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 state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Medicaid covers inpatient hospital swing bed services. Swing bed services are extended care services provided in a hospital bed that has been designated as such, and the services consist of one or more of the following:

a. Skilled nursing care and related services for patients requiring medical or nursing care.
b. Rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
c. On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

A swing bed 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 rebate Medicaid's payment to the beneficiary. 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 (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM staff, 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 DOM.

Medicaid policy requires that any hospital that has been certified for participation in the Medicare swing bed program and wants to participate in the Medicaid program may request a provider application and agreement from the fiscal agent. Upon completion, the application and agreement should be returned to the fiscal agent.

A separate provider agreement, and application separate from that of the hospital, is required for swing bed services, and a separate provider number will be issued for the swing bed provider. This number must be used on the UB-04 claim form, using the appropriate bill type for swing beds.

The Swing Bed 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 DOM-317 form 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 beneficiary in a swing bed must pay toward the cost of his/her care.

Form DOM-317 is to be initiated by the swing bed facility only when Medicaid reimbursement for long-term care will be billed by the facility. Form DOM-317 is not needed if Medicare is the primary payer for the swing bed stay.

The completed DOM-317 is used by the swing bed facility and the Medicaid regional office as an exchange of information form regarding applicants for and beneficiaries of Medicaid. It must be completed as follows:

1. The form is initiated by the swing bed facility at the time a Medicaid applicant/beneficiary enters, transfers in or out, is discharged, or expires in the facility.

   NOTE: The DOM-317 Form is initiated only when the facility will bill Medicaid as the primary payer for reimbursement.

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. The DOM-317 Form is used to notify the swing bed facility 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 swing bed facility 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 home or hospital that will be the swing bed provider, the information is entered into their computer, and it generates a DOM-317A form. This form is sent back to the nursing home 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 swing bed or hospital and one (1) copy 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 medical facility 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/swing bed administrator should sign the form.

16. Date
Enter the date the form is completed.

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

Client's Name _____

Medicaid ID # _____ Provider # _____

MEDICAID ELIGIBILITY STATUS

( ) Client is eligible for Medicaid effective _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

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

Effective _____, Medicaid Income $ _____

Effective _____, Medicaid Income $ _____

Effective _____, 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

Section 35.04 has been INTENTIONALLY LEFT BLANK.

Individuals who are placed in swing beds in a hospital may have Medicare only, Medicare and Medicaid, or Medicaid only. Claims must be filed as follows:

- Medicare only eligibles: no involvement with Medicaid; file claims with Medicare according to Medicare requirements.
- Medicare and Medicaid dual eligibles: file claims directly with Medicare; Medicaid payment of coinsurance is made through the automatic crossover payment system.
- Medicaid only eligibles: file claims directly with the Medicaid fiscal agent.

In all instances where a Medicaid beneficiary is covered by Medicare, Medicare is the primary payer for a swing bed stay. The Medicare claim will cross over to Medicaid for payment of coinsurance charges. There is no Medicare deductible on a swing bed admission.

Medicaid will reimburse the facility for swing bed care of Medicare and Medicaid dual eligibles when;

1. The Medicaid beneficiary's medical condition does not qualify for Medicare or
2. Medicare benefits are exhausted.

In accordance with the Omnibus Budget Reconciliation Act of 1987 (OBRA 87), the Medicaid per diem rates for swing bed providers are determined as follows:

> The methods and standards used to determine payment rates to hospital providers of nursing facility (NF) services furnished by a swing bed hospital provides for payment for the routine NF services at the average rate per patient day paid to NFs for routine services furnished during the previous calendar year.

Beneficiaries who have Part A Medicare are the responsibility of the Medicare program when in a skilled nursing facility swing bed. Medicaid will pay the Medicare coinsurance after the 20th consecutive day in a swing bed for Medicare/Medicaid beneficiaries through day 100 or the last day covered by Medicare, whichever comes first.

The UB-04 claim form is used for all swing bed billing. Refer to the Division of Medicaid Billing Manual for specific instructions on filing a UB-04 claim form and coding structures.

Services And Items Covered By the Medicaid Per Diem Rate

The swing bed facility must provide and pay for all services and supplies required by the plan of care and ordered by a physician. During the course of a covered Medicaid stay, the facility may not charge a resident for the following items and services:

- Nursing services
- Specialized rehabilitative services
- Dietary services
- Activity programs
- Room/bed maintenance services
- Routine personal hygiene items and services
- Personal laundry
- Drugs not covered by the Medicaid Pharmacy program

Services and Items Not Covered in the Medicaid Per Diem Rate

Any item and services not covered in the per diem rate must be billed outside the per diem rate. These include:

1. Items and services covered by Medicare Part B or any other third party . These must be billed to Medicare Part B or the third party carrier. Applicable crossover claims should be filed with Medicaid.

