



MISSISSIPPI DIVISION OF  
**MEDICAID**

## Administrative Code

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### Title 23: Medicaid Part 207 Institutional Long Term Care

## Table of Contents

|                                                                                                                      |    |
|----------------------------------------------------------------------------------------------------------------------|----|
| Part 207 .....                                                                                                       | 1  |
| Title 23: Division of Medicaid.....                                                                                  | 1  |
| Part 207: Institutional Long Term Care .....                                                                         | 1  |
| Part 207 Chapter 1: Long Term Care Pre-admission Screening.....                                                      | 1  |
| Rule 1.1: Clinical Eligibility Determination.....                                                                    | 1  |
| Rule 1.2: Exclusions .....                                                                                           | 2  |
| Rule 1.3: Qualification Requirements for Pre-Admission Screening and Resident Review (PASRR) Level I Evaluators..... | 2  |
| Rule 1.4: Documentation of Informed Choice.....                                                                      | 3  |
| Rule 1.5: Reserved .....                                                                                             | 3  |
| Rule 1.6: Appeals.....                                                                                               | 3  |
| Part 207 Chapter 2: Nursing Facility .....                                                                           | 3  |
| Rule 2.1: General .....                                                                                              | 3  |
| Rule 2.2: Provider Enrollment Requirements.....                                                                      | 4  |
| Rule 2.3: Remedies and Termination of Agreements.....                                                                | 4  |
| Rule 2.4: Dual Eligibles.....                                                                                        | 6  |
| Rule 2.5: Reimbursement.....                                                                                         | 7  |
| Rule 2.6: Per Diem.....                                                                                              | 11 |
| Rule 2.7: Admission Requirements .....                                                                               | 15 |
| Rule 2.8: Temporary Leave .....                                                                                      | 16 |
| Rule 2.9: Resident Assessment Instrument (RAI) .....                                                                 | 20 |
| Rule 2.10: Case Mix Reimbursement and Case Mix Review.....                                                           | 22 |
| Rule 2.11: Resident Funds .....                                                                                      | 22 |
| Rule 2.12: Nurse Aide Training.....                                                                                  | 34 |
| Rule 2.13: Release of Information .....                                                                              | 37 |

|                                                                                                                                                                                         |    |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----|
| Rule 2.14: Pharmacy .....                                                                                                                                                               | 38 |
| Rule 2.15: Ventilator Dependent Care .....                                                                                                                                              | 39 |
| Rule 2.16: Therapy Services .....                                                                                                                                                       | 46 |
| Rule 2.17: Feeding Assistant Program.....                                                                                                                                               | 46 |
| Rule 2.18: Individualized, Resident Specific Custom Manual and/or Custom<br>Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a<br>Specific Resident ..... | 48 |
| Rule 2.19: Disaster Procedures .....                                                                                                                                                    | 54 |
| Rule 2.20: Facility Initiated Discharges.....                                                                                                                                           | 56 |
| Part 207 Chapter 3: Intermediate Care Facility for Individuals with Intellectual Disabilities<br>(ICF/IID) 57                                                                           |    |
| Rule 3.1: General .....                                                                                                                                                                 | 57 |
| Rule 3.2: Provider Enrollment Requirements .....                                                                                                                                        | 58 |
| Rule 3.3: Duration and Termination of Provider Agreements.....                                                                                                                          | 58 |
| Rule 3.4: Admission Review .....                                                                                                                                                        | 60 |
| Rule 3.5: Per Diem.....                                                                                                                                                                 | 61 |
| Rule 3.6: Reimbursement.....                                                                                                                                                            | 65 |
| Rule 3.7: Temporary Leave Payment .....                                                                                                                                                 | 67 |
| Rule 3.8: Resident Personal Funds .....                                                                                                                                                 | 70 |
| Rule 3.9: Utilization Review.....                                                                                                                                                       | 82 |
| Rule 3.10: Release of Information .....                                                                                                                                                 | 82 |
| Rule 3.11: Individualized, Resident Specific Custom Manual and/or Custom<br>Motorized/Power Wheelchairs Uniquely Constructed or Substantially Modified for a<br>Specific Resident ..... | 83 |
| Rule 3.12: Disaster Procedures .....                                                                                                                                                    | 89 |
| Rule 3.13: Facility Initiated Discharges.....                                                                                                                                           | 91 |
| Part 207 Chapter 4: Psychiatric Residential Treatment Facility.....                                                                                                                     | 93 |
| Rule 4.1: General .....                                                                                                                                                                 | 93 |
| Rule 4.2 Provider Enrollment .....                                                                                                                                                      | 93 |

|                                                                                                                       |     |
|-----------------------------------------------------------------------------------------------------------------------|-----|
| Rule 4.3: Staffing .....                                                                                              | 93  |
| Rule 4.4: Admission.....                                                                                              | 95  |
| Rule 4.5: Non-Covered Services.....                                                                                   | 96  |
| Rule 4.6: Reimbursement.....                                                                                          | 96  |
| Rule 4.7: Active Treatment.....                                                                                       | 100 |
| Rule 4.8: Assessment and Evaluation.....                                                                              | 101 |
| Rule 4.9: Treatment Planning .....                                                                                    | 101 |
| Rule 4.10: Therapeutic Interventions.....                                                                             | 104 |
| Rule 4.11: Medical Treatment and Early and Periodic Screening, Diagnosis, and<br>Treatment (EPSDT) Requirements ..... | 110 |
| Rule 4.12: Special Procedures .....                                                                                   | 111 |
| Rule 4.13: Medication.....                                                                                            | 115 |
| Rule 4.14: Discharge Aftercare.....                                                                                   | 116 |
| Rule 4.15: Reporting Requirement .....                                                                                | 118 |
| Rule 4.16: Maintenance of Records.....                                                                                | 120 |

## **Title 23: Division of Medicaid**

### **Part 207: Institutional Long Term Care**

#### **Part 207 Chapter 1: Long Term Care Pre-admission Screening**

##### *Rule 1.1: Clinical Eligibility Determination*

- A. A Pre-Admission Screening and Resident Review (PASRR) Level I must be performed prior to admission to a Medicaid certified nursing facility (NF), except for the exclusions listed under Miss. Admin. Code Part 207, Rule 1.2., to:
1. Assess the person's clinical eligibility and need for NF services.
    - a) A person must meet the Division of Medicaid's specific numerical threshold for clinical eligibility, or be approved based on a secondary review, in order to be considered clinically eligible.
    - b) Clinical eligibility determinations, which are unable to be determined by the Division of Medicaid, will be submitted to a Mississippi licensed physician for the determination.
    - c) A person must also have signed physician's orders upon admission to the NF.
  2. Confirm whether or not the person has a mental illness (MI), an intellectual disability/developmental disability (ID/DD) and/or a related condition (RC), and/or
  3. Assess whether the person requires specialized rehabilitative services or supplemental services and supports.
- B. If the PASRR Level I confirms that an individual has MI, ID/DD and/or an RC, or if specialized rehabilitative services or supplemental services and supports are required then the individual must complete a PASRR Level II prior to admission to the NF. [Refer to Miss. Admin. Code Part 206, Chapter 3]
- C. The PASRR Level I must be submitted to the Division of Medicaid via the Envision web portal upon completion. The completed PASRR Level I must be faxed to the Division of Medicaid if the provider is not a Mississippi Medicaid provider.
- D. The provider who performs the PASRR Level I certification must retain the document in the person's medical record and must make it available to the Division of Medicaid upon request.

Source: Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: Revised eff. 06/01/19.

*Rule 1.2: Exclusions*

- A. A Pre-Admission Screening and Resident Review (PASRR) Level I is not required when a person is:
1. Admitted to a nursing facility (NF) when the person was discharged from an acute care hospitalization directly into a NF for continued treatment of a condition for a period of less than thirty (30) days.
    - a) The person must be admitted to a NF short stay covered under Medicare Part A, Medicare Part C Plan, or other payor, as a skilled NF resident, and
    - b) The attending physician must certify before admission to the NF that the person is likely to require less than thirty (30) days of NF services.
  2. Discharged from a NF due to exhaustion of hospital temporary leave days and is subsequently re-admitted to a NF.
  3. Transferring from one (1) Medicaid certified NF to a different Medicaid certified NF with or without an intervening hospital stay.
- B. If a person who enters a NF as an exempted hospital discharge is later found to require more than thirty (30) days of NF care, the State mental health or intellectual disability authority must conduct a resident review within forty (40) calendar days of the NF admission.

Source: 42 C.F.R. § 483.106; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised. eff. 06/01/19.

*Rule 1.3: Qualification Requirements for Pre-Admission Screening and Resident Review (PASRR) Level I Evaluators*

The Pre-Admission Screening Resident Review (PASRR) Level I must be completed by the following qualified individuals:

- A. Physician,
- B. Nurse Practitioner or Registered Nurse,
- C. Licensed Social Worker,
- D. Rehabilitation Counselor,
- E. Designee by facility/setting, or

F. Certified Assessor.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

*Rule 1.4: Documentation of Informed Choice*

- A. A person must be advised of all identified placement options funded by the Division of Medicaid as part of ensuring that an informed choice is made regardless of where a person applies for services. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. [Refer to Miss. Code Part 200, Rule 3.6]
- B. The PASRR Level I Informed Choice section must be signed by the person and/or their legal and/or designated representative.
- C. The PASRR Level I will not be processed without the Informed Choice section having being completed and signed.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

*Rule 1.5: Reserved*

History: Reserved eff. 06.01.19.

*Rule 1.6: Appeals*

Persons have the right to appeal long-term care eligibility denials. [Refer to Miss. Admin. Code Part 300]

Source: Miss. Code Ann. §§ 43-13-116, 43-13-117, 43-13-121.

History: Revised eff. 06/01/19.

**Part 207 Chapter 2: Nursing Facility**

*Rule 2.1: General*

- A. The Division of Medicaid will execute a provider agreement with a nursing facility (NF) only when the Mississippi Department of Health (MSDH) or Centers for Medicare and Medicaid Services (CMS) has certified the NF has met all participation requirements in accordance with federal and state law.

- B. The Division of Medicaid does not make payments to any NF 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 facility. A provider agreement is not valid, even though certified by the State survey agency, if the facility fails to meet the civil rights requirements set forth in 45 C.F.R. Parts 80, 84 and 90.

Source: 45 C.F.R. Parts 80, 84, 90; 42 C.F.R. §§ 442.10, 442.12, 483.1; Miss. Code Ann. §§ 43-11-1, 43-13-117, 43-13-121.

History: Revised eff. 04/01/2020.

