Administrative Code

Title 23: Medicaid
Part 207
Institutional Long Term Care

Table of Contents

Title 23: Division of Medicaid 1

Part 207: Institutional Long Term Care 1

Part 207 Chapter 1: Long Term Care Pre-admission Screening 1

Rule 1.1: Clinical Eligibility Determination 1

Rule 1.2: Exclusions 2

Rule 1.3: Qualifications 2

Rule 1.4: Documentation of Informed Choice 3

Rule 1.5: Eligibility Period 3

Rule 1.6: Appeals 3

Part 207 Chapter 2: Nursing Facility 4

Rule 2.1: General 4

Rule 2.2: Provider Enrollment Requirements 4

Rule 2.3: Termination of Agreements 4

Rule 2.4: Dual Eligibles 6

Rule 2.5: Reimbursement 7

Rule 2.6: Per Diem/Covered Services 8

Rule 2.7: Admission Requirements 11

Rule 2.8: Temporary Leave Payment 12

Rule 2.9: Resident Assessments Minimum Data Set (MDS) 13

Rule 2.10: Case Mix Reimbursement 15

Rule 2.11: Resident Funds 15

Rule 2.12: Nurse Aide Training 26

Rule 2.13: Release of Information 29

Rule 2.14: Pharmacy 29

Rule 2.15: Out-of-State Placements 30
Rule 2.16: Therapy Services 31
Rule 2.17: Feeding Assistant Program 32
Part 207 Chapter 3: Intermediate Care Facility Mentally Retarded 33
Rule 3.1: General 33
Rule 3.2: Provider Enrollment/Provider Agreement 33
Rule 3.3: Admission Review 35
Rule 3.4: Per Diem Covered Services 36
Rule 3.5: Reimbursement 38
Rule 3.6: Temporary Leave Payment 40
Rule 3.7: Resident Funds 42
Rule 3.8: Utilization Review 53
Rule 3.9: Release of Information 54
Part 207 Chapter 4: Psychiatric Residential Treatment Facility 54
Rule 4.1: General 54
Rule 4.2 Provider Enrollment 55
Rule 4.3: Staffing 56
Rule 4.4: Admission 57
Rule 4.5: Non-Covered Services 58
Rule 4.6: Reimbursement 59
Rule 4.7: Active Treatment 62
Rule 4.8: Assessment and Evaluation 62
Rule 4.9: Treatment Planning 63
Rule 4.10: Therapeutic Interventions 65
Rule 4.11: Medical Treatment Requirements 71
Rule 4.12: Special Procedures 71
Rule 4.13: Medication 76

Rule 4.14: Discharge Aftercare 77

Rule 4.15: Reporting Requirement 79

Rule 4.16: Maintenance of Records 80

Title 23: Division of Medicaid

Part 207: Institutional Long Term Care

Part 207 Chapter 1: Long Term Care Pre-admission Screening

Rule 1.1: Clinical Eligibility Determination

A. All elderly and physically disabled applicants applying for or being recertified for the Division of Medicaid's long term care services must complete a Pre-admission Screening (PAS) for clinical eligibility determination and placement into the following long term care service settings/programs:

   1. Nursing Facility (NF),

   2. Assisted Living Waiver (AL),

   3. Elderly and Disabled Waiver (E&D),

   4. Independent Living Waiver (IL), or

   5. Traumatic Brain Injury/Spinal Cord Injury Waiver (TBI/SCI).

B. Individuals seeking long term care services must meet the Division of Medicaid's defined threshold numerical score, or be approved based on a secondary review, in order to be considered clinically eligible.

C. In addition to the PAS score, a physician must certify clinical eligibility.

D. The PAS must be submitted within thirty (30) days of the physician's certification and expires thirty (30) days from the date of the physician's certification.

E. Individuals enrolled in the Division of Medicaid's long term care program must be recertified annually, with the exception of nursing facility residents. Home and Community Based Services (HCBS) waiver beneficiaries desiring continued waiver services must be recertified by submission of a new PAS at least ten (10) days, but no more than ninety (90) days, prior to date of expiration of the current PAS.

F. An individual seeking nursing facility placement must also meet the Pre-Admission Screening and Resident Review (PASRR) requirements.

G. All individuals who are admitted to a Medicaid certified nursing facility must have a Level I Pre-Admission Screening (PAS) completed to determine whether or not the resident is appropriate for nursing facility placement and to identify indicators of mental illness or mental retardation (MI/MR).

1. The PAS must be completed regardless of the resident's method of payment, either by Medicare, Medicaid or private pay.

2. This requirement is based upon certification of the bed and includes Title 19, or Medicaid only, and Title 18/19, dually or certified for Medicare and Medicaid beds.

3. A PAS is not required for Title 18 or Medicare only beds.

H. Individuals who have or are suspected to have MI/MR or related conditions must not be admitted to a Medicaid certified nursing facility unless approved through a Level II PASRR determination. Refer to Part 300, Chapter 4 Pre-Admission Screening and Resident Review.

Source: Miss. Code Ann. § 43-13-121

Rule 1.2: Exclusions

A. A Pre-Admission Screening (PAS) does not have to be completed on individuals being admitted to a nursing facility (NF) when the following conditions exist:

1. The individual is discharged from an acute care hospitalization directly into a nursing facility for continued treatment of a condition for a period of less than thirty (30) days. This includes short stay admissions covered under Medicare Part A, as a skilled nursing facility resident.

2. A PAS application should not be completed for individuals being admitted to a nursing facility that is not a Medicaid-certified Nursing Facility.

B. A PAS is not required for a re-entry to a Nursing Facility when the discharge is due to exhaustion of hospital leave days. However, if an individual is going to a different nursing facility, a PAS must be completed.

Source: Miss. Code Ann. § 43-13-121

Rule 1.3: Qualifications

A. The Pre-Admission Screening (PAS) must be completed by qualified individuals. Qualified individuals include:

1. Physician,

2. Nurse Practitioner or Registered Nurse,

3. Licensed Social Worker,

4. Rehabilitation Counselor, or

5. Designee by facility/setting.

B. Individuals must adhere to the appropriate program rules regarding specific qualifications.

Source: Miss. Code Ann. § 43-13-121

Rule 1.4: Documentation of Informed Choice

A. An individual must 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. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.

B. The PAS Informed Choice section requires a signature by the applicant or their legal representative.

C. The PAS cannot be processed without the signed Informed Choice section or the signed Physician Certification section.

Source: Miss. Code Ann. § 43-13-121

Rule 1.5: Eligibility Period

A. HCBS waiver beneficiaries desiring continued waiver services must be recertified annually by submission of a new PAS.

B. A PAS must be submitted at least ten (10) days, but no more than ninety (90) days, prior to date of expiration of the current PAS. Documentation must be submitted that provides justification when a new PAS is submitted less than ten (10) days of the expiration date of the current PAS.

Source: Miss. Code Ann. § 43-13-121

Rule 1.6: Appeals

A. Applicants/beneficiaries have the right to appeal long term care eligibility denials. Appeals are processed in accordance with existing state rules for each individual long term care program.

B. A complete PAS must be retained by the screening organization. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

C. A complete PAS must be available for the Division of Medicaid review upon request.

Source: Miss. Code Ann. § 43-13-121

Part 207 Chapter 2: Nursing Facility

Rule 2.1: General

A. The Division of Medicaid may not execute a provider agreement with a facility for nursing facility services unless the State survey agency or the Centers for Medicare and Medicaid Services (CMS) has certified the facility as having met all of the participation requirements in accordance with Sections 1919 (a), (b), (c), and (d) of the Act. The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification, pursuant to federal law and regulation, certify nursing facilities for participation in the Medicaid program.

B. Medicaid payments may not be made to any nursing facility prior to the date of certification and execution of a valid Medicaid provider agreement.

C. If the Medicaid agency has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. A provider agreement is not valid, even though 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.

Source: Miss. Code Ann. § 43-13-121; *§ 43-11-1, 42CFR § 442.12; § 483.1; § 442.10;* 45 CFR Parts 80, 84, 90

Rule 2.2: Provider Enrollment Requirements

Nursing facility providers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Written confirmation from the IRS confirming the tax identification number and legal name.

C. Copy of license or current certification letter and from the state of servicing location.

Source: Miss. Code Ann. § 43-13-121

Rule 2.3: Termination of Agreements

A. 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 a nursing facility:

    1. Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present, or

2. Fails to submit an acceptable plan of correction within the timeframe specified by CMS and/or the Division of Medicaid, or

3. Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS and/or the Division of Medicaid, or

4. Does not meet the eligibility criteria for continuation of payment as set forth in 42CFR 488.412(a)(1) and 42CFR 448.456. CMS or Medicaid may terminate the nursing facility's provider agreement or may allow the facility to continue to participate for no longer than six (6) months from the last day of the survey if the facility has not met all requirements under this section.

B. Notice of Termination: Before terminating a provider agreement, CMS and/or Medicaid must provide written notification to the facility and public notification via local and/or general newspaper publication as follows:

1. At least two (2) calendar days before the effective date of the termination for a facility with immediate jeopardy deficiencies, and

2. At least fifteen (15) calendar days before the effective date of termination for a facility with non-immediate jeopardy deficiencies that constitute noncompliance.

C. Reimbursement: 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 if it is determined that:

1. Reasonable efforts are being made to transfer the residents to another facility, community care, or other alternate care, and

2. Additional time is needed to effect an orderly transfer of the residents.

D. Discharge and Relocation of Residents

1. When the State or CMS terminates a facility's provider agreement, the State will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another facility. The facility must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising them of the impending closure.

2. 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:

   a) Title XIX certified and in good standing under its provider agreement; and

b) Able to meet the needs of the resident.

E. Resident Trust Fund Accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by 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, and receipts of purchases. In addition, the facility must maintain a current surety bond to cover the total amount of funds in the trust fund account.

F. Reinstatement After Termination

1. When a provider agreement has been terminated by the Office of Inspector General (OIG), CMS and/or Medicaid under 42 CFR 489.53, a new agreement with that provider will not be accepted unless it is found that:

   a) The reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur, and

   b) The provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.

2. To be considered for re-instatement the Division of Medicaid must receive:

   a) A notification of re-instatement from the appropriate entity,

   b) An application for re-instatement to participate in the Medicaid program, and

   c) The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.10; 42 CFR § 489.53; 42 CFR § 488.456; 42 CFR § 488.456; 42 CFR § 489.55; 42 CFR § 488.426; 42 CFR § 483.75; 42 CFR § 489.53; 42 CFR § 488.412 (a)(11)

Rule 2.4: Dual Eligibles

A state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full; and the dually eligible cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment. Medicare is the primary payor for dually eligible recipients, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all covered

services available under both programs, but a claim must be filed with Medicare, if Medicare covers the service.

