

Title 23: Division of Medicaid

Part 207: Institutional Long-Term Care

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

Rule 3.1: General

- A. The Division of Medicaid may not execute a provider agreement with an intermediate care facility for individuals with intellectual disabilities (ICF/IID) for services unless the State survey agency or the Centers for Medicare and Medicaid Services (CMS) has certified the ICF/IID as having met all of the participation requirements. The Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification, pursuant to federal law and regulation, certifies ICF/IIDs for participation in the Medicaid program.
- B. The Division of Medicaid does not reimburse an ICF/IID prior to the date of certification and execution of a valid Medicaid provider agreement.
- C. If the Division of Medicaid has adequate documentation showing good cause, it may refuse to execute an agreement, or may cancel an agreement, with a certified ICF/IID. A provider agreement is not valid, even though certified by the State survey agency, if the ICF/IID fails to meet civil rights requirements.

Source: 42 U.S.C. §1396r; 42 C.F.R. § 442.12; 45 C.F.R. Parts 80, 84 and 90; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.2: Provider Enrollment Requirements

Intermediate care facility for individuals with intellectual disabilities (ICF/IID) providers must satisfy all requirements set forth in Part 200, Rule 4.8 in addition to the following provider type specific requirements:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).
- B. Written confirmation from the Internal Revenue Service (IRS) confirming the tax identification number and legal name.
- C. Copy of license or current certification letter and from the state of servicing location.

Source: Miss. Code Ann. § 43-13-121.

History: New rule eff. 08/01/2017.

Rule 3.3: Duration and Termination of Provider Agreements

- A. The duration of an intermediate care facility for individuals with intellectual disabilities' (ICF/IID's) Medicaid provider agreement is for the same period of time as an ICF/IID's certification or recertification for participation by the Mississippi State Department of Health (MSDH).
- B. The certification or recertification for an ICF/IID remains in effect until it is determined that the ICF/IID is no longer in compliance with the Conditions of Participation as determined by MSDH and/or the Centers for Medicare and Medicaid Services (CMS).
 - 1. ICF/IIDs must be surveyed by MSDH licensure and certification:
 - a) No later than fifteen (15) months after the last day of the previous survey to determine compliance with the Conditions of Participation, and
 - b) At a state-wide average interval of twelve (12) months or less which is computed at the end of each federal fiscal year by comparing the last day of the most recent survey for each participating ICF/IID to the last day of each ICF/IID's previous survey.
 - 2. ICF/IIDs in compliance with the Conditions of Participation with standard level deficiencies, defined as when there is noncompliance with any single requirement or several requirements within a particular standard that are not of such character as to substantially limit an ICF/IID's capacity to furnish adequate care, or which would not jeopardize or adversely affect the health or safety of beneficiaries if the deficient practice recurred, may be conditionally certified with the understanding that certification will continue if either of the following applies:
 - a) All deficiencies have been satisfactorily corrected, or
 - b) The ICF/IID has made substantial progress in correcting the deficiencies and has a new plan of correction that is acceptable.
- C. The Division of Medicaid may deny payment for new admissions to an ICF/IID that no longer meets the applicable Conditions of Participation as determined by MSDH and/or CMS.
 - 1. The Division of Medicaid will:
 - a) Provide the ICF/IID up to sixty (60) days to come into compliance with the Conditions of Participation, and
 - b) Notify the ICF/IID of the intent to deny payment for new admissions and an opportunity for an informal hearing.

2. The Division of Medicaid will provide an informal hearing upon written request which includes:
 - a) The opportunity to present to a Division of Medicaid official not involved in making the initial determination, evidence or documentation, in writing or in person, to refute the decision that the ICF/IID is out of compliance with the Conditions of Participation, and
 - b) A written decision stating the facts and legal basis governing the resolution of the dispute.
 3. If the decision of the informal hearing is to deny payment for new admissions the Division of Medicaid will inform the ICF/IID and the public at least fifteen (15) days before the effective date of the sanction with a notice that includes the:
 - a) Effective date of the denial of payments, and
 - b) Reasons for the denial of payments.
- D. The denial of payments for new admissions will continue for eleven (11) months after the month it was imposed unless, before the end of that period:
1. The ICF/IID has come into compliance or is making a good faith effort to achieve compliance with the Conditions of Participation and the deficiencies do not present an immediate jeopardy to residents' safety and health, or
 2. The non-compliance is such that it presents an immediate jeopardy to residents' safety and health and it is necessary to terminate the ICF/IID's provider agreement.
- E. The Division of Medicaid must terminate an ICF/IID's provider agreement if an ICF/IID has been unable to achieve compliance with the Conditions of Participation during the period that payments for new admissions have been denied with the termination effective the day following the last day of the denial of payments.
- F. The Division of Medicaid may terminate an ICF/IID's provider agreement when the ICF/IID is not in substantial compliance with program requirements.
1. The Division of Medicaid will provide written notification to the ICF/IID and the public.
 2. The Division of Medicaid will notify CMS of the decision to terminate the ICF/IID's provider agreement.
 3. The notice of termination will include an opportunity for the ICF/IID to request a hearing before an Administrative Law Judge prior to termination.

