

Title 23: 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.]

15. Non-emergency transportation.

- a) The facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.
- b) The facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - 1) The facility arranges the transportation, and
 - 2) Pays the NET provider directly.

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. 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 effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]
 9. Emergency transportation described in Miss. Admin. Code Part 201.
- E. Prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity 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 Nursing Facility for the Severely Disabled (NF-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 an individual eligible for Medicaid benefits.

Source: 42 C.F.R. § 483.10; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 01/01/2017; Removed Miss. Admin. Code Part 207, Rule 2.6.D.6 (retroactively eff. 01/02/2015) eff. 11/01/2016; Revised eff. 01/02/2015.

Rule 2.11: Resident Funds

A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.
2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems of accounting for resident funds.
3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.

- B. The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:
1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.
 2. There is no obligation for the resident to deposit funds with the facility.
 3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:
 - a) The resident's right to receive, retain and manage his/her personal funds or have this done by a legal guardian, if any,
 - b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,
 - c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and
 - d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested by the resident.
 4. Any charge for this service is included in the facility's basic rate.
 5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.
 6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.
 7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.
- C. Individual Records - The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can

determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.

D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading “Individual Records” of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:
 - a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,
 - b) Personal comfort items, including tobacco, novelties, and candy,
 - c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,
 - d) Personal clothing,
 - e) Personal reading material,
 - f) Gifts purchased on behalf of the resident,
 - g) Flowers and plants for the resident’s room,
 - h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,
 - i) Private sitters or aides,
 - j) Private room provided that a private room is not medically necessary, like isolation for infection control,
 - k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and
 - l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.
2. Unacceptable charges to resident funds include the following categories and examples:
 - a) Any charge not authorized and documented.

- b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.
 - c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.
 - d) Transportation.
 - e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.
 - f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.
 - g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.
 - h) Any item or service as a condition of admission or continued stay.
- E. Resident's Access to Financial Records and Quarterly Statements - The facility must provide each resident, responsible party, or legal representative of each resident, reasonable access to the resident's financial records. In addition, the facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.
- F. Commingling of Residents' Funds - The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility. The facility may not open any additional accounts within the trust fund account, such as donation accounts, miscellaneous accounts, or the like. Only funds of the facility's residents may be maintained as part of the resident trust fund account.
- G. Deposit of Resident Funds into an Interest or Non-Interest Bearing Account

1. The facility must deposit any resident's personal funds in excess of fifty dollars (\$50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:
 - a) Prorated to each resident's account on an actual interest-earned basis; or
 - b) Prorated to each resident's account on the basis of its end-of-quarter balance.
2. The facility must maintain a resident's personal funds that do not exceed fifty dollars (\$50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars (\$50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.
3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars (\$50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

H. Access to Funds

1. Funds held in the facility - The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturdays and Sundays. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding and accounting and that are maintained in a petty cash fund.
2. Funds held outside the facility - For a resident's personal funds that the facility has received and that are deposited in an account outside the facility, the facility, upon request, must, within five (5) business days, return to the resident, the legal guardian, or the representative payee, all or any part of those funds.

I. Accounting on Change of Ownership

1. Duties of new owner - Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.
2. Duties to resident - The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.
3. Rights of resident - In the event of a disagreement with the accounting provided by the

facility, the resident retains all rights and remedies provided under state law.

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

J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:
 - a) Resident's next of kin,
 - b) Resident's representative, or
 - c) Clerk of the probate court of the county in which the resident died.
2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility
 - a) Any resident who dies intestate and leaves no known heirs and has no representative party shall have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner.
 - b) The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased person and his/her last known address prior to entering the nursing facility; the name and last known address of each person who may possess an interest in such funds; and any other information which the State Treasurer prescribes by regulation as necessary.
 - c) In the event a party with a claim to the deceased resident's funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer. All reports of unclaimed funds filed by the facility prior to November 1st of each year will be included in a list published by the State Treasurer within one hundred twenty (120) days following November 1st. Claimants have ninety (90) days from the date of publishing to file for such funds. After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.

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

K. Surety Bond

1. The facility must purchase a surety bond or otherwise provide assurance as to the security of all personal funds of residents deposited with the facility. A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (the residents of the trust fund), wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds; that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.
2. Unlike other types of insurance, the surety bond protects the obligee (the residents of the trust fund), not the principal, from loss. The surety bond differs from a fidelity bond, also called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.
3. The surety bond is the commitment of the facility to meet the standard of conduct. The facility assumes the responsibility to compensate the obligee (the residents of the trust fund), for the amount of the loss up to the entire amount of the surety bond. Therefore, the surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit. A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.
4. Reasonable alternatives to a surety bond must:
 - a) Designate the obligee, (the resident, individually, or in aggregate), who can collect in case of a loss,
 - b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and
 - c) Be managed by a third party unrelated in any way to the facility or its management.
5. The facility cannot be named as an obligee. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

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

L. Resident Incapable of Managing Funds

1. If a resident is incapable of managing personal funds and has no representative, the facility must refer the resident to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.
2. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.
3. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source, like a Social Security check, cannot be commingled with facility funds prior to those funds being transferred to the trust fund account.

M. Notice of Resource Limits, Medicaid or SSI

1. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars (\$200) less than the SSI resource limit and five hundred dollars (\$500), less than the Medicaid resource limit, to remain eligible for Medicaid long term care benefits. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the applicable resource limits, the resident may lose eligibility for Medicaid or SSI.
2. The facility must issue written notification to the Medicaid regional office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

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

1. Basic Rate - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the

resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.