2. Any services or supplies that are billed directly to Medicaid for swing bed residents. These include:
   - Lab services
   - X-rays
   - Drugs covered by the Medicaid Pharmacy Program
   - Therapy services as specified in the Division of Medicaid Therapy Manual Section
   - Durable Medical Equipment as specified in section 10.02 of the DME manual section

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make such records available to representatives of DOM or the Office of the Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

In order for DOM to fulfill its obligations to verify services to Medicaid beneficiaries and those paid for by Medicaid, providers of swing bed services must maintain auditable records that will substantiate the claim submitted to Medicaid. At a minimum, the records must contain the following on each beneficiary:

- dates of service
- history and physical exam with update if necessary
- physicians' progress notes
- medical indication
- results and findings of all diagnostic and lab procedures
- treatment rendered
- provider's signature or initials
- documentation of services consisting of skilled nursing care and related services for patients requiring medical or nursing care
- documentation of rehabilitation services for the rehabilitation of injured, disabled, or sick persons **and/or**
- on a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available only through institutional facilities.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the swing bed facility.

If a swing bed provider's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within 60 days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the swing bed provider.

A swing bed provider who knowingly or willfully makes, or causes to be made, false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws and can be subject to civil monetary penalties or fines, and/or be disqualified as a provider of Medicaid services.

Definition

Swing bed services are extended care services provided in a hospital bed that has been designated as such. Services consist of one or more of the following:

- Skilled nursing care and related services for patients requiring medical or nursing care;
- Rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- On a regular basis, health related care and services to individuals who, because of their medical status, require care and services above the level of room and board which can be made available to them only through institutional facilities.

Coverage Criteria

Swing bed services are covered when **all** these criteria are met;

- Services to be furnished are ordered by a physician, are consistent with the nature and severity of the beneficiary's illness or injury, medical needs, and accepted standards of medical practice, and are reasonable in duration and quantity;
- The beneficiary requires daily and continuous (not intermittent) skilled nursing and/or rehabilitation services to prevent or minimize deterioration or to sustain health status;
- The beneficiary does not require daily supervision of a physician but does require a physician visit and evaluation at least every thirty (30) days while the beneficiary is in the swing bed setting;
- A nursing facility bed is not available and the required services cannot be safely and effectively provided in the beneficiary's residence;
- In addition to the need for skilled nursing and/or rehabilitation services, the beneficiary must require, at a minimum, assistance with at least three (3) activities of daily living (eating, toileting, personal hygiene, bathing, ambulation, dressing) which cannot be safely and cost-effectively provided in the beneficiary's residence and which must be performed by, or under the supervision of, registered nurses, licensed practical nurses, physical therapists, or occupational therapists.

Swing bed services are **not** covered when the beneficiary does not meet the coverage criteria in this policy. Examples include, but are not limited to, the following:

- The primary service is oral medications;
- The beneficiary is capable of independent ambulation, dressing, feeding, toileting, and hygiene;
- Insulin injections are the only service a beneficiary is receiving, and prior to hospitalization, the beneficiary was on self-injections at the beneficiary's residence;
- The beneficiary and/or primary caregiver are capable of being taught to safely perform the necessary treatment at the beneficiary's residence;

- When services can be safely and more cost-effectively provided in the beneficiary's residence;
- If the beneficiary needs intermittent rather than daily and continuous care;
- If a beneficiary's condition requires an acute inpatient hospital level of care.

Duration

Swing bed services may be covered as long as the beneficiary meets the coverage criteria and there is no available bed in a nursing facility. It is expected that the beneficiary will be discharged or transferred to a nursing facility when the beneficiary's condition allows or a nursing home bed becomes available.

HealthSystems of Mississippi (HSM) is the UM/QIO for the Division of Medicaid.

HealthSystems of Mississippi
175 East Capitol Street
Suite 250, Lockbox 13
Jackson, MS 39201

Telephone 601-352-6353
Facsimile 601-352-6358

Certifications may be submitted using the following contact information:

Type Certification	Fax Number	Phone Number	Web Address
Inpatient Hospital	1-888-204-0504	1-888-204-0502	www.hsom.org
Psychiatric Residential Treatment Facility	1-888-204-0504		
Private Duty Nursing	1-888-204-0504		
Home Health	1-888-204-0159		www.hsom.org
Durable Medical Equipment and Medical Supplies	1-888-204-0159		
Orthotics/Prosthetics	1-888-204-0159		
Outpatient Hospital Mental Health Services	1-866-740-2292		
Outpatient Therapy	1-888-557-1920		

Additional contact numbers include:

Type Line	Purpose	Phone Number
Helpline	Provide assistance to providers	1-866-740-2221 toll free or 601-360-4949 Jackson area
Hotline	Report quality concerns	1-888-204-0221

Telephone lines are staffed from 8:00 am to 5:00 pm, Monday through Friday, except for holidays. The Inpatient telephone line has extended staffing hours from 7:00 am to 5:30 pm.