- G. When a provider agreement is terminated, the Division of Medicaid may continue to make payments for up to thirty (30) days to provide time for an orderly transfer of residents, whose primary source of payment is Medicaid, as specified in federal law. The ICF/IID must notify every resident, whose primary source of payment is Medicaid, and/or guardian or legal representative in writing within forty-eight (48) hours of receipt by the ICF/IID of the notice of termination.
- H. An ICF/IID may request an evidentiary hearing in writing within sixty (60) days of the receipt of the notice of a denial of payments or notice of termination or nonrenewal of its provider agreement.
1. The evidentiary hearing must be completed either before the effective date of the adverse action or within one hundred twenty (120) days after said date, and
 2. If the hearing is made available only after the effective date of the action, the Division of Medicaid will, before that date, offer the ICF/IID an informal reconsideration that meets the following requirements:
 - a) A written notice to the ICF/IID of the denial, termination or nonrenewal and the findings upon which it was based,
 - b) A reasonable opportunity for the ICF/IID to refute those findings in writing, and
 - c) A written affirmation or reversal of the denial, termination, or nonrenewal.

Source: 42 C.F.R. §§ 431.108, 431.153-154, 442.15, 442.109-110, 442.117-119; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2017; Revised eff. 12/01/2015.

Rule 3.4: Admission Review

- A. The Mississippi Department of Mental Health (DMH) is responsible for conducting reviews of each beneficiary's need for admission to an intermediate care facility for individuals with intellectual disabilities (ICF/IID).
- B. An ICF/IID pre-admission form must be completed no more than thirty (30) days prior to the admission of the beneficiary to an ICF/IID and submitted with a copy of the current physical examination, medical and social history, and the preliminary evaluation.
- C. A physician must certify that each applicant's or beneficiary's ICF/IID level of care criteria were met at the time of admission. Recertification must be made at least every twelve (12) months thereafter.
- D. The interdisciplinary team must prepare for each resident, within thirty (30) days after admission, an individual program plan (IPP) that states the specific objectives necessary to

meet the beneficiary's needs. At least annually, the comprehensive functional assessment of each beneficiary must be reviewed by the interdisciplinary team for relevancy and must be updated and the IPP is revised as needed.

Source: 42 C.F.R. §§ 456.350 - 456.381, 456.400, 456.431; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2017.

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.
 - 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) Disposable diapers and disposable underpads, 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.

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.

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.
- 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. 08/01/2017; 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; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016; Revised eff. 01/02/2015.

Rule 3.6: Reimbursement

- A. Participating Mississippi intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) must prepare and submit a Long-term Care Medicaid cost report for reimbursement.
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 calculated from cost report data.
 2. The rates are calculated annually with an effective date of January first (1st).
 3. In no case may the reimbursement rate for services provided exceed an individual ICF/IID'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, audits, 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 cost report financial reviews of selected ICF/IIDs 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 ICF/IID 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 ICF/IID.
 - b) All non-governmental ICF/IIDs must file cost reports based on the accrual method of accounting.
 - c) Governmental ICF/IIDs 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 ICF/IID 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.

Source: 42 C.F.R. § 447, Subparts B and C; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.7: Temporary Leave Payment

- A. The Division of Medicaid defines temporary leave as the absence of the resident from the intermediate care facility for individuals with intellectual disabilities (ICF/IID) for more than eight (8) hours, beginning the day the resident leaves the ICF/IID.
- B. The Division of Medicaid reimburses an ICF/IID for temporary leave when a resident is absent due to home/therapeutic leave or inpatient hospital leave.
- C. The Division of Medicaid reimburses an ICF/IID for fifteen (15) days of home/therapeutic leave per one (1) absence for up to a total of eighty-four (84) days per state fiscal year.