Source: Miss. Code Ann. § 43-13-121; 42 U.S.C. 1396u–3; 42 CFR § 447.15; Balanced Budget Act of 1997, Social Security Act 1902 (a) (10)(E)

Rule 2.5: Reimbursement

A. Cost Reports

1. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

2. Medicaid uses a prospective method of reimbursement. The rates are determined from cost reports and resident case-mix assessment data. Standard rates are determined annually with an effective date of January 1. Rates are adjusted quarterly based on changes in the case-mix of the facility.

3. In no case may the reimbursement rate for services exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

4. Prospective rates may be adjusted by Medicaid pursuant to changes in federal and/or state laws or regulations.

5. Prospective rates may be adjusted by Medicaid based on revisions to allowable costs or case-mix scores or to correct errors. These revisions may result from amended cost reports, field visit reviews, or other corrections. Facilities are notified in writing of amounts due to or from Medicaid as a result of these adjustments. There is no time limit for requesting settlement of these amounts.

B. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports.

C. Retention of Records

1. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as

prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

2. Providers must maintain adequate documentation, including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program. The cost report must be based on the documentation maintained by the facility. All non-governmental facilities must file cost reports based on the accrual method of accounting. Governmental facilities have the option to use the cash basis of accounting for reporting.

3. Documentation of financial and statistical data should be maintained in a manner consistent manner from one (1) period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

4. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance with Medicaid rules. These records shall be made available as requested by the Division of Medicaid. All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

Source: Miss. Code Ann. § 43-13-121; 42CFR §447 Subparts B & C; Miss. Code Ann. § 43-13-117

Rule 2.6: Per Diem/Covered Services

A. Services and Items Covered by the Medicaid per Diem Rate

1. 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:

   a) Nursing services,

   b) Specialized rehabilitative services,

   c) Dietary services,

   d) Activity programs,

   e) Room/bed maintenance services,

   f) Routine personal hygiene items and services,

g) Personal laundry, or

h) Drugs not covered by the Medicaid drug program.

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

a) 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.

b) 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:

1) Laboratory services,

2) X-ray services,

3) Drugs covered by the Medicaid drug program,

4) Physical Therapy, Occupational Therapy, and Speech-Language Pathology, and

5) Durable Medical Equipment items supplied to residents.

B. Hair Hygiene Supplies and Services

1. A facility's hair hygiene policy must include the provision of combs, brushes, shampoos, trims and simple haircuts 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 haircuts 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.

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

3. 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.

C. Private Room Coverage

1. The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room due to medical necessity prescribed and ordered by a physician. No extra charge will be made to the resident, the resident's family, or the Medicaid program. The Medicaid reimbursement will be considered as payment in full for the resident.

2. When a resident is in a private room, by resident or family choice, 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. Facilities may not charge residents or their families for services covered by the Medicaid reimbursement rate, which specifically includes semi-private room accommodations.

3. 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.

4. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services 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.

D. 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.

E. 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.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.10; 42 CFR 483.10 (5)(6); 42 CFR 447.15; 42 CFR 483.10(8)(i)(e)

Rule 2.7: Admission Requirements

A. 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.

B. Individuals with mental illness and/or mental retardation (MI/MR), determined to require nursing facility level of care, must receive a Level II evaluation. The Level II determination is to ensure appropriate placement and the provision of specialized services if necessary to individuals who have been diagnosed with MI/MR.

C. The PAS Section X. Summary, physician's certification and Level II, if required, must be submitted to the Medicaid Regional Office of the individual's county of residence.

D. The nursing facility receiving the individual for admission must complete and submit a Form DOM-317 to the Medicaid Regional Office. The Medicaid Regional Office is responsible for determining eligibility for individuals applying for long term care as authorized by Title XIX of the Social Security Act.

E. Private Nursing Facility for the Severely Disabled (PNF-SD): Individuals admitting into a PNF-SD must meet the following additional requirements:

1. A minimal diagnosis of 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.

2. The MDS classification must be one of the following RUGS III 34 Grouper categories SE1; SE2; SE3; SSC; SSB; SSA.

3. 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 PNF-SD.

4. The extent of care medically necessary cannot be provided in a traditional nursing facility in Mississippi.

5. Medicaid will deny payment for beneficiary admissions by PNF-SD that do not fall within these parameters

Source: Miss. Code Ann. § 43-13-121; 42CFR § 483.112 Subpart C; 42 CFR §483.120; MS Code 43-13-117 (44)(a)(b); Title XIX of Social Security Act

Rule 2.8: Temporary Leave Payment

A. Under the provisions outlined in this section, 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 (1st) day of leave.

B. 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.

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

D. The Division of Medicaid pays for the day of admission to a facility. The day of discharge is not paid by Medicaid, 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.

E. Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing forms. All resident hospital and therapeutic leave periods, regardless of payment source, must be submitted to the Division of Medicaid electronically prior to the close of the quarter in which it occurred.

F. 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.

G. Home/Therapeutic Leave

1. 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 includes routine outpatient treatments. Outpatient treatment for dialysis and outpatient treatment for catastrophic illnesses, like chemotherapy that occurs two (2) or more days per week will not count as therapeutic leave days.

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

   a) 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.

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

c) 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.

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

H. Leave for Inpatient Hospital Stay

1. 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.

2. The hospital leave rules apply as follows:

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

b) 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.

c) 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.

d) 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.

Source: Miss. Code Ann. § 43-13-121; § 43-13-117; 42 CFR §447.40

Rule 2.9: Resident Assessments Minimum Data Set (MDS)

A. 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.

B. 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 3.0 (MDS 3.0) including section S, is the RAI specified by the State of Mississippi and approved by CMS.

C. Certifications - Resident assessments are required to 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.

D. Reproduction and Maintenance of Assessments - A copy of all MDS forms within the last 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/or computer generated forms are equally acceptable. At the end of the 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.

E. Minimum Data Set 3.0 Assessment Schedule

1. The OBRA regulations require nursing homes that are Medicare certified or Medicaid certified or both to conduct the following assessments for all residents: Admission, comprehensive; Annual, comprehensive; Significant Change in Status, comprehensive; Quarterly, Significant Correction to prior comprehensive, Significant Correction to prior Quarterly and Discharge assessments.

2. 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 may result in a default classification (BC1).

F. State Specific Discharge Requirements

1. Residents that are out of the facility and not on a paid bed-hold stay must be discharged

as a return not anticipated at the time of discharge, even though the facility may anticipate a return.

2. Paid bed hold stays must not exceed fifteen (15) consecutive days. Residents that have not returned to the facility by the sixteen (16th) day must be discharged as a return not anticipated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.20; 42 CFR § 483.315; Social Security Act Section 1819 (b)(3), (e)(5), (f)(6)(B), 1919(e)(5) and (f)(6)(B)

Rule 2.10: Case Mix Reimbursement

A. Mississippi Division of Medicaid utilizes a RUGs-III modified 34 grouper model for case mix calculation. Each of the thirty-four (34) resident classifications as well as the default classification is assigned case-mix weights. The Mississippi base weights for all M^3PI categories. The classifications are calculated electronically at the Division of Medicaid using the MDS assessment data and the M^3PI calculation program.

B. Clinical documentation that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. It is required that information contained in the clinical record supports the MDS assessment. For payment purposes, documentation must substantiate the resources and services needed to provide care to the resident. Documentation requirements for case mix reimbursement can be found on the agency's website.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.75

Rule 2.11: Resident Funds

A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.

2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems of accounting for resident funds.

3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.

B. Statement Provided at Time of Admission - The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:

1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.

2. There is no obligation for the resident to deposit funds with the facility.

3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:

   a) The resident's right to receive, retain and manage his/her personal funds or have this done by a legal guardian, if any,

   b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

   c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and

   d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested by the resident.

4. Any charge for this service is included in the facility's basic rate.

5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.

7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

C. 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. 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.

D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading "Individual Records" of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:

   a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,

   b) Personal comfort items, including tobacco, novelties, and candy,

   c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,

   d) Personal clothing,

   e) Personal reading material,

   f) Gifts purchased on behalf of the resident,

   g) Flowers and plants for the resident's room,

   h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,

   i) Private sitters or aides,

   j) Private room provided that a private room is not medically necessary, like isolation for infection control,

   k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and

   l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

2. Unacceptable charges to resident funds include the following categories and examples:

   a) Any charge not authorized and documented.

b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.

d) Medical transportation. All transportation for nursing facility residents, whether emergency or non-emergency must be arranged by nursing facility staff. Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Transportation may also be arranged using nursing facility vehicles, or by utilizing outside resources. Costs for providing this level of service are to be reported by the nursing facility on their cost reports and are reimbursed through the facility per diem. The nursing facility may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the nursing facility may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to Medicaid for direct reimbursement. If a resident is transferred from a nursing facility to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the nursing facility, transportation for these residents should be arranged by the hospital. If there has not been a final discharge from the nursing facility and the resident had a hospital stay of less than fifteen (15) days, transportation back to the nursing facility must be arranged by the nursing facility staff.

e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

h) Any item or service as a condition of admission or continued stay.

E. Resident's Access to Financial Records and Quarterly Statements - The facility must provide

each resident, responsible party, or legal representative of each resident, reasonable access to the resident's financial records. In addition, the facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.

F. Comingling of Residents' Funds - The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility. The facility may not open any additional accounts within the trust fund account, such as donation accounts, miscellaneous accounts, or the like. Only funds of the facility's residents may be maintained as part of the resident trust fund account.

G. Deposit of Resident Funds into an Interest or Non-Interest Bearing Account

1. The facility must deposit any resident's personal funds in excess of fifty dollars ($50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

   a) Prorated to each resident's account on an actual interest-earned basis; or

   b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.

3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

H. Access to Funds

1. Funds held in the facility - The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturdays and Sundays. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding and accounting and that are maintained in a petty cash fund.

2. Funds held outside the facility - For a resident's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request, must, within five (5) business days, return to the resident, the legal guardian, or the representative payee, all or any part of those funds.

I. Accounting on Change of Ownership

1. Duties of new owner - Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

2. Duties to resident - The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

3. Rights of resident - In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.

4. Sponsor signatures for fiscal responsibility - A nursing facility cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where Medicaid beneficiaries have no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:

   a) Resident's next of kin,

   b) Resident's representative, or

   c) Clerk of the probate court of the county in which the resident died.

2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility

   a) Any resident who dies intestate and leaves no known heirs and has no representative party shall have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner.

b) The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased person and his/her last known address prior to entering the nursing facility; the name and last known address of each person who may possess an interest in such funds; and any other information which the State Treasurer prescribes by regulation as necessary.

c) In the event a party with a claim to the deceased resident's funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer. All reports of unclaimed funds filed by the facility prior to November 1st of each year will be included in a list published by the State Treasurer within one hundred twenty (120) days following November 1st. Claimants have ninety (90) days from the date of publishing to file for such funds. After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.