2. Book Balance - The total balance of all resident trust funds and petty cash held according to the accounting ledger.
3. Census - The total number of residents in a facility.
4. Compliance - The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) requires a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."
5. DOM - Division of Medicaid.
6. Fiduciary - A fiduciary has rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting in this capacity.
7. Fiscal Agent - The agency, under contract with the Division of Medicaid, for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.
8. GAAP - Generally Accepted Accounting Principles. GAAP for resident trust funds means that the facility employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance. Proper bookkeeping techniques may, include a computer software package for the accounting of resident trust funds, an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained.
9. Intestate - Without a valid will at the time of death.
10. Legal Guardian - A legal guardian, or conservator, is a person or persons appointed by

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

11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month for room and board.
12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.
13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.
14. Per Diem Rate - Refer to "Basic Rate."
15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.
16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:
 - a) Documentation that the exception has been corrected,
 - b) The measures that have been put in place to ensure that the exception will not be repeated, and
 - c) The measures that have been put in place to monitor the continued effectiveness of the changes.
17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.
19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.
20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two(2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.
21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).
22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.
23. Testate - Having a valid will at the time of death.
24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.
25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 447.15, 483.10; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

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 for all items and services required to meet the needs of a resident according to the comprehensive functional assessment and the individual program plan.
- 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, Veteran's Administration (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) is 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.

15. Non-emergency transportation.

- a) The facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.
- b) The facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - 1) The facility arranges the transportation, and
 - 2) Pays the NET provider directly.

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

6. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015, and/or
 7. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 3.10 for definition and coverage criteria]
 8. Emergency transportation described in Miss. Admin. Code Part 201.
- 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.
 4. Notify the resident and the resident's guardian or legal representative of a transfer or discharge in an easily understood written notice.
 - a) The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:
 - 1) The safety or health of the individuals in the facility would be endangered,
 - 2) The resident no longer requires the level of care provided by the facility,

- 3) An immediate transfer or discharge is required by the resident's urgent medical needs, or
 - 4) The resident has not resided in the facility for thirty (30) calendar days.
- b) The notice must include the following information:
- 1) The reason for the transfer or discharge,
 - 2) The effective date of the transfer or discharge,
 - 3) The location to which the resident is being transferred or discharged,
 - 4) A statement that the resident has the right to appeal the action to the appropriate state authorities,
 - 5) The name, address and telephone number of the State long-term care ombudsman,
 - 6) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals, and
 - 7) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.
5. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.
6. Provide sufficient preparation and orientation to residents to ensure safe and orderly transfers or discharges.
- 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 an individual eligible for Medicaid benefits.

I. Refer to Miss. Admin. Code Part 224, Rule 1.4 for coverage of immunizations.

Source: 42 C.F.R. § 483.12; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 01/01/2017; Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015) eff. 11/01/2016. Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015) eff. 11/01/2016; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016. Revised eff. 01/02/2015.

Rule 3.7: Resident Funds

- A. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds.
1. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility.
 2. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.
- B. Resident fund accounts are reviewed to ensure the facility's compliance and to assist facilities in developing acceptable systems of accounting for resident funds. Penalties may be assessed on any licensed ICF/IID that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with federal regulations.
- C. The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:
1. All services provided by the facility, distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.
 2. There is no obligation for the resident to deposit funds with the facility.
 3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:
 - a) The resident's right to receive, retain, and manage his/her personal funds or have this done by a legal guardian, if any,
 - b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which

he/she may be entitled,

- c) The resident's right to designate, in writing, another person to act for the purpose of managing his or her personal funds except when Rule.7, C.2 of this section applies, and
 - d) The resident's right to require the facility to hold, safeguard and account for such personal funds under a system established and maintained by the facility requested by the resident.
4. Any charge for this service is included in the facility's basic rate.
 5. The facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.
 6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.
 7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.
- D. The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which have been given for holding, safeguarding, and accounting.
1. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner.
 2. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the facility to employ proper bookkeeping techniques by which it can determine upon request all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.
- E. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation as specified under the heading "Individual Records" of this section, is provided. The facility must notify the resident in advance that there will be a charge for non-Medicaid covered items and services, such as:
1. Personal communication/entertainment items and services, including telephone, television, radio, and computer.
 2. Personal comfort items, including tobacco, novelties, and candy.

3. Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services.
 4. Personal clothing.
 5. Personal reading material.
 6. Gifts purchased on behalf of the resident.
 7. Flowers and plants for the resident's room.
 8. Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate.
 9. Private sitters or aides.
 10. Private room, provided a private room is not medically necessary, including isolation for infection control.
 11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the facility.
 12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.
- F. Unacceptable charges to resident funds include:
1. Any charge not authorized and documented.
 2. Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.
 3. Medically necessary items and services reimbursed as part of the Medicaid per diem rate.
 - a) Any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity.
 - b) Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.
 4. Transportation.

5. Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by an ICF/IID for ICF/IID costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.
 6. Loans or collateral for loans to anyone, including the facility, and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.
 7. Transfers or gifts of money not authorized by the resident including when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.
 8. Any item or service as a condition of admission or continued stay.
- G. The facility must provide each resident, or a legal representative of the resident, reasonable access to his/her own financial records.
1. The facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative.
 2. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.
- H. The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility.
1. The facility may not open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.
 2. Only funds of the facility's residents may be maintained as part of the resident trust fund account.
- I. The facility must deposit any resident's personal funds in excess of fifty (\$50.00) dollars into an interest-bearing account(s) separate from any of the facility's operating accounts.
1. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:
 - a) Prorated to each resident's account on an actual interest-earned basis; or
 - b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars (\$50.00) in a non-interest bearing account, an interest bearing account or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars (\$50.00) or less in a pooled account with all other resident's funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately. The facility must neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars (\$50.00). A facility must not establish policy that conflicts with the absolute right of residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.
- J. The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturday and Sunday. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding, and accounting in a petty cash fund.
 - K. For a resident's personal funds that the facility has received and are deposited in an account outside the facility, the facility, upon request, must within five (5) business days return to the resident, the legal guardian, or the representative payee, any or all of those funds.
 - L. Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written account, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles, of all resident funds being transferred and obtain a written receipt for those funds from the new owner.
 1. The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.
 2. In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.
 3. An ICF/IID cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where a Medicaid beneficiary has no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.
 - M. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.
 1. There is no minimum dollar amount that would relieve the facility of this fiduciary responsibility.
 2. If the deceased or discharged resident's estate has no executor or administrator, the

facility must convey the resident's funds and provide a final accounting to the:

