Under the provisions outlined in this section (42 CFR 447.40), a temporary absence of a resident from a nursing facility will not interrupt the monthly payments to the facility. The period of leave will be determined by counting the day the resident left the facility as the first day of leave.

An absence from the facility for eight (8) to twenty-four (24) hours constitutes a leave day. The facility must reserve the resident's bed in anticipation of the resident's return. The bed may not be filled with another resident during the covered period of leave. Leave days may not be billed if the facility refuses to readmit the resident under their resident return policy.

A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

The Division of Medicaid (DOM) pays for the day of admission to a facility. The day of discharge is not paid by DOM unless it is the same day as the date of admission. Facilities may not bill the resident or responsible party for the day of discharge.

Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing forms and MDS 2.0 Section S.

Before the resident departs on therapeutic or in-patient leave, the facility must provide written information to the resident and/or family member or legal representative explaining leave policies. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility. The notice must also state that, if the resident's absence exceeds Medicaid's bed-hold limit, the resident will be readmitted to the facility upon the first availability of a semi-private bed if the resident still requires the services provided by the facility.

Home/Therapeutic Leave

Home/therapeutic leave residents in a nursing facility may have absences for home/therapeutic leave from the nursing facility other than for in-patient hospital leave. ~~Home/therapeutic leave also includes dialysis and other outpatient treatments.~~ Home/therapeutic leave includes routine outpatient treatments. **Outpatient treatment for dialysis and outpatient treatment for catastrophic illnesses (e.g. chemotherapy) that occurs two (2) or more days per week will not count as therapeutic leave days.**

Specific requirements applicable to home/therapeutic leave are as follows:

- Medicaid coverage of home/therapeutic leave days per State fiscal year (July 1 to June 30) for nursing facilities is fifty-two (52) days in addition to Christmas Day, the day before Christmas, the day after Christmas, Thanksgiving Day, the day before Thanksgiving and the day after Thanksgiving. Thus, a resident may have up to fifty-eight (58) total days in a State fiscal year for home/therapeutic leave.

- All home/therapeutic leave days must be approved by the attending physician.

- Fifteen (15) days home/therapeutic leave are allowed each absence. A resident must be discharged from the facility for Medicaid billing if he/she remains on home/therapeutic leave for

more than fifteen (15) days.

- A leave of absence for home/therapeutic leave is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

In-Patient Leave in a Hospital

Nursing facility residents are allowed fifteen (15) days hospital leave for each hospital stay. There is no maximum number of hospital leave days each year. Hospital leave applies to acute care hospital stays in a licensed hospital, including geri-psychiatric units.

The hospital leave rules apply as follows:

- A resident must be discharged from the facility for Medicaid billing if he remains in the hospital for more than fifteen (15) days. When the resident is readmitted to the facility after a hospital stay, readmission certification on a new Pre-Admission Screening (PAS) form is not necessary if the resident has been continuously institutionalized. ~~Refer to Section 36.11, Minimum Data Set Plus 2.0, for the appropriate assessment and timing of the assessment to file~~. Refer to Provider Policy Manual Section 36.11 for Resident Assessments Minimum Data Set (MDS) policy. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

- Facilities may not refuse to readmit a resident from in-patient hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires nursing facility services.

- Facilities which bill Medicaid for fifteen (15) days of in-patient hospital leave, discharge the resident, and subsequently refuse to readmit the resident under their resident return policy when a bed is available, must repay Medicaid for the fifteen (15) days of hospital leave and are subject to additional remedies for failure to comply with the requirements relating to residents' rights.

- In-patient hospital leave will not be paid for days in which the resident is placed in a Medicare skilled nursing facility (SNF) or a swing bed.