3. Disposition of Funds for Deceased Resident Who Dies Intestate in a State Institution - Section A above shall not be applicable for residents of any state institution. The funds of any resident in a state institution who dies intestate and without any known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

K. Surety Bond

1. The facility must purchase a surety bond or otherwise provide assurance as to the security of all personal funds of residents deposited with the facility. A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (the residents of the trust fund), wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds; that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee (the residents of the trust fund), not the principal, from loss. The surety bond differs from a fidelity bond, also called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the facility to meet the standard of conduct. The facility assumes the responsibility to compensate the obligee (the residents of the trust fund), for the amount of the loss up to the entire amount of the surety bond. Therefore, the surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit. A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at

the facility and available for inspection.

4. Reasonable alternatives to a surety bond must:

   a) Designate the obligee, (the resident, individually, or in aggregate), who can collect in case of a loss,

   b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

   c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

6. If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the residents in the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

L. Resident Incapable of Managing Funds

1. If a resident is incapable of managing personal funds and has no representative, the facility must refer the resident to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

2. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.

3. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source, like a Social Security check, cannot be commingled with facility funds prior to those funds being transferred to the trust fund account.

M. Notice of Resource Limits, Medicaid or SSI

1. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200) less than the SSI resource limit and five hundred dollars ($500), less than the Medicaid

resource limit, to remain eligible for Medicaid long term care benefits. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the applicable resource limits, the resident may lose eligibility for Medicaid or SSI.

2. The facility must issue written notification to the Medicaid regional office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

N. Glossary and Explanation of Common Terms Used in the Performance of Resident Trust Fund Reviews

1. Basic Rate - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.

2. Book Balance - The total balance of all resident trust funds and petty cash held according to the accounting ledger.

3. Census - The total number of residents in a facility.

4. Compliance - The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) requires a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."

5. DOM - Division of Medicaid.

6. Fiduciary - A fiduciary has rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting in this capacity.

7. Fiscal Agent - The agency, under contract with the Division of Medicaid, for the purpose

of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

8. GAAP - Generally Accepted Accounting Principles. GAAP for resident trust funds means that the facility 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 each individual resident's fund balance. Proper bookkeeping techniques may, include a computer software package for the accounting of resident trust funds, 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.

9. Intestate - Without a valid will at the time of death.

10. Legal Guardian - A legal guardian, or conservator, is a person or persons appointed by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.

11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month for room and board.

12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.

13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.

14. Per Diem Rate - Refer to "Basic Rate."

15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:

a) Documentation that the exception has been corrected,

b) The measures that have been put in place to ensure that the exception will not be repeated, and

c) The measures that have been put in place to monitor the continued effectiveness of the changes.

17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.

19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.

20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two(2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.

21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).

22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

23. Testate - Having a valid will at the time of death.

24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.

25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; 42 CFR 447.15; 42 CFR 483.10; Social Security Act 1919 (c)(16); 1919 (5)(A)(i); 1919 (6)

Rule 2.12: Nurse Aide Training

A. Nurse Aide Training and Testing Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for nurse aide training and testing expenses incurred by nursing facilities.

2. Reasonable cost of training and competency testing of nurse aides in order to meet the requirements necessary for the nurse aide to be certified are to be billed directly to Medicaid

B. In-House Training Programs

1. The nursing facility will be directly reimbursed by Medicaid for covered services, equipment, and supplies. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. 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. Nurse aide 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.

3. Only costs actually incurred by the facility will be considered for reimbursement. No reimbursements will be made for estimated cost.

4. In-house training programs refer to the training area set up within a nursing facility or

training center. In-house training programs include training areas set up by a nursing facility in a remote location due to space restrictions. A training center is an area set up for nurse aide training which serves more than one (1) facility and is located in an area remote from any of the associated facilities.

C. Testing Fees are allowable for direct reimbursement for nurse aides who have been through an approved certification training program. Medicaid will reimburse for written or oral and clinical testing fees based on the fee schedule from the current testing services contracted by MSDH. Testing reimbursement will be subject to a nursing facility's Medicaid utilization percent just like training reimbursement. Testing must be billed by the employing facility of the nurse aide who was tested. This applies even to nurse aides trained in a training center. Training centers do not bill the nurse aide testing fees. Medicaid will reimburse the cost for a nurse aide to be tested up to three (3) times. If after three (3) attempts, a nurse aide fails to pass the tests, Medicaid requires the aide to complete another training program before any additional tests will be reimbursed. Testing fees must be billed with thirty (30) days of the test date. Pass/fail results must be included with the billing. Pass/fail results can include either the results received from the current testing service or the actual results given to the aides at the time of the tests.

D. Out of Facility Training

1. Facilities which do not have an approved nurse aide training and testing program and are not associated with an approved training center may acquire training for their employed aides at any approved non-facility-based Nurse Aide Training and Competency Evaluation Program (NATCEP). Medicaid has set a limit on reimbursable cost on training and evaluating a nurse aide outside the facility.

2. The current limit is set at five hundred dollars ($500.00) for each nurse aide's training session and testing. Medicaid will apply the Medicaid utilization percent of the employing facility to the lesser of the cost incurred or the limit to determine the amount reimbursable. Under no circumstances will Medicaid reimburse a facility for off-site training and testing costs when it is determined that the off-site training and testing site is receiving reimbursement from Medicaid for the same training or testing session. Out of facility training should be billed using the billing form for nurse assistant training expenses. Pass/fail results should be submitted with the billing form if the aide was tested.

3. Facilities that do not have an approved nurse aide training program, which receive training for their employed nurse aides at an approved site that is a related party, are subject to reimbursement limits at cost. The training program must submit to Medicaid a record of the actual allowable costs incurred to run the training program for a month. Costs are determined allowable following the guidelines stated for approved training centers. Documentation must be submitted with the record of costs in accordance with other paragraphs of this section. The allowable reimbursement for each nurse aide trained for the related party nursing facility will be limited to cost and will be subject to the application of the Medicaid utilization percent.

4. The Medicaid utilization percent is determined by the total allowable monthly costs that will be divided by two (2) to recognize the time for two (2) training sessions of two (2) weeks each in each month. The monthly costs will be further divided by the maximum number of aides allowed in each training session. This calculation will result in the determination of the allowable tuition rate for a nurse aide employed by a related party nursing facility. The related party nursing facility will bill Medicaid the predetermined allowable tuition rate. Medicaid will then apply the facility's Medicaid utilization percent when approving the billing. The training program will be allowed to submit actual monthly costs as often as once per month. Submission of costs for subsequent months are only required when there is a permanent change. Facilities will have an option exercisable at the beginning of each state fiscal year and at the inception of the training program to report actual numbers of aides trained in total and for the related party nursing facility in each training session in order to prorate the monthly costs.

E. Reimbursement to an Individual Not Yet Employed at the Time of Training - Medicaid will reimburse the cost of an approved nurse aide training and competency evaluation program to an individual who is not employed, or who does not have an offer of employment, as a nurse aide on a pro rata basis under the following conditions:

1. The individual is employed or receives an offer of employment from a nursing facility not later than twelve (12) months after completing an approved program.

2. The individual incurred costs for the training and testing and can provide documentary evidence of them. Medicaid will not reimburse costs to an individual who received training through a grant.

3. Medicaid will not approve costs in excess of the training and testing limits set for out-of-facility training. The Medicaid utilization percent(s) of the facility(s) which employs the nurse aide will be applied to the approved cost to determine the reimbursement amount.

4. Medicaid will reimburse one-half (1/2) of the settlement after six (6) months of full time employment by one (1) or more Mississippi nursing facilities. The remaining one-half (1/2) of the settlement will be reimbursed after the nurse aide has been employed full time for twelve (12) months by Mississippi nursing facilities.

5. The facility which employs the nurse aide must submit the bill for reimbursement to Medicaid on the billing form for Nurse Assistant Training Expenses.

F. Prohibition of Charges - No nurse aide who is employed by, or who has an offer of employment from, a facility on the date on which the aide begins training and testing program may be charged for any portion of the program.

G. Withdrawal of Program Approval - MSDH will notify 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. As an exception, 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, 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 at the Medicaid utilization percent in effect at the time of original reimbursement.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; OBRA 1987

Rule 2.13: Release of Information

A. Public access to records maintained by the Medicaid agency is mandated. The exceptions to public access are those records which are exempt as confidential or privileged.

B. Beneficiary-Specific Information will only be released by the Medicaid agency when the requirements of federal regulation are met.

C. Provider-Specific Information, including, but not limited to, cost reports, reimbursement rates, reimbursement amounts and reports not beneficiary-specific, will be available to the public when:

    1. A written request for the information is made to the Executive Director of the Medicaid agency,

    2. The information is available in existing agency files or reports, and

    3. The requestor reimburses the Medicaid agency for the costs associated with the compilation of the requested material, as permitted by law.

D. Statistical Data that does not contain protected health information is available as requested. This type of information is generally available in the Medicaid agency annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Medicaid agency for the costs associated with the compilation of the requested material, as permitted by law.

Source: Miss. Code Ann. § 43-13-121; 25-61-1; 42 CFR 431.300 - 431.307; 45 CFR 160.164

Rule 2.14: Pharmacy

A. Beneficiaries in nursing facilities may obtain medications from pharmacies holding retail, closed door or institutional permits. Nursing facility (NF) residents may receive unlimited prescriptions per month if the medication orders, signed by the prescribing provider, are documented in the individual patient record and maintained at the nursing facility.

B. Beneficiaries maintain the ability to obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them to that beneficiary. Participation in any package plan for medical care, such as those furnished by nursing facilities, must be strictly voluntary.

C. A resident of a long-term care facility is allowed freedom of choice of pharmacy providers for drugs covered by the Medicaid drug program. The freedom of choice is limited to pharmacies that meet labeling and packaging requirements established by the Mississippi State Board of Pharmacy.

D. Consequently, once a beneficiary chooses a particular provider or NF, he or she has clearly exercised freedom of choice with the respect to all items of medical care included within the scope of that nursing facility, including all services provided or arranged for by the NF which are reimbursed through the NF rates.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

Rule 2.15: Out-of-State Placements

A. Ventilator Dependent- Out of State Nursing Facility Placements

1. Beneficiaries may be approved for out-of-state nursing facility placement when the individual is ventilator dependent and the needs of the beneficiary cannot be met in the state of Mississippi. The out-of-state facility accepting the beneficiary must have prior authorization from the Division of Medicaid's Executive Director.

2. To qualify for out-of-state placement, the following criteria must be met:

   a) All efforts for in-state placement must be exhausted.

   b) The beneficiary must be Mississippi Medicaid eligible.

   c) The beneficiary must be eligible for long term care placement.

   d) The beneficiary must be ventilator dependent.

   e) Completion of a Pre-Admission Screening Application with a PAS score of fifty (50) or greater.

B. Reimbursement

1. The out of state facility must be enrolled as a Mississippi Medicaid provider. Medicaid will not be responsible for payment for any placements in an approved out-of-state facility without prior authorization from the Executive Director. Beneficiaries receiving Medicare benefits admitted to an approved facility for weaning from ventilator dependency but who fail to meet the goal of being weaned must receive executive

approval from Medicaid to receive reimbursement. If the beneficiary is weaned from the ventilator during the stay in the out-of-state facility, reimbursement will be discontinued.

