division of Medicaid will fill in the approved amount for each item.

7. Total Amount of this Billing

Add the dollar amounts listed on the billing form and insert the sum on this line. In cases where the billing is more than one page, the total for all pages should be filled in only on the last page.

8. Attach Copies of Invoices for the Expenses Listed Above

Manuals must be supported by copies of the vendor's invoice and method of payment indicating purchase date. Salary expenses must be supported by a copy of the curriculum schedule used for the class.

9. Certification

Each billing form must be dated and signed by the current administrator of the facility or by a prior approved designated employee of the facility to certify that the billing includes only costs actually incurred for the training of feeding assistants. In cases where the billing is more than one page, the certification is required only on the last page which includes the "total amount of the billing".

10. Amount Approved for Reimbursement

The Division of Medicaid will determine the amount approved for reimbursement by applying the facility's or center's Medicaid utilization percent to the approved gross amount of the billing.

Withdrawal of Program Approval

The Mississippi State Department of Health (MSDH) will withdraw approval of a program if it is determined that any of the minimum requirements are not met by the program.

Upon withdrawal of approval, MSDH will notify the entity in writing and will explain the reason(s) for the withdrawal of the approval. Students who have started a program from which approval has been withdrawn must be allowed to complete the course.

MSDH will notify the Division of Medicaid in writing when program approval is withdrawn. As a result, reimbursement from Medicaid will be stopped as of the date of withdrawal of program approval. The only exception is that the Division of Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval.

Forms

DOM-317

Revised 01-01-03

EXCHANGE OF INFORMATION BETWEEN NURSING FACILITY OR HOSPITAL AND REGIONAL MEDICAID OFFICE

Name of Nursing Facility/Hospital _____

Provider No. _____

Address _____

City _____ State _____ Zip _____

Client's Name _____

Medicaid ID _____ Social Security No. _____

Name of Responsible Relative _____

Address of Relative _____

Client's County of Residence Before Entering Facility _____

Does this client receive SSI? () Yes () No Amount _____

NOTICE OF ACTION TAKEN

() Client entered facility (Month, Day, Year) _____
 Family or client has been given an application form? () Yes () No

() Client has been discharged to another medical facility as of _____ (date).
 Name/address of new facility: _____

() Client has been transferred to another facility as of _____ (date).

() Client has been discharged to hospice care within same facility effective _____ (date).

() Client has been discharged to a private living arrangement: _____ (date).

() Client is deceased. Date of death: _____

 SIGNATURE

 DATE

DOM-317
Revised 01-01-03
Page 2

Client's Name _____

Medicaid ID # _____ Provider # _____

MEDICAID ELIGIBILITY STATUS

() Client is eligible for Medicaid effective _____

Effective _____, Medicaid Income \$ _____

() Client has had a change in Medicaid Income. _____

Effective _____, Medicaid Income \$ _____

() Yearly review has been completed, no change in Medicaid Income.

() Client has been denied Medicaid benefits.

() Client Medicaid benefits terminate effective _____

The Medicaid Income figures shown represent a total monthly amount. When collecting Medicaid Income from a patient for a partial month stay in your facility, the above figure must be prorated according to the number of days of the stay.

REMARKS: _____

SIGNATURE

DATE

				Revised: 12/12/00
DIVISION OF MEDICAID				
BILLING FORM - NURSE ASSISTANT TRAINING EXPENSES				
Facility Name				
Provider Number		Training Program Approval Number		
Mailing Address				
TRAINING CENTER'S ONLY - INDICATE FACILITY NAME PAYMENT IS TO BE MADE UNDER				
Remit Payment To:				
INVOICE DATE	VENDOR NAME	DESCRIPTION	AMOUNT	FOR MEDICAID USE ONLY (APPROVAL)
(1)	(2)	(3)	(4)	(5)
TOTAL AMOUNT OF THIS BILLING			(6)	\$
(7) NOTE: Copies of invoices for the expenses listed above must be attached.				
I CERTIFY THAT ALL EXPENSES LISTED ABOVE WERE INCURRED BY THE FACILITY OR TRAINING CENTER FOR A NURSE ASSISTANT TRAINING PROGRAM.				
(8)		TITLE		DATE
SIGNATURE		TITLE		DATE
(9) FOR MEDICAID USE ONLY				
Gross Amount of this Billing	\$	_____		
Medicaid Percentage	X	_____	%	_____
Amount Reimbursed by Medicaid	\$	_____		
APPROVED BY				DATE