Statutory requirements of Section 1819(b)(3), 1819(e) (5), 1819(f)(6) (B), 1919(e)(5) and 1919(f)(6)(B) of the Social Security Act specify assessment requirements for Skilled Nursing Facilities (SNFs) for Medicare and Nursing Facilities (NFs) for Medicaid which provide nursing, medical and rehabilitative care to Medicare and/or Medicaid beneficiaries. These provisions require facilities to conduct comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI) that has been specified by the State. In addition, all resident assessment instruments must include the minimum data set for core elements, common definitions and utilization guidelines specified by the Centers for Medicare and Medicaid Services (CMS). **These assessments must be completed on all residents regardless of source of payment.**

The State is responsible for specifying the RAI for use by facilities in the State and may use its own instrument, provided that it includes the minimum data set and has been approved by CMS. The providers are responsible for using the specific assessment instrument that has been specified by the State. The Minimum Data Set 2.0 (MDS 2.0) including sections S, T, and U, is the RAI specified by the State of Mississippi and approved by CMS. Questions regarding completion and/or submission of the MDS ~~2.0+~~ 2.0 should be made to: Case Mix Hotline, 601-359-5191 or 601-359-6750.

Electronic submissions of all resident assessments are submitted to the Division of Medicaid via the MSDH Division of Health Facilities Licensure and Certification. The verification of data submitted to the Division of Medicaid is via interim rosters mailed to the facility two times prior to the close of each quarter. The scheduled dates are as follows:

Finals are forwarded to Reimbursement Division for Mail Out with the Facility's Current Quarter Rates.

First Quarter	**January 1 – March 31**
March 15	**1st Quarter Interim Roster mailed**
April 15	**1st Quarter 2nd Interim Roster mailed**
May 5	**1st Quarter Final forwarded to Reimbursement**
Second Quarter	**April 1 – June 30**
June 15	**2nd Quarter Interim Roster mailed**
July 15	**2nd Quarter 2nd Interim Roster mailed**
August 5	**2nd Quarter Final forwarded to Reimbursement**
Third Quarter	**July 1 – September 30**
September 15	**3rd Quarter Inter m Roster mailed**
October 15	**3rd Quarter 2nd Interim Roster mailed**
November 5	**3rd Quarter Final forwarded to Reimbursement**
Fourth Quarter	**October 1 – December 31**
December 15	**4th Quarter Interim Roster mailed**
January 15	**4th Quarter 2nd Interim Roster mailed**
February 5	**4th Quarter Final forwarded to Reimbursement**

Certifications

The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires that each MDS 2.0 assessment must be conducted or coordinated by a registered professional nurse who signs and certifies completion of the assessment. The assessment can be conducted with the appropriate participation of other health professionals. Each individual who completes a portion of the assessment must sign and certify as to the accuracy of that portion of the assessment.

Reproduction and Maintenance of Assessments

A hard copy of all MDS forms within the last ~~15~~ fifteen (15) months, including the signatures of the facility staff, attesting to the accuracy and completion of the records must be maintained in the resident's clinical record. Both hand written and a computer generated forms are equally acceptable. According to CMS policy and accepted Medicaid policy, it is required that facilities maintain ~~15~~ fifteen (15) months of assessment data in the resident's active clinical record. At the end of the ~~15~~ fifteen (15) month period, resident assessment instrument information may be thinned from the clinical record and stored in the medical records department, provided that it is easily retrievable. Refer to the CMS RAI Manual for further requirements and instructions.

Minimum Data Set 2.0 Assessment Schedule

TYPE OF ASSESSMENT	TIMING OF ASSESSMENT
Admission (Initial Assessment Comprehensive)	Must be completed by the 14th day of the resident's stay.
Annual Reassessment (Comprehensive)	Must be completed within 366 days of the most recent comprehensive assessment
Significant Change in Status Reassessment	Must be completed by the end of the 14th calendar day following determination that a significant change has occurred.
Quarterly Assessment, Full Assessment or MPAF	Set of MDS items, mandated by State (contains at least CMS established subset of MDS items). Must be completed every **ninety (90) days.**
Significant Correction of a Prior Full Assessment	Completed no later than 14 days following determination that a significant error in a prior full assessment has occurred.
Significant Correction of a Prior Quarterly Assessment	Completed no later than 14 days following determination that a significant error in a prior Quarterly assessment has occurred.

Refer to the Resident Assessment Instrument Manual, most recent version, for specific instructions and completion of the full document.

~~Refer to the Case Mix Documentation Guide for Medicaid requirements for completion of the Resident Assessment Instrument (RAI) in Section 36.12 of this Provider Policy Manual.~~

Refer to Provider Policy Manual Section 36.12 for Case Mix guidelines policy.