Title 23: Division of Medicaid

Part 207: Institutional Long Term Care

Chapter 2: Nursing Facility

Rule 2.6: Per Diem

A. The nursing facility must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,

2. Nursing services,

3. Dietary services, including nutritional supplements,

4. Activity services,

5. Medically-related social services,

6. Routine personal hygiene items and services,

7. Laundry services including the residents' personal laundry,

8. Over-the-counter (OTC) drugs,

9. Legend drugs not covered by Medicaid drug program, Medicare, private, VA, or any other payor source,

10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the nursing facility. [Refer to Miss. Admin. Code. Part 207, Rule 2.6.D for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

b) Diabetic supplies,

c) Diapers and blue pads, and

d) Oxygen administration supplies.

11. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the nursing facility.

12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

a) Hair hygiene supplies,

b) Comb and brush,

c) Bath soap,

d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part

of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary:

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

14. Ventilators. [Refer to Miss. Admin Code Part 207, Rule 2.15.]

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the nursing facility's cost report, and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the nursing facility:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services,

5. Ostomy supplies,

6. Oxygen cylinders and the contents,

7. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

8. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015.

9. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]

E. Prior authorization from the Utilization Management/Quality Improvement Organization (UM/QIO) is required for the following:

1. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident, and

2. PT, OT and SLP services.

F. Prior authorization from the Division of Medicaid or UM/QIO is required for ventilators except for those in a Private Nursing Facility for the Severely Disabled (PNF-SD).

G. All nursing facilities must prominently display the below information in the nursing facility, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

H. The nursing facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the nursing facility services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the nursing facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 2.6.G.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

I. The nursing facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services consistent with the notice stated in Miss. Admin. Code Part 207, Rule 2.6.G.

1. The nursing facility's non-Medicaid per diem rate may be set above the Medicaid per diem rate but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the nursing facility not covered under Title XVIII or the nursing facility's Medicaid per diem rate must be available and priced identically for all residents in the facility.

J. A nursing facility cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

Source: 42 CFR §§ 483.10, 483.10(b)(5)-(6), 483.10(b)(10), 483.10(c)(8); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015.

Rule 2.15: Ventilator Dependent Care

A. The Division of Medicaid defines ventilator dependent care (VDC) as mechanical ventilation for life support designed to replace and/or support normal ventilatory lung function.

B. Effective January 1, 2015, the Division of Medicaid provides an established reimbursement per diem rate in addition to the standard per diem rate to nursing facilities, excluding Private Nursing Facilities for the Severely Disabled (PNF-SD), for residents requiring VDC services. On January 1, 2015, the nursing facility will receive the following for a ventilator dependent resident:

1. A standard per diem, and

2. A ventilator per diem.

C. VDC provider enrollment requirements include:

1. The nursing facility must accept residents with pending Medicaid status.

2. Beneficiaries admitted under Medicare must receive approval from the Division of Medicaid prior to the nursing facility receiving reimbursement.

3. The nursing facility must file an Addendum to its current Provider Agreement and it must be approved by the Division of Medicaid.

a) The Addendum must include required attestations regarding the nursing facility requirements consistent with Miss. Admin. Code Part 207, Rule 2.15. including, but not limited to:

1) Number of beds designated to serve ventilator dependent residents,

2) Required equipment,

3) Staffing ratios for the VDC resident(s), and

4) Documentation of a formal relationship between the nursing facility and a local hospital for the emergency care of all ventilator dependent residents.

b) The Division of Medicaid reserves the right to approve Addendums at its discretion based on:

1) Geographic coverage,

2) Market saturation, and/or

3) The ability of the nursing facility to demonstrate compliance with certification requirements.

c) The approval of the Addendum is dependent upon:

1) Successful completion of an Addendum and submission of required documents,

2) Establishment of policies to support the operations of VDC services,

3) Successful completion of an on-site visit by Mississippi Department of Health, Health Facilities Licensure and Certification (HFLC), and

4) The nursing facility's completion of all other required documents applicable to providing VDC services as requested by HFLC or the Division of Medicaid.

d) The Division of Medicaid will close an Addendum for VDC services if the provider fails to submit any requested information or documentation within thirty (30) days of a request by the Division of Medicaid. Once closed, a provider is not eligible to re-apply for three (3) months.

