Title 23: Division of Medicaid

Part 207: Institutional Long-Term Care

Chapter 2: Nursing Facilities

Rule 2.5: Reimbursement

A. Participating Mississippi nursing facilities must prepare and submit a 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 reports and resident case-mix assessment data.

   2. Standard rates are calculated annually with an effective date of January first (1st).

   3. Rates are adjusted quarterly based on changes in the case-mix of the facility.

   4. In no case may the reimbursement rate for services exceed an individual nursing facility's customary charges to the general public for such services in the aggregate, except for those public nursing facilities rendering such services free of charge or at a nominal charge.

   5. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations.

   6. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or case-mix scores or to correct errors.

      a) These revisions may result from amended cost reports, field visit reviews, 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.

C. The Division of Medicaid conducts periodic cost report financial reviews of selected nursing facilities to verify the accuracy and reasonableness of the financial and statistical information

contained in the Medicaid cost reports. Adjustments will be made as necessary to the cost reports based on the results of the reviews.

D. Each nursing facility that is participating in the Medicaid program must 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 who are required to pay assessments must keep and preserve books and records as necessary to determine the amount of the assessments for which it is liable for no less than five (5) years.

   2. 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 nursing facility.

      b) All non-governmental nursing facilities must file cost reports based on the accrual method of accounting.

      c) Governmental nursing facilities have the option to use the cash basis of accounting for reporting.

   3. Documentation of financial and statistical data must be maintained in a manner consistent from one (1) period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.

   4. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the nursing facility cost report for the purpose of determining compliance with Medicaid rules.

      a) These records must be made available as requested by the Division of Medicaid.

      b) All documentation which substantiates the information included in the nursing facility cost report, including any documentation relating to home office and/or management company costs must be made available to the Division of Medicaid reviewers as requested by the Division of Medicaid.

E. The Division of Medicaid reimburses for the day of admission to a nursing facility.

   1. The day of discharge is not reimbursed by the Division of Medicaid unless it is the same day as the date of admission.

2. Nursing facilities cannot bill the resident or responsible party for the day of discharge.

F. The Division of Medicaid reimburses for home/therapeutic and inpatient hospital temporary leave.

1. Home/therapeutic temporary leave is limited to forty-two (42) days per year in addition to holidays listed in Miss. Admin. Code Part 207, Rule 2.8. Reimbursement is limited to fifteen (15) consecutive days per leave period.

2. Inpatient hospital temporary leave days are not limited except for reimbursement of a maximum of fifteen (15) consecutive days per leave period.

3. If the resident has utilized the fifteen (15) consecutive day maximum, the resident must return to the facility for twenty-four (24) consecutive hours before the nursing facility can be reimbursed for a new temporary leave period.

G. The Division of Medicaid does not reimburse for the following instances:

1. Nursing facilities which bill the Division of Medicaid for fifteen (15) consecutive days of home/therapeutic or inpatient hospital temporary leave, discharge the resident from the nursing facility, and subsequently refuse to readmit the resident under the nursing facility's resident return policy when a bed is available.

2. Inpatient hospital temporary leave for days when a resident is transferred to a Medicare skilled nursing facility (SNF) or a swing bed after an acute care hospitalization.

3. Medicaid billing of home/therapeutic or inpatient hospital temporary leave for more than fifteen (15) consecutive days.

H. Nursing facilities must bill the appropriate day code as follows:

1. For a resident who has a home/therapeutic temporary leave bill a home/therapeutic leave day code beginning the calendar day the resident:

a) Leaves the facility for eight (8) consecutive hours or more during the day excluding:

1) Dialysis,

2) Chemotherapy,

3) Physical therapy,

4) Speech therapy,

5) Occupational therapy, or

6) Medical treatments that occur two (2) or more days per week,

b) Is out of the facility at twelve midnight (12 a.m.),

c) Is out of the facility for a hospital observation stay of eight (8) or more consecutive hours, or

d) Returns from a therapeutic leave if the resident was out of the facility for eight (8) or more consecutive hours on the return day except for the day of return after a hospital observation stay of eight (8) or more consecutive hours.

2. For a resident who has an inpatient hospital temporary leave, bill an inpatient hospital leave day code beginning the calendar day the resident is admitted to an inpatient hospital for continuous acute care.

3. Bill a room and board day code:

a) If the resident does not meet the criteria for either a home/therapeutic or inpatient hospital temporary leave,

b) If the resident receives:

1) Dialysis,

2) Chemotherapy,

3) Physical therapy,

4) Speech therapy,

5) Occupational therapy, or

6) Medical treatments that occur two (2) or more days per week.

c) The day the resident returns to the nursing facility from an inpatient hospital acute care stay or a hospital observation stay of eight (8) or more consecutive hours, or

d) The day the resident returns to the nursing facility from a home/therapeutic leave if the resident was out of the facility for less than eight (8) consecutive hours. [Refer to Miss. Admin. Code Part 207, Rule 2.5.H.3.c)]

I. Nursing facilities are required to maintain complete and accurate room and board and temporary leave records in order to accurately bill the fiscal intermediary.

J. Nursing facilities must enter the correct temporary leave, regardless of the resident's payment source, in the case-mix web portal to match the billing records as specified in Miss.

Admin. Code Part 207, Rule 2.5.H.1. or 2.

1. The deadline for entering temporary leave information for the quarter is the fifth (5th) day of the second (2nd) month following the end of the quarter the leave occurred.

2. The case-mix review process includes a review and reconciliation of the facility's official home/therapeutic and inpatient hospital temporary leave records.

Source: 42 C.F.R. Part 447, Subparts B and C; Miss. Code Ann. §§ 43-13-117, 43-13-121, 43-13-145.