- a) Resident's next of kin,
 - b) Resident's representative; or
 - c) Clerk of the probate court of the county in which the resident died.
3. The Disposition of funds for deceased residents who die intestate within a long term care facility is as follows:
- a) Any beneficiary who dies in the State of Mississippi and leaves no known heirs must have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner:
 - 1) The report of such funds shall be verified, shall be on a form prescribed or approved by the State Treasurer and shall include:
 - (a) The name of the deceased person and his/her last known address prior to entering the ICF/IID,
 - (b) The name and last known address of each person who may possess an interest in such funds, and
 - (c) Any other information which the State Treasurer prescribes by regulation as necessary.
 - 2) In the event a party with a claim to the deceased residents' funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer.
 - (a) All reports of unclaimed funds filed by the facility prior to November first (1st) of each year will be included in a list published by the State Treasurer within one hundred twenty-one (120) days following November first (1st).
 - (b) Claimants have ninety (90) days from the date of publishing to file for such funds.
 - (c) After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.
4. Disposition of funds for deceased residents who die intestate in a state institution is as follows:

- a) Part 207, Chapter 3, Rule 3.7. M. 3, shall not be applicable for residents of any state institution.
 - b) The funds of any resident in a state institution who dies intestate and without known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.
- N. The facility must purchase a surety bond or otherwise provide assurance as to all personal funds of residents deposited with the facility.
- 1. The Division of Medicaid defines a surety bond as an agreement between the principal, the or facility, the surety, the insurance company, and the obligee, or the residents of the trust fund, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds, that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.
 - 2. Unlike other types of insurance, the surety bond protects the obligee, or the residents of the trust fund, not the principal, from loss. The surety bond differs from a fidelity bond, sometimes called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.
 - 3. The surety bond is the commitment of the facility to meet the standard of conduct.
 - a) The facility assumes the responsibility to compensate the obligee, or the residents of the trust fund, for the amount of the loss up to the entire amount of the surety bond.
 - b) The surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit.
 - c) A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.
 - 4. Any reasonable alternative to a surety bond must:
 - a) Designate the obligee, or the residents, individually or in aggregate, who can collect in case of a loss,
 - b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and
 - c) Be managed by a third party unrelated in any way to the facility or its management.

5. The facility cannot be named as an obligee.
 - a) Self-insurance is not an acceptable alternative to a surety bond. Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.
 - b) If a corporation has a surety bond that covers all of its facilities, the corporation surety bond must be sufficient to ensure that all of the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.
- O. If a resident is incapable of managing personal funds and has no representative, the facility must refer the patient to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.
 1. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.
 2. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source cannot be commingled with facility funds prior to those funds being transferred to the trust account.
- P. The facility must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the facility by the resident. The property record must be available to the resident.
- Q. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars (\$200.00) less than the SSI resource limit and five hundred dollars (\$500.00) less than the Medicaid resource limit to remain eligible for Medicaid long term care benefits.
 1. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other non-exempt resources, reaches the applicable resource limits; the resident may lose eligibility for such medical assistance or SSI.
 2. The facility must issue written notification to the Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.

R. The Division of Medicaid defines:

1. The basic rate as the standard or per diem rate Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility as well as the items and services not included in the basic rate; and the amount of such charges that may be charged to the resident.
2. The book balance as the total balance of all resident trust funds and petty cash held according to the accounting ledger.
3. Census as the total number of residents in a facility.
4. Compliance of The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) as requiring a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this and follows the policies and procedures and this manual is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."
5. Exception as any item or area selected for review that does not meet the regulatory standards.
6. Fiduciary as having rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting.
7. Finding and exception are used interchangeable for resident trust fund review purposes.
8. Fiscal Agent as the agency under contract with the Division of Medicaid for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.
9. Generally Accepted Accounting Principles (GAAP), for resident trust funds, as the facility's proper bookkeeping techniques by which it can determine, upon request, all

deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance.

10. Intestate as without a valid will at the time of death.
11. Legal guardian, or conservator, as a person(s) by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.
12. Medicaid income as the maximum liability that the resident owes to the facility each month for room and board.
13. Medically necessary items and services as those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary and therefore justifiable as an expenditure of the resident's personal funds.
14. Obligee as the residents of the trust fund, the party to whom the facility is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the facility to hold, safeguard, manage, and account for the residents' funds.
15. Per Diem Rate - Refer to Rule 3.7.R.1.
16. Personal needs allowance (PNA) as the amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.
17. Plan of Correction as an acceptable plan of correction that must address each exception noted in the findings letter and include the following:
 - a) Documentation that the exception has been corrected;
 - b) Measures that have been put in place to ensure that the exception will not be repeated;
 - c) Measures that have been put in place to monitor the continued effectiveness of the changes.
18. Reconciliation as at all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be

accounted for by documented outstanding credits and debits or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.