				TABLE 2
BASIC CURRICULUM FOR THE NURSE ASSISTANT TRAINING PROGRAM				
DAY:	1	DATE:	June 1, 2000	
				TIME SPENT
	Introduction to "How To Be A Nurse Assistant"			0.5
	Overview of Program			1
	The Nursing Home and Residents			0.75
	Rights of the Residents			2
	Responsibilities of a Nurse Assistant			1.5
	Taking Care of Yourself			2
	Residents Are Human Beings			0.25
			TOTAL TIME SPENT	8
DAY:	2	DATE:	June 2, 2000	
				TIME SPENT
	Residents Records			1.25
	Accident Prevention			1.25
	Assessment of the Resident and His/her Environment			1.25
	Care of the Resident's Environment			2
	Communicating with the Resident			1
	Eye and Ear			1.25
			TOTAL TIME SPENT	8
DAY:	3	DATE:	June 3, 2000	
				TIME SPENT
	Personal Care of the Resident			2
	Food and Nutrition			2
	Maintaining Fluid Intake			2
	Prevention and Control of Infection			2
			TOTAL TIME SPENT	8

DAY:	7	DATE:	June 9, 2000		
				TIME SPENT	
	Clinical				
		Admitting a Resident		0.5	
		ADL Assessment		0.5	
		Bed making: occupied/unoccupied		0.5	
		Bedpan Use		0.5	
		Bladder Training		0.5	
		Bowel Training		0.5	
		Catheter Care		0.5	
		Communication		0.5	
		Discharge of a Resident		0.5	
		Exercise: Passive ROM, Active ROM		0.5	
		Feeding		0.5	
		Fluid Monitoring/Intake/Output		0.5	
		Foot Care		0.25	
		Hand washing		0.25	
		Weight/Height Measurement		0.5	
		Nourishment: Mealtime/Between Meals		0.5	
		Personal Care: Bath, complete/partial, shower, shaving		0.5	
			TOTAL TIME SPENT	8	
DAY:	8	DATE:	June 10, 2000		
				TIME SPENT	
	The Health Care Team			1	
	Ensuring Quality Care			1.5	
	Values and Ethics			1	
	Being With Others			1.5	
	Sexual Needs of the Resident			1.5	
	Spiritual Needs of the Resident			1.5	
			TOTAL TIME SPENT	8	

DAY:	9	DATE:	June 11, 2000		
					TIME SPENT
					2
					2
					4
				TOTAL TIME SPENT	8
DAY:	10	DATE:	June 12, 2000		
					TIME SPENT
					2
					1
					1
					2
					2
				TOTAL TIME SPENT	8
DAY:	13	DATE:	June 15, 2000		
					TIME SPENT
					2
					2
					4
				TOTAL TIME SPENT	8
					19