D. The Division of Medicaid reserves the right to terminate a Nursing Facility Provider Agreement, including the Addendum, based on failure to comply with Administrative Code requirements and/or state licensure and federal requirements.

1. Upon receipt of a termination notice, the facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process.

2. Upon the Division of Medicaid's approval of the transfer plan, all transfers resulting from the termination of the agreement must be completed within thirty (30) days from the date of the termination notice.

3. Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code, Title 23, Part 300.

4. The Division of Medicaid reserves the right to enforce an immediate transfer of ventilator dependent residents if the nursing facility's compliance failure is so egregious in nature that the resident(s) safety is threatened.

5. Once terminated, the provider may not reapply to provide VDC services for one (1) year from the date of termination.

E. Nursing facilities providing services to ventilator dependent residents must:

1. Meet all federal and state regulations governing nursing facilities.

2. Provide residents in need of VDC services with the following licensed staff which cannot be included as part of the HFLC nursing facility state minimum staffing requirements:

a) One (1) Registered Nurse (RN) assigned the primary responsibility for the VDC services and ventilator dependent residents twenty-four (24) hours a day seven (7) days a week in addition to:

1) One (1) RN for every ten (10) ventilator dependent residents (1:10),

2) One (1) RN and one (1) Licensed Practical Nurse (LPN) for every eleven (11) to fourteen (14) ventilator dependent residents, and

3) Two (2) RNs for every fifteen (15) to twenty (20) ventilator dependent residents.

b) One (1) in-house licensed respiratory therapist (RT) twenty-four (24) hours a day seven (7) days a week with a ratio of one (1) RT for every ten (10) ventilator dependent residents (1:10).

3. Must maintain separate staffing records for the nursing staff and respiratory staff responsible for the ventilator dependent residents.

4. Ensure physician visits are conducted in accordance with the federal and state regulations for nursing facilities.

5. Must provide adequate equipment and supplies for the provision of VDC services including, but not limited to,

a) Primary ventilators,

b) Back up ventilators,

c) Emergency batteries,

d) Oxygen tanks,

e) Suction machines,

f) Nebulizers,

g) Manual resuscitator,

h) Pulse oximetry monitoring equipment,

i) Nutrient infusion pumps, and

j) Any medically necessary durable medical equipment (DME) and supplies.

6. Must have an audible, redundant external alarm system located outside the resident's room to alert of ventilator failure.

7. Must have written policies and procedures for ventilator dependent residents including, but not limited to:

   a) Ventilator monitoring expectations,

   b) Routine maintenance of ventilator equipment,

   c) Specific staff training related to ventilator care and operation,

   d) Staffing requirements,

   e) Infection control program for:

      1) Ventilator dependent residents, to include:

         (a) Actions to investigate, control, and prevent infections,

         (b) Isolation procedures,

         (c) Standard precautions,

      2) Maintenance and care requirements of equipment and disposal of supplies.

8. Place individuals admitted with any contagious diagnoses related to a respiratory illness in isolation according to the Centers for Disease Control (CDC) and requirements under 42 CFR § 483.65.

9. Provide staff education and in-service training to direct and indirect care staff.

a) Required training must be completed prior to the provision of care, including infection control procedures and addressing the needs of a ventilator dependent resident.

b) Required training must be conducted annually to all staff provided by a:

1) Licensed RT, or

2) A Board Certified Pulmonologist.

c) Additional training of nursing staff is required to be conducted by a full-time RN who has completed documented training in the care of ventilator dependent individuals by a Respiratory Therapist or a Board Certified Pulmonologist. This RN will be responsible for:

1) Quarterly and on-going training to all VDC nursing staff as evidenced by documentation.

2) Providing initial in-service training for ten (10) work days to all direct care and indirect care staff assuring they are competent to care for VDC residents.

10. Ensure the nursing facility's Emergency Plan includes:

a) Provisions for continuous operation of ventilator equipment during power outages and/or ventilator equipment failure, and

b) A revised Emergency Operations Plan approved by the MSDH Office of Emergency Planning and Response which includes the VDC services.