1. The Division of Medicaid reimburses for the following home/therapeutic days in addition to the eighty-four (84) day limit:
 - a) Christmas Day,
 - b) The day before Christmas,
 - c) The day after Christmas,
 - d) Thanksgiving Day,
 - e) The day before Thanksgiving, and
 - f) The day after Thanksgiving.
 2. Home/therapeutic leave must be approved by the attending physician.
 3. Home/therapeutic leave includes routine outpatient treatments.
 4. Outpatient treatment that occurs two (2) or more days per week, including dialysis, chemotherapy or treatment for a catastrophic illness, does not count towards the home/therapeutic leave day limit.
- D. The Division of Medicaid reimburses an ICF/IID for fifteen (15) days of inpatient hospital leave per absence.
1. Inpatient hospital leave applies to acute care hospital stays in a licensed hospital, including geriatric psychiatry units.
 2. When the resident is readmitted to the ICF/IID after an inpatient hospital stay, a new pre-admission form, certification of need for care and medical, psychological, and social evaluations are not necessary if the resident has been continuously hospitalized.
 3. There is no limit to the number of absences due to an inpatient hospital stay.
- E. The Division of Medicaid reimburses for the day of admission to the ICF/IID.
- F. The Division of Medicaid does not reimburse for:
1. The day of discharge unless it is the same day as the day of admission. The ICF/IID cannot bill the resident or responsible party for the day of discharge.
 2. Days in which the resident is placed in a Medicare skilled nursing facility (SNF) or a swing bed.

3. Temporary leave days taken in excess of the allowable or authorized number of days.
4. Temporary leave days if the ICF/IID discharges a resident whose absence exceeds the Division of Medicaid's home/therapeutic leave or inpatient hospital stay leave limit and refuses to readmit the resident when a bed is available.

G. The ICF/IID must:

1. Provide written information to the resident and the resident's guardian or legal representative explaining the ICF/IID's leave policies before the resident begins a home/therapeutic leave or inpatient hospital stay.
 - a) This information must define the period of time during which the resident will be permitted to return and resume residence in the ICF/IID.
 - b) The information must also state that, if the resident's absence exceeds Medicaid's temporary leave limit, the resident will be readmitted to the ICF/IID upon the first availability of a semi-private bed if the resident still requires the services provided by the ICF/IID.
2. Reserve the resident's bed in anticipation of the resident's return. The ICF/IID cannot fill the bed with another resident during the covered temporary leave period.
3. Readmit a resident from an inpatient hospital stay or home/therapeutic leave when the resident has not been absent for more than fifteen (15) days and still requires ICF/IID services.
4. Maintain leave records and indicate periods of inpatient hospital stays and home/therapeutic leave days on billing documents.

H. The Division of Medicaid considers a resident's return to the ICF/IID for twenty-four (24) consecutive hours the end of a temporary leave period.

Source: 42 C.F.R. §447.40; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.8: Resident Personal Funds

- A. The intermediate care facility for individuals with intellectual disabilities (ICF/IID) must, upon written authorization by the resident, and/or guardian or legal representative accept responsibility for holding, safeguarding and accounting for the resident's personal funds.
 1. The ICF/IID 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 rule remains with the ICF/IID.

2. The ICF/IID must include any charges for this service in the ICF/IID's basic daily rate and cannot charge the resident.
- B. Penalties may be assessed on any ICF/IID that fails to maintain an auditable system of accounting for residents' personal funds or has had repeated instances of noncompliance with federal regulations.
- C. The ICF/IID must provide each resident and/or guardian or legal representative with a written statement at the time of admission that states the following:
1. All services provided by the ICF/IID, distinguishing between services are included in the ICF/IID's basic rate and those services that are not. The written statement must include 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 ICF/IID.
 3. The resident has the right to select how personal funds will be handled including the following rights to:
 - a) Receive, retain, and manage his/her personal funds or have this done by a guardian or legal representative, if any,
 - b) 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) Designate, in writing, another person to act for the purpose of managing his or her personal funds except when the resident does not deposit funds with the ICF/IID, and
 - d) Require the ICF/IID to hold, safeguard and account for resident personal funds under a system established and maintained by the ICF/IID requested by the resident.
 4. Any charge for this service is included in the ICF/IID's basic rate.
 5. The ICF/IID may only accept a resident's personal funds to hold, safeguard and account when:
 - a) Provided with written authorization by the resident and/or guardian or legal representative, or
 - b) The ICF/IID is appointed as the resident's representative payee.
 6. The ICF/IID 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 guardian or legal representative.