#### *Rule 2.2: Provider Enrollment Requirements*

Nursing facility providers must meet all of the applicable requirements set forth in Miss Admin. Code Title 23, Part 200, Chapter 4.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2026.

#### *Rule 2.3: Remedies and Termination of Agreements*

- A. The Division of Medicaid will use one (1) or more of the following remedies when deemed appropriate by the Centers for Medicare and Medicaid Services (CMS) or the Division of Medicaid based on results of surveys conducted by the Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification (MSDH HFLC):
  - 1. Temporary Management,
  - 2. Denial of payment for new admissions,
  - 3. Civil money penalties,
  - 4. Transfer of residents,
  - 5. Closure of the facility and transfer of residents, and/or
  - 6. State monitoring.
- B. Remedies will be applied in accordance with federal and state requirements.
- C. The Division of Medicaid and/or CMS may terminate any Medicaid participating nursing facility's (NF's) provider agreement if an NF nursing facility:



1. Is not in substantial compliance with the requirements of participation, regardless of whether or not immediate jeopardy is present,
  2. Fails to submit an acceptable plan of correction within the timeframe specified by CMS and/or the Division of Medicaid, or
  3. Fails to relinquish control to the temporary manager, if that remedy is imposed by CMS and/or the Division of Medicaid.
- D. Notice of Termination: Before terminating a provider agreement, CMS and/or the Division of Medicaid will provide written notification to the NF and public notification via local and/or general newspaper publication as follows:
1. At least two (2) calendar days before the effective date of the termination for an NF with immediate jeopardy deficiencies, and
  2. At least fifteen (15) calendar days before the effective date of termination for an NF with non-immediate jeopardy deficiencies that constitute noncompliance.
- E. Reimbursement: When a provider agreement is terminated, federal regulations provide that payments may continue for no more than thirty (30) days from the date the provider agreement is terminated if it is determined that:
1. Reasonable efforts are being made to transfer the residents to another NF, community care, or other alternate care, and
  2. Additional time is needed to facilitate an orderly transfer of the residents.
- F. Discharge and Relocation of Residents
1. When CMS or the Division of Medicaid terminates a nursing facility's (NF) provider agreement, the Division of Medicaid will arrange for the safe and orderly transfer of all Medicare and Medicaid residents to another NF. The NF must send written notification to each Medicaid resident, legal representative and/or responsible party, and attending physician, advising of the impending closure.
  2. The resident or the resident's legal representative and/or responsible party must be given an opportunity to designate a preference for a specific NF or other alternative arrangements. A resident's rights/freedom of choice in selecting an NF or alternative to NF placement must be respected. An NF chosen for the relocation of a Medicaid beneficiary must be:
    - a) Title XIX certified and in good standing under its provider agreement, and
    - b) Able to meet the needs of the resident.

G. Resident Trust Fund Accounts maintained by the closing facility must be properly inventoried and receipts obtained for audit purposes by the Division of Medicaid. All documentation required to perform an audit of the residents' trust fund account must be maintained and available for review. This includes, but is not limited to, residents' trial balances, residents' transactions histories, bank statements, vouchers, and receipts of purchases. In addition, the NF must maintain a current surety bond to cover the total amount of funds in the trust fund account.

#### H. Reinstatement After Termination

1. When a provider agreement has been terminated by the Office of Inspector General (OIG), CMS and/or the Division of Medicaid under 42 C.F.R. § 489.53, a new agreement with that provider will not be accepted unless it is found that:
  - a) The reason for termination of the previous agreement has been removed and there is reasonable assurance that it will not recur, and
  - b) The provider has fulfilled, or has made satisfactory arrangements to fulfill, all of the statutory and regulatory responsibilities of its previous agreement.
2. To be considered for re-instatement the Division of Medicaid must receive:
  - a) A notification of re-instatement from the appropriate entity,
  - b) An application for re-instatement to participate in the Medicaid program, and
  - c) The Division of Medicaid has the sole discretion to determine the final retro-eligibility effective date.

Source: 42 C.F.R. Part 488, Subpart F; 42 C.F.R. §§ 483.10; 483.75; 489.53; 489.55; Miss. Admin. Code Title 15, Part 16, Subpart 1, Chapter 45; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2020.

#### *Rule 2.4: Dual Eligibles*

A state is not required to pay for any expenses related to payment for deductibles, coinsurance, or co-payments for Medicare cost sharing for dually eligibles that exceed what the state's Medicaid program would have paid for such service for a beneficiary who is not a dually eligible. When a state's payment for Medicare cost-sharing for a dually eligible is reduced or eliminated, the Medicare payment plus the state's Medicaid payment is considered payment in full; and the dually eligible cannot be billed the difference between the provider's charge and the Medicare and Medicaid payment. Medicare is the primary payor for dually eligible recipients, and providers are obligated to comply with the requirements covering the coordination between the two programs. Persons eligible for Medicare and Medicaid are entitled to all covered

services available under both programs, but a claim must be filed with Medicare, if Medicare covers the service.

Source: Miss. Code Ann. § 43-13-121; 42 U.S.C. 1396u-3; 42 CFR § 447.15; Balanced Budget Act of 1997, Social Security Act 1902 (a) (10)(E)

*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 (1<sup>st</sup>).
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 (5<sup>th</sup>) day of the second (2<sup>nd</sup>) 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 to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff 07/01/2021; 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 2.6: Per Diem*

- A. The nursing facility must provide and pay for all items and services required to meet the needs of a resident.
- B. Items and services covered by Medicare or any other third party must be billed to Medicare or the other third party and are considered non-allowable on the cost report. Applicable crossover claims must also be filed with the Division of Medicaid.
- C. The following items and services are included in the Medicaid per diem rates and cannot be billed separately to the Division of Medicaid or charged to a resident:
  1. Room/bed maintenance services,
  2. Nursing services,
  3. Respiratory therapy (RT) services,
  4. Dietary services, including nutritional supplements,
  5. Activity services,
  6. Medically-related social services,
  7. Laundry services including the residents' personal laundry,
  8. Over-the-counter (OTC) drugs,

9. Legend drugs not covered by Medicaid drug program, Medicare, private, Veterans Affairs (VA), or any other payor source,
10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the nursing facility. [Refer to Miss. Admin. Code Part 207, Rule 2.6.D. for medical supplies which must be billed outside the per diem rate.]
  - a) Enteral supplies,
  - b) Diabetic supplies,
  - c) Incontinence garments, and
  - d) Oxygen administration supplies.
11. Durable medical equipment (DME), and/or medical appliances, except for DME and/or medical appliances listed in Miss. Admin. Code Part 207, Rule 2.6.D. The Division of Medicaid defines DME and/or medical appliances as an item that (1) can withstand repeated use, (2) primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the nursing facility.
12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:
  - a) Hair hygiene supplies,
  - b) Comb and brush,
  - c) Bath soap,
  - d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,
  - e) Razor and shaving cream,
  - f) Toothbrush and toothpaste,
  - g) Denture adhesive and denture cleaner,
  - h) Dental floss,



- i) Moisturizing lotion,
- j) Tissues, cotton balls, and cotton swabs,
- k) Deodorant,
- l) Incontinence supplies,
- m) Sanitary napkins and related supplies,
- n) Towels and washcloths,
- o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and
- p) Bathing.

13. Private room coverage as medically necessary:

- a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.
- b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.

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

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

16. The nursing facility cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. Nursing facilities may use NET providers that also provide NET services for the NET Broker if:

- a) The nursing facility arranges the transportation, and
- b) Pays the NET provider directly.

D. The following items and services are not included in the Medicaid per diem rates, are

considered non-allowable costs on the nursing facility's cost report, and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the nursing facility:

1. Laboratory services,
  2. X-ray services,
  3. Drugs covered by the Medicaid drug program, Medicare, Veteran's Affairs (VA), or any other payor source,
  4. Physical therapy (PT), occupational therapy (OT), and speech-language pathology (SLP) services,
  5. Ostomy supplies,
  6. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,
  7. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015.
  8. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident effective January 2, 2015. [Refer to Miss. Admin. Code Part 207, Rule 2.18 for definition and coverage criteria.]
  9. Emergency transportation described in Miss. Admin. Code Part 201.
- E. Prior authorization from a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid or designated entity is required for the following:
1. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident, and
  2. PT, OT and SLP services, and
  3. All other DME and/or medical appliances identified in Part 209 requiring prior authorization.
- F. Prior authorization from the Division of Medicaid or UM/QIO is required for ventilators except for those in a Nursing Facility for the Severely Disabled (NFSD).
- G. All nursing facilities must prominently display the below information in the nursing facility, and provide to applicants for admission and residents the below information in both oral and written form:
1. How to apply for and use Medicare and Medicaid benefits, and

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

H. The nursing facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of:
  - a) The items and services that are included in the nursing facility services under the State Plan and for which the resident may not be charged, and
  - b) Those other items and services that the nursing facility offers and for which the resident may be charged, and the amount of charges for those services.
2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 2.6.G.1.
3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

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

1. The nursing facility's non-Medicaid per diem rate may be set above the Medicaid per diem rate but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.
2. Items and services available in the nursing facility not covered under Title XVIII or the nursing facility's Medicaid per diem rate must be available and priced identically for all residents in the facility.

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

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

History: Revised eff. 05/01/2022; Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 2.6.C.15 and D.9 eff. 09/01/2018; Revised to correspond to SPA 18-0001 (eff. 01/01/2018) eff. 8/01/2018. Revised eff. 08/01/2017; Removed Miss. Admin. Code Part 207, Rule 2.6.D.6 (retroactively eff. 01/02/2015) eff. 11/01/2016; Revised eff. 01/02/2015.

*Rule 2.7: Admission Requirements*

- A. A Pre-Admission Screening and Resident Review (PASRR) Level I must be completed to determine clinical eligibility for persons seeking admission to a Division of Medicaid certified nursing facility (NF) regardless of payment source except for the exclusions listed in Miss. Admin. Code Part 207, Rule 1.2.
  - 1. The PASRR Level I must be submitted to the Division of Medicaid's Envision web portal upon completion. The completed PASRR Level I must be faxed to the Division of Medicaid if the provider is not a Mississippi Medicaid provider.
  - 2. A person must receive a PASRR Level I numerical threshold score of fifty (50) or greater to be clinically eligible for NF placement, or be determined clinically eligible through a secondary review or physician's determination.
  - 3. Persons with mental illness (MI), an intellectual disability/developmental disability (ID/DD) and/or a related condition (RC) determined to require a NF level of care must receive a PASRR Level II to ensure appropriate placement and the provision of necessary specialized rehabilitative services or supplemental services and supports regardless of payment source.
- B. The PASRR Level I Section X summary, physician's admission orders for the persons immediate care, applicable communication form, and PASRR Level II, if required, must be submitted electronically by the admitting NF to the Medicaid Regional Office of the person's county of residence for determining Medicaid eligibility.
- C. Persons seeking admission to a Nursing Facility for the Severely Disabled (NF-SD) must meet the following additional requirements:
  - 1. Have a diagnosis of spinal cord injury, closed head injury, long-term ventilator dependency or another diagnosis similar or closely related to the severity and involvement of care of those diagnoses, and
  - 2. Be assigned one (1) of the following Minimum Data Set (MDS) Resource Utilization Group (RUG)-IV 48 Grouper categories: ES3, ES2, HE2, HE1, HD2, HD1, HC2, HC1, HB2, HB1, LE2, LE1, LD2, LD1, LC2, LC1, LB2, LB1.

