

Title 23: Division of Medicaid

Part 207: Institutional Long-Term Care

Part 207: Chapter 2: Nursing Facility

Rule 2.7: Admission Requirements

- A. A Pre-Admission Screening (PAS) application must be completed to determine clinical eligibility for individuals seeking admission to a Division of Medicaid certified nursing facility on all residents regardless of payment source.
1. The PAS application must be submitted to the Division of Medicaid within thirty (30) days of the physician's certification.
 2. An individual must receive a PAS score of fifty (50) or greater to be clinically eligible for nursing facility placement.
 3. Individuals with mental illness and/or an intellectual/developmental disability (MI/ IDD) determined to require a nursing facility level of care must receive a Level II evaluation to ensure appropriate placement and the provision of necessary specialized services regardless of payment source.
- B. The PAS Section X summary, physician's certification, and Level II evaluation, if required, must be submitted by the admitting nursing facility to the Medicaid Regional Office of the individual's county of residence for determining Medicaid eligibility.
- C. Individuals seeking admission to a Nursing Facility for the Severely Disabled (NF-SD) must meet the following additional requirements:
1. Have a diagnosis of spinal cord injury, closed head injury, long-term ventilator dependency or another diagnosis similar or closely related to the severity and involvement of care of those diagnoses, and
 2. Be assigned one (1) of the following MDS RUG-IV 48 Grouper categories: ES3, ES2, HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1, LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1.

Source: 42 USC §§ 1395i-3, 1396r; 42 CFR §§ 435.1010, 483.100-483.106, 483.112; 483.120; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.9: Resident Assessment Instrument (RAI)

- A. Nursing facilities must complete the Minimum Data Set (MDS) 3.0, including Section S, which is the Resident Assessment Instrument (RAI) specified by the Division of Medicaid

and approved by the Centers of Medicare and Medicaid Services (CMS), on all residents regardless of source of payment.

B. The RAI must:

1. Be conducted or coordinated by a registered nurse who signs and certifies completion of the RAI.
 - a) The RAI may be conducted with the participation of other appropriate staff members.
 - b) Each staff member who completes a portion of the RAI must sign and certify as to the accuracy of that portion of the RAI.
2. Be maintained in the resident's active clinical record:
 - a) Either in handwritten and/or electronic form, consisting of the previous fifteen (15) months of assessments, including the signatures of the facility staff attesting to the accuracy and completion of the assessment, and
 - b) After the fifteen (15) month period, the RAI information may be stored in the medical records department provided it is easily retrievable.
3. Include the following assessments for all residents:
 - a) Admission, comprehensive,
 - b) Annual, comprehensive,
 - c) Significant Change in Status, comprehensive,
 - d) Quarterly,
 - e) Significant Correction to a Prior Comprehensive,
 - f) Significant Correction to a Prior Quarterly,
 - g) Other Medicare Reasons for Assessment (OMRA), if applicable, and
 - h) Discharge, Death, Transfer or Re-entry.
4. Be completed per the current CMS Long-Term Care Facility Resident Assessment Instrument User's Manual.

Source: 42 USC §§ 1395i-3, 1396r; 42 CFR §§ 483.20, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.10: Case Mix Reimbursement

- A. The Division of Medicaid utilizes a RUG-IV 48 grouper model for case mix calculation for reimbursement.
 - 1. Each of the forty-eight (48) resident classifications as well as the default classification is assigned case-mix weights.
 - 2. The classifications are calculated electronically using the MDS assessment data and the RUG-IV calculation program.
- B. Clinical documentation must be maintained in the clinical record which supports the MDS 3.0 assessment and substantiates the resources and services needed to provide care to the resident.
- C. Documentation for case-mix reimbursement must adhere to the Division of Medicaid's Supportive Documentation Requirements.

Source: 42 CFR § 483.75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

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 Nursing Facilities for the Severely Disabled (NF-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 15-004.

History: Revised to correspond with SPA 15-004 (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.16: Therapy Services

- A. All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability rules, is obligated to cover these services.
- B. Prior authorization/pre-certification of certain physical, occupation, and speech-language pathology services is required by the Division of Medicaid. Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for Medicaid. Failure to obtain prior authorization will result in denial of payment to billing providers.
- C. The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of procedure codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by Medicaid.
- D. Providers must also adhere to all Medicaid outpatient therapy rules.
- E. Private Nursing Facility for the Severely Disabled - Miss. Admin. Code Part 207, Rule 2.16 is not applicable to a Nursing Facility for the Severely Disabled (NFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.
- F. Medicaid-Only Residents - Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current Medicaid provider number. Nursing facilities may apply for a group therapy provider number for billing purposes.
- G. Dually Eligible Residents - Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid dual eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

Source: Miss. Code Ann. § 43-13-121, SPA 15-004.