7. The ICF/IID must maintain a complete copy of its resident's personal funds policies and procedures and must make them accessible and available for review.
- D. The ICF/IID 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 ICF/IID must act as fiduciary of the resident's personal funds and account for these funds in an auditable manner.
 2. The ICF/IID must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. The Division of Medicaid requires the ICF/IID 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 each resident's personal funds.
- E. Acceptable charges to resident personal funds include, but are not limited to, the following general categories and examples, if properly authorized and documented as specified in Miss. Admin. Code Rule 3.8.D. is provided. The ICF/IID must notify the resident in advance of charges for non-Medicaid covered items and services, including, but not limited to:
1. Personal communication/entertainment items and services, including, but not limited to, telephone, television, radio, and computer.
 2. Personal comfort items, including, but not limited to, tobacco, novelties, and candy.
 3. Items and services in excess of those included in the Medicaid per diem rate, including, but not limited to, grooming or cosmetic items 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 included in the Medicaid per diem rate.
 9. Private sitters or aides.
 10. Private room, unless the private room is medically necessary including, but not limited to, isolation for infection control.

11. Specially prepared or alternative food requested instead of, or in addition to, the food generally prepared by the ICF/IID.
 12. Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.
- F. Unacceptable charges to resident's personal funds include, but are not limited to:
1. Any charge not:
 - a) Authorized by the resident and/or guardian or legal representative, or
 - b) 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 including, but not limited to, 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 medically necessary.
 - b) Failure to maintain the physician's denial of medical necessity statement may result in the ICF/IID's reimbursement of charges to a resident's account.
 4. Medical transportation.
 - a) All transportation for ICF/IID residents, whether emergency or non-emergency, must be arranged by ICF/IID 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 be arranged using the ICF/IID's vehicles or by utilizing outside resources. Costs for providing this level of service are to be reported by the ICF/IID on their cost reports and are reimbursed through the ICF/IID per diem. The ICF/IID 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/IID 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/IID to a hospital and remains hospitalized for longer than fifteen (15) days and is discharged from the ICF/IID, transportation for

these residents should be arranged by the hospital. If there has not been a final discharge from the ICF/IID and the resident had a hospital stay of less than fifteen (15) days, transportation back to the ICF/IID must be arranged by the ICF/IID staff.

5. Any item or service requiring a waiver of the resident's personal needs allowance, including, but not limited to, repayment of a debt owed to the ICF/IID. The personal needs allowance may be used by an ICF/IID for ICF/IID costs only upon the written authorization of the resident and/or guardian or legal representative with the understanding that this action is voluntary and is not a requirement.
 6. Loans or collateral for loans to anyone, including the ICF/IID, 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 and/or guardian or legal representative including, but not limited to, the resident's guardian or legal representative transferring 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 ICF/IID must provide each resident and/or guardian or legal representative reasonable access to his/her own financial records.
1. The ICF/IID must provide a written financial statement, at least quarterly, to each resident and/or guardian or legal representative.
 2. The quarterly financial statement must reflect any resident's personal funds which the ICF/IID has deposited in an interest bearing or a non-interest bearing account, as well as any resident personal funds held by the ICF/IID in a petty cash account.
- H. The ICF/IID must keep any funds received from a resident for holding, safeguarding and accounting separate from the ICF/IID's funds and from the funds of any person other than another resident in that ICF/IID.
1. The ICF/IID cannot open any additional accounts within the trust fund account, including donation accounts or miscellaneous accounts.
 2. Only funds of the ICF/IID's residents may be maintained as part of the resident's personal funds account.
- I. The ICF/IID 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 ICF/IID's operating accounts.
1. The ICF/IID must credit all interest earned on such separate account(s) in one of the following ways, at the election of the ICF/IID:

- a) Prorated to each resident's personal funds account on an actual interest-earned basis, or
 - b) Prorated to each resident's personal funds account on the basis of its end-of-quarter balance.
2. The ICF/IID 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 personal funds, and interest is accumulated based on the total amount of funds in the trust fund account, all residents must be allocated interest proportionately.
 3. The ICF/IID 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). An ICF/IID must not establish policy that conflicts with the absolute right of residents for the ICF/IID to hold, safeguard, manage, and account for all residents' funds deposited with the ICF/IID.
- 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 ICF/IID must, upon request or upon the resident's transfer or discharge, during normal business hours, return to the resident, guardian, or legal representative all funds remaining that the ICF/IID has received for holding, safeguarding, and accounting in a petty cash fund.
- K. For a resident's personal funds that the ICF/IID has received and are deposited in an account outside the ICF/IID, the ICF/IID, upon request, must within five (5) business days return to the resident, guardian, or legal representative, any or all of those funds.
- L. Upon sale of the ICF/IID or other transfer of ownership, the ICF/IID 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 personal funds being transferred and obtain a written receipt for those funds from the new owner.
1. The ICF/IID must give each resident, guardian, or legal representative a written accounting of any resident's personal funds held by the ICF/IID before any transfer of ownership occurs.
 2. In the event of a disagreement with the accounting provided by the ICF/IID, 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 ICF/IID must, within thirty (30) days of a resident's death or discharge, convey the resident's personal 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 ICF/IID of this fiduciary responsibility.
 2. If the deceased or discharged resident's estate has no executor or administrator, the ICF/IID must convey the resident's personal 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. If a resident dies in the State of Mississippi and leaves no known heirs, the ICF/IID must have the 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:
 - a) The report of such funds shall be verified, shall be on a form prescribed or approved by the State Treasurer and shall include:
 - 1) The name of the deceased resident and his/her last known address prior to entering the ICF/IID,
 - 2) The name and last known address of each person who may possess an interest in such funds, and
 - 3) Any other information which the State Treasurer prescribes by regulation as necessary.
 - b) In the event a party with a claim to the deceased residents' personal funds comes to be known after funds have been conveyed to the State Treasurer, the party may file a claim with the State Treasurer.
 - 1) All reports of unclaimed funds filed by the ICF/IID prior to November first (1st) of each year will be included in a list published by the State Treasurer within one hundred twenty (120) days following November first (1st).
 - 2) Claimants have ninety (90) days from the date of publishing to file for such funds.
 - 3) 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) Miss. Admin. Code Part 207, Rule 3.8.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 ICF/IID's operational account, after a period of one (1) year from the date of death.
- N. The ICF/IID must purchase a surety bond or otherwise provide assurance as to all personal funds of residents deposited with the ICF/IID.
1. The Division of Medicaid defines a surety bond as an agreement between the principal, which is the ICF/IID, the surety, which is the insurance company, and the obligee, who is the resident(s) or the residents participating in the trust fund, wherein the ICF/IID and the insurance company agree to compensate the resident for any loss of residents' personal funds that the ICF/IID holds, safeguards, manages and for which the ICF/IID accounts. The purpose of the surety bond is to guarantee that the ICF/IID will pay the resident for losses occurring for any failure by the ICF/IID to hold, safeguard, manage, and account for the residents' personal 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 ICF/IID to meet the standard of conduct.
 - a) The ICF/IID 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 personal 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 ICF/IID 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 ICF/IID, 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 ICF/IID or its management.
5. The ICF/IID 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 ICF/IID 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 ICF/IID 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 ICF/IID funds prior to those funds being transferred to the trust account.
- P. The ICF/IID must maintain a current, written record for each resident that includes written receipt for all personal possessions deposited with the ICF/IID by the resident. The property record must be available to the resident.
- Q. The ICF/IID 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 supplemental security income (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 ICF/IID 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 ICF/IID per Medicaid resident per day, as established periodically from cost reports. The basic rate is important in the discussion of resident personal 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 ICF/IID 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 personal funds and petty cash held according to the accounting ledger.
3. Census as the total number of residents in an ICF/IID.
4. Compliance with The Omnibus Budget Reconciliation Act (OBRA) of 1987 as requiring an ICF/IID to establish and maintain a system that fully and completely accounts for the resident's personal funds managed by the provider.
5. Exception as any item or area selected for review that does not meet the regulatory standards. Finding and exception are used interchangeably for resident trust fund review purposes.
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 personal 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. 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.
8. Generally Accepted Accounting Principles (GAAP) as guidelines for proper accounting practices codified by the Financial Accounting Standards Board which includes proper bookkeeping techniques by which the ICF/IID 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.