19. Representative payee as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.
20. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.
21. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.
22. Responsible party for resident trust fund purposes, as a sponsor or resident's representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization, to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation such as a receipt or invoice.
23. State institutions as facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.
24. Testate as having a valid will at the time of death.
25. Trial balance as a listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.
26. Written authorization as authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific funds transaction for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 431.53, 483.10; Miss. Code Ann. § 43-13-121.

History: Revised eff. 01/01/2017.

Chapter 4: Psychiatric Residential Treatment Facility (PRTF)

Rule 4.6: Reimbursement

- A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.
1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.
 2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars (\$50.00) per day and may result in the termination of the provider agreement.
- B. The Division of Medicaid uses a prospective method of reimbursement.
1. The rates are determined from cost report data.
 2. Standard rates are determined annually with an effective date of January first (1st).
 3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.
 4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.
 5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.
 - a) These revisions may result from amended cost reports, field visit reviews, or other corrections.
 - b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.
 - c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.
- C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the intellectually disabled, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.

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

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.
 - a) The cost report must be based on the documentation maintained by the facility.
 - b) All non-governmental facilities must file cost reports based on the accrual method of accounting.
 - c) Governmental facilities have the option to use the cash basis of accounting for reporting.
2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.
3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.
 - a) These records must be made available as requested by the Division of Medicaid.
 - b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

1. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan.
2. While the facility may set their basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate.

3. Any items and services available in the facility that are not covered under Title XVIII or the facility's basic per diem rate or charge must be available and priced identically for all residents in the facility.
- F. Medicaid allows payment for the date of admission to the PRTF. Medicaid does not cover the date of discharge from the facility. A Medicaid-eligible beneficiary cannot be charged for the date of discharge. If a beneficiary is discharged on the date of admission, the day is covered as the date of admission.
- G. Private room coverage by Medicaid is as follows:
1. The overall average cost per day determined from the cost report includes the cost of private rooms.
 2. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in the reimbursement rate and no extra charge can be made to the beneficiary, his/her family or the Medicaid program.
 3. Medicaid reimbursement is considered as payment in full for the beneficiary.
- H. The following rules apply to hospital leave:
1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.
 2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.
 3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.
- I. If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the twenty-four (24) hours, the child/adolescent must go through a readmission process.
- J. The following rules apply to therapeutic leave:
1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.
 2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.

3. Each therapeutic leave day taken each month must be reported on the billing mechanism.
4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

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

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.
2. Each facility is required to maintain leave records and indicate periods of therapeutic leave days.
3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.
4. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

L. The PRTF must provide non-emergency transportation.

1. The PRTF must document the cost of providing non-emergency transportation services on the cost report.
2. The PRTF cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - a) The facility arranges the transportation, and
 - b) Pays the NET provider directly.

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

History: Added Miss. Admin. Code Rule 4.6.L. eff. 01/01/2017.

Title 23: 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.]

15. Non-emergency transportation.

- a) The facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.
- b) The facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - 1) The facility arranges the transportation, and
 - 2) Pays the NET provider directly.

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. 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 effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]

9. Emergency transportation described in Miss. Admin. Code Part 201.

- E. Prior authorization from ~~the~~ a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity 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 Nursing Facility for the Severely Disabled (NF-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 an ~~an~~ ~~card carrying~~ Medicaid beneficiary individual eligible for Medicaid benefits.

Source: 42 C.F.R. § 483.10; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 01/01/2017; Removed Miss. Admin. Code Part 207, Rule 2.6.D.6 (retroactively eff. 01/02/2015) eff. 11/01/2016; Revised eff. 01/02/2015.

Rule 2.11: Resident Funds

A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.
2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems of accounting for resident funds.
3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.

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

1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.
2. There is no obligation for the resident to deposit funds with the facility.
3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:
 - a) The resident's right to receive, retain and manage his/her personal funds or have this done by a legal guardian, if any,
 - b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,
 - c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and
 - d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested by the resident.
4. Any charge for this service is included in the facility's basic rate.
5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for, only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.
6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.
7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.

C. Individual Records - The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can

determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.

D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading “Individual Records” of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:
 - a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,
 - b) Personal comfort items, including tobacco, novelties, and candy,
 - c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,
 - d) Personal clothing,
 - e) Personal reading material,
 - f) Gifts purchased on behalf of the resident,
 - g) Flowers and plants for the resident’s room,
 - h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,
 - i) Private sitters or aides,
 - j) Private room provided that a private room is not medically necessary, like isolation for infection control,
 - k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and
 - l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.
2. Unacceptable charges to resident funds include the following categories and examples:
 - a) Any charge not authorized and documented.

- b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.
- c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.
- ~~d) Medical transportation. All transportation for nursing facility residents, whether emergency or non-emergency must be arranged by nursing facility staff. Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Transportation may also be arranged using nursing facility vehicles, or by utilizing outside resources. Costs for providing this level of service are to be reported by the nursing facility on their cost reports and are reimbursed through the facility per diem. The nursing facility may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the nursing facility may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to Medicaid for direct reimbursement. If a resident is transferred from a nursing facility to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the nursing facility, transportation for these residents should be arranged by the hospital. If there has not been a final discharge from the nursing facility and the resident had a hospital stay of less than fifteen (15) days, transportation back to the nursing facility must be arranged by the nursing facility staff.~~ Transportation.
- e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.
- f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.
- g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.
- h) Any item or service as a condition of admission or continued stay.

