Title 23: Division of Medicaid

Part 207: Institutional Long - Term Care

Part 207 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, 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) Disposable diapers and disposable underpads, and

d) Oxygen administration supplies.

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

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

a) Hair hygiene supplies,

b) Comb and brush,

c) Bath soap,

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

e) Razor and shaving cream,

f) Toothbrush and toothpaste,

g) Denture adhesive and denture cleaner,

h) Dental floss,

i) Moisturizing lotion,

j) Tissues, cotton balls, and cotton swabs,

k) Deodorant,

l) Incontinence care and supplies,

m) Sanitary napkins and related supplies,

n) Towels and washcloths,

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

of routine grooming care, and

p) Bathing.

13. Private room coverage as medically necessary:

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

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

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

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

1. Laboratory services,

2. X-ray services,

3. Drugs covered by the Medicaid drug program,

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

5. Ostomy supplies,

6. 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.]

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 (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; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: 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 2.9: Resident Assessment Instrument (RAI)

A. Nursing facilities must complete the Minimum Data Set (MDS) 3.0, including Section S, which is the Resident Assessment Instrument (RAI) specified by the Division of Medicaid and approved by the Centers of Medicare and Medicaid Services (CMS), on all residents regardless of source of payment.

B. Section S identifies beneficiaries residing in an Alzheimer's/dementia care unit of a nursing facility which must be completed on all residents during the specified time period of each of the following MDS assessments including, but not limited to:

1. Comprehensive (NC) which includes:

   a) Admission,

   b) Annual,

   c) Significant Change in Status Assessment (SCSA), and

   d) Significant Correction to Prior Comprehensive Assessment (SCPA),

2. Prospective Payment System (PPS),

3. Quarterly (NQ),

4. Significant Correction to Prior Quarterly Assessment (SCQA),

5. Entry Tracking Record (NT),

6. Death in Facility Tracking Record (NT),

7. Discharge Assessment – Return not anticipated (ND), and

8. Discharge Assessment – Return Anticipated (ND).

C. Nursing facilities cannot indicate in Section S that a resident has received care in an Alzheimer's/dementia care unit if the nursing facility does not have a designated Alzheimer's/dementia care unit. The fourteen (14) day look-back period cannot include:

1. A resident's hospital stay in a geriatric psychiatric unit, or

2. An Alzheimer's/dementia care unit stay in another nursing facility.

D. The RAI must be completed in accordance with the most current CMS Long-Term Care Facility Resident Assessment Instrument User's Manual.

Source: 42 U.S.C. §§ 1395i-3, 1396r; 42 C.F.R. §§ 483.20, 483.315; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 08/01/2017; Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.