Services and Items Covered by the Medicaid Per Diem Rate

The nursing facility must provide and pay for all services and supplies required to meet the needs of the resident. The facility may not charge a resident for the following:

- Nursing services
- Specialized rehabilitative services
- Dietary services
- Activity programs
- Room/bed maintenance services
- Routine personal hygiene items and services: Refer to 42 CFR, Section 483.10©(8)(i)(e)
- Personal laundry
- Drugs not covered by the Medicaid drug program

Services and Items that must be billed outside the Medicaid per diem rate include:

- 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.

- Any services or supplies that may be billed directly to Medicaid for nursing facility residents are non-allowable costs on the cost report and must be billed directly. These providers must have a separate provider number from that of the nursing facility. These services/supplies include:

    - Laboratory services
    - X-ray services
    - Drugs covered by the Medicaid drug program
    - Physical Therapy, Occupational Therapy, and Speech-Language Pathology: Refer to Provider Policy Manual Section 36.18 for Therapy Services Policy
    - Durable Medical Equipment items supplied to residents: Refer to Provider Policy Manual Section 10.0 for Durable Medical Equipment policy

Hair Hygiene Supplies and Services

A facility's hair hygiene policy must include the provision of combs, brushes, shampoos, trims and simple hair cuts by the facility at no charge to residents. Hair hygiene services include trims and simple haircuts provided by the facility staff as part of routine grooming care. Trims and simple hair cuts include all

haircuts that maintain or enhance each resident's dignity and respect in full recognition of his or her individuality. Included in allowable costs for Medicaid purposes are all hair hygiene supplies and services not charged to the resident. A facility may charge only for hair hygiene supplies and services requested in addition to or in place of those normally supplied or offered by the facility. Haircuts, permanent waves, hair coloring and relaxing performed by barbers and beauticians not employed by a facility may be charged to a resident requesting these services. However, if the facility's policy is to use licensed barbers and/or beauticians for trims and simple haircuts, then residents may not be charged for these services. The resident must be informed of the charge for the supplies and services in advance and an authorization form must be signed by the responsible party and/or resident in advance.

Each facility must maintain written hair hygiene policies that describe what supplies and services are included in the per diem rate.

Hair hygiene supplies, such as combs, brushes and shampoo, are considered care-related costs and should be reported as "Supplies Care Related" on the Medicaid cost report. Allowable barber and beauty supplies should also be reported as care related costs.

Private Room Coverage

The overall average cost per day determined from the cost reports includes the costs of private rooms. The average cost per day is used to compute nursing facility reimbursement rates. Therefore, the cost of a private room is included in the Medicaid reimbursement rates.

When a resident is in a private room due to medical necessity, no extra charge will be made to the resident, the resident's family, or the Medicaid program. In accordance with 42 CFR 447.15, the LTC Reimbursement Plan and Provider Agreement, the Medicaid reimbursement will be considered as payment in full for the resident.

When a resident is in a private room deemed not to be medically necessary, a resident may be charged the difference between the private room charge and the semi-private room charge, if the provider informs the resident at the time of their admission of the amount of the charge. In accordance with the LTC Reimbursement Plan and Medicaid policy, facilities may not charge residents or their families for services covered by the Medicaid reimbursement rate, which specifically includes semi-private room accommodations.

The long-term care facility must provide the Medicaid resident and the non-Medicaid resident notification of the items and services offered by the facility, but not covered by the per diem rate. This notification must include both the items and services and the corresponding amounts for which the resident may be charged. The information must be presented in writing before or at the time of admission or upon the resident's becoming eligible for Medicaid. Residents and/or their responsible parties must be notified in advance of all changes in the provision of services and charges for these services.

The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan consistent with the notice stated in the above paragraph. While the facility may set its basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate. Any items and services available in the facility that are not covered under Title XVIII or the facility's Medicaid basic per diem rate or charge must be available and priced identically for all residents in the facility.

Medicare and Medicaid Benefits

All nursing facilities must provide residents with oral or written information regarding Medicare and Medicaid benefits. This information must cover the application for and the use of these benefits along with instruction on the receipt of refunds for previous payments, which are covered by such benefit. Also, this written information must be prominently displayed in the nursing facility.

Deposits

A nursing facility cannot require a deposit before admitting a card-carrying Medicaid resident. This is in direct violation of federal and state rules and regulations, and the Provider Agreement as cited above. It is under rare circumstances that a SSI Medicaid beneficiary will not be Medicaid eligible upon entry into a nursing home.

All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability policies, is obligated to cover these services.

Prior authorization/pre-certification of certain physical, occupation, and speech-language pathology services is required by the Division of Medicaid (DOM). Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for DOM. Failure to obtain prior authorization will result in denial of payment to billing providers.

The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of CPT codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by DOM.

Providers must also adhere to all DOM outpatient therapy policies. Refer to Provider Policy Manual Sections 47.0 for Outpatient Physical Therapy policy, Section 48.0 for Outpatient Occupational Therapy policy and Section 49.0 for Outpatient Speech-Language Pathology policy.

Private Nursing Facility for the Severely Disabled

This policy is not applicable to a Private Nursing Facility for the Severely Disabled (PNFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.

Medicaid-Only Residents

Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current DOM provider number. Nursing facilities may apply for a group therapy provider number for billing purposes. All claims must be billed on a CMS 1500 claim using Current Procedural Terminology (CPT) codes.

Dually Eligible Residents

Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid (dual) eligible. Refer to Third Party Recovery, Section 6, in this manual. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage.

All therapy providers must meet state and federal requirements.