Source: 42 U.S.C. §§ 1395i-3, 1396r; 42 C.F.R. §§ 435.1010, 483.100-483.106, 483.112; 483.120; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised eff. 06/01/19; Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

#### *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 (1<sup>st</sup>) 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 (1<sup>st</sup>) 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 (1<sup>st</sup>) 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.

*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 and the Division of Medicaid's requirements as follows:
1. An Admission Assessment, which is a comprehensive assessment, must be completed by the fourteenth (14<sup>th</sup>) calendar day of the resident's admission.
  2. An Annual Assessment, which is a comprehensive assessment, must be completed within three hundred sixty-six (366) calendar days of the previous assessment reference date for an OBRA comprehensive and ninety-two (92) calendar days of the previous assessment reference date for an OBRA Quarterly assessment.
  3. A Significant Change in Status Assessment, which is a comprehensive assessment, must be completed by the fourteenth (14<sup>th</sup>) calendar day following the determination that a significant change has occurred.
  4. A Quarterly Assessment, which is a non-comprehensive assessment, must be completed no less than eighty (80) calendar days and no more than ninety-two (92) calendar days from the previous assessment reference date.
  5. A Significant Correction to Prior Comprehensive Assessment must be completed no later than the fourteenth (14<sup>th</sup>) calendar day following the determination that a significant error in a prior comprehensive assessment has occurred.

6. A Significant Correction to Prior Quarterly Assessment, which is a non-comprehensive assessment, must be completed no later than fourteen (14) days following the determination that a significant error in a prior quarterly assessment has occurred.

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. 05/01/2022; Revised eff. 08/01/2017; Revised to correspond to MS SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.10: Case Mix Reimbursement and Case Mix Review*

- A. The Division of Medicaid utilizes a resource utilization grouper-version 4 (RUG-IV) forty-eight (48) group model for case mix calculation for reimbursement.
  1. Each of the forty-eight (48) resident classifications as well as the default classification is assigned case mix weights.
  2. The classifications are calculated electronically using the minimum data set (MDS) assessment data and the RUG-IV calculation program.
- B. Clinical documentation must be maintained in the clinical record which supports the MDS 3.0 assessment and substantiates the resources and services needed to provide care to the resident.
  1. Review results are based only on the supporting original clinical documentation available and presented during the review.
  2. No additional original clinical documentation will be accepted after the exit conference.
- C. Documentation for case mix reimbursement must adhere to the Division of Medicaid's Supportive Documentation Requirements.
- D. In addition to the clinical documentation review, the case mix review process includes a review of the facilities' official bed hold record which includes therapeutic and hospital leave records.

Source: 42 C.F.R. § 483.75; Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; Revised eff. 04/01/2017. Revised to correspond to SPA 15-004 (eff. 01/01/2015) eff. 07/01/2015.

*Rule 2.11: Resident Funds*

- A. Basic Requirements

1. The facility must, upon written authorization by the resident, accept responsibility for holding, safeguarding and accounting for the resident's personal funds. The facility may make arrangements with a federally or state insured banking institution to provide these services, but the responsibility for the quality and accuracy of compliance with the requirements of this section remains with the facility. The facility may not charge the resident for these services, but must include any charges in the facility's basic daily rate.
  2. Resident fund accounts are reviewed to assist facilities in developing acceptable systems of accounting for resident funds.
  3. Penalties may be assessed on any licensed nursing facility that fails to maintain an auditable system of accounting for residents' funds or has had repeated instances of noncompliance with the provisions of federal law and of the requirements contained in this section.
- B. Statement Provided at Time of Admission - The facility must provide each resident and responsible party with a written statement at the time of admission that states the following:
1. All services provided by the facility must be distinguished between the services included in the facility's basic rate and those services not included in the facility's basic rate. The statement must include both the services that may be charged to the resident's personal funds and the amount of such charges.
  2. There is no obligation for the resident to deposit funds with the facility.
  3. The resident has the right to select how personal funds will be handled. The following alternatives must be included:
    - a) The resident's right to receive, retain and manage his/her personal funds or to have this done by a legal guardian, if any,
    - b) The resident's right to apply to the Social Security Administration to have a representative payee designated for purposes of federal or state benefits to which he/she may be entitled,
    - c) The resident's right to designate, in writing, another person to act for the purpose of managing his/her personal funds, and
    - d) The resident's right to require the facility to hold, safeguard, and account for such personal funds under a system established and maintained by the facility, if requested by the resident.
  4. Any charge for this service is included in the facility's basic rate.
  5. The facility is permitted to accept a resident's funds to hold, safeguard, and account for,

only upon the written authorization of the resident or representative, or if the facility is appointed as the resident's representative payee.

6. The facility is required to arrange for the management of the resident's personal funds if the resident becomes incapable of managing his/her personal funds and does not have a representative.
  7. The facility must maintain a complete copy of its resident trust fund policies and procedures and must make them accessible and available for review.
- C. Individual Records - The facility must maintain current, written, individual records of all financial transactions involving the resident's personal funds which the facility has been given for holding, safeguarding, and accounting. The facility must act as fiduciary of the resident's funds and account for these funds in an auditable manner. The facility must use Generally Accepted Accounting Principles (GAAP) when maintaining these records. GAAP means that the facility, for example, employs proper bookkeeping techniques by which it can determine, upon request, all deposits and withdrawals for each resident, how much interest these funds have earned for each resident, and the amount of individual resident funds. Resident fund records must:
1. Include the resident's name.
  2. Identify the resident's representative, if any.
  3. Include the resident's admission date.
  4. Show the actual transaction date and amount of each deposit and withdrawal.
  5. Reflect the actual date of an adjusting or correcting entry.
  6. State the name of the person who accepted the withdrawn funds.
  7. Show the balance after each transaction.
  8. Provide the appropriate signatures for all disbursements of funds, such as:
    - a) Resident's signature,
    - b) Resident's mark, or "x" with two witnesses' signatures,
    - c) Power of attorney's signature,
    - d) Resident's responsible party when the amount disbursed is supported by appropriate documentation, or
    - e) Two signatures of facility personnel when the amount disbursed is supported by

appropriate documentation.

9. Document transaction with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, except the residents and their power of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. The facility must reimburse the resident's account for any undocumented transactions.
10. For powers of attorney, the provider must maintain a copy of the power of attorney in the resident's file, and before the provider can allow withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them.
11. Reflect the resident's earned interest, if any.
12. Be reconcilable, at all times, with the current bank statement and/or petty cash.
13. Not include as an outstanding item any check written on a resident's account that has not been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 3 Rule 3.7 M., and
14. Be kept for at least five years after the resident's discharge or death.

#### D. Limitation on Charges to Resident Funds

1. Acceptable charges to resident funds include, but are not limited to, the following general categories and examples, if proper authorization and documentation, as specified in under the heading "Individual Records" of this section is provided. The facility must notify the resident and/or responsible party, in advance, that there will be a charge for non-Medicaid covered items and services, such as:
  - a) Personal communication/entertainment items and services, like a telephone, television, radio, and computer,
  - b) Personal comfort items, including tobacco, novelties, and candy,
  - c) Items and services in excess of those included in the Medicaid per diem rate, such as grooming or cosmetic items which are requested by the resident. The resident must be furnished in advance with an itemized statement of charges for these items and services,

- d) Personal clothing,
  - e) Personal reading material,
  - f) Gifts purchased on behalf of the resident,
  - g) Flowers and plants for the resident's room,
  - h) Entertainment and social events outside the scope of that provided by the facility and included in the Medicaid per diem rate,
  - i) Private sitters or aides,
  - j) Private room provided that a private room is not medically necessary, such as isolation for infection control,
  - k) Specially prepared or alternative food requested instead of or in addition to the food generally prepared by the facility, and
  - l) Authorized cost-sharing in Medicaid-covered services, including Medicaid Income liability for room and board.
2. Unacceptable charges to resident funds include the following categories and examples:
- a) Any charge not authorized and documented.
  - b) Nursing, dietary, activities, room/bed maintenance, and personal hygiene services.
  - c) Medically necessary items and services are reimbursed as part of the Medicaid per diem rate. However, any properly made charge for equipment or services, such as geriatric or geri-chairs, wheelchairs, support shoes, gurneys, and counseling services, must be supported by a written statement from the resident's physician that documents the item or service was not of medical necessity. Failure to maintain the physician's denial of medical necessity statement may result in the facility's reimbursement of charges to a resident's account.
  - d) Transportation.
  - e) Any item or service requiring a waiver of the resident's personal needs allowance, such as for repayment of a debt owed the facility. The personal needs allowance may be used by a nursing facility for nursing facility costs only upon the written authorization of the resident or the resident's responsible party and with the understanding by the resident that this action is voluntary and is not a requirement.
  - f) Loans or collateral for loans to anyone, including the facility and other residents in the trust fund. A resident's balance must be positive at all times, as a resident with a

negative balance is in effect borrowing money from the other residents.

g) Transfers or gifts of money not authorized by the resident, such as when the resident's responsible party transfers funds without documentation that the funds were used for the benefit of the resident.

h) Any item or service as a condition of admission or continued stay.

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

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

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

1. The facility must deposit any resident's personal funds in excess of fifty dollars (\$50.00) in an interest bearing account(s) that is separate from any of the facility's operating accounts. The facility must credit all interest earned on such separate account(s) in one of the following ways, at the election of the facility:

a) Prorated to each resident's account on an actual interest-earned basis; or

b) Prorated to each resident's account on the basis of its end-of-quarter balance.

2. The facility must maintain a resident's personal funds that do not exceed fifty dollars (\$50.00) in a non-interest bearing account, an interest-bearing account, or a petty cash fund. However, if the facility maintains a resident's personal funds of fifty dollars (\$50.00) or less in a pooled account with all other residents' funds, interest is accumulated based on the total amount of funds in the trust fund account; therefore, all residents must be allocated interest proportionately in that instance.