11. Execute a written agreement with a local acute care hospital:

a) Located within twenty (20) miles or thirty (30) minutes of an Emergency Department with the capability to treat emergencies for beneficiaries with ventilator dependency.

b) With provisions for twenty-four (24) hour access to VDC services.

c) Documenting a formal relationship between the nursing facility and a local acute care hospital that confirms the ability and willingness of the hospital to serve the acute care needs of residents requiring mechanical ventilation:

1) On an as-needed basis, and

2) In emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital.

3) The agreement should outline transfer logistics and financial responsibilities.

F. Residents in a nursing facility receiving VDC services must:

1. Have long term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

2. Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

3. Require daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

4. Be medically stable and not require acute care services prior to the transfer to the nursing facility.

5. Be prior authorized by the Division of Medicaid or the Utilization Management/Quality Improvement Organization (UM/QIO) for admission and recertified as required by the Division of Medicaid or UM/QIO to determine if the resident's medical condition warrants VDC services.

   a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid or UM/QIO.

   b) The resident is considered appropriate for VDC services until the weaning process is completed.

G. The Division of Medicaid does not cover admissions as a VDC resident for those who only require CPAP or BiPAP.

H. The Division of Medicaid approves out-of-state nursing facility placements for ventilator dependent beneficiaries when all the following are met:

1. The nursing facility is a Mississippi Medicaid Provider,

2. All efforts for in-state placement are exhausted,

3. The transferring facility provides documentation of denial statements from Mississippi nursing facilities unable to care for the beneficiary or there are no nursing facilities beds available in Mississippi to treat VDC residents.

4. The needs of the ventilator dependent beneficiary cannot be met in the state of Mississippi.

5. The Division of Medicaid must prior authorize for medical necessity and approval must be obtained from the Executive Director,

6. The beneficiary is:

    a) Mississippi Medicaid eligible.

    b) Eligible for long-term care placement.

    c) Ventilator dependent and meets all the following requirements:

        1) The Division of Medicaid does not cover admission or recertification as a VDC resident for those who only require CPAP or BiPAP.

        2) Medically stable and not require acute care services prior to the transfer to the nursing facility.

        3) Has long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

        4) Requires daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

        5) Be dependent on mechanical ventilation via a tracheostomy of at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

        6) Be prior authorized by the Division of Medicaid for admission and recertified as required by the Division of Medicaid to determine if the resident's medical condition warrants VDC services.

            (a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid.

            (b) The resident is considered appropriate for VDC services until the weaning process is completed.

7. Completion of an admission assessment as required by federal and state regulations and/or the Division of Medicaid.

I. Beneficiaries admitted to an out-of-state nursing facility receiving reimbursement from Medicare must obtain approval from the Division of Medicaid prior to receiving Medicaid reimbursement.

J. The Division of Medicaid reimburses out-of-state nursing facilities utilizing Mississippi's Case Mix payment rate system.

1. The approved out-of-state facility must:

a) Provide an initial and quarterly Minimum Data Set (MDS) assessment for review,

b) Provide a desk audit to determine the category classification using the current calculation for reimbursement, and

c) Complete all required Omnibus Budget Reconciliation Act (OBRA) MDS assessments.

2. VDC reimbursement is discontinued to the nursing facility once the resident is successfully weaned from mechanical ventilation.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 14-019.

History: Revised to correspond with SPA 14-019 (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.18: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair".

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

1. Standard manual wheelchairs,

2. Standard manual wheelchairs with added accessories,

3. Standard motorized/power wheelchairs, and/or

4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

3. Not primarily used as a restraint, and

4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

a) The reason for the evaluation visit was a mobility examination.

b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age of equipment, and specifically why it is not meeting the resident's needs.