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Part 207: Institutional Long-Term Care

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Rule 2.7: Admission Requirements

A. A Pre-Admission Screening (PAS) application must be completed to determine clinical eligibility for individuals seeking admission to a Division of Medicaid certified nursing facility ~~ies on all residents regardless of payment source.~~

1. The PAS application must be submitted to the Division of Medicaid within thirty (30) days of the physician's certification.

2. An individual ~~seeking Medicaid eligibility for nursing home placement~~ must receive a PAS score of fifty (50) or greater to be clinically eligible for nursing facility placement.

~~B.~~ 3. Individuals with mental illness and/or ~~mental retardation~~ an intellectual/developmental disability (MI/MR-IDD); determined to require a nursing facility level of care; must receive a Level II evaluation. ~~The Level II determination is~~ to ensure appropriate placement and the provision of necessary specialized services regardless of payment source. ~~if necessary to individuals who have been diagnosed with MI/MR.~~

~~C.~~ B. The PAS Section X- ~~S~~summary, physician's certification, and Level II evaluation, if required, must be submitted by the admitting nursing facility to the Medicaid Regional Office of the individual's county of residence for determining Medicaid eligibility.

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

~~E.~~ C. ~~Private~~ Individuals seeking admission to a Nnursing Ffacility for the Severely Disabled (PNF-SD): ~~Individuals admitting into a PNF-SD~~ must meet the following additional requirements:

1. ~~Have A~~ a ~~minimal~~ diagnosis of spinal cord injury, closed head injury, ~~or~~ long-term ventilator dependency; ~~or another diagnosis~~ ies allowed should be similar or closely related to the severity and involvement of care of those diagnoses, and.

2. ~~Be assigned~~ The MDS classification must be one (1) of the following ~~RUGS III 34~~ MDS RUG-IV 48 Grouper categories: SE1; SE2; SE3; SSC; SSB; SSA. ES3, ES2, HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1, LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1.

3. ~~Any beneficiary whose classification falls into a lower classification category will be considered to require a less specialized level of care than that available through a PNF-SD.~~

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

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

Source: ~~42 USC §§ 1395i-3, 1396r; Miss. Code Ann. § 43-13-121; 42 CFR §§ 435.1010, 483.100-483.106, 483.112-Subpart C; 42 CFR § 483.120; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.-(44)(a)(b); Title XIX of Social Security Act~~

History: Revised to correspond to SPA 15-004(eff. 01/01/2015) eff. 07/01/2015.

Rule 2.9: Resident Assessments Instrument (RAI) -Minimum Data Set (MDS)

~~A. Statutory requirements of Section 1819(b)(3), 1819(e) (5), 1819(f)(6) (B), 1919(e)(5) and 1919(f)(6)(B) of the Social Security Act specify assessment requirements for Skilled Nursing Facilities (SNFs) for Medicare and Nursing Facilities (NFs) for Medicaid which provide nursing, medical and rehabilitative care to Medicare and/or Medicaid beneficiaries. These provisions require Nursing facilities must to conduct complete the Minimum Data Set (MDS) 3.0, including Section S, which is the comprehensive, accurate, standardized and reproducible assessments of each resident's functional capacity using a Resident Assessment Instrument (RAI) that has been specified by the State Division of Medicaid and approved by the Centers of Medicare and Medicaid Services (CMS). In addition, all resident assessment instruments must include the minimum data set for core elements, common definitions and utilization guidelines specified by the Centers for Medicare and Medicaid Services (CMS). These assessments must be completed on all residents regardless of source of payment.~~

~~B. The State is responsible for specifying the RAI for use by facilities in the State and may use its own instrument, provided that it includes the minimum data set and has been approved by CMS. The providers are responsible for using the specific assessment instrument that has been specified by the State. The Minimum Data Set 3.0 (MDS 3.0) including section S, is the RAI specified by the State of Mississippi and approved by CMS.~~

~~C. B. Certifications—Resident assessments are required—The RAI must to:~~

~~1. bBe conducted or coordinated by a registered ~~professional~~nurse who signs and certifies completion of the ~~assessment~~ RAI.~~

~~a) The ~~assessment~~ RAI may be conducted with the ~~appropriate~~ participation of other ~~health professionals~~ appropriate staff members.~~