3. The facility may neither limit nor restrict any resident with funds on deposit within the resident trust fund account to a maximum of fifty dollars (\$50.00). A facility may not establish policy that conflicts with this absolute right of the residents for the facility to hold, safeguard, manage, and account for all residents' funds deposited with the facility.

#### H. Access to Funds

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

#### I. Accounting on Change of Ownership

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

#### J. Accounting Upon Death or Discharge of Resident

1. The facility must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the facility must convey the resident's funds and provide a final accounting to the:
  - a) Resident's next of kin,
  - b) Resident's representative, or
  - c) Clerk of the probate court of the county in which the resident died.



2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility

- a) Any Medicaid beneficiary receiving medical assistance for services provided in a long-term care facility who dies intestate and leaves no known heirs shall have deemed, through acceptance of such medical assistance, the Division of Medicaid as the beneficiary of funds in his/her possession at the time of death, in an amount not to exceed two hundred fifty dollars (\$250.00). The Division of Medicaid is the beneficiary of these funds regardless of whether a claim is later made to the beneficiary's property in accordance with Miss. Code Ann. § 43-13-120(3) and (4).
- b) The long-term care facility shall make a report to the State Treasurer of all funds, including any accrued interest, in the possession of the Medicaid beneficiary at the time of death. The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased Medicaid beneficiary and his/her last known address prior to entering the facility, the name and last known address of each person who may possess an interest in such funds, and any other information which the State Treasurer prescribes by regulation. This report must be filed with the State Treasurer, with a copy to the Division of Medicaid, prior to November 1 of the year in which the facility provided services to the Medicaid beneficiary having funds to which this section applies.
- c) Within one hundred twenty (120) days from November 1 of each year in which a report is made, the State Treasurer shall cause notice to be published in the newspaper in accordance with Miss. Code Ann. § 43-13-120(3). The Division of Medicaid shall pay the cost of publishing the notice.
- d) The long-term care facility that makes a report of funds of a deceased Medicaid beneficiary shall pay over and deliver such funds, including any accrued interest, to the State Treasurer not later than ten (10) days after notice of such funds has been published by the State Treasurer.
- e) If within ninety (90) days of the State Treasurer's publication no claims are made to the funds in excess of the two hundred fifty dollars (\$250.00) the Division of Medicaid has already received pursuant to 2.a) above, the State Treasurer shall place those funds in a special account in the State Treasury to the credit of the Division of Medicaid.

3. Disposition of Funds for Deceased Resident Who Dies Intestate in a State Institution

- a) Miss. Admin. Code Part 207, Rule 2.11.J.2. 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 any known heirs may be deposited in the facility's operational account, after a period of

one (1) year from the date of death.

#### K. Surety Bond

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

facilities. The intent of focus is to ensure that if a corporation were to go bankrupt or otherwise cease to operate, the funds of the residents in the corporation's facilities would be protected.

#### L. Resident Incapable of Managing Funds

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

#### M. Notice of Resource Limits, Medicaid or SSI

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

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

1. Basic Rate - Also referred to as the standard or per diem rate. This is the rate that Medicaid pays the facility per Medicaid resident per day, as established periodically from cost reports and assessment data. The basic rate is important in the discussion of resident funds in that items and services included in the rate cannot be charged to a resident; the resident must be informed, in writing at the time of admission, of the items and services provided by the facility, as well as the items and services not included in the basic rate, and the amount of such charges that may be charged to the resident.

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

disbursements from the resident fund, just as any other responsible party for any other resident.

11. Medicaid Income - The Medicaid income is the dollar amount shown on a resident's form DOM-317. It is the maximum liability that the resident owes to the facility each month for room and board.
12. Medically Necessary Items and Services - Those items and services that are documented by the attending physician or medical personnel delegated by the attending physician as reasonable and necessary. If a resident's personal funds are expended for an item or service covered in the facility's basic rate, evidence must be in the resident's file to verify that the item or service is not medically necessary, and therefore justifiable as an expenditure of the resident's personal funds.
13. Obligee - The party to whom the facility is legally or morally bound, i.e. "the residents of the trust fund". The obligee is the beneficiary of funds collected in the event of the failure of the facility to hold, safeguard, manage, and account for the resident's funds.
14. Per Diem Rate - Refer to "Basic Rate."
15. Personal Needs Allowance (PNA) - The amount of funds a resident is allowed to keep after room and board liability, supplemental health insurance premiums, and allowable minimum monthly needs allowances are deducted from the resident's gross income.
16. Plan of Correction - An acceptable plan of correction must address each exception noted in the findings letter and include the following:
  - a) Documentation that the exception has been corrected,
  - b) The measures that have been put in place to ensure that the exception will not be repeated, and
  - c) The measures that have been put in place to monitor the continued effectiveness of the changes.
17. Reconciliation - At all times, the total of the residents' funds held, as noted from the bank's current statement of the balance and any cash held at the facility, must equal the total of the resident's funds as noted from the facility's accounting ledger for all residents participating in the resident trust fund. Any difference between the two (2) totals must be accounted for by documented outstanding credits and debits, or documented reconciling items such as unposted current interest, unposted petty cash vouchers, or corrections.
18. Representative Payee - A resident may have someone designated to receive and manage their Social Security, Veterans Administration, Railroad Board, or other federal or state benefits. That party is the representative payee for the resident. A facility must be willing to be designated as a temporary representative payee if no responsible party is

available to represent the resident.

19. Resident's Personal Funds - All of a resident's money on deposit with the facility, including all of the resident's funds, regardless of the source, that are placed in trust at the facility.
20. Resource Limit - The maximum amount of assets a resident may have in order to qualify for Medicaid services. For trust fund review purposes, there are two (2) resource limits to be considered, the Supplemental Security Income (SSI) resource limit and the Medicaid resource limit.
21. Responsible Party - For resident trust fund purposes, may be known as sponsor or residents representative. A resident may serve as his own responsible party. In other instances, the responsible party is the individual who signs appropriate documentation, commonly known as a Trust Fund Authorization form, to assist the resident in managing the personal funds of the resident that are maintained within the resident trust fund account. Any withdrawal of funds by a responsible party must be for the benefit of the resident, must be signed, and must be supported by appropriate documentation (e.g., receipts or invoice).
22. State Institution - These are facilities owned and operated by the State, such as: Mississippi State Hospital, Ellisville State School, East Mississippi State Hospital, North Mississippi Regional Center, Hudspeeth Regional Center, South Mississippi Regional Center, University of Mississippi Medical Center, and the Boswell Regional Center. This listing is not intended to be all inclusive.
23. Testate - Having a valid will at the time of death.
24. Trial Balance - A listing of all residents participating in the resident trust fund and the balance of each resident's trust fund.
25. Written Authorization - Authorization to establish a resident trust fund for a resident must be in the form of a written statement signed by the resident or responsible party. In addition, authorization to perform a specific transaction of funds for the resident must be in writing and/or documented with a receipt of purchase.

Source: 42 U.S.C. § 1396r; 42 C.F.R. §§ 431.53, 447.15, 483.420; Miss. Code Ann. §§ 43-13-120, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/2018; Revised eff. 12/1/2017.

### *Rule 2.12: Nurse Aide Training*

#### **A. Nurse Aide Training and Testing Reimbursement**

1. The Division of Medicaid uses the direct reimbursement method for nurse aide training

and testing expenses incurred by nursing facilities.

2. Reasonable cost of training and competency testing of nurse aides in order to meet the requirements necessary for the nurse aide to be certified are to be billed directly to Medicaid

#### B. In-House Training Programs

1. The nursing facility will be directly reimbursed by Medicaid for covered services, equipment, and supplies. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.
2. Services and supplies approved for payment will be subject to application of the nursing facility's percentage of Medicaid utilization. The Medicaid utilization percentages of every facility are redetermined annually and are applicable for one (1) state fiscal year. The percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Nurse aide training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.
3. Only costs actually incurred by the facility will be considered for reimbursement. No reimbursements will be made for estimated cost.
4. In-house training programs refer to the training area set up within a nursing facility or training center. In-house training programs include training areas set up by a nursing facility in a remote location due to space restrictions. A training center is an area set up for nurse aide training which serves more than one (1) facility and is located in an area remote from any of the associated facilities.

- C. Testing Fees are allowable for direct reimbursement for nurse aides who have been through an approved certification training program. Medicaid will reimburse for written or oral and clinical testing fees based on the fee schedule from the current testing services contracted by MSDH. Testing reimbursement will be subject to a nursing facility's Medicaid utilization percent just like training reimbursement. Testing must be billed by the employing facility of the nurse aide who was tested. This applies even to nurse aides trained in a training center. Training centers do not bill the nurse aide testing fees. Medicaid will reimburse the cost for a nurse aide to be tested up to three (3) times. If after three (3) attempts, a nurse aide fails to pass the tests, Medicaid requires the aide to complete another training program before any additional tests will be reimbursed. Testing fees must be billed with thirty (30) days of the test date. Pass/fail results must be included with the billing. Pass/fail results can include either the results received from the current testing service or the actual results given to the aides at the time of the tests.

