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. Respiratory therapy (RT) services,

4. Dietary services, including nutritional supplements,

5. Activity services,

6. Medically-related social 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, Veterans Affairs (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) Incontinence garments, and

d) Oxygen administration supplies.

11. Durable medical equipment (DME), and/or medical appliances, except for DME and/or medical appliances listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME and/or medical appliances 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 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. The nursing facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

a) Effective February 1, 2019, the nursing facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Nursing facilities may use NET providers that also provide NET services for the NET Broker if:

1) The nursing facility arranges the transportation, and

2) Pays the NET provider directly.

b) Prior to February 1, 2019, the nursing facility must:

1) Arrange and pay for non-emergency transportation and place the cost on the cost report, or

2) Utilize the NET Broker to arrange non-emergency transportation for residents.

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, Medicare, Veteran's Affairs (VA), or any other payor source,

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, and

3. All other DME and/or medical appliances identified in Part 209 requiring prior authorization.

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 (NFSD).

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

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

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

H. The nursing facility must:

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

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

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

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

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

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

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

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

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

Source: 42 C.F.R. §§ 483.10, 483.65; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 09/01/2018; Revised to correspond to SPA 18-0001 (eff. 01/01/2018) eff. 8/01/2018. Revised eff. 08/01/2017; 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 2.20: Facility Initiated Discharges

A. A nursing facility must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.

1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:

a) The safety or health of the individuals in the nursing facility would be endangered,

b) The resident no longer requires the level of care provided by the nursing facility,

c) An immediate transfer or discharge is required by the resident's urgent medical needs, or

d) The resident has not resided in the nursing facility for thirty (30) calendar days.

2. The notice must be written, easily understood and include the following information:

a) The reason for the transfer or discharge,

b) The effective date of the transfer or discharge,

c) The location to which the resident is being transferred or discharged,

d) A statement that the resident has the right to appeal the action to the appropriate state authorities,

e) The name, address and telephone number of the State long-term care ombudsman,

f) 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

g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

B. The nursing facility must maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

C. Residents must be provided sufficient preparation and orientation by the nursing facility to ensure safe and orderly transfers or discharges.

Source: 42 C.F.R. § 483.15; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 09/01/19.

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

Rule 3.5: 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 (IPP).

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. Laundry services including the residents' personal laundry.

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

9. Legend drugs not covered by the Medicaid program, Medicare, private, Veteran's Administration (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 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) Incontinence garments and

d) Oxygen administration supplies.

11. 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.]

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 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. The ICF/IID must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

a) Effective February 1, 2019, the ICF/IID cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. ICF/IIDs may use NET providers that also provide NET services for the NET Broker if:

1) The ICF/IID arranges the transportation, and

2) Pays the NET provider directly.

c) Prior to February 1, 2019, the ICF/IID must:

1) Arrange and pay for non-emergency transportation and place the cost on the cost report, or

2) Utilize the NET Broker to arrange non-emergency transportation for residents.

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.

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 ICF/IID and of charges for those services, including any charges for services not covered under Medicare or by the ICF/IID's per diem rate.

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

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

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

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

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

Source: 42 C.F.R. §§ 483.12, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 09/01/2018; Revised eff. 08/01/2017; 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 3.13: Facility Initiated Discharges

A. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.

1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:

   a) The safety or health of the individuals in the nursing facility would be endangered,

   b) The resident no longer requires the level of care provided by the nursing facility,

   c) An immediate transfer or discharge is required by the resident’s urgent medical needs, or

   d) The resident has not resided in the nursing facility for thirty (30) calendar days.

2. The notice must be written, easily understood and include the following information:

   a) The reason for the transfer or discharge,

   b) The effective date of the transfer or discharge,

   c) The location to which the resident is being transferred or discharged,

   d) A statement that the resident has the right to appeal the action to the appropriate state authorities,

   e) The name, address and telephone number of the State long-term care ombudsman,

   f) 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

g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

B. The (ICF/IID) must:

1. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

2. Develop a final summary of the resident's developmental, behavioral, social, health and nutritional status and, with the consent of the resident or legal guardian, provide a copy to authorized persons and agencies, and

3. Provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

C. Residents must be provided sufficient preparation and orientation by ICF/IID to ensure safe and orderly transfers and/or discharges.

Source: 42 C.F.R. §§ 483.15, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 09/01/19.

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. Respiratory therapy (RT) services,

4. Dietary services, including nutritional supplements,

5. Activity services,

6. Medically-related social services,

~~7. Routine personal hygiene items and services,~~

7~~8~~. Laundry services including the residents' personal laundry,

8~~9~~. Over-the-counter (OTC) drugs,

9~~10~~. Legend drugs not covered by Medicaid drug program, Medicare, private, Veterans Affairs (VA), or any other payor source,

10~~1~~. 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) ~~Disposable diapers and disposable underpads~~Incontinence garments, and

d) Oxygen administration supplies.