6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair, not previously purchased by the Medicaid program.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent evaluation that the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident and the resident must:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

    a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the nursing facility.

    b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident's needs, must ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

   a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

   b) RESNA certifications must be updated every two (2) years.

   c) NRRTS certifications must be updated annually.

   d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

   a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The nursing facility is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January 2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Rule 3.4: Per Diem

A. The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,
2. Nursing services,
3. Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services,
4. Dietary services, including nutritional supplements,
5. Activity services,
6. Medically-related social services,
7. Routine personal hygiene items and services,
8. Laundry services including the residents' personal laundry,
9. Over-the-counter (OTC) drugs,
10. Legend drugs not covered by the Medicaid program, Medicare, private, VA or any other payor source,
11. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily

serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for medical supplies which must be billed outside the per diem rate.]

a) Enteral supplies,

b) Diabetic supplies,

c) Diapers and blue pads, and

d) Oxygen administration supplies.

12. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 3.4.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for DME which must be billed outside the per diem rate.]

13. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

a) Hair hygiene supplies,

b) Comb and brush,

c) Bath soap,

d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

14. Private room coverage as medically necessary.

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the ICF/IID's cost report and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the ICF/IID:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Ostomy supplies,

5. Oxygen cylinders and the contents,

6. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,

7. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015.

8. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when

prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 3.10 for definition and coverage criteria]

E. All ICF/IID's must prominently display the below information in the ICF/IID, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

F. The ICF/IID must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the ICF/IID or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the ICF/IID services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the ICF/IID offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 3.4.F.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

G. The ICF/IID may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services, consistent with the notice stated in Miss. Admin. Code Part 207, Rule 3.4.F.

1. The ICF/IID's non-Medicaid per diem rate may be set above the Medicaid per diem rate, but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the ICF/IID not covered under Title XVIII or the ICF/IID's Medicaid per diem rate must be available and priced identically for all residents in the facility.

H. An ICF/IID cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015.

Rule 3.10: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair.

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

    1. Standard manual wheelchairs,

    2. Standard manual wheelchairs with added accessories,

    3. Standard motorized/power wheelchairs, and/or

    4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

    1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

    2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

    3. Not primarily used as a restraint, and

    4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

    1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

a) The reason for the evaluation visit is a mobility examination,

b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age of equipment and specifically why it is not meeting the resident's needs.

6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Division of Medicaid at the time of the initial evaluation.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident. The resident must meet the following criteria:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the ICF/IID.

b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of

an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and/or custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident's needs, must

ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

    a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

    b) RESNA certifications must be updated every two (2) years.

    c) NRRTS certifications must be updated annually.

    d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

    a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

    b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The ICF/IID is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January 2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred. This includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

Title 23: Division of Medicaid

Part 207: Institutional Long Term Care

Chapter 2: Nursing Facility

Rule 2.6: Per Diem

A. The nursing facility must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,

2. Nursing services,

3. Dietary services, including nutritional supplements,

4. Activity services,

5. Medically-related social services,

6. Routine personal hygiene items and services,

7. Laundry services including the residents' personal laundry,

8. Over-the-counter (OTC) drugs,

9. Legend drugs not covered by Medicaid drug program, Medicare, private, VA, or any other payor source,

10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the nursing facility. [Refer to Miss. Admin. Code. Part 207, Rule 2.6.D for medical supplies which must be billed outside the per diem rate.]

    a) Enteral supplies,

b) Diabetic supplies,

c) Diapers and blue pads, and

d) Oxygen administration supplies.

11. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the nursing facility.

12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

a) Hair hygiene supplies,

b) Comb and brush,

c) Bath soap,

d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part

of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary:

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

14. Ventilators. [Refer to Miss. Admin Code Part 207, Rule 2.15.]

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the nursing facility's cost report, and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the nursing facility:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services,

5. Ostomy supplies,

6. Oxygen cylinders and the contents,

7. Continuous Positive Airway Pressure (CPAP) Devices effective January ~~1~~2, 2015,

8. Bi-level Positive Airway Pressure (BiPAP) Devices effective January ~~1~~2, 2015.

9. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident effective January ~~1~~2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]

E. Prior authorization from the Utilization Management/Quality Improvement Organization (UM/QIO) is required for the following:

1. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident, and

2. PT, OT and SLP services.

F. Prior authorization from the Division of Medicaid or UM/QIO is required for ventilators except for those in a Private Nursing Facility for the Severely Disabled (PNF-SD).