CHART OF TRAINING PROGRESS BY TOPIC:		Training and Testing		Completion Date: June 9, 2000		TABLE 1				
Instructor/Coordinator:		Mrs. Jones, RN								
TOPIC		CLASSROOM				CLINICAL SKILLS				
		Discussion Date	Time Spent	IVD Sessions Date	Time Spent	Lab Time Spent	Supervisor	Date	Unit Time Spent	Supervisor
Unit I: INTRODUCTION										
Module 1:	Introduction	06/01	4.5	06/01	1.5	06/01	1	06/01	1	
Module 2:	Introduction to the Nursing Facility									
Unit II: RESIDENTS AND THEIR RIGHTS										
Module 3:	Getting to Know the Residents	06/02	4.5	06/02	3.5					
Module 4:	Residents' Rights									
Unit III: RESIDENTS AND THEIR RIGHTS										
Module 5:	The Health-Care Team									
Module 6:	Responsibilities of a Nurse Aide									
Module 7:	Taking Care of Yourself									
Module 8:	Prevention and Control of Infection	06/03	4.5	06/03	1.5	06/03	0.5	06/03	0.5	
Module 9:	Resident Records	06/04	2	06/04	1.5	06/04	4			
Module 10:	Accident Prevention									
Module 11:	Fire Safety/Emergency Procedures									
Unit IV: COMMUNICATION I										
Module 12:	Sensory Losses - Eye and Ear	06/05	1.75	06/05	3					
Module 13:	Communicating with the Resident							06/05	1.5	1.75
Module 14:	Working with the Family									
Unit V: RESIDENTS' DAILY NEEDS I										
Module 15:	Personal Care of the Resident									
Module 16:	Assistance with Positioning, Transfers & Walking									
Module 17:	Care of a Resident's Room									
Unit VI: COMMUNICATION II										
Module 18:	Being with Others									
Module 19:	Personality and Behavior									
Unit VII: ARRIVING AND LEAVING THE NURSING FACILITY										
Module 20:	Admission of the Resident									
Module 21:	Discharge of the Resident	06/06	1	06/06	2	06/06	1.5	06/06	1.5	
Unit VIII: RESIDENTS' DAILY NEEDS II										
Module 22:	Skin Care									
Unit IX: NUTRITION AND FLUIDS										
Module 23:	Food and Nutrition	06/07	0.5	06/07	0.5	06/07	0.5	06/07	0.5	
Module 24:	Digestion	06/07	0.5	06/07	0.5	06/07	0.5	06/07	0.5	
Module 25:	Maintaining Fluid Intake	06/07	0.5	06/07	0.5	06/07	0.5	06/07	0.5	
Module 26:	Urinary Tract	06/07	0.5	06/07	0.5	06/07	0.5	06/07	0.5	
Unit X: MOBILITY										
Module 27:	Exercise									
Module 28:	Muscles, Bones, and Nerves	06/08	1.5	06/08	2					
Unit XI: SOCIAL AND EMOTIONAL NEEDS										
Module 29:	Spiritual Needs of the Resident									
Module 30:	Sexual Needs of the Resident									
Module 31:	Death and Care and Dignity					06/09	1	06/09		
Unit XII: SPECIFIC HEALTH PROBLEMS										
Module 32:	Diabetes & the Endocrine System	06/09	3			06/09	1	06/09	3	
Module 33:	Breathing									
Module 34:	Circulation									

In order to participate in the Mississippi Medicaid Program, a facility must be licensed and certified for participation by the State Survey Agency, Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification (HFLC) or the Centers for Medicare and Medicaid Services (CMS). Any information regarding licensure and/or certification should be obtained from the Director of that agency. In some instances, for state-owned facilities and facilities with validation reviews, the survey and certification function is performed by federal survey staff from CMS.

Medicaid payments may not be made to any ICF/MR prior to the date of certification and execution of a valid provider agreement received from the Division of Medicaid (DOM). In general, the certification process is based on an annual survey of the facility through use of federal regulations, and an acceptable plan of correction is required for any deficiencies determined by HFLC. An ICF/MR cannot qualify for certification if it is not in substantial compliance with federal survey regulations. Each facility is required to send a copy of each new license issued by the Mississippi State Department of Health to the fiscal agent. Failure to keep licensure information current in the fiscal agent's provider files may result in denial of claims.

A provider agreement with the Division of Medicaid is not valid, even though the facility may be certified by the State Survey Agency, if the facility fails to meet the civil rights requirements set forth in 45 CFR Parts 80, 84, and 90.