11~~2~~. Durable medical equipment (DME), and/or medical appliances, except for DME and/or medical appliances listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME and/or medical appliances 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~~3~~. 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.

134. 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.

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

156. The nursing facility must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

a) Effective February 1, 2019, the nursing facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Nursing facilities may use NET providers that also provide NET services for the NET Broker if:

1) The nursing facility arranges the transportation, and

2) Pays the NET provider directly.

b) Prior to February 1, 2019, the nursing facility must:

1) Arrange and pay for non-emergency transportation and place the cost on the cost report, or

2) Utilize the NET Broker to arrange non-emergency transportation for residents.

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, Medicare, Veteran's Affairs (VA), or any other payor source,

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, and

3. All other DME and/or medical appliances identified in Part 209 requiring prior authorization.

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 (NFSD).

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

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

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

H. The nursing facility must:

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

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

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

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

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

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

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

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

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

Source: 42 C.F.R. §§ 483.10, 483.65; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 09/01/2018; Revised to correspond to SPA 18-0001 (eff. 01/01/2018) eff. 8/01/2018. Revised eff. 08/01/2017; 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 2.20: Facility Initiated Discharges

A. A nursing facility must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.

1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:

   a) The safety or health of the individuals in the nursing facility would be endangered,

   b) The resident no longer requires the level of care provided by the nursing facility,

   c) An immediate transfer or discharge is required by the resident's urgent medical needs, or

   d) The resident has not resided in the nursing facility for thirty (30) calendar days.

2. The notice must be written, easily understood and include the following information:

   a) The reason for the transfer or discharge,

   b) The effective date of the transfer or discharge,

   c) The location to which the resident is being transferred or discharged,

   d) A statement that the resident has the right to appeal the action to the appropriate state authorities,

   e) The name, address and telephone number of the State long-term care ombudsman,

   f) 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

   g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

B. The nursing facility must maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

C. Residents must be provided sufficient preparation and orientation by the nursing facility to ensure safe and orderly transfers or discharges.

Source: 42 C.F.R. § 483.15; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 09/01/19.

~~Part 207~~ Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)

Rule 3.5: 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 (IPP).

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.~~

7~~8~~. Laundry services including the residents' personal laundry.

8~~9~~. Over-the-counter (OTC) drugs.

9~~10~~. Legend drugs not covered by the Medicaid program, Medicare, private, Veteran's Administration (VA) or any other payor source.

10~~1~~. 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) Incontinence garments~~Disposable diapers and disposable underpads,~~ and

d) Oxygen administration supplies.

11~~2~~. 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.]

12~~3~~. 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.

134. 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.

145. The ICF/IID must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.

a) Effective February 1, 2019, the ICF/IID cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. ICF/IIDs may use NET providers that also provide NET services for the NET Broker if:

1) The ICF/IID arranges the transportation, and

2) Pays the NET provider directly.

c) Prior to February 1, 2019, the ICF/IID must:

1) Arrange and pay for non-emergency transportation and place the cost on the cost report, or

2) Utilize the NET Broker to arrange non-emergency transportation for residents.

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.

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 ICF/IID and of charges for those services, including any charges for services not covered under Medicare or by the ICF/IID'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 ICF/IID would be endangered,~~

~~2) The resident no longer requires the level of care provided by the ICF/IID,~~

~~3) An immediate transfer or discharge is required by the resident's urgent medical needs, or~~

~~4) The resident has not resided in the ICF/IID 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.~~ [Moved to Miss. Admin. Code Part 207, Rule 3.13]

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 ICF/IID.

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

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

Source: 42 C.F.R. §§ 483.12, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 09/01/2018; Revised eff. 08/01/2017; 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 3.13: Facility Initiated Discharges

A. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.

1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:

a) The safety or health of the individuals in the nursing facility would be endangered,

b) The resident no longer requires the level of care provided by the nursing facility,

c) An immediate transfer or discharge is required by the resident's urgent medical needs, or

d) The resident has not resided in the nursing facility for thirty (30) calendar days.

2. The notice must be written, easily understood and include the following information:

a) The reason for the transfer or discharge,

b) The effective date of the transfer or discharge,

c) The location to which the resident is being transferred or discharged,

d) A statement that the resident has the right to appeal the action to the appropriate state authorities,

e) The name, address and telephone number of the State long-term care ombudsman,

f) 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

g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

B. The (ICF/IID) must:

1. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.

2. Develop a final summary of the resident's developmental, behavioral, social, health and nutritional status and, with the consent of the resident or legal guardian, provide a copy to authorized persons and agencies, and

3. Provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

C. Residents must be provided sufficient preparation and orientation by ICF/IID to ensure safe and orderly transfers and/or discharges.

Source: 42 C.F.R. §§ 483.15, 483.440; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: New Rule eff. 09/01/19.