#### D. Out of Facility Training

1. Facilities which do not have an approved nurse aide training and testing program and are not associated with an approved training center may acquire training for their employed aides at any approved non-facility-based Nurse Aide Training and Competency Evaluation Program (NATCEP). Medicaid has set a limit on reimbursable cost on training and evaluating a nurse aide outside the facility.
  2. The current limit is set at five hundred dollars (\$500.00) for each nurse aide's training session and testing. Medicaid will apply the Medicaid utilization percent of the employing facility to the lesser of the cost incurred or the limit to determine the amount reimbursable. Under no circumstances will Medicaid reimburse a facility for off-site training and testing costs when it is determined that the off-site training and testing site is receiving reimbursement from Medicaid for the same training or testing session. Out of facility training should be billed using the billing form for nurse assistant training expenses. Pass/fail results should be submitted with the billing form if the aide was tested.
  3. Facilities that do not have an approved nurse aide training program, which receive training for their employed nurse aides at an approved site that is a related party, are subject to reimbursement limits at cost. The training program must submit to Medicaid a record of the actual allowable costs incurred to run the training program for a month. Costs are determined allowable following the guidelines stated for approved training centers. Documentation must be submitted with the record of costs in accordance with other paragraphs of this section. The allowable reimbursement for each nurse aide trained for the related party nursing facility will be limited to cost and will be subject to the application of the Medicaid utilization percent.
  4. The Medicaid utilization percent is determined by the total allowable monthly costs that will be divided by two (2) to recognize the time for two (2) training sessions of two (2) weeks each in each month. The monthly costs will be further divided by the maximum number of aides allowed in each training session. This calculation will result in the determination of the allowable tuition rate for a nurse aide employed by a related party nursing facility. The related party nursing facility will bill Medicaid the predetermined allowable tuition rate. Medicaid will then apply the facility's Medicaid utilization percent when approving the billing. The training program will be allowed to submit actual monthly costs as often as once per month. Submission of costs for subsequent months are only required when there is a permanent change. Facilities will have an option exercisable at the beginning of each state fiscal year and at the inception of the training program to report actual numbers of aides trained in total and for the related party nursing facility in each training session in order to prorate the monthly costs.
- E. Reimbursement to an Individual Not Yet Employed at the Time of Training - Medicaid will reimburse the cost of an approved nurse aide training and competency evaluation program to an individual who is not employed, or who does not have an offer of employment, as a nurse



aide on a pro rata basis under the following conditions:

1. The individual is employed or receives an offer of employment from a nursing facility not later than twelve (12) months after completing an approved program.
  2. The individual incurred costs for the training and testing and can provide documentary evidence of them. Medicaid will not reimburse costs to an individual who received training through a grant.
  3. Medicaid will not approve costs in excess of the training and testing limits set for out-of-facility training. The Medicaid utilization percent(s) of the facility(s) which employs the nurse aide will be applied to the approved cost to determine the reimbursement amount.
  4. Medicaid will reimburse one-half (1/2) of the settlement after six (6) months of full time employment by one (1) or more Mississippi nursing facilities. The remaining one-half (1/2) of the settlement will be reimbursed after the nurse aide has been employed full time for twelve (12) months by Mississippi nursing facilities.
  5. The facility which employs the nurse aide must submit the bill for reimbursement to Medicaid on the billing form for Nurse Assistant Training Expenses.
- F. Prohibition of Charges - No nurse aide who is employed by, or who has an offer of employment from, a facility on the date on which the aide begins training and testing program may be charged for any portion of the program.
- G. Withdrawal of Program Approval - MSDH will notify Medicaid in writing when program approval is withdrawn. As a result, reimbursement from Medicaid will be stopped as of the date of withdrawal of program approval. As an exception, Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval. If it is determined by the MSDH that the equipment and supplies purchased for the nurse aide training program were never used for nurse aide training, Medicaid will require reimbursement from the facility for all costs incurred by Medicaid. Where possible used training equipment should be transferred to another approved training site. Any funds received from the sale of nurse aide training equipment, which was paid for by Medicaid must be refunded at the Medicaid utilization percent in effect at the time of original reimbursement.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 483; OBRA 1987

*Rule 2.13: Release of Information*

- A. Public access to records maintained by the Medicaid agency is mandated. The exceptions to public access are those records which are exempt as confidential or privileged.
- B. Beneficiary-Specific Information will only be released by the Medicaid agency when the requirements of federal regulation 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 Medicaid agency,
  2. The information is available in existing agency files or reports, and
  3. The requestor reimburses the Medicaid agency 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 Medicaid agency annual report or other reports generated for agency reporting or administrative purposes. The requestor shall reimburse the Medicaid agency for the costs associated with the compilation of the requested material, as permitted by law.

Source: Miss. Code Ann. § 43-13-121; 25-61-1; 42 CFR 431.300 - 431.307; 45 CFR 160.164

*Rule 2.14: Pharmacy*

- A. Beneficiaries in nursing facilities may obtain medications from pharmacies holding retail, closed door or institutional permits. Nursing facility (NF) residents may receive unlimited prescriptions per month if the medication orders, signed by the prescribing provider, are documented in the individual patient record and maintained at the nursing facility.
- B. Beneficiaries maintain the ability to obtain Medicaid services from any institution, agency, pharmacy, person or organization that is qualified to furnish the services and willing to furnish them to that beneficiary. Participation in any package plan for medical care, such as those furnished by nursing facilities, must be strictly voluntary.
- C. A resident of a long-term care facility is allowed freedom of choice of pharmacy providers for drugs covered by the Medicaid drug program. The freedom of choice is limited to pharmacies that meet labeling and packaging requirements established by the Mississippi State Board of Pharmacy.
- D. Consequently, once a beneficiary chooses a particular provider or NF, he or she has clearly exercised freedom of choice with the respect to all items of medical care included within the scope of that nursing facility, including all services provided or arranged for by the NF which are reimbursed through the NF rates.

Source: Miss. Code Ann. § 43-13-121; Social Security Act 1902 (a)(23)

*Rule 2.15: Ventilator Dependent Care*

- A. The Division of Medicaid defines ventilator dependent care (VDC) as mechanical ventilation for life support designed to replace and/or support normal ventilatory lung function.
- B. Effective January 1, 2015, the Division of Medicaid provides an established reimbursement per diem rate in addition to the standard per diem rate to Mississippi nursing facilities, excluding out-of-state nursing facilities and Nursing Facilities for the Severely Disabled (NF-SD), for residents requiring VDC services. Effective January 1, 2015, Mississippi nursing facilities will receive the following reimbursement for a ventilator dependent resident:
  - 1. A standard per diem, and
  - 2. A ventilator per diem.
- C. Mississippi nursing facilities providing VDC services must file a VDC Addendum to its current provider agreement and it must be approved by the Division of Medicaid.
  - 1. The VDC Addendum must include required attestations regarding the nursing facility requirements consistent with Miss. Admin. Code Part 207, Rule 2.15 including, but not limited to:
    - a) Number of beds designated to serve ventilator dependent residents,
    - b) Required equipment,
    - c) Staffing ratios for the VDC resident(s), and
    - d) Documentation of a formal relationship between the nursing facility and a local hospital for the emergency care of all ventilator dependent residents.
  - 2. The Division of Medicaid reserves the right to approve VDC Addendums at its discretion based on:
    - a) Geographic coverage,
    - b) Market saturation, and/or
    - c) The ability of the nursing facility to demonstrate compliance with certification requirements.
  - 3. The approval of the VDC Addendum is dependent upon:
    - a) Successful completion of the VDC Addendum and submission of required documents,

- b) Establishment of policies to support the operations of VDC services,
  - c) Successful completion of an on-site visit by Mississippi State Department of Health (MSDH), Health Facilities Licensure and Certification (HFLC), and
  - d) The nursing facility's completion of all other required documents applicable to providing VDC services as requested by HFLC or the Division of Medicaid.
- 4. The Division of Medicaid will close a VDC Addendum if the provider fails to submit any requested information or documentation within thirty (30) days of a request by the Division of Medicaid. Once closed, a provider is not eligible to re-apply for three (3) months.
- D. The Division of Medicaid reserves the right to terminate a nursing facility's provider agreement, including the VDC Addendum, based on failure to comply with Administrative Code requirements and/or state licensure and federal requirements.
  - 1. Upon receipt of a termination notice, the nursing facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process.
  - 2. Upon the Division of Medicaid's approval of the transfer plan, all transfers resulting from the termination of the provider agreement must be completed within thirty (30) days from the date of the termination notice.
  - 3. Providers notified of termination may appeal this decision pursuant to Miss. Admin. Code Part 300.
  - 4. The Division of Medicaid reserves the right to enforce an immediate transfer of ventilator dependent residents if the nursing facility's compliance failure is so egregious in nature that a resident's safety is threatened.
  - 5. Once terminated, the provider may not reapply to provide VDC services for one (1) year from the date of termination.
- E. Nursing facilities providing services to ventilator dependent residents must:
  - 1. Meet all federal and state regulations governing nursing facilities.
  - 2. Provide residents in need of VDC services with the following licensed staff which cannot be included as part of the HFLC nursing facility state minimum staffing requirements:
    - a) One (1) registered nurse (RN) or one (1) licensed respiratory therapist (RT) must be assigned the primary responsibility for the VDC services and ventilator dependent residents and be available twenty-four (24) hours a day seven (7) days a week.

- b) The following nurse staffing ratios must be met for VDC services and ventilator dependent residents:
  - 1) One (1) RN for every ten (10) ventilator dependent residents (1:10),
  - 2) One (1) RN and one (1) licensed practical nurse (LPN) for every eleven (11) to fourteen (14) ventilator dependent residents, and
  - 3) Two (2) RNs for every fifteen (15) to twenty (20) ventilator dependent residents.
- c) One (1) in-house licensed respiratory therapist (RT) onsite twenty-four (24) hours a day seven (7) days a week.
- 3. Must maintain separate staffing records for the nursing staff and respiratory staff responsible for the ventilator dependent residents.
- 4. Ensure physician visits are conducted in accordance with the federal and state regulations for nursing facilities.
- 5. Must provide adequate equipment and supplies for the provision of VDC services including, but not limited to:
  - a) Primary ventilators,
  - b) Back up ventilators,
  - c) Emergency batteries,
  - d) Oxygen tanks,
  - e) Suction machines,
  - f) Nebulizers,
  - g) Manual resuscitator,
  - h) Pulse oximetry monitoring equipment,
  - i) Nutrient infusion pumps, and
  - j) Any medically necessary durable medical equipment (DME) and supplies.
- 6. Must have an audible, redundant external alarm system located outside the resident's room to alert of ventilator failure.

7. Must have written policies and procedures for ventilator dependent residents including, but not limited to:
  - a) Ventilator monitoring expectations,
  - b) Routine maintenance of ventilator equipment,
  - c) Specific staff training related to ventilator care and operation,
  - d) Staffing requirements,
  - e) Infection control program for:
    - 1) Ventilator dependent residents, to include:
      - (a) Actions to investigate, control, and prevent infections,
      - (b) Isolation procedures,
      - (c) Standard precautions,
    - 2) Maintenance and care requirements of equipment and disposal of supplies.
8. Place individuals admitted with any contagious diagnoses related to a respiratory illness in isolation according to the Centers for Disease Control (CDC) and requirements under 42 C.F.R. § 483.65.
9. Provide staff education and in-service training to direct and indirect care staff.
  - a) Required training must be completed prior to the provision of care, including infection control procedures and addressing the needs of a ventilator dependent resident.
  - b) Required training must be conducted annually to all staff provided by a:
    - 1) Licensed RT, or
    - 2) Board certified pulmonologist.
  - c) Additional training of nursing staff is required to be conducted by a full-time RN who has completed documented training in the care of ventilator dependent individuals by an RT or a board certified pulmonologist. This RN will be responsible for:
    - 1) Quarterly and on-going training to all VDC nursing staff as evidenced by documentation.