G. All nursing facilities must prominently display the below information in the nursing facility, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

H. The nursing facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the nursing facility services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the nursing facility offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 2.6.G.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

I. The nursing facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services consistent with the notice stated in Miss. Admin. Code Part 207, Rule 2.6.G.

1. The nursing facility's non-Medicaid per diem rate may be set above the Medicaid per diem rate but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the nursing facility not covered under Title XVIII or the nursing facility's Medicaid per diem rate must be available and priced identically for all residents in the facility.

J. A nursing facility cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

Source: 42 CFR §§ 483.10, 483.10(b)(5)-(6), 483.10(b)(10), 483.10(c)(8); Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015.

Rule 2.15: Ventilator Dependent Care

A. The Division of Medicaid defines ventilator dependent care (VDC) as mechanical ventilation for life support designed to replace and/or support normal ventilatory lung function.

B. Effective January 1, 2015, the Division of Medicaid provides an established reimbursement per diem rate in addition to the standard per diem rate to nursing facilities, excluding Private Nursing Facilities for the Severely Disabled (PNF-SD), for residents requiring VDC services. On January 1, 2015, the nursing facility will receive the following for a ventilator dependent resident:

1. A standard per diem, and

2. A ventilator per diem.

C. VDC provider enrollment requirements include:

1. The nursing facility must accept residents with pending Medicaid status.

2. Beneficiaries admitted under Medicare must receive approval from the Division of Medicaid prior to the nursing facility receiving reimbursement.

3. The nursing facility must file an Addendum to its current Provider Agreement and it must be approved by the Division of Medicaid.

a) The Addendum must include required attestations regarding the nursing facility requirements consistent with Miss. Admin. Code Part 207, Rule 2.15. including, but not limited to:

1) Number of beds designated to serve ventilator dependent residents,

2) Required equipment,

3) Staffing ratios for the VDC resident(s), and

4) Documentation of a formal relationship between the nursing facility and a local hospital for the emergency care of all ventilator dependent residents.

b) The Division of Medicaid reserves the right to approve Addendums at its discretion based on:

1) Geographic coverage,

2) Market saturation, and/or

3) The ability of the nursing facility to demonstrate compliance with certification requirements.

c) The approval of the Addendum is dependent upon:

1) Successful completion of an Addendum and submission of required documents,

2) Establishment of policies to support the operations of VDC services,

3) Successful completion of an on-site visit by Mississippi Department of Health, Health Facilities Licensure and Certification (HFLC), and

4) The nursing facility's completion of all other required documents applicable to providing VDC services as requested by HFLC or the Division of Medicaid.

d) The Division of Medicaid will close an Addendum for VDC services if the provider fails to submit any requested information or documentation within thirty (30) days of a request by the Division of Medicaid. Once closed, a provider is not eligible to re-apply for three (3) months.

D. The Division of Medicaid reserves the right to terminate a Nursing Facility Provider Agreement, including the Addendum, based on failure to comply with Administrative Code requirements and/or state licensure and federal requirements.

1. Upon receipt of a termination notice, the facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process.

2. Upon the Division of Medicaid's approval of the transfer plan, all transfers resulting from the termination of the agreement must be completed within thirty (30) days from the date of the termination notice.

3. Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code, Title 23, Part 300.

4. The Division of Medicaid reserves the right to enforce an immediate transfer of ventilator dependent residents if the nursing facility's compliance failure is so egregious in nature that the resident(s) safety is threatened.

5. Once terminated, the provider may not reapply to provide VDC services for one (1) year from the date of termination.

E. Nursing facilities providing services to ventilator dependent residents must:

1. Meet all federal and state regulations governing nursing facilities.

2. Provide residents in need of VDC services with the following licensed staff which cannot be included as part of the HFLC nursing facility state minimum staffing requirements:

a) One (1) Registered Nurse (RN) assigned the primary responsibility for the VDC services and ventilator dependent residents twenty-four (24) hours a day seven (7) days a week in addition to:

1) One (1) RN for every ten (10) ventilator dependent residents (1:10),

2) One (1) RN and one (1) Licensed Practical Nurse (LPN) for every eleven (11) to fourteen (14) ventilator dependent residents, and

3) Two (2) RNs for every fifteen (15) to twenty (20) ventilator dependent residents.

b) One (1) in-house licensed respiratory therapist (RT) twenty-four (24) hours a day seven (7) days a week with a ratio of one (1) RT for every ten (10) ventilator dependent residents (1:10).