2. Reimbursement must be established for each beneficiary utilizing Mississippi's Case Mix payment rate system. The approved out of state facility must provide an initial and quarterly Minimum Data Set assessment for review and desk audit to determine category classification utilizing the M3PI for reimbursement.

Source: Miss. Code Ann. § 43-13-121

Rule 2.16: Therapy Services

A. 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 ruless, is obligated to cover these services.

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

C. 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 procedure 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 Medicaid.

D. Providers must also adhere to all Medicaid outpatient therapy rules.

E. Private Nursing Facility for the Severely Disabled - This rules 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.

F. Medicaid-Only Residents - Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current Medicaid provider number. Nursing facilities may apply for a group therapy provider number for billing purposes.

G. 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 eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

Source: Miss. Code Ann. § 43-13-121

Rule 2.17: Feeding Assistant Program

A. Feeding Assistant Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for feeding assistant training expenses incurred by nursing facilities. Reasonable costs of training of feeding assistants in order to meet the requirements necessary for the feeding assistant to be certified and are to be billed directly to Medicaid. The nursing facility will be directly reimbursed by Medicaid for covered services and items as defined on the agency website. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. 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.

3. The Division of Medicaid will reimburse the nursing facilities or related training centers for the minimum required services and supplies. 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, like for electricity, gas, or water. No reimbursements will be made for estimated cost. The cost of manuals approved for use by MSDH will be reimbursed.

4. Training programs 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 (1) facility and is located in an area remote from any of the associated facilities.

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

B. Billing rules requirements for billing of training can be found on the agency website.

C. Withdrawal of Program Approval

1. 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.

2. 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.

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

Source: Miss. Code Ann. § 43-13-121; 42 CFR §483.158; 42 CFR § 483.160

Part 207 Chapter 3: Intermediate Care Facility Mentally Retarded

Rule 3.1: General

A. The Division of Medicaid may not execute a provider agreement with a facility for services unless the State survey agency or the Centers for Medicare and Medicaid Services (CMS) has certified the facility as having met all of the participation requirements. The Mississippi State Department of Health, Division of Health Facilities Licensure and Certification pursuant to federal law and regulation, certifies facilities for participation in the Medicaid program.

B. Medicaid payments may not be made to any ICF/MR prior to the date of certification and execution of a valid Medicaid provider agreement.

C. If the Division of Medicaid has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified facility. A provider agreement is not valid, even though certified by the State survey agency, if the facility fails to meet civil rights requirements.

Source: Sections 1919 (a), (b), (c), and (d) of the Act; 42 CFR § 447.15; 42 CFR. § 431.10; Miss. Code Ann. § 43-13-107; § 43-13-121; § 43-13-103; 42 CFR § 442.12; § 483.1; § 442.10; Miss. Code Ann. § 43-11-1; 42 CFR § 442.12; 45 CFR Parts 80, 84 and 90.

Rule 3.2: Provider Enrollment/Provider Agreement

A. 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.

B. 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.

1. A facility that fully meets the applicable requirements may be certified for up to twelve (12) months.

2. Where an ICF/MR is in compliance with the conditions of participation but has deficiencies which must be corrected, the Division of Medicaid may execute a conditional agreement up to twelve (12) full calendar months, subject to an automatic cancellation clause. Unless the corrections have been completed or there is substantial progress in carrying out the plan of corrections, the agreement will be cancelled.

C. An ICF/MR agreement expires at the close of the last day of its specified term and will not be automatically renewable from term to term.

1. Where the term of an agreement is extended, the Division of Medicaid defines the "close of the last day of the specified term" as the close of the day to which the agreement has been extended.

2. In the case of an agreement which is automatically cancelled, the agreement ends at the close of the predetermined date specified in the automatic cancellation clause.

D. The term of an agreement may be extended by the Division of Medicaid for a single period of two (2) full calendar months if:

1. The health and safety of the patients are not jeopardized,

2. The determination supporting the extension is made before the expiration date of the agreement and,

3. It is necessary to prevent irreparable harm to the facility,

4. It is necessary to prevent hardship to the beneficiaries being furnished care by the facility, or

5. It is impractical to determine whether the facility is in compliance as documented in writing with supporting evidence.

E. The Division of Medicaid may terminate any Medicaid participating ICF/MR provider agreement if an ICF/MR:

1. Is not in compliance with the requirements/ conditions of participation, regardless of whether or not immediate jeopardy is present, or

2. Fails to submit an acceptable plan of correction within the timeframe specified by the Division of Medicaid, or

3. Fails to relinquish control to the temporary manager, if that remedy is imposed by the

Division of Medicaid, or

4. Does not meet the criteria for continuation of payment and/or time limited agreement under this section.

F. When a provider agreement is terminated, federal regulations provide that payments may continue for up to thirty (30) days to provide time for an orderly transfer of Medicaid residents. The facility must notify all Medicaid residents, families and/or sponsors in writing within forty-eight (48) hours of receipt by the facility of the decertification letter.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 442.15; 42 CFR § 442.16; 42 CFR § 442.117; 42 CFR § 442.119

Rule 3.3: Admission Review

A. The Department of Mental Health is the agency responsible for conducting reviews for admission to an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

B. Under federal regulations, the Mississippi Department of Health, Division of Health Facilities Licensure and Certification, is responsible for the following review activities:

1. Certification and recertification of need for inpatient care,

2. Individual program plan, and

3. Utilization review plan.

C. An ICF/MR Pre-Admission Team Report and Request for Medicaid Certification for ICF/MR Care must be completed no more than thirty (30) days prior to the admission of the beneficiary to an ICF/MR and submitted with a copy of the current physical examination, medical and social history, and the preliminary evaluation.

D. A physician must certify for each applicant or beneficiary that ICF/MR services are or were needed at the time of admission. Re-Certification must be made at least every twelve (12) months after certification.

E. The Interdisciplinary team must prepare for each client, within thirty (30) days after admission, an individual program plan that states the specific objective necessary to meet the beneficiary's needs. At least annually, the comprehensive functional assessment of each beneficiary must be reviewed by the interdisciplinary team for relevancy and must be updated and revised as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 456.360; 42 CFR § 456.380; 42 CFR § 456.400; 42 CFR § 456.350 - 456.381; 42 CFR; 42 CFR § 456.431; 42 CFR § 456.370

Rule 3.4: Per Diem Covered Services

A. The facility must provide and pay for all services and supplies covered in the Medicaid per diem rate required to meet the needs of the resident. The facility may not charge a resident for the following:

   1. Nursing services,

   2. Specialized rehabilitative services,

   3. Dietary services,

   4. Activity programs,

   5. Room/bed maintenance services,

   6. Routine personal hygiene items and services,

   7. Personal laundry, or

   8. Drugs not covered by the Medicaid program.

B. 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 Part 209, Chapter 1.

C. A facility's hair hygiene policy must include the provision of combs, brushes, shampoos, trims, and simple haircuts 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. The Division of Medicaid defines trims and simple haircuts as all haircuts that maintain or enhance each resident's dignity and respect in full recognition of his or her individuality.

1. All hair hygiene supplies and services not charged to the resident are included in allowable costs for Medicaid purposes.

2. A facility must charge only for hair supplies and services requested in addition to or in place of, those normally supplied or offered by the facility.

3. 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.

   a) If the facility's policy is to use licensed barbers and/or beauticians for trims and simple haircuts, residents cannot be charged for these services.

   b) The resident must be informed of the charge for the supplies and services in advance and an authorization must be signed by the responsible party and/or resident in advance.

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

5. 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.

D. Certain supply items are covered by the Division of Medicaid for ICF/MR residents.

   1. An ICF/MR must bill Medicare Part B for those supplies used by a resident which are covered by Part B.

   2. An ICF/MR may include the cost of these items for residents under the age of sixty-five (65) who are not covered by Medicare Part B on the facility's cost report. Proper documentation must be retained to support these costs.

E. The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room due to medical necessity prescribed and ordered by a physician. No extra charge must be made to the resident, the resident's family, or the Medicaid program. The Medicaid reimbursement is considered as payment in full for the resident.

   1. When a resident is in a private room by resident or family choice, a resident must 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.

   2. Facilities may not charge residents or their families for services covered by the Medicaid reimbursement rate, which specifically includes semi-private room accommodations.

F. The long-term care facility must provide both Medicaid residents and the non-Medicaid residents notification of the items and services offered by the facility, but not covered by the Medicaid per diem rate.

1. This notification must include both the items and services and the corresponding amounts for which the resident may be charged.

2. The information must be presented in writing before or at the time of admission or upon the resident's becoming eligible for Medicaid.

3. Residents and/or their responsible parties must be notified in advance of all changes in the provision of services and charges for these services.

G. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services, consistent with the notice stated in 3.4.F above.

1. 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.

2. 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 for all residents in the facility.

H. All facilities must provide residents with oral or written information regarding Medicare and Medicaid benefits.

1. This information must cover the application for and the use of these benefits, along with instructions on the receipt of refunds for previous payments which are covered by such benefits.

2. This written information must be prominently displayed in the ICF/MR.

I. An ICF/MR cannot require a deposit before admitting a card-carrying Medicaid-eligible resident.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483.10; 42 CFR 447.15

Rule 3.5: Reimbursement

A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.

1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.

2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement.

1. The rates are determined from cost report data.

2. Standard rates are determined annually with an effective date of January first (1st).

3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.

   a) These revisions may result from amended cost reports, field visit reviews, or other corrections.

   b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

   c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.

    a) The cost report must be based on the documentation maintained by the facility.

    b) All non-governmental facilities must file cost reports based on the accrual method of accounting.

    c) Governmental facilities have the option to use the cash basis of accounting for reporting.

2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.

    a) These records must be made available as requested by the Division of Medicaid.

    b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

Source: Miss. Code Ann. § 43-13-121, 42 CFR § 447 Subparts B & C, Miss. Code Ann. § 43-13-117

Rule 3.6: Temporary Leave Payment

A. A temporary absence of a resident from an ICF/MR will not interrupt the monthly payments to the facility.

    1. The Division of Medicaid defines the period of leave by counting the day the resident left the facility as the first day of leave. The Division of Medicaid defines an absence from the facility for eight (8) to twenty-four (24) hours a leave day.

    2. The facility must reserve the resident's bed in anticipation of the resident's return.

        a) The bed may not be filled with another resident during the covered period of leave.

        b) Leave days may not be billed if the facility refuses to readmit the resident under their resident return policy.

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

B. The Division of Medicaid pays for the day of admission to a facility.

C. The day of discharge is not paid by the Division of Medicaid unless it is the same day as the date of admission. Facilities cannot bill the resident or responsible party for the day of discharge.

D. Each facility is required to maintain leave records and indicate periods of hospitalization and therapeutic leave days on billing documents.