History: Revised eff. 11/01/2019; Revised eff. 08/01/2018 except for Miss Admin Code Part 207, Rule 2.5.F.1. revised to correspond with SPA 18-0005 (eff. 07/01/2018) eff. 08/01/2018.

Rule 2.8: Temporary Leave

A. The Division of Medicaid defines temporary leave as a temporary absence for one (1) or more calendar days the resident is out of the nursing facility for:

1. A home/therapeutic temporary leave.

   a) The temporary leave is defined as:

      1) Eight (8) consecutive hours or more during the day excluding:

         (a) Dialysis,

         (b) Chemotherapy,

         (c) Physical therapy,

         (d) Speech therapy,

         (e) Occupational therapy, or

         (f) Medical treatments that occur two (2) or more days per week.

      2) An absence at twelve midnight (12 a.m.), or

      3) A hospital observation stay of eight (8) or more consecutive hours.

   b) The first (1st) day of a temporary leave begins the calendar day the resident left the nursing facility.

   c) The end of the home/therapeutic temporary leave is the calendar day:

1) The resident returns to the nursing facility,

2) After the resident returns if the resident was out of the nursing facility for eight (8) or more hours as of midnight (12 a.m.) on the day the resident returned to the nursing facility,

3) The resident returns to the nursing facility after a hospital observation stay of eight (8) or more consecutive hours, or

4) The resident is admitted to an inpatient hospital acute care stay from an observation stay.

2. An inpatient hospital temporary leave.

a) The temporary leave is defined as an admission to the inpatient hospital for continuous acute care.

b) The first (1st) day of a temporary leave begins the calendar day the resident is admitted to the inpatient hospital for continuous acute care.

c) The end of the temporary leave is the calendar day the resident returns to the nursing facility.

B. Before the resident departs on home/therapeutic or inpatient hospital temporary leave, the nursing facility must provide a written notice to the resident and/or family member or legal representative explaining the nursing facility's temporary leave, bed-hold and resident return policies.

1. The written notice must define the period of time during which the resident is permitted to return and resume residence in the nursing facility.

2. The written notice must also state that if the resident's absence exceeds the Division of Medicaid's bed-hold limit the resident will be readmitted to the nursing facility upon the first availability of a semi-private bed if the resident still requires the services provided by the nursing facility.

C. The Division of Medicaid covers up to fifteen (15) consecutive days of home/therapeutic temporary leave per one (1) absence for up to a total of forty-two (42) days per state fiscal year, which begins July 1 and ends June 30 of the following calendar year, in addition to certain holidays.

1. The holidays included in home/therapeutic temporary leave are:

a) Christmas Day,

b) The day before Christmas Day,

c) The day after Christmas Day,

d) Thanksgiving Day,

e) The day before Thanksgiving Day, and

f) The day after Thanksgiving Day.

2. All home/therapeutic temporary leave days must be approved by the attending physician.

3. Home/therapeutic temporary leave includes the resident's absence for:

    a) Eight (8) or more consecutive hours during the calendar day or at midnight (12 a.m.),

    b) A hospital observation stay of eight (8) or more consecutive hours when the resident is not admitted for an inpatient hospital acute care stay, or

    c) Outpatient treatments except for:

        1) Dialysis,

        2) Chemotherapy,

        3) Physical therapy,

        4) Speech therapy,

        5) Occupational therapy, or

        6) Medical treatments that occur two (2) or more days per week.

4. The nursing facility must reserve the resident's bed in anticipation of the resident's return and cannot fill the resident's bed with another resident during the covered period of home/therapeutic temporary leave.

5. Nursing facilities cannot refuse to readmit a resident from home/therapeutic temporary leave if the facility has billed for home/therapeutic leave days and the resident still requires the services provided by the nursing facility.

6. After a fifteen (15) day home/therapeutic temporary leave period has been exhausted, a new leave of absence for home/therapeutic temporary leave does not begin until the resident has returned to the nursing facility for twenty-four (24) hours or longer.

D. The Division of Medicaid covers fifteen (15) consecutive days of inpatient hospital

temporary leave per each absence for continuous acute care during an inpatient hospital stay.

1. The period of leave is determined by counting the first (1st) day of leave as the calendar day the resident was admitted to an inpatient hospital for continuous acute care after leaving the nursing facility.

2. There is no maximum number of inpatient hospital temporary leave days per each state fiscal year.

3. Inpatient hospital temporary leave applies to acute care hospital stays in a licensed hospital including geriatric psychiatric units.

4. Inpatient hospital temporary leave does not apply if the resident is admitted for:

   a) Hospital observation stays,

   b) Medicare-only skilled nursing facility (SNF) stays, or

   c) Swing-bed stays.

5. After a fifteen (15) day inpatient hospital temporary leave period has been exhausted, a new leave of absence for acute hospitalization does not begin until the resident has returned to the nursing facility for a period of twenty-four (24) hours or longer.

6. As long as the resident has remained in the inpatient hospital receiving acute care and returns to any Medicaid certified nursing facility, the nursing facility is not required to complete a new Pre-Admission Screening (PAS) form.

7. Nursing facilities cannot refuse to readmit a resident from inpatient hospital temporary leave if the facility has billed for inpatient hospital leave days and still requires the services provided by the nursing facility.

8. The nursing facility must reserve the resident's bed in anticipation of the resident's return and cannot fill the resident's bed with another resident during the covered period of inpatient hospital temporary leave.

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

History: Revised eff. 11/01/2019; Revised eff. 08/01/2018 except for Miss Admin Code Part 207, Rule 2.8.C. revised to correspond with SPA 18-0005 (eff. 07/01/2018) eff. 08/01/2018.