3. Must maintain separate staffing records for the nursing staff and respiratory staff responsible for the ventilator dependent residents.

4. Ensure physician visits are conducted in accordance with the federal and state regulations for nursing facilities.

5. Must provide adequate equipment and supplies for the provision of VDC services including, but not limited to,

a) Primary ventilators,

b) Back up ventilators,

c) Emergency batteries,

d) Oxygen tanks,

e) Suction machines,

f) Nebulizers,

g) Manual resuscitator,

h) Pulse oximetry monitoring equipment,

i) Nutrient infusion pumps, and

j) Any medically necessary durable medical equipment (DME) and supplies.

6. Must have an audible, redundant external alarm system located outside the resident's room to alert of ventilator failure.

7. Must have written policies and procedures for ventilator dependent residents including, but not limited to:

   a) Ventilator monitoring expectations,

   b) Routine maintenance of ventilator equipment,

   c) Specific staff training related to ventilator care and operation,

   d) Staffing requirements,

   e) Infection control program for:

      1) Ventilator dependent residents, to include:

         (a) Actions to investigate, control, and prevent infections,

         (b) Isolation procedures,

         (c) Standard precautions,

      2) Maintenance and care requirements of equipment and disposal of supplies.

8. Place individuals admitted with any contagious diagnoses related to a respiratory illness in isolation according to the Centers for Disease Control (CDC) and requirements under 42 CFR § 483.65.

9. Provide staff education and in-service training to direct and indirect care staff.

a) Required training must be completed prior to the provision of care, including infection control procedures and addressing the needs of a ventilator dependent resident.

b) Required training must be conducted annually to all staff provided by a:

1) Licensed RT, or

2) A Board Certified Pulmonologist.

c) Additional training of nursing staff is required to be conducted by a full-time RN who has completed documented training in the care of ventilator dependent individuals by a Respiratory Therapist or a Board Certified Pulmonologist. This RN will be responsible for:

1) Quarterly and on-going training to all VDC nursing staff as evidenced by documentation.

2) Providing initial in-service training for ten (10) work days to all direct care and indirect care staff assuring they are competent to care for VDC residents.

10. Ensure the nursing facility's Emergency Plan includes:

a) Provisions for continuous operation of ventilator equipment during power outages and/or ventilator equipment failure, and

b) A revised Emergency Operations Plan approved by the MSDH Office of Emergency Planning and Response which includes the VDC services.

11. Execute a written agreement with a local acute care hospital:

a) Located within twenty (20) miles or thirty (30) minutes of an Emergency Department with the capability to treat emergencies for beneficiaries with ventilator dependency.

b) With provisions for twenty-four (24) hour access to VDC services.

c) Documenting a formal relationship between the nursing facility and a local acute care hospital that confirms the ability and willingness of the hospital to serve the acute care needs of residents requiring mechanical ventilation:

1) On an as-needed basis, and

2) In emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital.

3) The agreement should outline transfer logistics and financial responsibilities.

F. Residents in a nursing facility receiving VDC services must:

1. Have long term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

2. Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

3. Require daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

4. Be medically stable and not require acute care services prior to the transfer to the nursing facility.

5. Be prior authorized by the Division of Medicaid or the Utilization Management/Quality Improvement Organization (UM/QIO) for admission and recertified as required by the Division of Medicaid or UM/QIO to determine if the resident's medical condition warrants VDC services.

   a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid or UM/QIO.

   b) The resident is considered appropriate for VDC services until the weaning process is completed.

G. The Division of Medicaid does not cover admissions as a VDC resident for those who only require CPAP or BiPAP.

H. The Division of Medicaid approves out-of-state nursing facility placements for ventilator dependent beneficiaries when all the following are met:

1. The nursing facility is a Mississippi Medicaid Provider,

2. All efforts for in-state placement are exhausted,

3. The transferring facility provides documentation of denial statements from Mississippi nursing facilities unable to care for the beneficiary or there are no nursing facilities beds available in Mississippi to treat VDC residents.