9. Intestate as without a valid will at the time of death.
10. Legal guardian, legal representative, or conservator as a person(s) 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 personal funds, and/or a periodic accounting to the court to document income and disbursements. A legal guardian, legal representative or conservator must supply documentation to the ICF/IID for disbursements from the resident fund, just as any other responsible party for any other resident.
11. Medicaid income as the maximum liability that the resident owes to the ICF/IID each month for room and board.
12. 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 ICF/IID'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 as the residents of the trust fund, the party to whom the ICF/IID is legally or morally bound. The obligee is the beneficiary of funds, collected in the event of the failure of the ICF/IID to hold, safeguard, manage, and account for the residents' personal funds.
14. Per Diem Rate - Refer to Miss. Admin. Code Part 207, Rule 3.8.R.1.
15. 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.
16. Plan of Correction as an acceptable plan 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, and
 - c) Measures that have been put in place to monitor the continued effectiveness of the changes.

17. Reconciliation as at all times, the total of the residents' personal funds held, as noted from the bank's current statement of the balance and any cash held at the ICF/IID, equaling the total of the resident's personal funds as noted from the ICF/IID'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 as someone designated by the resident to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. An ICF/IID must be willing to be designated as a temporary representative payee if no guardian or legal representative is available to represent the resident.
19. Resident's personal funds as all of a resident's money on deposit with the facility, including all of the resident's personal funds, regardless of the source.
20. Resource limit as the maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit are the two resource limits to be considered.
21. Trust Fund Authorization as the documentation the resident and/or guardian or legal representative signs appointing an individual to assist the resident in managing his/her personal funds maintained within the resident trust fund account. Any withdrawal of funds by this appointed individual must be for the benefit of the resident, must be signed for, and supported by appropriate documentation such as a receipt or invoice.
22. State institutions as facilities owned and operated by the State.
23. Testate as having a valid will at the time of death.
24. Trial balance as a listing of all residents participating in the resident personal fund account with the balance of each resident's personal fund.
25. Written authorization as authorization to establish a resident personal fund in the form of a written statement signed by the resident and/or guardian or legal representative. 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, 447.15, 483.420; Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.9: Utilization Review

The Mississippi State Department of Health (MSDH) Division of Licensure and Certification is the State Agency designated to conduct reviews in intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), as required by the Division of Medicaid. The regulatory requirements for review include:

- A. Review of Need for Admission,
- B. Certification/Recertification of Need for Care,
- C. Plan of Care, and
- D. Utilization Review.

Source: 42 C.F.R. Parts 456 and 483, Subpart I; Miss. Code Ann. §§ 43-11-1, 43-11-13, 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.10: Release of Information

- A. Public access to records maintained by the Division of Medicaid is mandated. The exception to public access is those records which are exempt as confidential or privileged.
- B. Beneficiary-specific information will only be released by the Division of Medicaid when the requirements of federal regulations are met.
- C. Provider-specific information, including, but not limited to, cost reports, reimbursement rates, reimbursement amounts and reports not beneficiary-specific, will be available to the public when:
 - 1. A written request for the information is made to the Executive Director of the Division of Medicaid,
 - 2. The information is available in existing agency files and reports, and
 - 3. The requestor reimburses the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.
- D. Statistical data that does not contain protected health information is available as requested. This type of information is generally available in the Division of Medicaid's annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Division of Medicaid for the costs associated with the compilation of the requested material, as permitted by law.

Source: 42 C.F.R. § 431.300 – 307, 45 C.F.R. Parts 160 and 164; Miss. Code Ann. §§ 25-61-1, 43-13-121.

History: Revised eff. 08/01/2017.

Rule 3.11: Individualized, Resident Specific Custom Manual and/or Custom Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a Specific Resident