In addition, the Division of Medicaid, with adequate documentation showing good cause, may refuse to execute a provider agreement or may cancel an existing agreement with a certified facility.

An ICF/MR provider's participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid's payment. The provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid's payment to the beneficiary. Only services not covered under the Medicaid program can be billed directly to the Medicaid beneficiary.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provisions of the Mississippi Medical Assistance Act. The Division of Medicaid is responsible for formulating program policy and directly responsible for the administration of the program. Under the direction of the Division of Medicaid, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid policy as it relates to these factors is initiated by the Division of Medicaid.

Provider Agreements

All ICF/MR provider agreements are time-limited with the length of time primarily determined by the findings of the survey agency on visits to the facility.

The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification (HFCLC) pursuant to federal law regulation, certifies ICF/MR's for participation in the Medicaid program. The duration of a facility's provider agreement will be for the same period of time, initially twelve (12) months or less, as certified or recertified for participation by the survey agency. An exception to this duration of the agreement may occur if the Division of Medicaid has adequate documentation showing proper cause, whereby it may refuse to execute an agreement or may cancel an existing agreement with a certified facility.

When the Division of Medicaid receives the properly executed certification notice from the state or federal survey agency certifying the facility for participation in the Medicaid program, the Division of Medicaid will implement the following:

1. A Mississippi Medicaid Provider Enrollment application and two (2) Provider Agreements will be sent to the facility.
2. The Medicaid Provider Enrollment application and a cover letter that directs all forms will be signed and returned to the fiscal agent along with:
 - a. a copy of the current license of the facility;
 - b. a copy of the Certificate of Need (not required for a participating provider with no changes); and
 - c. a certified copy of the minutes, or other legally sufficient documents, authorizing the person who signs the agreements to do so on behalf of the corporation.
3. When the above material is received, it will be reviewed for completeness, and, if complete, submitted to the Executive Director of the Division of Medicaid for approval or disapproval.
4. If approved, the Executive Director will sign both agreements; one (1) will be returned to the facility and one (1) will be filed in the facility's Medicaid record. The Medicaid Provider Enrollment form will be sent to the fiscal agent so that a Medicaid provider number may be assigned.
5. If the Executive Director disapproves, the facility will be notified in writing. The reasons or the disapproval will be clearly stated, and information will be given on how to appeal the decision.

For further information on Provider Agreements, refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.2 and Part 200, Chapter 4.

Note: Applications and Provider Agreements are available on the website at www.medicaid.ms.gov

Eligibility

The ICF/MR receiving an individual for admission must complete a Form DOM-317 to determine Medicaid eligibility for individuals in long term care. The Medicaid Regional Office of the individual's county of residence is responsible for authorizing Medicaid reimbursement payments via Form DOM-317 for each Medicaid beneficiary, including SSI beneficiaries. This form can be obtained from any Medicaid Regional Office.

The Form DOM-317 documents the most recent date of Medicaid eligibility and the amount of Medicaid income due from the beneficiary each month. Medicaid income is the amount of money the resident in the ICF/MR must pay toward the cost of his/her care.

The completion of the Form DOM-317 is used by the ICF/MR or hospital and Medicaid Regional Office as an exchange of information form regarding applicants for and beneficiaries of Medicaid. It must be completed as follows:

- 1) The ICF/MR or hospital initiates the form at the time a Medicaid applicant/beneficiary enters, transfers in or out, is discharged, or expires in the facility.
- 2) The Medicaid Regional Office completes the form at the time an application has been approved for Medicaid and will notify the facility and the fiscal agent of the effective date of Medicaid eligibility and the amount of the individual's Medicaid income. Form DOM-317 is used to notify the ICF/MR or hospital and the fiscal agent of any change in Medicaid income and to report when Medicaid eligibility is denied or terminated.
- 3) The form is also used to notify the fiscal agent of the date a vendor payment is to begin and the amount the beneficiary must pay toward the cost of care (Medicaid income).