4. The needs of the ventilator dependent beneficiary cannot be met in the state of Mississippi.

5. The Division of Medicaid must prior authorize for medical necessity and approval must be obtained from the Executive Director,

6. The beneficiary is:

    a) Mississippi Medicaid eligible.

    b) Eligible for long-term care placement.

    c) Ventilator dependent and meets all the following requirements:

        1) The Division of Medicaid does not cover admission or recertification as a VDC resident for those who only require CPAP or BiPAP.

        2) Medically stable and not require acute care services prior to the transfer to the nursing facility.

        3) Has long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.

        4) Requires daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.

        5) Be dependent on mechanical ventilation via a tracheostomy of at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.

        6) Be prior authorized by the Division of Medicaid for admission and recertified as required by the Division of Medicaid to determine if the resident's medical condition warrants VDC services.

            (a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid.

            (b) The resident is considered appropriate for VDC services until the weaning process is completed.

7. Completion of an admission assessment as required by federal and state regulations and/or the Division of Medicaid.

I. Beneficiaries admitted to an out-of-state nursing facility receiving reimbursement from Medicare must obtain approval from the Division of Medicaid prior to receiving Medicaid reimbursement.

J. The Division of Medicaid reimburses out-of-state nursing facilities utilizing Mississippi's Case Mix payment rate system.

1. The approved out-of-state facility must:

a) Provide an initial and quarterly Minimum Data Set (MDS) assessment for review,

b) Provide a desk audit to determine the category classification using the current calculation for reimbursement, and

c) Complete all required Omnibus Budget Reconciliation Act (OBRA) MDS assessments.

2. VDC reimbursement is discontinued to the nursing facility once the resident is successfully weaned from mechanical ventilation.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 14-019.

History: Revised to correspond with SPA 14-019 (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.18: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair".

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

1. Standard manual wheelchairs,

2. Standard manual wheelchairs with added accessories,

3. Standard motorized/power wheelchairs, and/or

4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

3. Not primarily used as a restraint, and

4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

a) The reason for the evaluation visit was a mobility examination.

b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age of equipment, and specifically why it is not meeting the resident's needs.

6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair, not previously purchased by the Medicaid program.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent evaluation that the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident and the resident must:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

    a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the nursing facility.

    b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident's needs, must ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

   a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

   b) RESNA certifications must be updated every two (2) years.

   c) NRRTS certifications must be updated annually.

   d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

   a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The nursing facility is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January ~~1~~2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred, which includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for a rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Rule 3.4: Per Diem

A. The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must provide and pay for all items and services required to meet the needs of a resident.

B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.

C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:

1. Room/bed maintenance services,
2. Nursing services,
3. Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP) services,
4. Dietary services, including nutritional supplements,
5. Activity services,
6. Medically-related social services,
7. Routine personal hygiene items and services,
8. Laundry services including the residents' personal laundry,
9. Over-the-counter (OTC) drugs,
10. Legend drugs not covered by the Medicaid program, Medicare, private, VA or any other payor source,
11. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily

serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for medical supplies which must be billed outside the per diem rate.]

a) Enteral supplies,

b) Diabetic supplies,

c) Diapers and blue pads, and

d) Oxygen administration supplies.

12. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 3.4.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for DME which must be billed outside the per diem rate.]

13. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:

a) Hair hygiene supplies,

b) Comb and brush,

c) Bath soap,

d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and

p) Bathing.

14. Private room coverage as medically necessary.

a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.

b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the ICF/IID's cost report and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the ICF/IID:

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

4. Ostomy supplies,

5. Oxygen cylinders and the contents,

6. Continuous Positive Airway Pressure (CPAP) Devices effective January ~~1~~2, 2015,

7. Bi-level Positive Airway Pressure (BiPAP) Devices effective January ~~1~~2, 2015.

8. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when

prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO) effective January ~~1~~2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 3.10 for definition and coverage criteria]

E. All ICF/IID's must prominently display the below information in the ICF/IID, and provide to applicants for admission and residents the below information in both oral and written form:

1. How to apply for and use Medicare and Medicaid benefits, and

2. How to receive refunds for previous payments covered by such benefits.

F. The ICF/IID must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the ICF/IID or when the resident becomes eligible for Medicaid of:

a) The items and services that are included in the ICF/IID services under the State Plan and for which the resident may not be charged, and

b) Those other items and services that the ICF/IID offers and for which the resident may be charged, and the amount of charges for those services.