- A. The Division of Medicaid defines a wheelchair as a seating system that is designed to increase the mobility of residents who would otherwise be restricted by inability to ambulate or transfer from one place to another.
- B. The Division of Medicaid defines an individualized, resident specific custom manual and/or custom motorized/power wheelchair as one that has been uniquely constructed or substantially modified for a specific resident referred to in this Rule as “custom manual wheelchair” and/or “custom motorized/power wheelchair.”
- C. The Division of Medicaid does not classify the following wheelchairs as custom manual and/or custom motorized/power wheelchairs:
 - 1. Standard manual wheelchairs,
 - 2. Standard manual wheelchairs with added accessories,
 - 3. Standard motorized/power wheelchairs, and/or
 - 4. Standard motorized/power wheelchairs with added accessories.
- D. The Division of Medicaid covers custom manual and/or custom motorized/power wheelchairs and accessories for rental up to the purchase price or purchase when:
 - 1. Medically necessary with comprehensive documentation that a standard wheelchair cannot meet the resident’s needs and the resident requires the custom manual and/or custom motorized/power wheelchair for six (6) months or longer,
 - 2. Ordered by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist,
 - 3. Not primarily used as a restraint, and
 - 4. Prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity.
- E. The Division of Medicaid requires the following documentation for a custom manual and/or custom motorized/power wheelchair.
 - 1. A face-to-face evaluation by a pediatrician, orthopedist, neurosurgeon, neurologist, or a physiatrist who is prescribing the custom manual and/or custom motorized/power wheelchair which includes, but is not limited to:

- a) The reason for the evaluation visit is a mobility examination,
 - b) If the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Medicaid program.
 - c) A certificate of medical necessity with comprehensive documentation that describes the medical reason(s) why a custom manual and/or custom motorized/power wheelchair is medically necessary such that no other type of wheelchair can meet the needs of the resident including, but not limited to:
 - 1) The diagnosis/co-morbidities and conditions relating to the need for a custom manual and/or custom motorized/power wheelchair.
 - 2) Description and history of limitation/functional deficits.
 - 3) Description of physical and cognitive abilities to utilize equipment.
 - 4) History of previous interventions/past use of mobility devices.
 - 5) Description of existing equipment, age of equipment and specifically why it is not meeting the resident's needs.
 - 6) Explanation as to why a less costly mobility device is unable to meet the resident's needs.
 - 7) Description of the resident's ability to safely tolerate/utilize the prescribed custom manual and/or custom motorized/power wheelchair.
 - 8) The type of custom wheelchair and each individual attachment and/or accessory required by the resident.
2. An initial evaluation by a physical therapist (PT) or occupational therapist (OT), not employed by the Durable Medical Equipment (DME) provider or the manufacturer, within three (3) months of the date of the written prescription to determine the individualized needs of the resident which includes whether the resident currently possesses a custom manual and/or custom motorized/power wheelchair not previously purchased by the Division of Medicaid at the time of the initial evaluation.
 3. An agreement by both the prescribing physician and the PT or OT performing the initial evaluation that the individualized equipment being ordered is appropriate to meet the needs of the resident.
 4. A subsequent evaluation after the delivery of the custom manual and/or custom motorized/power wheelchair by a PT or OT, not employed by the DME provider or the

manufacturer, to determine if the custom manual and/or custom motorized/power wheelchair is appropriate for the resident's needs.

5. The PT/OT initial and subsequent evaluations must include the appropriate seating accommodation for the resident's height and weight, specifically addressing anticipated growth and weight gain or loss.
- F. The Division of Medicaid covers a custom motorized/power wheelchair only when a custom manual wheelchair cannot meet the needs of the resident. The resident must meet the following criteria:
1. Be bed/chair confined with documented severe abnormal upper extremity dysfunction or weakness,
 2. Expect to have physical improvements or the reduction of the possibility of further physical deterioration from the use of a custom motorized/power wheelchair,
 3. Be for the necessary treatment of a medical condition,
 4. Have a poor prognosis for being able to self-propel a functional distance,
 5. Not exceed the weight capacity of the custom motorized/power wheelchair prescribed,
 6. Have sufficient eye and/or hand perceptual capabilities to operate the custom motorized/power wheelchair safely,
 7. Have sufficient cognitive skills to understand directions, such as left, right, front, and back, and be able to maneuver the motorized/power wheelchair in these directions independently,
 8. Be independently able to move away from potentially dangerous or harmful situations when seated in the custom motorized/power wheelchair,
 9. Demonstrate the ability to start, stop, and guide the custom motorized/power wheelchair within a reasonably confined area,
 10. Be in an environment conducive to the use of the custom motorized/power wheelchair.
 - a) The environment must have sufficient floor surfaces and sufficient door, hallway, and room dimensions for the custom motorized/power wheelchair to turn and enter and exit, as well as necessary ramps to enter and exit the ICF/IID.
 - b) The environmental evaluation must be documented and signed by the resident/caregiver and DME provider for the custom motorized/power wheelchair.