- 2) Providing initial in-service training for ten (10) work days to all direct care and indirect care staff assuring they are competent to care for VDC residents.
10. Ensure the nursing facility's Emergency Plan includes:
    - a) Provisions for continuous operation of ventilator equipment during power outages and/or ventilator equipment failure, and
    - b) A revised Emergency Operations Plan approved by the MSDH Office of Emergency Planning and Response which includes the VDC services.
  11. Execute a written agreement with a local acute care hospital:
    - a) Located within twenty (20) miles or thirty (30) minutes of an Emergency Department with the capability to treat emergencies for beneficiaries with ventilator dependency.
    - b) With provisions for twenty-four (24) hour access to VDC services.
    - c) Documenting a formal relationship between the nursing facility and a local acute care hospital that confirms the ability and willingness of the hospital to serve the acute care needs of residents requiring mechanical ventilation:
      - 1) On an as-needed basis, and
      - 2) In emergency situations when the entire VDC population of the unit/ventilator dependent residents must be temporarily transferred to the hospital.
      - 3) The agreement should outline transfer logistics and financial responsibilities.
- F. Residents in a nursing facility receiving VDC services must:
1. Have long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.
  2. Be dependent on mechanical ventilation via a tracheostomy for at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.
  3. Require daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.
  4. Be medically stable and not require acute care services prior to the transfer to the nursing facility.
  5. Be prior authorized by the Division of Medicaid or the Utilization Management/Quality Improvement Organization (UM/QIO) for admission and recertified as required by the

Division of Medicaid or UM/QIO to determine if the resident's medical condition warrants VDC services.

- a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid or UM/QIO.
  - b) The resident is considered appropriate for VDC services until the weaning process is completed.
- G. The Division of Medicaid does not cover admissions as a VDC resident for those who only require continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BiPAP).
- H. The Division of Medicaid approves out-of-state nursing facility placements for ventilator dependent beneficiaries when all the following are met:
1. The nursing facility is a Mississippi Medicaid Provider,
  2. All efforts for in-state placement are exhausted,
  3. The transferring facility provides documentation of denial statements from Mississippi nursing facilities unable to care for the beneficiary or there are no nursing facilities beds available in Mississippi to treat VDC residents.
  4. The needs of the ventilator dependent beneficiary cannot be met in the state of Mississippi.
  5. The Division of Medicaid must prior authorize for medical necessity and approval must be obtained from the Executive Director,
  6. The beneficiary is:
    - a) Mississippi Medicaid eligible.
    - b) Eligible for long-term care placement.
    - c) Ventilator dependent and meets all the following requirements:
      - 1) The Division of Medicaid does not cover admission or recertification as a VDC resident for those who only require CPAP or BiPAP.
      - 2) Medically stable and not require acute care services prior to the transfer to the nursing facility.
      - 3) Has long-term ventilator dependency greater than six (6) hours per day, for more than twenty-one (21) consecutive days prior to admission as a VDC resident.



- 4) Requires daily respiratory intervention, including, but not limited to, oxygen therapy, chest physiotherapy or deep suctioning.
- 5) Be dependent on mechanical ventilation via a tracheostomy of at least fifty percent (50%) of each day or continuous mechanical ventilation via a tracheostomy for at least six (6) hours each day while in need of VDC services except during the weaning process.
- 6) Be prior authorized by the Division of Medicaid for admission and recertified as required by the Division of Medicaid to determine if the resident's medical condition warrants VDC services.
  - (a) The nursing facility must provide documentation of continued medical necessity and weaning attempts to the Division of Medicaid.
  - (b) The resident is considered appropriate for VDC services until the weaning process is completed.
7. Completion of an admission assessment as required by federal and state regulations and/or the Division of Medicaid.
- I. Beneficiaries admitted to an out-of-state nursing facility receiving reimbursement from Medicare must obtain approval from the Division of Medicaid prior to receiving Medicaid reimbursement.
- J. The Division of Medicaid reimburses out-of-state nursing facilities the lesser of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for their classification; however, the rates may be negotiated. The negotiated rate for nursing facilities may not exceed the higher of the Medicaid rate of the domicile state or the maximum Mississippi Medicaid rate for nursing facilities, as case mix adjusted. The out-of-state facility must:
  1. Provide an initial and quarterly Minimum Data Set (MDS) assessment for review,
  2. Provide a desk audit to determine the category classification using the current calculation for reimbursement, and
  3. Complete all required Omnibus Budget Reconciliation Act (OBRA) MDS assessments.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; SPA 15-004.

History: Revised eff. 06/01/2024. Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022; Revised eff. 07/01/2021; Revised eff. 04/01/2017. Revised to correspond with SPA 15-004 (eff. 01/01/2015) eff. 01/02/2015.

### *Rule 2.16: Therapy Services*

- A. All nursing facilities are required to provide rehabilitation services for residents. Requirements include physical, occupational and speech-language pathology therapies. Medicaid, consistent with third party liability rules, is obligated to cover these services.
- B. Prior authorization/pre-certification of certain physical, occupation, and speech-language pathology services is required by the Division of Medicaid. Therapy providers must prior authorize services through the Utilization Management and Quality Improvement Organization (UM/QIO) for Medicaid. Failure to obtain prior authorization will result in denial of payment to billing providers.
- C. The UM/QIO will determine medical necessity, the types of therapy services, and the number of visits/treatments reasonably necessary to treat the beneficiary's condition. A complete list of procedure codes that require prior authorization may be obtained through the UM/QIO. All procedures and criteria set forth by the UM/QIO are applicable and are approved by Medicaid.
- D. Providers must also adhere to all Medicaid outpatient therapy rules.
- E. Nursing Facility for the Severely Disabled - Miss. Admin. Code Part 207, Rule 2.16 is not applicable to a Nursing Facility for the Severely Disabled (NFSD). Therapy services for this provider type are inclusive in the per diem rate and cannot be billed separately.
- F. Medicaid-Only Residents - Therapy services for Medicaid-only residents may be provided by state-licensed therapists who have a current Medicaid provider number. Nursing facilities may apply for a group therapy provider number for billing purposes.
- G. Dually Eligible Residents - Mississippi law requires providers participating in the Medicaid program to determine if a beneficiary is covered by a third party source, and to file and collect all third party coverage prior to billing Medicaid. This includes beneficiaries who are Medicare/Medicaid dual eligibles. Therapists providing services to dually eligible beneficiaries must bill Medicare as the primary coverage. All therapy providers must meet state and federal requirements.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121, SPA 15-004.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022;  
Revised eff. 07/01/2021.

### *Rule 2.17: Feeding Assistant Program*

#### A. Feeding Assistant Reimbursement

1. The Division of Medicaid uses the direct reimbursement method for feeding assistant training expenses incurred by nursing facilities. Reasonable costs of training of feeding

assistants in order to meet the requirements necessary for the feeding assistant to be certified and are to be billed directly to Medicaid. The nursing facility will be directly reimbursed by Medicaid for covered services and items as defined on the agency website. In order to receive Medicaid reimbursement, the training program must have approval from the Mississippi State Department of Health (MSDH), Division of Health Facilities Licensure and Certification.

2. Services and supplies approved for payment will be subject to application of the nursing facility's percentage of Medicaid utilization. The Medicaid utilization percentages of every facility are redetermined annually and are applicable for one (1) state fiscal year. The Medicaid utilization percentages are taken from the most recent cost report at the time of redetermination. Nursing facilities and training centers are notified in writing of their Medicaid utilization percent. In cases where no cost report data is available, eighty (80) percent will be applied to approved billings until such time that the correct Medicaid utilization percent can be determined. Training centers' Medicaid utilization percentage will be redetermined annually and will be calculated based on the weighted average of Medicaid utilization percentages of associated facilities weighted by bed size.
3. The Division of Medicaid will reimburse the nursing facilities or related training centers for the minimum required services and supplies. A facility or training center will be reimbursed for no more than four (4) training sessions per year. No costs actually incurred by the facility or the training center will be considered for reimbursement, like for electricity, gas, or water. No reimbursements will be made for estimated cost. The cost of manuals approved for use by MSDH will be reimbursed.
4. Training programs refer to the training area set up within a nursing facility or training center. Training programs include, but are not limited to, training areas set up by a nursing facility in a remote location due to space restrictions and training centers where an area has been set up for training that serves more than one (1) facility and is located in an area remote from any of the associated facilities.
5. No reimbursement is available for training costs incurred by individuals or for tuition to outside entities.

B. Billing rules requirements for billing of training can be found on the agency website.

C. Withdrawal of Program Approval

1. The Mississippi State Department of Health (MSDH) will withdraw approval of a program if it is determined that any of the minimum requirements are not met by the program.
2. Upon withdrawal of approval, MSDH will notify the entity in writing and will explain the reason(s) for the withdrawal of the approval. Students who have started a program from which approval has been withdrawn must be allowed to complete the course.

3. MSDH will notify Medicaid in writing when program approval is withdrawn. As a result, reimbursement will be stopped as of the date of withdrawal of program approval. However, Medicaid will reimburse the allowable costs incurred to complete a training session which is in progress on the date of withdrawal of program approval.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; 42 CFR §483.158; 42 CFR § 483.160.

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022;  
Revised eff. 07/01/2021.

*Rule 2.18: 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 the Utilization Management/Quality Improvement Organization (UM/QIO).

- 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 was 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 Medicaid program.

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. The DME provider cannot bill the Division of Medicaid until the PT/OT documentation verifies on the subsequent evaluation that 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 and the resident must:
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 nursing facility.
  - 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/power 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 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 providers 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 nursing facility 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 the UM/QIO 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 the UM/QIO.
  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, which 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 a 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: Social Security Act § 1834; Miss. Code Ann. §§ 43-13-117; 43-13-121.

History: New eff. 01/02/2015.