E. 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.

1. This information must define the period of time during which the resident will be permitted to return and resume residence in the facility.

2. 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.

F. Residents in an ICF/MR may have absences for home/therapeutic leave from the ICF/MR other than for in-patient hospital leave. Home/therapeutic leave also includes dialysis and other outpatient treatments. Specific requirements applicable to home/therapeutic leave are as follows:

1. The Division of Medicaid's coverage of home/therapeutic leave days per fiscal year, July 1 to June 30, for ICF/MR facilities is eighty-four (84) 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.

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

3. 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.

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

G. The Division of Medicaid allows fifteen (15) days of hospital leave for each hospital stay for ICF/MR residents.

1. There is no maximum number of hospital leave days each year.

2. Hospital leave applies to acute care hospital stays in a licensed hospital, including geri-psychiatric units.

3. The hospital leave rules apply as follows:

   a) A resident must be discharged from the facility for Medicaid billing if he/she remains in the hospital for more than fifteen (15) days.

   b) When the resident is readmitted to the facility after a hospital stay, readmission certification on a new Medicaid Certification for ICF/MR Care is not necessary if the resident has been continuously institutionalized. A leave of absence for hospitalization is broken only if the resident returns to the facility for twenty-four (24) hours or longer.

   c) 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 ICF/MR services.

   d) 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.

   e) 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.

Source: Miss. Code Ann. § 43-13-121; 42 CFR §447.40, Miss. Code Ann. § 43-13-117

Rule 3.7: Resident Funds

A. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds.

   1. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility.

   2. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.

B. Resident fund accounts are reviewed to ensure the facility's compliance and to assist facilities in developing acceptable systems of accounting for resident funds. Penalties may be assessed on any licensed ICF/MR that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with federal regulations.

C. The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:

1. All services provided by the facility, distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.

2. There is no obligation for the resident to deposit funds with the facility.

3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:

   a) The resident's right to receive, retain, and manage his/her personal funds or have this done by a legal guardian, if any,

   b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,

   c) The resident's right to designate, in writing, another person to act for the purpose of managing his or her personal funds except when Rule.7, C.2 of this section applies, and

   d) The resident's right to require the facility to hold, safeguard and account for such personal funds under a system established and maintained by the facility requested by the resident.

4. Any charge for this service is included in the facility's basic rate.

5. The facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.

7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

D. 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.

1. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner.

2. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the facility to employ 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.

E. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation as specified under the heading "Individual Records" of this section, is provided. The facility must notify the resident in advance that there will be a charge for non-Medicaid covered items and services, such as:

1. Personal communication/entertainment items and services, including telephone, television, radio, and computer.

2. Personal comfort items, including tobacco, novelties, and candy.

3. Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services.

4. Personal clothing.

5. Personal reading material.

6. Gifts purchased on behalf of the resident.

7. Flowers and plants for the resident's room.

8. Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate.

9. Private sitters or aides.

10. Private room, provided a private room is not medically necessary, including isolation for infection control.

11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the facility.

12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

F. Unacceptable charges to resident funds include:

1. Any charge not authorized and documented.

2. Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.

3. Medically necessary items and services reimbursed as part of the Medicaid per diem rate.

   a) Any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity.

   b) Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.

4. Medical transportation.

   a) All transportation for ICF/MR residents, whether emergency or non-emergency, must be arranged by ICF/MR staff.

   b) Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Refer to Part 201, Chapter 1.

   c) Transportation may also be arranged using ICF/MR vehicles or by utilizing outside resources. Costs for providing this level of service are to be reported by the ICF/MR on their cost reports and are reimbursed through the facility per diem. The ICF/MR may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the ICF/MR may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to the Division of Medicaid for direct reimbursement. Refer to Part 201, Chapter 2.

   d) If a resident is transferred from an ICF/MR to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the ICF/MR, transportation for these residents should be arranged by the hospital. If there has not been a final discharge from the ICF/MR and the resident had a hospital stay of less than fifteen (15) days, transportation back to the ICF/MR must be arranged by the ICF/MR staff.

5. Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by an ICF/MR for ICF/MR costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

6. Loans or collateral for loans to anyone, including the facility, and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.

7. Transfers or gifts of money not authorized by the resident including when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

8. Any item or service as a condition of admission or continued stay.

G. The facility must provide each resident, or a legal representative of the resident, reasonable access to his/her own financial records.

1. The facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative.

2. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.

H. The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility.

1. The facility may not open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.

2. Only funds of the facility's residents may be maintained as part of the resident trust fund account.

I. The facility must deposit any resident's personal funds in excess of fifty ($50.00) dollars into an interest-bearing account(s) separate from any of the facility's operating accounts.

1. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

a) Prorated to each resident's account on an actual interest-earned basis; or

b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars ($50.00) in a non-interest bearing account, an interest bearing account or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars ($50.00) or less in a pooled account with all other resident's funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately. The facility must neither limit nor restrict any

resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars ($50.00). A facility must not establish policy that conflicts with the absolute right of residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

J. The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturday and Sunday. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding, and accounting in a petty cash fund.

K. For a resident's personal funds that the facility has received and are deposited in an account outside the facility, the facility, upon request, must within five (5) business days return to the resident, the legal guardian, or the representative payee, any or all of those funds.

L. Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written account, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles, of all resident funds being transferred and obtain a written receipt for those funds from the new owner.

1. The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.

2. In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.

3. An ICF/MR cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where a Medicaid beneficiary has no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

M. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.

1. There is no minimum dollar amount that would relieve the facility of this fiduciary responsibility.

2. If the deceased or discharged resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:

a) Resident's next of kin,

b) Resident's representative; or

c) Clerk of the probate court of the county in which the resident died**.**

3. The Disposition of funds for deceased residents who die intestate within a long term care facility is as follows:

a) Any beneficiary who dies in the State of Mississippi and leaves no known heirs must have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner:

1) The report of such funds shall be verified, shall be on a form prescribed or approved by the State Treasurer and shall include:

i) The name of the deceased person and his/her last known address prior to entering the ICF/MR,

ii) The name and last known address of each person who may possess an interest in such funds, and

iii) Any other information which the State Treasurer prescribes by regulation as necessary.

2) In the event a party with a claim to the deceased residents' funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer.

i) All reports of unclaimed funds filed by the facility prior to November first (1st) of each year will be included in a list published by the State Treasurer within one hundred twenty-one (120) days following November first (1st).

ii) Claimants have ninety (90) days from the date of publishing to file for such funds.

iii) After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.

4. Disposition of funds for deceased residents who die intestate in a state institution is as follows:

a) Part 207, Chapter 3, Rule 3.7. M. 3, shall not be applicable for residents of any state institution.

b) The funds of any resident in a state institution who dies intestate and without known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

N. The facility must purchase a surety bond or otherwise provide assurance as to all personal funds of residents deposited with the facility.

1. The Division of Medicaid defines a surety bond as an agreement between the principal, the or facility, the surety, the insurance company, and the oblige, or the residents of the trust fund, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds, that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.

2. Unlike other types of insurance, the surety bond protects the obligee, or the residents of the trust fund, not the principal, from loss. The surety bond differs from a fidelity bond, sometimes called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.

3. The surety bond is the commitment of the facility to meet the standard of conduct.

   a) The facility assumes the responsibility to compensate the obligee, or the residents of the trust fund, for the amount of the loss up to the entire amount of the surety bond.

   b) The surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit.

   c) A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.

4. Any reasonable alternative to a surety bond must:

   a) Designate the obligee, or the residents, individually or in aggregate, who can collect in case of a loss,

   b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and

   c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee.

   a) Self-insurance is not an acceptable alternative to a surety bond. Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

b) If a corporation has a surety bond that covers all of its facilities, the corporation surety bond must be sufficient to ensure that all of the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

O. If a resident is incapable of managing personal funds and has no representative, the facility must refer the patient to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.

1. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.

2. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source cannot be commingled with facility funds prior to those funds being transferred to the trust account.

P. The facility must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the facility by the resident. The property record must be available to the resident.

Q. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars ($200.00) less than the SSI resource limit and five hundred dollars ($500.00) less than the Medicaid resource limit to remain eligible for Medicaid long term care benefits.

1. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other non-exempt resources, reaches the applicable resource limits; the resident may lose eligibility for such medical assistance or SSI.

2. The facility must issue written notification to the Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

R. The Division of Medicaid defines:

1. The basic rate as the standard or per diem rate Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility as well

as the items and services not included in the basic rate; and the amount of such charges that may be charged to the resident.

2. The book balance as the total balance of all resident trust funds and petty cash held according to the accounting ledger.

3. Census as the total number of residents in a facility.

4. Compliance of The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) as requiring a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this and follows the policies and procedures and this manual is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."

5. Exception as any item or area selected for review that does not meet the regulatory standards.

6. Fiduciary as having rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting.

7. Finding and exception are used interchangeable for resident trust fund review purposes.

8. Fiscal Agent as the agency under contract with the Division of Medicaid for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.

9. Generally Accepted Accounting Principles (GAAP), for resident trust funds, as the facility's 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 each individual resident's fund balance.

10. Intestate as without a valid will at the time of death.

11. Legal guardian, or conservator, as a person(s) by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a

court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.

12. Medicaid income as the maximum liability that the resident owes to the facility each month for room and board.

13. Medically necessary items and services as those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary and therefore justifiable as an expenditure of the resident's personal funds.

14. Obligee as the residents of the trust fund, the party to whom the facility is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the facility to hold, safeguard, manage, and account for the residents' funds.

15. Per Diem Rate - Refer to Rule 3.7.R.1.

16. Personal needs allowance (PNA) as the amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.

17. Plan of Correction as an acceptable plan of correction that must address each exception noted in the findings letter and include the following:

    a) Documentation that the exception has been corrected;

    b) Measures that have been put in place to ensure that the exception will not be repeated;

    c) Measures that have been put in place to monitor the continued effectiveness of the changes.

18. Reconciliation as at all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

19. Representative payee as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available

to represent the resident.

20. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.

21. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.

22. Responsible party for resident trust fund purposes, as a sponsor or resident's representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization, to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation such as a receipt or invoice.

23. State institutions as facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

24. Testate as having a valid will at the time of death.

25. Trial balance as a listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.

26. Written authorization as authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific funds transaction for the resident must be in writing and/or documented with a receipt of purchase.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; Section 1-7 (C); 1919 (5) (a) (ii) of the Social Security Act; 42 CFR 447.15; 42 CFR 431.53; OBRA (1987), paragraph 17, 399, Section 1919(6)(A)

Rule 3.8: Utilization Review

The Mississippi State Department of Health Division of Licensure and Certification is the State Agency designated to conduct reviews in ICF/MR facilities, as required by the Division of Medicaid. The regulatory requirements for review include:

A. Review of Need for Admission,

B. Certification/Recertification of Need for Care,

C. Plan of Care, and

D. Utilization Review.

Source: Miss. Code Ann. § 43-13-121; § 43-11-1; § 43-11-13; 42 CFR, Part 456 and 483, Subpart I, 42 CFR 456.271; 456.371; 456.372; 42 CFR 456.360; 42 CFR 456.380; 42 CFR 456.650

Rule 3.9: Release of Information

A. Public access to records maintained by the Division of Medicaid is mandated. The exception to public access is those records which are exempt as confidential or privileged.