The ICF/MR or hospital originating the form will prepare an original and one (1) copy. The original is mailed to the appropriate Medicaid Regional Office while a copy is retained by the facility.

When the Medicaid Regional Office receives a DOM-317 form from the ICF/MR or hospital that will be the ICF/MR provider, the information is entered into their computer, and it generates a DOM-317A form. This form is sent back to the ICF/MR or hospital by the fiscal agent to inform them of the Medicaid eligibility status, Medicaid income, and other optional information necessary to complete the exchange of information from the regional office. This form should be kept in the beneficiary's file.

DOM-317 forms completed by the regional office to report rejected applications, approvals of yearly reviews with no change in previously reported Medicaid income amounts, or closures with no change in Medicaid income will not be submitted to the fiscal agent for billing purposes. In these instances, the original is returned to the ICF/MR or hospital and one copy (1) is retained in the case record.

MEDICAID INSTRUCTIONS FOR COMPLETING THE DOM-317

Items 1-16 are identifying information about the Medicaid beneficiary and are completed by the facility originating the form.

1. Name of ICF/MR or Hospital
Enter the name of the ICF/MR or hospital in which the beneficiary resides.
 2. Provider Number
Enter the provider's Medicaid ID number.
 3. Address
Enter the complete street address or post office box of the medical facility.
 4. City
Enter the city of the medical facility.
 5. State
Enter the state of the medical facility.
 6. ZIP
Enter the zip code of the medical facility.
 7. Client's Name
Enter the name of the beneficiary.
 8. Medicaid ID
Enter the beneficiary's Medicaid ID number, if known.
 9. Social Security Number
Enter the beneficiary's Social Security number.
 10. Name of Responsible Relative
Enter the name of the relative(s) authorized to act in the beneficiary's behalf.
 11. Address of Relative
Enter the responsible relative's address.
 12. Client's County of Residence Before Entering Facility
Enter the name of the county where the beneficiary lived or maintained a home before
-

entering the medical facility.

13. Does This Beneficiary Receive SSI?

Mark whether or not the beneficiary is a recipient of SSI. If the beneficiary receives an SSI check, enter the amount of the SSI check, if known.

14. Notice of Action Taken

This portion of the form is completed by the nursing facility or hospital at the time the following occur:

A. Client Entered Facility

Enter the month, day, and year the beneficiary entered the facility.

Family or Beneficiary Has Been Given An Application Form

Enter "X" in appropriate place.

B. Client Has Been Discharged to Another Medical Facility as of -

Enter the date the beneficiary was discharged to another medical facility.

Name/Address of New Facility Is -

Enter complete name and address of new facility.

C. Client Has Been Transferred to Another Medical Facility as of -

Enter the date the beneficiary was transferred to another medical facility.

Name/Address of New Facility Is -

Enter complete name and address of new facility.

D. Client Has Been Discharged to Hospice Care within same facility effective -

Enter the date the beneficiary was enrolled into hospice care, provided the beneficiary remains in the same nursing facility.

E. Client Has Been Discharged to a Private Living Arrangement

Enter date beneficiary was discharged.

F. Client is Deceased. Date of Death

Enter beneficiary's date of death.

15. Signature

The nursing facility administrator should sign the form.

16. Date

Enter the date the form is completed.

For more information on Eligibility refer to the Title 23 Administrative Code Part 101.

Admission Review

Pre-Admission Review (42 CFR 456.372)

Purpose Statement

The purpose of the Pre-Admission Review program is to enable the Division of Medicaid:

- To identify statewide the medical need of Title XIX beneficiaries who are residents of an ICF/MR or desire to be admitted to an ICF/MR in order to provide the appropriate type of care and services for an illness or a disability;
- To assure quality of life while safeguarding against over or under utilization of service and costs;
- To ensure that certification for placement and reimbursement of ICF/MR services is given prior to placement or admission to the Medicaid system.