*Rule 2.19: Disaster Procedures*

- A. Nursing facilities must comply with all federal, state, local, and Mississippi State Department of Health (MSDH) emergency preparedness requirements, and must establish and maintain an emergency preparedness program in accordance with 42 C.F.R. § 483.73.
- B. Nursing facilities must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually and must:
  - 1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
  - 2. Include strategies for addressing emergency events identified by the risk assessment.
  - 3. Address resident population, including, but not limited to, persons at-risk; the type of services the nursing facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
  - 4. Include a process for cooperation and collaboration with local, tribal, regional, state, or federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the nursing facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.
- C. Nursing facilities must develop a system to track the location of on-duty staff and sheltered residents in the nursing facility's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the nursing facility must document the specific name and location of the receiving facility or other location.
- D. Nursing facilities may temporarily transfer or discharge residents to other in-state nursing facilities or to an evacuation location identified in their MSDH approved emergency operations plan during declared public health emergencies and must:
  - 1. Determine by day fifteen (15) of the evacuation whether or not residents will be able to return to the evacuating facility within thirty (30) days from the date of the evacuation.
  - 2. Notify all residents and/or their responsible parties, receiving facilities, MSDH and the Division of Medicaid of the determination of whether or not the residents will be able to return to the evacuating facility within thirty (30) days. The evacuating facility must confirm and document that all parties noted above have received their determination and notice.
    - a) Nursing facilities transferring residents to an in-state nursing facility with an anticipated return to the evacuating facility within thirty (30) days may bill the Division of Medicaid for the services that were provided at the receiving facility for a maximum of thirty (30) days and:

- 1) Must notify the resident and, if known, a family member or legal guardian/representative of the transfer and the transfer location.
  - 2) Must code the Minimum Data Set (MDS) as though the resident was never transferred as long as the resident's return to the facility is within the thirty (30) day timeframe.
  - 3) Must follow all inpatient hospital and home/therapeutic leave policies regardless of whether the resident is on home leave, at the evacuating facility, or the receiving facility.
  - 4) Are responsible for payment to the receiving facility for the services that the receiving facility provides to the evacuated residents.
  - 5) Cannot include the evacuating residents in their census and must report actual costs incurred by the evacuating facility for all residents in its care. The receiving facility must report the actual census, including the evacuated residents, and the actual costs incurred by the receiving facility. No offset of the revenue received from the evacuating facility will be required.
  - 6) Cannot include payments made or transferred to the receiving facility for evacuated residents on the cost report.
- b) Evacuating nursing facilities must discharge residents within the thirty (30) day timeframe who will not return to the facility within thirty (30) days and must:
- 1) Notify the resident and, if known, a family member or legal guardian/representative of the discharge and the location to where the resident is being evacuated.
  - 2) Complete and submit the applicable communication form, including the discharge date, to the appropriate Division of Medicaid Regional Office.
  - 3) Complete and submit a discharge MDS assessment, a discharge summary including the discharge date, along with the following medical information, including, but not limited to:
    - (a) Current physician orders,
    - (b) Most recent history and physical,
    - (c) Current medication administration record,
    - (d) Nutritional assessment, and

(e) Advanced directives, and

- 4) Comply with all admission requirements for any subsequent readmissions after the thirty (30) day timeframe.
- c) The nursing facility receiving evacuated residents who will not return to the evacuated facility within thirty (30) days must admit the evacuated nursing facility residents within the thirty (30) day timeframe and:
  - 1) Must comply with all nursing facility admission requirements.
  - 2) Complete and submit the applicable communication form, including the admission date, to the appropriate Division of Medicaid Regional Office.
  - 3) Is not required to complete a new preadmission form for the admission of evacuated residents during the disaster period.
- E. Nursing facilities may submit requests to MSDH or the Centers for Medicare and Medicaid Services (CMS) to operate under the 1135 waiver authority during a disaster or emergency.

Source: 42 C.F.R. § 483.73; Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 207, Rule 2.19.D. and removed Part 207, Rule 2.19.E. eff. 04/01/2018; New Rule eff. 08/01/2017.

*Rule 2.20: Facility Initiated Discharges*

- A. A nursing facility must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.
  1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:
    - a) The safety or health of the individuals in the nursing facility would be endangered,
    - b) The resident no longer requires the level of care provided by the nursing facility,
    - c) An immediate transfer or discharge is required by the resident's urgent medical needs, or
    - d) The resident has not resided in the nursing facility for thirty (30) calendar days.
  2. The notice must be written, easily understood and include the following information:
    - a) The reason for the transfer or discharge,

- b) The effective date of the transfer or discharge,
  - c) The location to which the resident is being transferred or discharged,
  - d) A statement that the resident has the right to appeal the action to the appropriate state authorities,
  - e) The name, address and telephone number of the State long-term care ombudsman,
  - f) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals, and
  - g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.
- B. The nursing facility must maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.
- C. Residents must be provided sufficient preparation and orientation by the nursing facility to ensure safe and orderly transfers or discharges.

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

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

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

#### *Rule 3.1: 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 meet all of the applicable requirements set forth in Miss. Admin. Code Title 23, Part 200, Chapter 4.

Source: Miss. Code Ann. § 43-13-121.

History: Revised eff. 08/01/2026. 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. Laundry services including the residents' personal laundry.
8. Over-the-counter (OTC) drugs.
9. Legend drugs not covered by the Medicaid program, Medicare, private, Veteran's Administration (VA) or any other payor source.
10. Medical supplies including, but not limited to, those listed below. The Division of Medicaid defines medical supplies as medically necessary disposable items, primarily serving a medical purpose, having therapeutic or diagnostic characteristics essential in enabling a resident to effectively carry out a practitioner's prescribed treatment for illness, injury, or disease and appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for medical supplies which must be billed outside the per diem rate.]
  - a) Enteral supplies,
  - b) Diabetic supplies,
  - c) Incontinence garments and
  - d) Oxygen administration supplies.
11. Durable medical equipment (DME), except for DME listed in Miss. Admin. Code Part 207, Rule 3.4.D. The Division of Medicaid defines DME as an item that (1) can withstand repeated use, (2) is primarily and customarily used to serve a medical purpose, (3) is generally not useful to a resident in the absence of illness, injury or congenital defect, and (4) is appropriate for use in the ICF/IID. [Refer to Miss. Admin. Code Part 207, Rule 3.4.D. for DME which must be billed outside the per diem rate.]
12. Routine personal hygiene items and services as required to meet the needs of the residents including, but not limited to:
  - a) Hair hygiene supplies,
  - b) Comb and brush,
  - c) Bath soap,
  - d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection,
  - e) Razor and shaving cream,

- f) Toothbrush and toothpaste,
  - g) Denture adhesive and denture cleaner,
  - h) Dental floss,
  - i) Moisturizing lotion,
  - j) Tissues, cotton balls, and cotton swabs,
  - k) Deodorant,
  - l) Incontinence supplies,
  - m) Sanitary napkins and related supplies,
  - n) Towels and washcloths,
  - o) Hair and nail hygiene services, including shampoos, trims and simple haircuts as part of routine grooming care, and
  - p) Bathing.
13. Private room coverage as medically necessary.
- a) The Medicaid per diem reimbursement rate includes reimbursement for a resident's placement in a private room if medically necessary and ordered by a physician. The Medicaid reimbursement for a medically necessary private room is considered payment in full for the private room. The resident, the resident's family or the Division of Medicaid cannot be charged for the difference between a private and semi-private room if medically necessary.
  - b) The resident may be charged the difference between the private room rate and the semi-private room rate when it is the choice of the resident or family if the provider informs the resident in writing of the amount of the charge at the time of admission or when the resident becomes eligible for Medicaid.
14. The ICF/IID must provide non-emergency transportation unless the resident chooses to be transported by a family member or friend.
15. The ICF/IID cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. ICF/IIDs may use NET providers that also provide NET services for the NET Broker if:
- a) The ICF/IID arranges the transportation, and

- b) Pays the NET provider directly.
- D. The following items and services are not included in the Medicaid per diem rates, are considered non-allowable costs on the ICF/IID's cost report and must be billed directly to the Division of Medicaid by a separate provider with a separate provider number from that of the ICF/IID:
- 1. Laboratory services,
  - 2. X-ray services,
  - 3. Drugs covered by the Medicaid drug program,
  - 4. Ostomy supplies,
  - 5. Continuous Positive Airway Pressure (CPAP) Devices effective January 2, 2015,
  - 6. Bi-level Positive Airway Pressure (BiPAP) Devices effective January 2, 2015, and/or
  - 7. Individualized, resident specific custom manual and/or custom motorized/power wheelchairs uniquely constructed or substantially modified for a specific resident when prior authorized by a Utilization Management/Quality Improvement Organization (UM/QIO), the Division of Medicaid, or a designated entity effective January 2, 2015.
  - 8. Emergency transportation described in Miss. Admin. Code Part 201.
- E. All ICF/IID's must prominently display the below information in the ICF/IID, and provide to applicants for admission and residents the below information in both oral and written form:
- 1. How to apply for and use Medicare and Medicaid benefits, and
  - 2. How to receive refunds for previous payments covered by such benefits.
- F. The ICF/IID must:
- 1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the ICF/IID or when the resident becomes eligible for Medicaid of:
    - a) The items and services that are included in the ICF/IID services under the State Plan and for which the resident may not be charged, and
    - b) Those other items and services that the ICF/IID offers and for which the resident may be charged and the amount of charges for those services.
  - 2. Inform each resident when changes are made to the items and services specified in Miss. Admin. Code Part 207, Rule 3.4.F.1.

3. Inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the ICF/IID and of charges for those services, including any charges for services not covered under Medicare or by the ICF/IID's per diem rate.
- G. The ICF/IID may charge any amount greater than or equal to the Medicaid rate for non-Medicaid residents for items and services, consistent with the notice stated in Miss. Admin. Code Part 207, Rule 3.4.F.
1. The ICF/IID's non-Medicaid per diem rate may be set above the Medicaid per diem rate, but the items and services included in the non-Medicaid rate must be identical to the items and services included in the Medicaid per diem rate.
  2. Items and services available in the ICF/IID not covered under Title XVIII or the ICF/IID's Medicaid per diem rate must be available and priced identically for all residents in the ICF/IID.
- H. An ICF/IID cannot require a deposit before admitting a Medicaid beneficiary.
- I. Refer to Miss. Admin. Code Part 224, Rule 1.4 for coverage of immunizations.

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

History: Revised eff. 05/01/2022; Revised eff. 09/01/19; Added Miss. Admin. Code Part 207, Rule 3.4.C.15 and D.8 eff. 09/01/2018; Revised eff. 08/01/2017; Removed Miss. Admin. Code Part 207, Rule 3.4.D.5 (retroactively eff. 01/02/2015), eff. 11/01/2016; Added Miss. Admin. Code Part 207, Rule 3.4.F.4.-6., eff. 04/01/2016; Revised eff. 01/02/2015.

### *Rule 3.6: 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 (5<sup>th</sup>) 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 (1<sup>st</sup>).
  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 to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022;  
Revised eff. 07/01/2021; Revised eff. 08/01/2017.

*Rule 3.7: Temporary Leave Payment*

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 intermediate care facility for individuals with intellectual disabilities (ICF/IID) 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 dialysis, chemotherapy or 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.
  - b) The first (1<sup>st</sup>) day of a temporary leave begins the calendar day the resident left the ICF/IID.
  - c) The end of the home/therapeutic temporary leave is the calendar day:
    - 1) The resident returns to the ICF/IID,
    - 2) After the resident returns if the resident was out of the ICF/IID for eight (8) or more hours as of midnight (12 a.m.) on the day the resident returned to the

ICF/IID.