B. Beneficiary-specific information will only be released by the Division of Medicaid when the requirements of federal regulations are met.

C. Provider-specific information, including, but not limited to, cost reports, reimbursement rates, reimbursement amounts and reports not beneficiary-specific, will be available to the public when:

    1. A written request for the information is made to the Executive Director of the Division of Medicaid,

    2. The information is available in existing agency files and reports, and

    3. The requestor reimburses the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.

D. Statistical data that does not contain protected health information are available as requested. This type of information is generally available in the Division of Medicaid's annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.

Source: Miss. Code Ann. § 43-13-121; Section 25-61-1 et.seq. of the Mississippi Code of 1972, as amended; 42 CFR 431.300 – 307; 45 CFR 160,164

Part 207 Chapter 4: Psychiatric Residential Treatment Facility

Rule 4.1: General

A. The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a Psychiatric

Residential Treatment Facility (PRTF).

B. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid Program.

C. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22).

D. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.

E. PRTF providers must adhere to applicable state and federal regulations related to their license.

F. The facility must have a signed transfer agreement with one or more general hospitals to provide needed diagnostic and medical services to residents.

G. The facility must have arrangements with community physicians to provide specialized medical care to residents when needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.151 (a)(2)(ii), (c)(1)(2), 441.152 (a)(3); OBRA section 4755; 42 CFR 441, Subpart D; 42 CFR 483.52

Rule 4.2 Provider Enrollment

Enrollment into the Medicaid program requires each provider to comply with the requirements outlined Part 200, Chapter 4, Rule 4.8, in addition to the following provider type specific requirements:

A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).

B. Board of Director's (Commissioner's) Resolution form, letter of signature authority, or copy of minutes indicating signature authority.

C. Written confirmation from the IRS confirming your tax identification number and legal business name.

D. CLIA certificate and completed certification form.

E. Joint Commission on Accreditation of Health Care Organization (JCAHO) or Council on Accreditation (COA) accreditation.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR 441, Subpart D; 42 CFR 441.151

Rule 4.3: Staffing

The Division of Medicaid requires Psychiatric Residential Treatment Facilities (PRTF) have the following staff:

A. The governing body of the PRTF must appoint an administrator to be responsible for the overall management of the facility. The administrator must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The administrator must be responsible for the fiscal and administrative support of the facility's clinical program.

B. The facility must appoint a medical director to be responsible for coordinating medical services and directing resident treatment. The medical director must be a board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.

C. The facility must appoint a full-time clinical director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be one of the following:

    1. A board-certified child/adolescent psychiatrist,

    2. A psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,

    3. A licensed psychologist who is experienced in child/adolescent mental health treatment,

    4. A psychiatric mental health nurse practitioner (PMHNP) who is experienced in child/adolescent mental health treatment, or

    5. A licensed certified social worker who is experienced in child/adolescent mental health treatment.

D. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry may serve as both medical director and clinical director provided that he/she is a full-time employee.

E. The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate resident supervision twenty-four (24) hours a day. At least fifty percent (50%) of the professional staff hours must be provided by full-time employees. Professional staff must be appropriately licensed and trained/experienced in providing mental health treatment. These staff members will include, but not be limited to, the following:

1. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,

2. A licensed psychologist,

3. A registered nurse,

4. A licensed certified social worker,

5. A certified teacher, and

6. A recreation specialist.

F. The PRTF must have access, through full/part-time or contract employment, the services of each of the following:

1. A licensed occupational therapist or credentialed creative arts therapist,

2. A rehabilitation counselor, and

3. A licensed speech-language pathologist.

G. The PRTF must provide an adequate staff-to-resident ratio on all shifts to provide for resident and staff safety.

H. The PRTF must notify the Division of Medicaid of changes in the Administrator, Medical Director or Clinical Director. Division of Medicaid must receive the notification in writing within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441. Subpart D; 42 CFR 441.151 (a)(2)

Rule 4.4: Admission

The Division of Medicaid covers PRTF services when a child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.

A. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges must approve each admission.

B. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.

C. The need for PRTF admission must be supported by documentation that:

1. The child has a diagnosable psychiatric disorder.

2. The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

3. The child's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.

4. The referring psychiatrist or psychologist advises that residential treatment is needed.

5. At least one (1) of the following:

   a) The child has failed to respond to less restrictive treatment in the last three (3) months.

   b) Adequate less restrictive options are not available in the child's community.

   c) The child is currently in an acute care facility whose professional staff advise that residential treatment is needed.

6. The admission has been certified by the UM/QIO as medically and psychologically necessary.

D. The facility must provide the parent/guardian with contact information for the Disability Rights Mississippi, including the phone number and mailing address, and document in the record.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.152 (a)(3); 456.180(b)(1); 441.152 (a)(2); 441.152 (a)(1); 483.356 (c); 483.366 (a); 483.356 (d)

Rule 4.5: Non-Covered Services

Division of Medicaid does not cover:

A. Admissions on the weekends. The Division of Medicaid defines weekend admissions as admission after 5:00 p.m. on a Friday. Covered days will not begin until the following Monday.

B. Non-covered days of stay.

C. Any days of stay not certified by the UM/QIO.

Source: Miss. Code Ann. § 43-13-121

Rule 4.6: Reimbursement

A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.

1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.

2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars ($50.00) per day and may result in the termination of the provider agreement.

B. The Division of Medicaid uses a prospective method of reimbursement.

1. The rates are determined from cost report data.

2. Standard rates are determined annually with an effective date of January first (1st).

3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.

4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.

   a) These revisions may result from amended cost reports, field visit reviews, or other corrections.

   b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.

   c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.

C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

D. Notwithstanding any other provision of this article, it shall be the duty of each nursing

facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.

   a) The cost report must be based on the documentation maintained by the facility.

   b) All non-governmental facilities must file cost reports based on the accrual method of accounting.

   c) Governmental facilities have the option to use the cash basis of accounting for reporting.

2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.

   a) These records must be made available as requested by the Division of Medicaid.

   b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

1. 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.

2. While the facility may set their 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.

3. Any items and services available in the facility that are not covered under Title XVIII or the facility's basic per diem rate or charge must be available and priced identically for all residents in the facility.

F. Medicaid allows payment for the date of admission to the PRTF. Medicaid does not cover the date of discharge from the facility. A Medicaid-eligible beneficiary cannot be charged for the date of discharge. If a beneficiary is discharged on the date of admission, the day is covered as the date of admission.

G. Private room coverage by Medicaid is as follows:

1. The overall average cost per day determined from the cost report includes the cost of private rooms.

2. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in the reimbursement rate and no extra charge can be made to the beneficiary, his/her family or the Medicaid program.

3. Medicaid reimbursement is considered as payment in full for the beneficiary.

H. The following rules apply to hospital leave:

1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.

2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.

3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

I. If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the twenty-four (24) hours, the child/adolescent must go through a readmission process.

J. The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.

2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.

3. Each therapeutic leave day taken each month must be reported on the billing mechanism.

4. The attending physician must approve all therapeutic leave days. Documentation must

include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

K. Payment during therapeutic leave from the facility is as follows:

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.

2. Each facility is required to maintain leave records and indicate periods of therapeutic leave days.

3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.

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

Source: Miss. Code Ann. § 43-13-121, 42 CFR § 447 Subparts B & C, Miss. Code Ann. § 43-13-117, 42 CFR § 447.15

Rule 4.7: Active Treatment

The use of the term "treatment' refers to the active treatment of the resident. The Division of Medicaid defines active treatment as a process comprising of the following:

A. Multi-disciplinary diagnostic assessment,

B. Interdisciplinary treatment planning,

C. Therapeutic intervention,

D. Treatment evaluation/revision, and

E. Discharge/aftercare planning.

Source: Miss. Code Ann. § 43-13-121; 142 CFR 441.154

Rule 4.8: Assessment and Evaluation

A. The diagnostic evaluation must document the need for the PRTF level of care.

B. Diagnostic evaluations must be completed within the first fourteen (14) days of admission. The assessment process must include, but is not limited to, the following:

1. A psychiatric evaluation.

2. A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.

3. A medical history and examination.

4. A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the resident's family.

5. A Child and Adolescent Needs and Strengths (CANS-MH) assessment.

6. An educational evaluation.

7. A nursing assessment.

8. A nutritional assessment, if indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.155(b)(1), 441.156(b)(2)

Rule 4.9: Treatment Planning

A. Treatment planning is defined by the Division of Medicaid as a collaborative venture which the members of various disciplines jointly develop a comprehensive, individualized plan for the treatment of each resident.

   1. The treatment plan charts a course designed to help the resident move to a less restrictive level of care as quickly as possible.

   2. An initial treatment plan must be in effect within seventy-two (72) hours after the resident's admission to the facility.

   3. The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the resident's admission, once at the conclusion of the first (1st) month of stay, and once a month thereafter.

   4. The treatment plan document must contain evidence of the resident's and his/her parent/guardian's active participation in the treatment planning/review/revision process.

B. The treatment team should include as many staff as possible who are involved in the treatment of the resident.

1. At a minimum, the team must include, either:

    a) A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry, or

    b) A Psychiatric Mental Health Nurse Practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy, or

    c) A licensed psychologist and a physician licensed to practice medicine or osteopathy.

2. The team must also include one (1) of the following:

    a) A licensed certified social worker who has a minimum of one (1) years' experience in treating children with serious emotional disturbances (SED), or

    b) A registered nurse who has a minimum of one (1) years' experience in treating individuals with SED.

C. The treatment plan delineates all aspects of the resident's treatment and includes, at a minimum:

1. A multi-axial diagnosis.

2. An assessment of the resident's immediate therapeutic needs.

3. An assessment of the resident's long-range therapeutic needs.

4. An assessment of the resident's personal strengths and liabilities.

5. Identification of the clinical problems that are to be the focus of treatment.

6. Measurable and realistic treatment goals for each identified problem.

7. Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.

8. Specific treatment modalities and/or strategies that will be employed to reach each objective.

    a) Special procedures must not be included in the treatment plan unless justified by current or historical evidence of aggressive behavior which, cannot be controlled by less restrictive interventions.

    b) If special procedures become necessary, the treatment plan must be amended or modified within one (1) working day of the first incident to reflect the use of the least restrictive necessary measures.

9. The clinician identified as responsible for each aspect of treatment.

10. Identification of goals, objectives and treatment strategies for the family as well as the resident, and identification of the clinician responsible for family treatment. If a geographically distant therapist will be utilized, this must be specified in the treatment plan.