2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 3.4.F.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

G. The ICF/IID may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services, consistent with the notice stated in Miss. Admin. Code Part 207, Rule 3.4.F.

1. The ICF/IID's non-Medicaid per diem rate may be set above the Medicaid per diem rate, but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.

2. Items and services available in the ICF/IID not covered under Title XVIII or the ICF/IID's Medicaid per diem rate must be available and priced identically for all residents in the facility.

H. An ICF/IID cannot require a deposit before admitting a card-carrying Medicaid beneficiary.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 01/02/2015.

Rule 3.10: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.

B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as "custom manual wheelchair" and/or "custom motorized/power wheelchair.

C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:

    1. Standard manual wheelchairs,

    2. Standard manual wheelchairs with added accessories,

    3. Standard motorized/power wheelchairs, and/or

    4. Standard motorized/power wheelchairs with added accessories.

D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:

    1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident's needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,

    2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,

    3. Not primarily used as a restraint, and

    4. Prior authorized by the Utilization Management/Quality Improvement Organization (UM/QIO).

E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.

    1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

a) The reason for the evaluation visit is a mobility examination,

b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.

c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:

1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.

2) Description and history of limitation/functional deficits.

3) Description of physical and cognitive abilities to utilize equipment.

4) History of previous interventions/past use of mobility devices.

5) Description of existing equipment, age of equipment and specifically why it is not meeting the resident's needs.

6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.

7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.

8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.

2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Division of Medicaid at the time of the initial evaluation.

3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.

4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.

F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident. The resident must meet the following criteria:

1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,

2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,

3. Be for the necessary treatment of a medical condition,

4. Have a poor prognosis for being able to self-propel a functional distance,

5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,

6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,

7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,

8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,

9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,

10. Be in an environment conducive to the use of the custom motorized/power wheelchair.

a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the ICF/IID.

b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of

an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.

1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.

2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.

3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.

4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.

5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.

H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:

1. Is made for only one (1) custom manual and/or custom motorized/power wheelchair at a time.

2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.

3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.

4. Is made only after the PT or OT subsequent evaluation is completed.

I. The DME providers must ensure the prescribed custom manual and/or custom motorized/power wheelchair and accessories are adequate to meet the resident’s needs, must

ensure the proper height and width, and must provide an automatic or special locking mechanism for residents unable to apply manual brakes.

J. The DME provider providing custom motorized/power wheelchairs to residents must:

1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).

    a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.

    b) RESNA certifications must be updated every two (2) years.

    c) NRRTS certifications must be updated annually.

    d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.

2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.

3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.

    a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.

    b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.

4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

K. DME providers providing custom motorized/power wheelchairs, customized electronic interphase devices, specialty and/or alternative controls for wheelchairs, extensive modifications and seating and positioning systems must have a designated repair and service department, with a technician available during normal business hours, between eight (8:00) a.m. and five (5:00) p.m. Monday through Friday. Each technician must keep on file records of attending continuing education courses or seminars to establish, maintain and upgrade their knowledge base.

L. The Division of Medicaid covers repairs, including labor and delivery, of a custom manual and/or custom motorized/power wheelchair owned by the resident not to exceed fifty percent (50%) of the maximum allowable reimbursement for the cost of replacement.

1. The ICF/IID is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January ~~1~~2, 2015.

2. Major repairs and/or replacement of parts require prior authorization from the UM/QIO and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.

3. An explanation of time involved for repairs and/or replacement of parts must be submitted to the UM/QIO.

4. Manufacturer time guides must be followed for repairs and/or replacement of parts.

5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.

6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred. This includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.

7. Reimbursement will be made for up to one (1) month for rental of a wheelchair while the resident's wheelchair is being repaired.

8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.