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

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

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

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

1. The facility must deposit any resident's personal funds in excess of fifty dollars (\$50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:
 - a) Prorated to each resident's account on an actual interest-earned basis; or
 - b) Prorated to each resident's account on the basis of its end-of-quarter balance.
2. The facility must maintain a resident's personal funds that do not exceed fifty dollars (\$50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars (\$50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.
3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars (\$50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

H. Access to Funds

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

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

I. Accounting on Change of Ownership

1. Duties of new owner - Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written accounting of all resident funds being transferred and obtain a written receipt for those funds from the new owner.
2. Duties to resident - The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.
3. Rights of resident - In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.
4. Sponsor signatures for fiscal responsibility - A nursing facility cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where Medicaid beneficiaries have no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.

J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:
 - a) Resident's next of kin,
 - b) Resident's representative, or
 - c) Clerk of the probate court of the county in which the resident died.
2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility
 - a) Any resident who dies intestate and leaves no known heirs and has no representative party shall have his final accounting of funds and conveyance of those funds sent to the Mississippi State Treasury Department within thirty (30) days of the resident's death. Such funds should be sent along with the report to the State Treasurer in the following manner.

- b) The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased person and his/her last known address prior to entering the nursing facility; the name and last known address of each person who may possess an interest in such funds; and any other information which the State Treasurer prescribes by regulation as necessary.
 - c) In the event a party with a claim to the deceased resident's funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer. All reports of unclaimed funds filed by the facility prior to November 1st of each year will be included in a list published by the State Treasurer within one hundred twenty (120) days following November 1st. Claimants have ninety (90) days from the date of publishing to file for such funds. After the ninety (90) day filing limit, all unclaimed funds are placed in an account by the State Treasurer to be used for Medicaid purposes.
3. Disposition of Funds for Deceased Resident Who Dies Intestate in a State Institution - Section A above shall not be applicable for residents of any state institution. The funds of any resident in a state institution who dies intestate and without any known heirs may be deposited in the facility's operational account, after a period of one (1) year from the date of death.

K. Surety Bond

1. The facility must purchase a surety bond or otherwise provide assurance as to the security of all personal funds of residents deposited with the facility. A surety bond is an agreement between the principal (the facility), the surety (the insurance company), and the obligee (the residents of the trust fund), wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds; that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.
2. Unlike other types of insurance, the surety bond protects the obligee (the residents of the trust fund), not the principal, from loss. The surety bond differs from a fidelity bond, also called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.
3. The surety bond is the commitment of the facility to meet the standard of conduct. The facility assumes the responsibility to compensate the obligee (the residents of the trust fund), for the amount of the loss up to the entire amount of the surety bond. Therefore, the surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit. A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at

the facility and available for inspection.

4. Reasonable alternatives to a surety bond must:
 - a) Designate the obligee, (the resident, individually, or in aggregate), who can collect in case of a loss,
 - b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and
 - c) Be managed by a third party unrelated in any way to the facility or its management.
5. The facility cannot be named as an obligee. Self-insurance is not an acceptable alternative to a surety bond. Likewise, funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.
6. If a corporation has a surety bond that covers all of its facilities, the corporation's surety bond must be sufficient to ensure that all of the residents in the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

L. Resident Incapable of Managing Funds

1. If a resident is incapable of managing personal funds and has no representative, the facility must refer the resident to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.
2. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA office and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.
3. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source, like a Social Security check, cannot be commingled with facility funds prior to those funds being transferred to the trust fund account.

M. Notice of Resource Limits, Medicaid or SSI

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

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

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

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

1. **Basic Rate** - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.
2. **Book Balance** - The total balance of all resident trust funds and petty cash held according to the accounting ledger.
3. **Census** - The total number of residents in a facility.
4. **Compliance** - —The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) requires a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."
5. **DOM** - Division of Medicaid.
6. **Fiduciary** - A fiduciary has rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting in this capacity.
7. **Fiscal Agent** - The agency, under contract with the Division of Medicaid, for the purpose

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

8. GAAP - Generally Accepted Accounting Principles. GAAP for resident trust funds means that the facility employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance. Proper bookkeeping techniques may, include a computer software package for the accounting of resident trust funds, an individual ledger card, ledger sheet or equivalent established for each resident on which only those transactions involving the resident's personal funds are recorded and maintained.
9. Intestate - Without a valid will at the time of death.
10. Legal Guardian - A legal guardian, or conservator, is a person or persons appointed by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.
11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month for room and board.
12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.
13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.
14. Per Diem Rate - Refer to "Basic Rate."
15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.
16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:

- a) Documentation that the exception has been corrected,
 - b) The measures that have been put in place to ensure that the exception will not be repeated, and
 - c) The measures that have been put in place to monitor the continued effectiveness of the changes.
17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.
 18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.
 19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.
 20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two(2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.
 21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).
 22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeith Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.

23. Testate - Having a valid will at the time of death.
24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.
25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: ~~42 U.S.C. § 1396r; 42 C.F.R. §§ 447.15, 483.10; Miss. Code Ann. § 43-13-121; 42 CFR § 483; 42 CFR 447.15; 42 CFR 483.10; Social Security Act 1919 (c)(16); 1919 (5)(A)(i); 1919 (6)~~

History: Revised eff. 01/01/2017.

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 for all items and services required to meet the needs of a resident according to the comprehensive functional assessment and the individual program plan.
- 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, Veteran's Administration (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) is 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.

15. Non-emergency transportation.

- a) The facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.
- b) The facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - 1) The facility arranges the transportation, and

2) Pays the NET provider directly.

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. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,
6. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015, and/or
7. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 3.10 for definition and coverage criteria]
8. Emergency transportation described in Miss. Admin. Code Part 201.