The following services are covered under the Mississippi Medicaid program. Definition, scope, duration, and policies are covered in the appropriate sections. Where items of service are limited to a fiscal year, reference is to the annual period of July 1 through June 30. For waiver benefits, refer to the appropriate waiver section.

Benefit	Limitation	Prior Authorization	Contact for Prior Authorization
Ambulatory Surgical Center services		No	
Chiropractic services	$700 maximum per fiscal year	No	
Christian Science Sanatoria services			
Community Mental Health Center (CMHC) services	See policy section 15.30	No	
Dental services Children • Preventive • Diagnostic • Restorative • Orthodontia Adults • Emergency pain relief • Palliative care	Dental $2,500 maximum per fiscal year-adults and children; additional benefits if prior authorized Orthodontia $4,200 maximum per lifetime per child.	If applicable See Dental Policy	DOM/MS*
Dialysis (freestanding or hospital-based) Center services		No	
Durable Medical Equipment		Yes	UM/QIO*
Emergency Ambulance services	Prior authorization required for Urgent Air Ambulance (Fixed Wing) only.	Yes	DOM/ MS
EPSDT Expanded EPSDT services	Limited to beneficiaries under 21 years of age. Prior authorization required for services not covered, or any service that exceeds service limits.	No Yes	 DOM/MCH*

Benefit	Limitation	Prior Authorization	Contact for Prior Authorization
Eyeglasses (Vision)	2 pair per fiscal year for children 1 pair every 5 years for adults	Yes, for children after 2nd pair per FY	DOM/MS
Family Planning services	Applies to physician office visit limit	No	
Federally Qualified Health Center services	Applies to physician office visit limit	No	
Health Department services	Applies to physician office visit limit	No	
Hearing services	Limited to beneficiaries under 21 years of age	Yes, for hearing aids	DOM/MS
Home Health services	25 visits per fiscal year	Yes, for visits exceeding 25 for beneficiaries under age 21	UM/QIO
Hospice	Limited to a diagnosis of 6 months or less life expectancy as certified by physician.	No	
Hospital services • Inpatient days • Outpatient ER visits • Swing Bed Services • Outpatient Mental Health Services	 30 days per fiscal year 6 visits per fiscal year	 Yes No No Yes	 UM/QIO UM/QIO
ICF/MR services	Therapeutic leave days limited to 90 days per fiscal year.	No	
Inpatient psychiatric services	Limited to beneficiaries under 21 years of age	Yes	UM/QIO
Laboratory and X-Ray services		No	
Medical Supplies		Yes, for diapers and underpads	UM/QIO
Non-emergency transportation services	Limited to Medicaid covered services only. Excluded if service limits have been exceeded. Excluded if beneficiary has transportation resources.	Yes	NET Broker
Nurse Practitioner services	Applies to physician office visit limit	No	
Nursing facility services	Therapeutic leave days limited to 58 days per fiscal year.	No	
Orthotics & Prosthetics	Limited to beneficiaries under 21 years of age	Yes	UM/QIO
Outpatient PT, OT, ST		Yes	UM/QIO
Pediatric skilled nursing (Private Duty Nursing) services	Limited to beneficiaries under 21 years of age	Yes	UM/QIO
Perinatal High Risk Management services			
Pharmacy Disease Management Services	12 visits per fiscal year	No	
Physician Assistant services	Applies to physician office visit limit	No	
Physician services • Office & ER visits • Psychiatry • Hospital inpatient visits • Long-term care visits	 12 per fiscal year 12 per fiscal year 30 per fiscal year 36 per fiscal year	 No No No No	
Podiatrist services	Applies to physician office visit limit	No	

Benefit	Limitation	Prior Authorization	Contact for Prior Authorization
Prescription drugs	5 per month with no more than 2 of the 5 being brand name drugs; beneficiaries under 21 can receive more than the monthly limits with a medical necessity PA	Yes- for beneficiaries under 21 that require more than 5 prescriptions per month	HID*
Psychiatric Residential Treatment Facility (PRTF) services	Limited to beneficiaries under 21	Yes	UM/QIO
Psychiatry services	12 per fiscal year Can be exceeded for under 21 with PA	Yes, for beneficiaries under 21 that require more than 12 visits	DOM/MH
Rural Health Clinic services	Applies to physician office visit limit	No	
Targeted Case Management services for children with special needs			
Therapeutic and Evaluative Mental Health Services for Children	See policy section 21.15	Yes, for evaluations or to exceed the service standard	DOM/MH*

Refer to Section 1.10 in this manual for information on obtaining prior authorizations from the UM/QIO.

* HID- Health Information Designs MCH- Maternal & Child Health MH- Mental Health

MS- Medical Services NET- Non-Emergency Transportation

UM/QIO- Utilization Management/Quality Improvement Organization