Approval by the Department of Mental Health for long-term care services for Medicaid beneficiaries is given only after alternative resources and settings of care appropriate to the total needs of the beneficiaries have been evaluated. Alternatives to ICF/MR care may include, but are not necessarily limited to, the following community services:

- Family
- Homemaking Services
- Diet and Nutrition
- Socialization
- Recreation
- Physical Therapy
- Speech Rehabilitation
- Transportation
- Economic Assistance
- Legal Assistance
- Counseling

- Mental Health Services
- Social Support Services
- Housing Assistance
- Handicapped Services
- Services provided when applicable under Titles III, IV, VI, XVIII, and XX.

The decision to deny or approve admission is an exercise of professional judgment, utilizing developed criteria applied by qualified professionals licensed in the healing arts.

The Preliminary Evaluation includes:

- Valid current testing to indicate a diagnosis of mental retardation or a “related condition”;
- Background information on the resident (reason for referral, etc.);
- Current, valid Specific Assessment of Functional Developmental Status;
- Mobility;
- Learning;
- Self-care;
- Communication;
- Self-direction;
- Capacity for independent living;
- Health status of resident;
- Nutritional status of resident;
- Social status (skills) of resident; and
- Behavioral status of client.

For further information on Admission Review refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.3.

Note: If a transfer is being done from one facility to another, a Preliminary Evaluation and a post discharge plan from the transferring facility are required.

Reimbursement

Cost Reports

Participating Mississippi facilities must prepare and submit a Medicaid cost report following the close of their standard reporting year of January 1st through December 31st, except for state and county operated facilities, which must report on their statutory fiscal years ending June 30th and September 30th, respectively. A facility may elect to change their cost reporting period to match the Medicare or home office period. When the due date of the cost report falls on a Saturday, Sunday, state or federal holiday, the cost report is due on the following business day. Cost reports must be prepared in accordance with the State Plan for reimbursement of long-term care facilities. A copy of the Plan is available upon written request and on the website at www.dom.state.ms.us.

For additional information on Cost Reports refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.5.

Per Diem Covered Services

Each Long Term Care facility, intermediate care facility for the mentally retarded (ICF/MR), must provide and pay for all services and supplies covered in the Medicaid per diem rate required to meet the needs of the resident.

Services and items which can be billed outside the Medicaid per diem rate include:

1. Items and services covered by Medicare Part B or any other third party must be billed to Medicare Part B or the other third party. Applicable crossover claims should also be filed with Medicaid.
2. Any services or supplies that may be billed directly to Medicaid for facility residents are not allowable costs on the cost report and must be billed directly. These providers must have a separate provider number from that of the facility. These include:
 - a) Laboratory services,
 - b) X-rays,
 - c) Drugs covered by the Medicaid drug program, and

- d) DME supplies. Refer to the Title 23 Administrative Code Part 209, Chapter 1, Rule 1.4 J(1)(2), K.

For further information on Per Diem Covered services refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.4.

Resident's Funds

Basic Requirements

All nursing facilities are required to maintain resident fund accounts, if requested by a resident. For further information on Resident Funds refer to the Title 23 Administrative Code Part 207, Chapter 3, Rule 3.7 A-R.

Individual Records

The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which have been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can determine upon request all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds. Proper bookkeeping techniques may, for example, include a computer software package for the accounting of resident trust funds, and/or an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained. Resident fund records must:

- Include the resident's name;
 - Identify the resident's representative, if any;
 - Include the resident's admission date;
 - Show the actual transaction date and amount of each deposit and withdrawal;
 - Reflect the actual date of an adjusting or correcting entry;
 - State the name of the person who accepted the withdrawn funds;
 - Show the balance after each transaction (i.e., maintain a running balance);
 - Provide the appropriate signatures for all disbursements of funds, such as;
-