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.
4. Notify the resident and the resident's guardian or legal representative of a transfer or discharge in an easily understood written notice.
 - a) The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:
 - 1) The safety or health of the individuals in the facility would be endangered,
 - 2) The resident no longer requires the level of care provided by the facility,
 - 3) An immediate transfer or discharge is required by the resident's urgent medical needs, or
 - 4) The resident has not resided in the facility for thirty (30) calendar days.
 - b) The notice must include the following information:
 - 1) The reason for the transfer or discharge,
 - 2) The effective date of the transfer or discharge,
 - 3) The location to which the resident is being transferred or discharged,
 - 4) A statement that the resident has the right to appeal the action to the appropriate state authorities,
 - 5) The name, address and telephone number of the State long-term care ombudsman,
 - 6) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals, and
 - 7) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.
5. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

6. Provide sufficient preparation and orientation to residents to ensure safe and orderly transfers or discharges.
- 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 ~~an card-carrying Medicaid beneficiary individual eligible for Medicaid benefits.~~
- I. Refer to Miss. Admin. Code Part 224, Rule 1.4 for coverage of immunizations.

Source: 42 C.F.R. § 483.12; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 01/01/2017; Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015) eff. 11/01/2016. -Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015) eff. 11/01/2016; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016. Revised eff. 01/02/2015.

Rule 3.7: Resident Funds

- A. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds.
1. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility.
 2. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.
- B. Resident fund accounts are reviewed to ensure the facility's compliance and to assist facilities in developing acceptable systems of accounting for resident funds. Penalties may be assessed on any licensed ICF/~~MR-IID~~ that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with federal regulations.

- C. The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:
1. All services provided by the facility, distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.
 2. There is no obligation for the resident to deposit funds with the facility.
 3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:
 - a) The resident's right to receive, retain, and manage his/her personal funds or have this done by a legal guardian, if any,
 - b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,
 - c) The resident's right to designate, in writing, another person to act for the purpose of managing his or her personal funds except when Rule.7, C.2 of this section applies, and
 - d) The resident's right to require the facility to hold, safeguard and account for such personal funds under a system established and maintained by the facility requested by the resident.
 4. Any charge for this service is included in the facility's basic rate.
 5. The facility is permitted to accept a resident's funds to hold, safeguard and account for, only upon written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.
 6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.
 7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.
- D. The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which have been given for holding, safeguarding, and accounting.

1. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner.
 2. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the facility to employ proper bookkeeping techniques by which it can determine upon request all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds.
- E. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation as specified under the heading "Individual Records" of this section, is provided. The facility must notify the resident in advance that there will be a charge for non-Medicaid covered items and services, such as:
1. Personal communication/entertainment items and services, including telephone, television, radio, and computer.
 2. Personal comfort items, including tobacco, novelties, and candy.
 3. Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services.
 4. Personal clothing.
 5. Personal reading material.
 6. Gifts purchased on behalf of the resident.
 7. Flowers and plants for the resident's room.
 8. Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate.
 9. Private sitters or aides.
 10. Private room, provided a private room is not medically necessary, including isolation for infection control.
 11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the facility.
 12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.

F. Unacceptable charges to resident funds include:

1. Any charge not authorized and documented.
2. Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.
3. Medically necessary items and services reimbursed as part of the Medicaid per diem rate.
 - a) Any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity.
 - b) Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.
4. ~~Medical T~~transportation.
 - a) ~~All transportation for ICF/MR residents, whether emergency or non-emergency, must be arranged by ICF/MR staff.~~
 - b) ~~Transportation that does not qualify for benefits through the Ambulance Program must be arranged through a family member, if available. Refer to Part 201, Chapter 1.~~
 - c) ~~Transportation may also be arranged using ICF/MR vehicles or by utilizing outside resources. Costs for providing this level of service are to be reported by the ICF/MR on their cost reports and are reimbursed through the facility per diem. The ICF/MR may not bill the resident or family for any means of transportation. For cases requiring transportation other than by ambulance to and from dialysis, the ICF/MR may make referrals to the Non-Emergency Transportation (NET) Program. The NET provider must, in these cases, submit claims to the Division of Medicaid for direct reimbursement. Refer to Part 201, Chapter 2.~~
 - d) ~~If a resident is transferred from an ICF/MR to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the ICF/MR, transportation for these residents should be arranged by the hospital. If there has not been a final discharge from the ICF/MR and the resident had a hospital stay of less than fifteen (15) days, transportation back to the ICF/MR must be arranged by the ICF/MR staff.~~
5. Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by an ICF/MR IID for ICF/IIDMR costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.

6. Loans or collateral for loans to anyone, including the facility, and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a negative balance is in effect borrowing money from the other residents.
 7. Transfers or gifts of money not authorized by the resident including when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.
 8. Any item or service as a condition of admission or continued stay.
- G. The facility must provide each resident, or a legal representative of the resident, reasonable access to his/her own financial records.
1. The facility must provide a written statement, at least quarterly, to each resident, responsible party, or legal representative.
 2. The quarterly statement must reflect any resident funds which the facility has deposited in an interest bearing or a non-interest bearing account, as well as any resident funds held by the facility in a petty cash account.
- H. The facility must keep any funds received from a resident for holding, safeguarding and accounting separate from the facility's funds and from the funds of any person other than another resident in that facility.
1. The facility may not open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.
 2. Only funds of the facility's residents may be maintained as part of the resident trust fund account.
- I. The facility must deposit any resident's personal funds in excess of fifty (\$50.00) dollars into an interest-bearing account(s) separate from any of the facility's operating accounts.
1. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:
 - a) Prorated to each resident's account on an actual interest-earned basis; or
 - b) Prorated to each resident's account on the basis of its end-of-quarter balance.
 2. The facility must maintain a resident's personal funds that do not exceed fifty dollars (\$50.00) in a non-interest bearing account, an interest bearing account or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars (\$50.00) or less in a pooled account with all other resident's funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately. The facility must neither limit nor restrict any

