Feeding Assistant Reimbursement

The Division of Medicaid (DOM) uses the direct reimbursement method for feeding assistant training expenses incurred by nursing facilities.

Services and Items Covered

Reasonable costs of training of feeding assistants in order to meet the requirements necessary for the feeding assistant to be certified in accordance with 42 CFR, Section 483.35 (4)(2) are to be billed directly to (DOM). The nursing facility will be directly reimbursed by DOM for covered services and items as set forth in this manual. In order to receive Medicaid reimbursement, the training program used must have program approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification. The reimbursement policies for feeding assistant training set forth in this manual are based on the Code of Federal Regulations, Volume 42, Part 483, Subparts B and D.

Services and supplies approved for payment will be subject to application of the nursing facility's percentage of Medicaid utilization. The Medicaid utilization percentages of every facility are redetermined annually and are applicable for one (1) state fiscal year. The percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.

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. A facility or training center will be reimbursed for no more than four (4) training sessions per year. No costs actually incurred by the facility or the training center will be considered for reimbursement, i.e., electricity, gas, water, etc. No reimbursements will be made for estimated cost. The cost of manuals approved for use by MSDH will be reimbursed.

Training programs, as used in this manual, refer to the training area set up within a nursing facility or training center. Training programs include, but are not limited to, training areas set up by a nursing facility in a remote location due to space restrictions and training centers where an area has been set up for training that serves more than one facility and is located in an area remote from any of the associated facilities.

No reimbursement is available for training costs incurred by individuals or for tuition to outside entities.

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 hours required for program approval by MSDH (sixteen (16) hours effective December 1, 2003). 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 DOM 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

DOM 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 Name**
   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)**
   DO NOT WRITE IN THIS AREA. DOM 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. **For Medicaid Use Only - Amount Approved for Reimbursement**
DO NOT WRITE IN THIS AREA. DOM 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 DOM in writing when program approval is withdrawn. As a result, reimbursement from the DOM will be stopped as of the date of withdrawal of program approval. The only exception is that the DOM will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval.

DIVISION OF MEDICAID
BILLING FORM - FEEDING ASSISTANT

Facility Name _____

Provider Number _____ Training Program Approval Number _____

Mailing Address _____

TRAINING CENTERS ONLY - INDICATE FACILITY NAME PAYMENT IS TO BE MADE UNDER

Remit Payment To: _____

DATE OF CLASS	INSTRUCTOR AND/OR VENDOR'S NAME	HOURS BEING BILLED If Applicable	SALARY PER HOUR If Applicable	AMOUNT	FOR MEDICAID USE ONLY (APPROVAL)
(1)	(2)	(3)	(4)	(5)	(6)
	TOTAL AMOUNT OF THIS BILLING			(7) $	$

(8) NOTE: Copies of invoices/curriculum schedules 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 FEEDING ASSISTANT PROGRAM.

(9) _____ _____ _____

SIGNATURE TITLE DATE

FOR MEDICAID USE ONLY

(10) Gross Amount of this Billing $ _____

Medicaid Percentage X _____ %

Amount Reimbursed by Medicaid $ _____

_____ _____

APPROVED BY DATE

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4. Below the provider number, indicate the Mailing Address of the facility.

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6. Complete each column. Each column must be appropriately completed for each item billed before reimbursement will be considered.

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

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

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DIVISION OF MEDICAID
BILLING FORM - FEEDING ASSISTANT

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Provider Number _____ Training Program Approval Number _____

Mailing Address _____

TRAINING CENTERS ONLY - INDICATE FACILITY NAME PAYMENT IS TO BE MADE UNDER

Remit Payment To: _____

DATE OF CLASS	INSTRUCTOR AND/OR VENDOR'S NAME	HOURS BEING BILLED If Applicable	SALARY PER HOUR If Applicable	AMOUNT	FOR MEDICAID USE ONLY (APPROVAL)
(1)	(2)	(3)	(4)	(5)	(6)
	TOTAL AMOUNT OF THIS BILLING			(7) $	$

(8) NOTE: Copies of invoices/curriculum schedules 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 FEEDING ASSISTANT PROGRAM.

(9) _____ _____ _____

SIGNATURE TITLE DATE

FOR MEDICAID USE ONLY

(10) Gross Amount of this Billing $ _____

Medicaid Percentage X _____ %

Amount Reimbursed by Medicaid $ _____

_____ _____

APPROVED BY DATE