- a) Resident's signature, or
 - b) Resident's mark, or "x" with two witnesses' signatures or
 - c) Power of attorney's signature, or
 - d) Resident's responsible party (amount disbursed must be supported by appropriate documentation, e.g., receipts, invoices, etc.), or
 - e) Two signatures of facility personnel (amount disbursed must be supported by appropriate documentation, e.g., receipts, invoices, etc.);
- Document transaction with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, other than the residents and their powers of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. (Note: *The facility must reimburse the resident's account for any undocumented transactions.*);
 - For powers of attorney, the provider must maintain a copy of the power of attorney in the resident's file, and before the provider can allow withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them. This power is normally designated as a "General Power of Attorney" and not as a "Limited or Special" power:
 - Reflect the resident's earned interest, if any;
 - Be reconcilable, at all times, with the current bank statement and/or petty cash;
 - Not include as an outstanding item any check written on a resident's account that has been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 3 Rule 3.7 M.; and
 - Be kept for at least five years.

A written authorization form must be kept on file for the following disbursements:

- Items and services charged by the facility and requested by a resident, such as telephone, television, private room, and privately hired nurses or aides, etc.;
- Beautician or barber services. The facility must ensure that a copy of the various services provided, with their respective prices, is displayed in a place that is frequented by a majority of the residents. The facility must inform the residents in advance when there are any changes in these charges. In addition, complete documentation must be kept for any service provided to the resident;
- Pharmacy charges and freedom of choice. A facility must provide all residents with freedom to use the pharmacy of their choice for all drugs not reimbursed through the ICF/MR per diem rate. (Note: The resident's or responsible party's hand-written choice of pharmacy indicates freedom of choice. The pharmacy drug purchase authorization form should in no way indicate pre-selection or encourage the choice of one pharmacy over another; therefore, pharmacy forms with the preprinted pharmacy names are not acceptable.);
- Insurance premium payments (e.g., burial and health, with supporting documentation such as, but not limited to, the insurance policy, which will reflect the amount due);
- Authorization to pay outside bills (e. g., utilities for an outside address);
- Disbursement of a resident's funds to pay any amount owed to the facility, such as room and board for a prior period of ineligibility for Medicaid.

Forms

DOM-317
Revised 01-01-03

**EXCHANGE OF INFORMATION BETWEEN ICF/MR FACILITY OR HOSPITAL AND
REGIONAL MEDICAID OFFICE**

Name of ICF/MR or Hospital _____

Provider No. _____

Address _____

City _____ State _____ Zip _____

Client's Name _____

Medicaid ID _____ Social Security o. _____

Name of Responsible Relative _____

Address of Relative _____

Client's County of Residence Before Entering Facility _____

Does this client receive SSI? () Yes () No Amount _____

NOTICE OF ACTION TAKEN

() Client entered facility (Month, Day, Year) _____

Family or client has been given an application form? () Yes () No

() Client has been discharged to another medical facility as of _____ (date).

Name/address of new facility: _____

() Client has been transferred to another facility as of _____ (date).

() Client has been discharged to hospice care within same facility effective _____ (date).

() Client has been discharged to a private living arrangement: _____ (date).

() Client is deceased. Date of death: _____

SIGNATURE

DATE

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Page 2

Client's Name _____

Medicaid ID No. _____ Provider No. _____

MEDICAID ELIGIBILITY STATUS

() Client is eligible for Medicaid effective _____

Effective _____, Medicaid Income \$ _____

() Client has had a change in Medicaid Income. _____

Effective _____, Medicaid Income \$ _____

() Yearly review has been completed, no change in Medicaid Income.

() Client has been denied Medicaid benefits.

() Client Medicaid benefits terminate effective _____

The Medicaid Income figures shown represent a total monthly amount. When collecting Medicaid Income from a patient for a partial month stay in your facility, the above figure must be prorated according to the number of days of the stay.

REMARKS: _____

SIGNATURE

DATE