~~b) Each ~~individual~~ staff members who completes a portion of the ~~assessment~~ RAI must sign and certify as to the accuracy of that portion of the ~~assessment~~ RAI.~~

~~D. 2. Reproduction and Maintenance of Assessments—A copy of all MDS forms within the last fifteen (15) months, including the signatures of the facility staff, attesting to the accuracy~~

~~and completion of the records must be~~ maintained in the resident's active clinical record:-

- ~~a) Both~~ Either in handwritten and/or computer-generated electronic forms, ~~are equally acceptable.~~ consisting of the previous fifteen (15) months of assessments, including the signatures of the facility staff attesting to the accuracy and completion of the assessment, and
- ~~b) At the end of the For a fifteen (15) month period, a~~ After which time resident assessment instrument the RAI the fifteen (15) month period, the RAI information may be ~~thinned from the clinical record and~~ stored in the medical records department; ~~provided that~~ it is easily retrievable.

~~E. Minimum Data Set 3.0 Assessment Schedule~~

- ~~1. 3. The OBRA regulations require nursing homes that are Medicare certified or Medicaid certified or both to conduct~~ Include the following assessments for all residents:
 - a) Admission, comprehensive;
 - b) Annual, comprehensive;
 - c) Significant Change in Status, comprehensive;
 - d) Quarterly;
 - e) Significant Correction to a pPrior e Comprehensive;
 - f) Significant Correction to a pPrior Quarterly, and
 - g) Other Medicare Reasons for Assessment (OMRA), if applicable, and
 - h) Discharge, Death, Transfer or Re-entry assessments.
- ~~4. Be completed per the current CMS Long-Term Care Facility Resident Assessment Instrument User's Manual.~~
- ~~2. Mississippi Division of Medicaid utilizes all assessment types in calculating the facility case mix average used for reimbursement, including Other Medicare Reasons for Assessment (OMRA). Some MDS 3.0 item sets do not contain all items necessary to calculate a RUGS III, 34 grouper payment classification. Use of these assessment combinations may result in a default classification (BC1).~~

~~F. State Specific Discharge Requirements~~

- ~~1. Residents that are out of the facility and not on a paid bed-hold stay must be discharged as a return not anticipated at the time of discharge, even though the facility may anticipate a return.~~

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

Source: ~~42 USC §§ 1395i-3, 1396r; Miss. Code Ann. § 43-13-121; 42 CFR §§ 483.20, 483.315; Social Security Act Section 1819 (b)(3), (e)(5), (f)(6)(B), 1919(e)(5) and (f)(6)(B)~~ Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

Rule 2.10: Case Mix Reimbursement

A. ~~The Mississippi~~ Division of Medicaid utilizes a ~~RUGs-III modified 34~~ RUG-IV 48 grouper model for case mix calculation for reimbursement.

1. Each of the ~~thirty-four~~ forty-eight (34)(48) resident classifications as well as the default classification is assigned case-mix weights. ~~The Mississippi base weights for all M³PI categories.~~

2. The classifications are calculated electronically at ~~the Division of Medicaid~~ using the MDS assessment data and the M³PI RUG-IV calculation program.

B. Clinical documentation ~~that furnishes a picture of the resident's care needs and response to treatment is an accepted standard of practice, is part of good resident care, and staff care planning. It is required that information contained must be maintained~~ in the clinical record which supports the MDS 3.0 assessment. ~~For payment purposes, documentation and must substantiate~~ the resources and services needed to provide care to the resident. ~~Documentation requirements for case mix reimbursement can be found on the agency's website.~~

C. Documentation for case-mix reimbursement must adhere to the Division of Medicaid's Supportive Documentation Requirements.

Source: ~~Miss. Code Ann. § 43-13-121; 42 CFR § 483.75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.~~

History: Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

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 ~~14-01915-004~~.

| History: Revised to correspond with SPA ~~14-01915-004~~ (eff. 01/01/2015) eff. 01/02/2015.

Rule 2.16: Therapy Services

- H. All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability rules, is obligated to cover these services.
- I. Prior authorization/pre-certification of certain physical, occupation, and speech-language pathology services is required by the Division of Medicaid. Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for Medicaid. Failure to obtain prior authorization will result in denial of payment to billing providers.
- J. The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of procedure codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by Medicaid.

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

L. Private Nursing Facility for the Severely Disabled - ~~This rules~~ Miss. Admin. Code Part 207, Rule 2.16 is not applicable to a ~~Private~~ Nursing Facility for the Severely Disabled (~~P~~NFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.

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

N. Dually Eligible Residents - Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid dual eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

| Source: Miss. Code Ann. § 43-13-121, SPA 15-004.