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

- J. The residents must have access to funds daily during normal business hours and for some reasonable time of at least two (2) hours on Saturday and Sunday. The facility must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, the legal guardian or the representative payee all funds remaining that the facility has received for holding, safeguarding, and accounting in a petty cash fund.
- K. For a resident's personal funds that the facility has received and are deposited in an account outside the facility, the facility, upon request, must within five (5) business days return to the resident, the legal guardian, or the representative payee, any or all of those funds.
- L. Upon sale of the facility or other transfer of ownership, the facility must provide the new owner with a written account, prepared by a Certified Public Accountant in accordance with the American Institute of Certified Public Accountants' Generally Accepted Accounting Principles, of all resident funds being transferred and obtain a written receipt for those funds from the new owner.
 - 1. The facility must give each resident or representative a written accounting of any personal funds held by the facility before any transfer of ownership occurs.
 - 2. In the event of a disagreement with the accounting provided by the facility, the resident retains all rights and remedies provided under state law.
 - 3. An ICF/~~MR~~-IID cannot require a family member or other individual to sign a financial responsibility statement for a Medicaid resident. In instances where a Medicaid beneficiary has no family member or individual available for such signatures, it is clearly discriminatory for a Medicaid provider to refuse admission to the resident.
- M. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate.
 - 1. There is no minimum dollar amount that would relieve the facility of this fiduciary responsibility.
 - 2. If the deceased or discharged resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:
 - a) Resident's next of kin,
 - b) Resident's representative; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The Division of Medicaid defines a surety bond as an agreement between the principal, the or facility, the surety, the insurance company, and the obligee, or the residents of the trust fund, wherein the facility and the insurance company agree to compensate the resident for any loss of residents' funds that the facility holds, safeguards, manages and for which the facility accounts. The purpose of the surety bond is to guarantee that the facility will pay the resident for losses occurring for any failure by the facility to hold, safeguard, manage, and account for the residents' funds, that is, losses occurring as a result of acts or errors of negligence, incompetence or dishonesty.
2. Unlike other types of insurance, the surety bond protects the obligee, or the residents of the trust fund, not the principal, from loss. The surety bond differs from a fidelity bond, sometimes called employee dishonesty insurance or a crime bond, which covers no acts or errors unless they involve dishonesty.
3. The surety bond is the commitment of the facility to meet the standard of conduct.
 - a) The facility assumes the responsibility to compensate the obligee, or the residents of the trust fund, for the amount of the loss up to the entire amount of the surety bond.
 - b) The surety bond coverage must be for an amount equal to or greater than the highest daily balance for all resident funds held on deposit.
 - c) A copy of the surety bond and evidence of the payment of the premium for the appropriate bond coverage amount must be kept at the facility and available for inspection.
4. Any reasonable alternative to a surety bond must:
 - a) Designate the obligee, or the residents, individually or in aggregate, who can collect in case of a loss,
 - b) Specify that the obligee may collect due to any failure by the facility, whether by commission, bankruptcy, or omission, to hold, safeguard, manage, and account for the residents' funds, and
 - c) Be managed by a third party unrelated in any way to the facility or its management.
5. The facility cannot be named as an obligee.
 - a) Self-insurance is not an acceptable alternative to a surety bond. Funds deposited in bank accounts protected by the Federal Deposit Insurance Corporation (FDIC), or similar entity, are not acceptable alternatives.

- b) If a corporation has a surety bond that covers all of its facilities, the corporation surety bond must be sufficient to ensure that all of the corporation's facilities are covered against any losses due to acts or errors by the corporation, its agents, or any of its facilities. The intent is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.
- O. If a resident is incapable of managing personal funds and has no representative, the facility must refer the patient to the local office of the Social Security Administration (SSA) and request that a representative payee be appointed.
- 1. In the time period between notification to the appropriate agencies, institution of formal guardianship proceedings, and notification to the local SSA and the actual appointment of a guardian or representative payee, the facility must serve as temporary representative payee for the resident.
 - 2. In order to safeguard and maintain an accurate accounting of the resident's account, funds received on behalf of the resident must initially be deposited in the trust fund account before they can be disbursed for any expenses. A resident's monthly income source cannot be commingled with facility funds prior to those funds being transferred to the trust account.
- P. The facility must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the facility by the resident. The property record must be available to the resident.
- Q. The facility must notify each resident receiving medical assistance under Title XIX, Medicaid, when the amount in the resident's account reaches two hundred dollars (\$200.00) less than the SSI resource limit and five hundred dollars (\$500.00) less than the Medicaid resource limit to remain eligible for Medicaid long term care benefits.
- 1. The notice must include the fact that if the amount in the account, in addition to the value of the resident's other non-exempt resources, reaches the applicable resource limits; the resident may lose eligibility for such medical assistance or SSI.
 - 2. The facility must issue written notification to the Medicaid Regional Office of any resident receiving medical assistance under Title XIX when the resident's account balance reaches the applicable resource limit.
- R. The Division of Medicaid defines:
- 1. The basic rate as the standard or per diem rate Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in

writing at the time of admission, of the items and services provided by the facility as well as the items and services not included in the basic rate; and the amount of such charges that may be charged to the resident.