11. An individualized discharge plan that includes:

    a) Discharge criteria, indicating specific goals to be met,

    b) An estimated discharge target date, and

    c) No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources to provide the greatest possible continuity of care for the resident.

D. The treatment team must meet to staff each resident and review/revise his/her treatment plan as often as necessary to provide optimum treatment. The treatment review team must assess the resident's progress in treatment by:

1. Noting treatment successes, discussing which objectives and/or goals have been achieved and when, and explaining treatment failures.

2. Making changes in the treatment plan, as needed.

3. Re-assessing the child's need for continued residential care, as opposed to less restrictive treatment.

4. Noting the child's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.154(a)(b); 441.155(b)(2); 441.155(c)(1)(2); 441.156(b)(1)(3)(4)(5); 441.156(c)(1)(2); 144.156(d)(1)(2).

Rule 4.10: Therapeutic Interventions

A. Psychotherapy is defined as the intentional, face to face interaction between a mental health professional and a client, either an individual, family, or group, in which a therapeutic relationship is established to help resolve symptoms of the resident's mental and/or emotional disturbance.

B. Individual therapy is defined as psychotherapy that takes place between a mental health therapist and a resident. Individual Therapy must be provided a minimum of one (1) hour

each week unless its contraindication is documented in the treatment plan. Individual Therapy must be provided by master's level mental health therapists.

C. Family therapy is defined as psychotherapy that takes place between a mental health therapist and a resident's family members or guardians, with or without the presence of the resident. If a resident is in the custody of the Department of Human Services (DHS), family therapy may also include others, including DHS representatives and foster family members, acting in loco parentis. Family Therapy must be at least twice a month, unless its contraindication is documented in the treatment plan.

1. Each resident's family, guardian, or person acting in loco parentis must participate in the family therapy sessions.

2. If the resident's family is more than a two (2) hour drive from the PRTF, one (1) face-to-face family therapy session and one (1) therapeutic conference call is acceptable.

3. Family Therapy must be therapeutic in nature to include discussing the resident's functioning, treatment progress, goals and objectives.

4. Social visits or phone calls are not considered family therapy.

5. Family Therapy must be provided by master's level mental health therapists.

6. Residents who are in the custody of the Department of Human Services (DHS) must complete one (1) face-to-face family therapy session with the social worker in the county of the PRTF, unless the social worker in the home county is available, and complete the second (2nd) family therapy session via telephone with the social worker in the home county.

7. A geographically distant therapist may provide family therapy when there are family issues that must be resolved or ameliorated before face-to-face sessions that include the resident can be productive and therapeutic.

   a) Distance alone is not justification for prescribing off-site therapy.

   b) When off-site therapy is appropriate, the treatment plan must identify the off-site therapist, indicate the goals for such therapy, and specify how information will be exchanged between the PRTF and the off-site therapist.

   c) Collaboration between therapists is the responsibility of the PRTF and must be documented in the clinical record.

D. Group therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2), but not more than eight (8) residents at the same time.

1. Possibilities for groups include, but are not limited to, those which focus on relaxation

training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

2. Each resident must participate in a minimum of three (3) hours of group therapy, provided in at least three (3) sessions, each week unless contraindication is documented in the treatment plan.

3. The length, frequency and timing of sessions in which services are delivered must be determined by what is developmentally appropriate for each resident.

4. Group therapy must be provided by master's level mental health therapists although larger groups up to twelve (12) participants can be co-led by a person with a lesser level of training.

E. Psychotherapy notes must be documented for each therapy session and include the following essential elements:

1. The date and time in and time out of the session,

2. The type of therapy, either individual, family or group,

3. The person(s) participating in the session,

4. The length of the session,

5. Clinical observations about the resident including their demeanor, mood, affect, mental alertness, thought processes or risks,

6. The content of the session,

7. Therapeutic interventions attempted and the resident's response to the intervention(s),

8. The resident's response to any significant others who may be present in the session,

9. The outcome of the session,

10. A statement summarizing the resident's degree of progress toward the treatment goals,

11. Reference at least monthly to the resident's progress in relation to the discharge criteria and the estimated discharge date,

12. The signature and printed name, if needed for clarity, of the therapist, and

13. Monthly summaries are not acceptable in lieu of psychotherapy session notes.

F. Milieu therapy is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Milieu therapy must be provided twenty-four (24) hours a day by all PRTF staff.

1. Emphasis is placed on clear, healthy, respectful communication between resident/resident, staff/staff, and staff/resident, and on shared problem-solving and decision-making.

2. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process. The physical environment of the facility must reflect a warm, child-friendly atmosphere with treatment-oriented information including, but not limited to, motivational/educational posters, schedules of activities, requirements for level systems and rules for unit, written in positive terms and age appropriate language. Materials must be posted in a manner that is highly visible and easily accessible to residents.

3. Milieu notes must be documented daily and:

   a) Present a clear picture of the resident's participation and interactions in the therapeutic community.

   b) Describe the resident's actions, staff interventions, and the resident's response to those interventions.

   c) Are usually completed by direct care staff.

   d) If a checklist is used, it must be accompanied by at least a brief narrative.

   e) Must be behaviorally focused.

   f) Behavior and events should be described rather than labeled.

   g) Must reflect a pattern of clear, respectful communication between staff and resident, with emphasis on the resident's involvement and collaboration in his/her own treatment.

4. The community meeting is a required element of milieu therapy. This is a time when all residents and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions, set goals, resolve conflicts and discuss ideas that may enhance treatment.

5. Documentation that community meetings are held at least daily and are attended by all residents and most, if not all, professional and direct care staff.

6. Documentation that the focus of community meetings is good communication and collaboration among residents and staff to solve problems, make community decisions,

and introduce/discuss ideas/suggestions that will enhance treatment.

7. Documentation that residents are knowledgeable about their treatment and actively participate in goal-setting and treatment evaluation.

8. Community meeting notes must be clearly identifiable.

9. Each resident's participation must be documented, or his/her absence justified, in a minimum of one (1) community meeting per day.

10. Notes must reflect that the community meetings are therapeutic in nature and address treatment issues including, but not limited to:

    a) Problem identification,

    b) Goal-setting,

    c) Problem-solving,

    d) Conflict resolution,

    e) Behavioral observations/evaluation,

    f) Problems in community living.

11. The nature of each resident's participation must be described.

12. If a checklist is used, it must be accompanied by at least a brief narrative.

G. Therapeutic Pass/Therapeutic Leave is defined as those times when a resident is permitted time "away" from the PRTF to practice skills learned in treatment or to work on significant relationships in a setting that is less structured and controlled.

1. Therapeutic Pass refers to "away" time of less than eight (8) hours.

    a) If a resident leaves the facility on a therapeutic pass accompanied by PRTF staff, no documentation is required.

    b) If a resident leaves the facility on a therapeutic pass with anyone other than staff, including relatives or representatives of DHS, therapeutic goals for the pass must be identified and documented. At the conclusion of the pass, documentation must indicate whether or not the therapeutic goals were met.

2. Therapeutic Leave refers to "away" time of eight (8) hours or more in the same calendar day. A single day of therapeutic leave is determined by the resident's absence from the

facility for eight (8) hours or more between the hours of 12:01 a.m. and 11:59 p.m. on any given day.

a) Therapeutic Leave is not allowed during the fourteen (14) day assessment period following admission.

b) The attending physician or PMHNP must approve all therapeutic leave days.

3. Documentation at the time a resident leaves the facility must include:

a) The date/time of check-out,

b) The required time of return,

c) The name(s) of the person(s) with whom the leave will be spent,

d) The resident's physical/emotional condition at the time of departure including vital signs,

e) The types and amounts of medication being provided and instructions in lay terms for taking them,

f) Therapeutic goals for the leave, as related to the goals established in the treatment plan,

g) The name and signature of the person with whom the resident is leaving, and

h) The signature of the staff person checking the resident out.

4. Documentation at the time of the resident's return must include:

a) The date and time of check-in,

b) The resident's physical/emotional condition at the time of return including vital signs and notation of any physical injury or complaint,

c) Whether or not any contraband was found,

d) The types and amounts of medication being returned, if any, and explanation of any missed doses,

e) An explanation of any early or late return from leave,

f) A brief report on the outcome of the leave by the parent or guardian,

g) The name and signature of the person returning the resident's to the facility,

h) The signature of the staff person checking resident in, and

i) An assessment of the outcome of the leave must be conducted by the resident's therapist within seventy-two (72) hours of the resident's return from leave.

H. Creative arts therapies is defined as those therapies, including art, movement/dance, music and poetry, which a qualified professional uses the creative process and the resident's response to the created product to help the resident resolve emotional conflicts, increase self-awareness, develop social skills, manage behavior, solve problems, reduce anxiety, improve reality orientation, and/or increase self-esteem.

I. Occupational therapy is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the resident achieve functional outcomes that promote the highest possible level of independence.

J. Recreation therapy is defined as a process that utilizes recreation services for purposive intervention in physical, emotional and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the resident.

K. Speech-Language Pathology is defined as remedial assistance with speech and/or language problems provided by a licensed speech-language pathologist.

L. When other therapies such as art therapy, recreational therapy, occupational therapy, dance/movement therapy, music therapy, speech/language therapy, are employed, their use must be documented in the clinical record in much the same manner as psychotherapy including date, length, type of session, together with a summary of the session's content, process, outcome and the therapist's name/signature.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441.155(b)(1)(4)(5)

Rule 4.11: Medical Treatment Requirements

Each unit must identify an appropriate place/procedure for responding to resident's physical/medical complaints.

Source: Miss. Code Ann. § 43-13-121

Rule 4.12: Special Procedures

A. The Division of Medicaid defines special procedures as seclusion and restraint and must be used as an immediate response only in emergency safety situations when needed to help a resident regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. The potential therapeutic effects of prevention of self and other injury and reinforcement of behavioral boundaries must be weighed against the counter-therapeutic effects.

1. Seclusion is defined as the involuntary confinement of a resident in an area from which she/he is physically prevented from leaving. It is used to ensure the physical safety of the resident or others and to prevent the destruction of property or serious disruption of the milieu.

2. Restraint is defined as the restriction of a resident's freedom of movement or normal access to his/her body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the resident's physical safety.

   a) Personal restraint is defined as the restraint of a resident through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a resident from causing harm to self or others or to prevent destruction of property.

   b) Mechanical restraint is defined as the restraint of a resident through the use of any mechanical device, material or equipment attached or adjacent to the resident's body that s/he cannot easily remove.

   c) Pharmacological restraint is defined as the use of a medication, which is not a standard part of the resident's treatment regimen, to control or alter the resident's mood or behavior or to restrict freedom of movement. Pharmacological restraint is used to insure the safety of the resident or others through a period of extreme agitation when less restrictive measures have not been effective. Standing PRN orders for pharmacological restraints are prohibited.