- G. The Division of Medicaid covers a customized electronic interphase device, specialty and/or alternative controls if the resident is unable to manage a custom motorized/power wheelchair without the assistance of said device. The Division of Medicaid requires documentation of an extensive evaluation of each customized feature required for physical status and specification of the medical benefit of each customized feature.
1. For a joystick, the resident must demonstrate safe operation of the custom motorized/power wheelchair with an extremity, such as the hand or foot, using a joystick hand or foot operated device. The resident can manipulate the joystick with fingers, hand, arm, or foot.
 2. For a chin control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the chin control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their chin and safely operate the chair in all circumstances.
 3. For a head control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the head control device. The resident must have a medical condition which prevents the use of their hands/arms but is able to move their head freely with control of their head and can safely operate the chair in all circumstances.
 4. For an extremity control device, the resident must demonstrate safe operation of the custom motorized/power wheelchair with manipulation of the extremity control device. The resident must have a medical condition which prevents or limits fine motor skills during the use of their extremities but is able to move their hands/arms/legs to safely operate the chair in all circumstances.
 5. For a sip and puff feature, the resident must demonstrate safe operation of the custom motorized wheelchair with manipulation of the sip and puff control. The resident cannot move their body at all and cannot operate any other driver except this one.
- H. Custom manual and custom motorized/power wheelchairs are limited to one (1) per resident every five (5) years based on medical necessity. Reimbursement:
1. Is made for only one (1) custom manual and/or custom motorized/power wheelchair at a time.
 2. Includes all labor charges involved in the assembly of the wheelchair and all covered additions, accessories and modifications.
 3. Includes support services such as emergency services, delivery, setup, education and ongoing assistance with use of the wheelchair.
 4. Is made only after the PT or OT subsequent evaluation is completed.

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

- J. The DME provider providing custom motorized/power wheelchairs to residents must:
 - 1. Have at least one (1) employee with Assistive Technology Professional (ATP) certification from Rehabilitation Engineering and Assistive Technology Society of North America (RESNA) who specializes in wheelchairs and who must be registered with the National Registry of Rehab Technology Suppliers (NRRTS).
 - a) The NRRTS and RESNA certified personnel must have direct, in-person, face-to-face interaction and involvement in the custom motorized/power wheelchair selection for the resident.
 - b) RESNA certifications must be updated every two (2) years.
 - c) NRRTS certifications must be updated annually.
 - d) If the certifications are found not to be current, the prior authorization request for the motorized/power wheelchair will be denied.
 - 2. Provide a lifetime warranty on the powered mobility base frame against defects in material and workmanship for the lifetime of the resident.
 - 3. Provide a two (2) year warranty of the major components, beginning on the date of delivery to the resident.
 - a) The main electronic controller, motors, gear boxes and remote joystick must have a two (2) year warranty from the date of delivery.
 - b) Cushions and seating systems must have a two (2) year warranty or full replacement for manufacturer defects or if the surface does not remain intact due to normal wear.
 - 4. If the DME provider supplies a custom motorized/power wheelchair that is not covered under a warranty, the DME provider is responsible for any repairs, replacement or maintenance that may be required within the two (2) years.

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

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

1. The ICF/IID is responsible for the repairs, including labor and delivery, of custom manual and/or custom motorized/power wheelchairs delivered to the resident prior to January 2, 2015.
2. Major repairs and/or replacement of parts require prior authorization from a UM/QIO, the Division of Medicaid, or designated entity and must include an estimated cost of the necessary repairs, including labor, and documentation from the practitioner that there is a continued need for the custom manual and/or custom motorized/power wheelchair.
3. An explanation of time involved for repairs and/or replacement of parts must be submitted to a UM/QIO, the Division of Medicaid, or designated entity.
4. Manufacturer time guides must be followed for repairs and/or replacement of parts.
5. The Division of Medicaid defines repair time as point of service and does not include travel time to point of service.
6. No payment is made for repairs or replacement if it is determined that intentional abuse, or misuse, of the wheelchair or components has occurred. This includes damage incurred due to inappropriate covered transportation for the prescribed custom manual and/or custom motorized/power wheelchair.
7. Reimbursement will be made for up to one (1) month for rental of a wheelchair while the resident's wheelchair is being repaired.
8. The Division of Medicaid does not cover the repair of a rented custom manual and/or custom motorized/power wheelchair.

Source: 42 U.S.C. § 1395m; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 08/01/2017; New eff. 01/02/2015.