2. The book balance as the total balance of all resident trust funds and petty cash held according to the accounting ledger.
3. Census as the total number of residents in a facility.
4. Compliance of The Omnibus Budget Reconciliation Act of 1987, Paragraph 17, 399, Section 1919(6)(A) as requiring a facility to establish and maintain a system that fully and completely accounts for the resident's funds managed by the provider. A facility that does this and follows the policies and procedures and this manual is issued an opinion by the Division of Medicaid that "the facility generally complies with Section 1919(6)(A)." A facility may be found to be in compliance and still have minor errors in its resident fund system; however, for a facility that lacks an accounting system, lacks several parts of an accounting system, or has a sufficient number of exceptions that would indicate a breakdown of the system of accounting, an opinion may be issued that "the facility does not comply with Section 1919(6)(A)."
5. Exception as any item or area selected for review that does not meet the regulatory standards.
6. Fiduciary as having rights and powers normally belonging to another person that must be exercised with a high standard of care for the benefit of the beneficiary. Regarding resident funds, a party who is entrusted to conduct the financial affairs of another person is acting in a fiduciary or trust capacity and has responsibility to use due care and to act in the best interests of the party for whom he is acting in this capacity. A party acting in a fiduciary capacity is also responsible to give an accounting of all transactions made on behalf of the party for whom he is acting.
7. Finding and exception are used interchangeable for resident trust fund review purposes.
8. Fiscal Agent as the agency under contract with the Division of Medicaid for the purpose of disbursing funds to providers of services under the Medicaid program. The fiscal agent collects eligibility and payment information from agencies administering Medicaid and processes the information for payment to providers.
9. Generally Accepted Accounting Principles (GAAP), for resident trust funds, as the facility's proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident and the amount of each individual resident's fund balance.
10. Intestate as without a valid will at the time of death.

11. Legal guardian, or conservator, as a person(s) by the court of jurisdiction to manage the resident's income and assets in the best interest of the resident. The court may require a court order prior to disbursements of the resident's funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian or conservator must supply documentation to the facility for disbursements from the resident fund, just as any other responsible party for any other resident.
12. Medicaid income as the maximum liability that the resident owes to the facility each month for room and board.
13. Medically necessary items and services as those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary and therefore justifiable as an expenditure of the resident's personal funds.
14. Obligee as the residents of the trust fund, the party to whom the facility is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the facility to hold, safeguard, manage, and account for the residents' funds.
15. Per Diem Rate - Refer to Rule 3.7.R.1.
16. Personal needs allowance (PNA) as the amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.
17. Plan of Correction as an acceptable plan of correction that must address each exception noted in the findings letter and include the following:
 - a) Documentation that the exception has been corrected;
 - b) Measures that have been put in place to ensure that the exception will not be repeated;
 - c) Measures that have been put in place to monitor the continued effectiveness of the changes.
18. Reconciliation as at all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.
19. Representative payee as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state

benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is available to represent the resident.

20. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.
21. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.
22. Responsible party for resident trust fund purposes, as a sponsor or resident's representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization, to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation such as a receipt or invoice.
23. State institutions as facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.
24. Testate as having a valid will at the time of death.
25. Trial balance as a listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.
26. Written authorization as authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific funds transaction for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 431.53, 483.10; Miss. Code Ann. § 43-13-121.; 42 CFR § 483; Section 17 (C); 1919 (5) (a) (ii) of the Social Security Act; 42 CFR 447.15; 42 CFR 431.53; OBRA (1987), paragraph 17, 399, Section 1919(6)(A).

History: Revised eff. 01/01/2017.

Chapter 4: Psychiatric Residential Treatment Facility (PRTF)

Rule 4.6: Reimbursement

- A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.
1. All cost reports are due by the end of the fifth (5th) calendar month following the reporting period.
 2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars (\$50.00) per day and may result in the termination of the provider agreement.
- B. The Division of Medicaid uses a prospective method of reimbursement.
1. The rates are determined from cost report data.
 2. Standard rates are determined annually with an effective date of January first (1st).
 3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.
 4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.
 5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors.
 - a) These revisions may result from amended cost reports, field visit reviews, or other corrections.
 - b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.
 - c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.
- C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the ~~mentally retarded~~ intellectually disabled, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.
- D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the ~~mentally retarded~~ intellectually disabled, psychiatric

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

1. Providers must maintain adequate documentation including, but not limited to, financial records and statistical data, for proper determination of costs payable under the Medicaid program.
 - a) The cost report must be based on the documentation maintained by the facility.
 - b) All non-governmental facilities must file cost reports based on the accrual method of accounting.
 - c) Governmental facilities have the option to use the cash basis of accounting for reporting.
2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.
3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.
 - a) These records must be made available as requested by the Division of Medicaid.
 - b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

1. The facility may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for the provision of services under the State Medicaid Plan.
2. While the facility may set their basic per diem charge for non-Medicaid residents at any level, the services covered by that charge must be identical to the services provided to Medicaid residents and covered by the Medicaid per diem rate.
3. Any items and services available in the facility that are not covered under Title XVIII or the facility's basic per diem rate or charge must be available and priced identically for all residents in the facility.

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

G. Private room coverage by Medicaid is as follows:

1. The overall average cost per day determined from the cost report includes the cost of private rooms.
2. The average cost per day is used to compute PRTF reimbursement rates. Therefore, the cost of a private room is included in the reimbursement rate and no extra charge can be made to the beneficiary, his/her family or the Medicaid program.
3. Medicaid reimbursement is considered as payment in full for the beneficiary.

H. The following rules apply to hospital leave:

1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.
2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.
3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.

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

J. The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.
2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.
3. Each therapeutic leave day taken each month must be reported on the billing mechanism.

4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

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

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.
2. Each facility is required to maintain leave records and indicate periods of therapeutic leave days.
3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.
4. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

L. The PRTF must provide non-emergency transportation.

1. The PRTF must document the cost of providing non-emergency transportation services on the cost report.
2. The PRTF cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Facilities may use NET providers that also provide NET services for the NET Broker if:
 - a) The facility arranges the transportation, and
 - b) Pays the NET provider directly.

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

History: Added Miss. Admin. Code Rule 4.6.L. eff. 01/01/2017.