B. Seclusion or restraint must only be used in situations where less restrictive interventions have been determined to be ineffective. Any use of seclusion or restraint must be:

   1. In accordance with appropriate techniques,

   2. Applied by staff trained and approved to use such techniques,

   3. Implemented in the least restrictive manner possible,

   4. In a room that is safe and sanitary, with adequate lighting, ventilation and temperature control, and

   5. Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the resident's condition.

C. Seclusion or restraint cannot be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a resident's behavior, or as a substitute for individualized treatment.

1. Restraint and seclusion must not be used simultaneously.

2. Any personal or mechanical restraint of a resident in a face-down position is prohibited.

3. Any personal or mechanical restraint of a resident in a spread-eagle position with legs and arms apart is prohibited.

4. Standing, or "as needed" (PRN), orders for seclusion or restraint are prohibited.

D. The following actions are required for any form of special procedure with the exceptions as noted below:

1. Only a physician or a PMHNP may order the seclusion or personal/mechanical restraint of a resident.

2. If seclusion or personal/mechanical restraint is initiated without orders from a physician or PMHNP, a verbal or telephone order must be obtained from the physician or PMHNP by an RN or LPN no later than one (1) hour after the start of the procedure. If the physician's or PMHNP's order cannot be obtained within the one (1) hour, the procedure must be discontinued.

3. Pharmacological restraint may be initiated only by medical staff acting on a physician's or PMHNP's orders. At the time of the order, the physician or PMHNP must identify a specific time when the procedure is expected to end and/or the expected duration of the medication's effects, at which time the resident's condition must be assessed and the incident must be processed with the resident.

4. The physician's or PMHNP's order for seclusion or personal/mechanical restraint must be for a time period not to exceed one (1) hour for residents younger than nine (9) years of age, or two (2) hours for residents nine (9) to twenty one (21) years of age.

   a) The original order may be renewed, if clinically justified, in accordance with these limits for up to a total of twenty four (24) hours.

   b) After the renewal limits of the original order are reached, a physician or PMHNP must see and assess the resident before issuing a new order.

5. The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure.

6. The staff person responsible for terminating a mechanical restraint must be physically present throughout the duration of the procedure.

7. Within one (1) hour of the initiation of the emergency safety intervention, a physician, PMHNP or RN must conduct a face-to-face assessment of the physical and psychological well-being of the resident.

8. Even if the emergency safety intervention is terminated in less than one (1) hour, the face-to-face assessment must be conducted within an hour of its initiation.

9. The health and comfort of the resident must be assessed every fifteen (15) minutes by direct observation, and staff must record their findings at the time of observation.

10. Vital signs must be taken every hour unless contraindicated and documented in the resident's record.

11. There must be clear criteria for ending the special procedure and the resident must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate.

12. A physician, PMHNP, or RN must evaluate the resident's well-being immediately after the seclusion or restraint is terminated.

13. At an appropriate time, but no later than twenty-four (24) hours following the conclusion of the special procedure, the resident must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention.

E. All staff who have direct resident contact must have ongoing education, training, and demonstration of knowledge of the proper and safe use of seclusion/ restraint and alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method, which does not involve restraining a resident in a face-down or spread-eagle position with legs and arms apart.

F. If a facility provides for the use of seclusion/restraint, it must inform the prospective resident and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. The facility must provide the parent/guardian with a copy of its policy regarding seclusion/restraint and obtain a signed acknowledgment from the parent/guardian documenting that the policy was explained and a copy given to them. This acknowledgment must be filed in the resident's record. In the event that a resident requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than twenty-four (24) hours after the initiation of the procedure.

G. Documentation of each incident of seclusion or restraint must be part of the resident's permanent record.

1. Documentation of each incident of seclusion or restraint, including personal, mechanical and pharmacological restraint, must include, but not be limited to, the following information:

a) The date and time the procedure started and ended,

b) The name of the physician or PMHNP who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring it, and/or were responsible for terminating it,

c) Whether or not the resident returned from therapeutic leave within the preceding twenty-four (24) hours,

d) The reason the procedure was used,

e) Which less restrictive options were attempted, and how they failed,

f) Criteria for ending the procedure,

g) The results of the face-to-face assessment conducted by a physician, PMHNP or RN within one (1) hour after initiation of the procedure including:

   (1) The resident's physical and psychological status,

   (2) The resident's behavior,

   (3) The appropriateness of the intervention measures, and

   (4) Any complications resulting from the intervention.

h) The resident's condition at the time of each fifteen (15) minute reassessment and at the end of the procedure,

i) The signature of the person documenting the incident,

j) A record of both staff/resident and staff only debriefing sessions, which must take place within twenty-four (24) hours of the use of seclusion/restraint, and must include the names of staff present for or excused from the debriefing and any changes to the resident's treatment plan that resulted from the debriefings, and

k) Notification of the resident's parents/guardians within twenty-four (24) hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification.

2. A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly. These meetings must be documented.

3. Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 483.364(b)(1)(2); 483.356(a)(1)(2)(3)(4); 483.366(a); 483.356(a)(3)(ii); 483.358(d)(e)(f); 483.364(a); 483.362(a)(c); 483.370(a)(b).

Rule 4.13: Medication

A. Documents pertaining to medication must be accurate and readily located. When medication is a prescribed intervention for a problem identified in the resident's treatment plan, it must be noted as such in the treatment plan. Medication changes must be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' update at the next available staffing opportunity.

B. When medications are prescribed or changed, a member of the professional staff must review, with each resident's parent/guardian, the following:

   1. The name/class of medication,

   2. The method of administration,

   3. The symptoms targeted,

   4. Possible side effects of the medication,

   5. Possible long-term effects of the medication,

   6. Treatment alternatives, and

   7. Likely outcomes of using/not using the medication.

C. When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference must be held by telephone, with the parent's/guardian's responses noted and dated.

   1. Two (2) PRTF staff must witness the form after talking with the parent/guardian.

   2. The informed consent must be signed by the parent/guardian within thirty (30) days after the telephone consent.

D. Documentation must substantiate that medications have been accurately administered in accordance with the physician's or PMHNP's orders. Any variances must be justified in the record by medical staff.

E. An instrument for monitoring medication side effects must be identified and routinely administered to each resident who is prescribed psychoactive medication upon admission, at least every sixty (60) days during his/her stay and again at discharge.

F. Medication adjustment is defined as the use of a resident's routine medication in a non-routine way to help the resident through a period of heightened stress or agitation. Medication adjustment is not considered to be a special procedure. Medication adjustments must not be sedating, must be administered orally, and must be taken voluntarily by the resident. Standing PRN orders for medication adjustments are acceptable.

Source: Miss. Code Ann. § 43-13-121.

Rule 4.14: Discharge Aftercare

A. No later than seven (7) days prior to the resident's projected discharge date, the treatment team must develop a provisional aftercare plan for the resident. The plan's content must include, but not be limited to:

1. The planned discharge date,

2. The date of the resident's admission and discharge,

3. The name of the person/agency expected to assume care and custody of the resident,

4. The physical location/address where the resident is expected to reside,

5. A list of the resident's psychiatric diagnoses,

6. Behavior management recommendations for parents and any other suggestions which might contribute towards the resident's successful participation in family life,

7. Educational summary and practical recommendations/suggestions for teachers which might contribute towards the resident's success at school, and

8. Treatment recommendations or observations/comments for follow-up mental health clinicians which may increase the likelihood of success in therapeutic aftercare.

B. At the time of the resident's discharge the facility must:

1. Amend the provisional aftercare plan to include:

a) The dates of the resident's admission and discharge,

b) The name of the person/agency expected to assume care and custody of the resident,

c) The physical location/address where the resident is expected to reside,

d) A list of the resident's psychiatric diagnoses,

e) Detailed information about the resident's medications the names, strengths and

dosage instruction in lay terms for all medications prescribed for the resident, as well as any special instructions such as lab work requirements,

f) Behavior management and other pertinent recommendations for parents/caregivers,

g) Names, addresses and telephone numbers of the agencies/persons who will provide follow -up mental health services, the date and time of initial aftercare appointments, and treatment recommendations for the providers of those services,

h) Place where the resident will be attending school, a summary of the resident's educational progress while at the PRTF, his/her current educational standing, and recommendations for the resident's teachers,

i) Other recommended resources, if applicable, including recreational, rehabilitative, or other special programs believed to offer benefit to the resident,

j) The parent/guardian's signed acknowledgment that she/he was provided:

1) A copy of the resident's aftercare plan,

2) A minimum of a seven (7) day supply of the resident's medications, and

3) Prescriptions for a thirty (30) day supply of the resident's medications.

2. Provide the parent/guardian with:

a) A written copy of the final aftercare plan.

b) A supply of all current medications prescribed for the resident, equal to the amount already stocked for that resident by the PRTF but not less than a seven (7) day supply or more than a thirty (30) day supply.

c) Prescriptions for a thirty (30) day supply of all medications prescribed for the resident.

3. Seek the parent's/guardian's consent to release copies of the resident's educational summary and recommendations to the resident's school. If this consent is obtained, the educational information must be mailed to the resident's school within one working day following the resident's discharge. The school must not be sent the resident's complete aftercare plan, but only the part pertaining to education.

4. Seek the parent's/guardian's consent to release copies of the resident's aftercare plan and discharge summary to the providers of follow-up mental health services. If this consent is obtained, the aftercare plan and discharge summary must be mailed to mental health aftercare within two (2) weeks following the resident's discharge.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart D

Rule 4.15: Reporting Requirement

A. The PRTF must keep the Division of Medicaid informed of serious occurrences involving residents of the PRTF.

   1. The death of any resident or a serious incident involving any resident, regardless of whether or not those involved were Medicaid beneficiaries, must be reported to the Division of Medicaid.

      a) The death of any resident must be reported to the Division of Medicaid as soon as possible, but no later than close of business the same day.

      b) Serious incidents must be reported by fax to the Division of Medicaid by close of the next business day.

   2. The Division of Medicaid defines serious incidents as:

      a) Serious injury of a resident, defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel.

         1) This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.

         2) All serious injuries that require medical intervention are to be reported.

      b) Suicide attempt by a resident.

      c) Elopement of a resident.

      d) Allegations of sexual contact between residents.

      e) Allegations of maltreatment, like abuse and/or neglect of a resident.

      f) Any injury of a resident sustained in the course of a seclusion or restraint.

   3. Each report must include:

      a) The name of the resident, if she/he is a Medicaid beneficiary,

      b) A description of the occurrence, and

      c) The name, street address, and telephone number of the facility.

B. Serious incidents must also be reported to the appropriate agencies or entities according to applicable state and federal regulations. These include, but are not limited to:

1. Department of Human Services (DHS).

2. Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification (MSDH).

3. Disability Rights Mississippi (DRM) formerly known as the State Protection and Advocacy office.

4. Regional Office of the Center for Medicare and Medicaid Services (CMS)

5. Medicaid Fraud Control Unit, Attorney General (MFCU)

6. Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121; 43-21-353; 42 CFR 483.374

Rule 4.16: Maintenance of Records

Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-21-353