- 3) The resident is admitted to an inpatient hospital acute care stay from an observation stay, or
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 ICF/IID.
- B. Before the resident departs on home/therapeutic or inpatient hospital temporary leave, the ICF/IID must provide a written notice to the resident and/or family member or legal representative explaining the ICF/IID'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 ICF/IID.
  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 ICF/IID upon the first availability of a semi-private bed if the resident still requires the services provided by the ICF/IID.
- 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 sixty-three (63) 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 day or at midnight (12 a.m.),
    - b) A hospital observation stay when the resident is not admitted for an inpatient hospital acute care stay, or
    - c) Outpatient treatments except for dialysis, chemotherapy and medical treatments that occur two (2) or more days per week.
  4. The ICF/IID 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. ICF/IIDs 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 ICF/IID.
  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 ICF/IID for twenty-four (24) consecutive 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 (1<sup>st</sup>) day of leave as the calendar day the resident was admitted to an inpatient hospital for continuous acute care after leaving the ICF/IID.
  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 ICF/IID for a period of twenty-four (24) consecutive hours or longer.
6. ICF/IIDs cannot refuse to readmit a resident from inpatient hospital temporary leave if the facility has billed for inpatient hospital leave days and the resident still requires the services provided by the ICF/IID.
7. The ICF/IID 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.
8. If the resident is on inpatient hospital leave and has not been discharged, the ICF/IID is responsible for providing transportation for the return to the ICF/IID.

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

History: Revised 05/01/2022; Revised eff. 08/01/2018 except for Miss Admin Code Part 207, Rule 3.7.C. revised to correspond with SPA 18-0005 (eff. 07/01/2018) eff. 08/01/2018. 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.

3. Resident fund records must:

- a) Include the resident's name.
- b) Identify the resident's representative, if any.
- c) Include the resident's admission date.
- d) Show the actual transaction date and amount of each deposit and withdrawal.
- e) Reflect the actual date of an adjusting or correcting entry.
- f) State the name of the person who accepted the withdrawn funds.
- g) Show the balance after each transaction (i.e., maintain a running balance).
- h) Provide the appropriate signatures for all disbursements of funds, such as:
  - (1) Resident's signature,
  - (2) Resident's mark, or "x" with two witnesses' signatures,
  - (3) Power of attorney's signature,
  - (4) Resident's responsible party when the amount disbursed is supported by appropriate documentation, or
  - (5) Two signatures of facility personnel when the amount disbursed is supported by appropriate documentation.
- i) Document transaction with receipts indicating the purpose for which any withdrawn funds were spent. This restriction is applicable to all parties, other than the residents and their powers of attorney, who have written authorization to withdraw funds from a resident's trust fund account. Applicable parties include, but are not limited to, responsible parties, facility personnel, representative payees, etc. The facility must reimburse the resident's account for any undocumented transactions.
- j) For powers of attorney, the provider must maintain a copy of the power of attorney in the resident's file, and before the provider can allow withdrawals of funds based upon the power, the provider must ensure that the power contains language sufficient to allow the holder to withdraw funds and expend them. This power is normally designated as a "General Power of Attorney" and not as a "Limited or Special" power.
- k) Reflect the resident's earned interest, if any.

- l) Be reconcilable, at all times, with the current bank statement and/or petty cash.
  - m) Not include as an outstanding item any check written on a resident's account that has not been cashed within one year of check date. Any check held as outstanding for 12 months or more should be reissued to the appropriate party or voided and credited to the appropriate resident's account. If the check was a refund for a discharged or deceased resident, the funds may be sent to the State Treasurer as unclaimed funds. For further information on Accounting Upon Death or Discharge of Resident refer to the Title 23 Administrative Code Part 207, Chapter 3 Rule 3.7 M., and
  - n) Be kept for at least five years after the resident's discharge or death.
- 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. Transportation.
  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. Accounting Upon Death or Discharge of Resident

1. The ICF/IID must, within thirty (30) days of a resident's death or discharge, convey the resident's funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident's estate. If the deceased resident's estate has no executor or administrator, the ICF/IID must convey the resident's funds and provide a final accounting to the:
  - a) Resident's next of kin,
  - b) Resident's representative, or
  - c) Clerk of the probate court of the county in which the resident died.
2. Disposition of Funds for Deceased Resident Who Dies Intestate Within a Long-Term Care Facility
  - a) Any Medicaid beneficiary receiving medical assistance for services provided in a long-term care facility who dies intestate and leaves no known heirs shall have deemed, through acceptance of such medical assistance, the Division of Medicaid as the beneficiary of funds in his/her possession at the time of death, in an amount not to exceed two hundred fifty dollars (\$250.00). The Division of Medicaid is the beneficiary of these funds regardless of whether a claim is later made to the beneficiary's property in accordance with Miss. Code Ann. § 43-13-120(3) and (4).



- b) The long-term care facility shall make a report to the State Treasurer of all funds, including any accrued interest, in the possession of the Medicaid beneficiary at the time of death. The report of such funds shall be on a form prescribed or approved by the State Treasurer and shall include the name of the deceased Medicaid beneficiary and his/her last known address prior to entering the facility, the name and last known address of each person who may possess an interest in such funds, and any other information which the State Treasurer prescribes by regulation. This report must be filed with the State Treasurer, with a copy to the Division of Medicaid, prior to November 1 of the year in which the facility provided services to the Medicaid beneficiary having funds to which this section applies.
  - c) Within one hundred twenty (120) days from November 1 of each year in which a report is made, the State Treasurer shall cause notice to be published in the newspaper in accordance with Miss. Code Ann. § 43-13-120(3). The Division of Medicaid shall pay the cost of publishing the notice.
  - d) The long-term care facility that makes a report of funds of a deceased Medicaid beneficiary shall pay over and deliver such funds, including any accrued interest, to the State Treasurer not later than ten (10) days after notice of such funds has been published by the State Treasurer.
  - e) If within ninety (90) days of the State Treasurer's publication no claims are made to the funds in excess of the two hundred fifty dollars (\$250.00) the Division of Medicaid has already received pursuant to 2.a) above, the State Treasurer shall place those funds in a special account in the State Treasury to the credit of the Division of Medicaid.
3. 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.2., 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 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. §§ 43-13-120, 43-13-121.

History: Revised eff. 05/01/2022; Revised eff. 09/01/2018; Revised eff. 12/01/2017; Revised eff. 08/01/2017.

### *Rule 3.9: Utilization Review*

The Division of Medicaid's Utilization Management/Quality Improvement Organization (UM/QIO) is the organization designated to conduct utilization reviews (UR) in intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), as required by the Division of Medicaid.

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

History: Revised eff. 10/01/2019. 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.

*Rule 3.12: Disaster Procedures*

- A. Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) must comply with all federal, state, local, and Mississippi State Department of Health (MSDH) emergency preparedness requirements and must establish and maintain an emergency preparedness program in accordance with 42 C.F.R. § 483.475.
- B. ICF/IIDs must develop and maintain an emergency preparedness plan that must be reviewed and updated at least annually and must:
  1. Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents.
  2. Include strategies for addressing emergency events identified by the risk assessment.
  3. Address the special needs of its ICF/IID population, including, but not limited to, persons at-risk; the type of services the ICF/IID has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
  4. Include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the ICF/IID's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.
- C. ICF/IIDs must develop a system to track the location of on-duty staff and sheltered residents in the ICF/IID's care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the ICF/IID must document the specific name and location of the receiving facility or other location.
- D. ICF/IIDs may temporarily transfer or discharge residents to other in-state ICF/IIDs or to an evacuation location identified in their MSDH approved emergency operations plan during declared public health emergencies and must:
  1. Determine by day fifteen (15) of the evacuation whether or not residents will be able to return to the evacuating facility within thirty (30) days from the date of the evacuation.
  2. Notify all residents and/or their responsible parties, receiving facilities, MSDH, the Department of Mental Health (DMH), and the Division of Medicaid of the determination

of whether or not the residents will be able to return to the evacuating facility within thirty (30) days. The evacuating facility must confirm and document that all parties noted above have received their determination and notice.

- a) ICF/IIDs transferring residents to an in-state ICF/IID with an anticipated return to the evacuating facility within thirty (30) days may bill the Division of Medicaid for the services that were provided at the receiving facility for a maximum of thirty (30) days and:
  - 1) Must notify the resident and, if known, a family member or legal guardian/representative of the transfer and the transfer location.
  - 2) Must follow all inpatient hospital and home/therapeutic leave policies regardless of whether the resident is on home leave, at the evacuating facility or the receiving facility.
  - 3) Are responsible for payment to the receiving facility for the services that the receiving facility provides to the evacuated residents.
  - 4) Cannot include the evacuating residents in their census and must report actual costs incurred by the evacuating facility for all residents in its care. The receiving facility must report the actual census, including the evacuated residents, and the actual costs incurred by the receiving facility. No offset of the revenue received from the evacuating facility will be required.
  - 5) Cannot include payments made or transferred to the receiving facility for evacuated residents on the cost report.
- b) Evacuating ICF/IIDs must discharge residents within the thirty (30) day timeframe who will not return to the evacuating facility within thirty (30) days and must:
  - 1) Notify the resident and, if known, a family member or legal guardian/representative of the discharge and location to where the resident is being evacuated.
  - 2) Complete and submit the applicable communication form, including the discharge date, to the appropriate Division of Medicaid Regional Office.
  - 3) Complete and submit to the receiving facility, a discharge summary, including the discharge date, along with the following medical information including, but not limited to:
    - (a) Current physician orders,
    - (b) Current Individual Support Plan (ISP),

- (c) Psychological history,
  - (d) Social history,
  - (e) Most recent history and physical,
  - (f) Current medication administration record,
  - (g) Nutritional assessment, and
  - (h) Advanced directives, and
- 4) Comply with all normal admission requirements for any subsequent readmissions after the thirty (30) day timeframe.
- c) The ICF/IID receiving evacuated residents who will not return to the evacuated facility within thirty (30) days must admit the evacuated ICF/IID residents within the thirty (30) day timeframe and:
    - 1) Must comply with all normal admission requirements.
    - 2) Complete and submit the appropriate communication form, including the admission date, to the appropriate Division of Medicaid Regional Office.
    - 3) Is not required to complete a new ICF/IID preadmission form for the admission of evacuated residents during the disaster period.

E. ICF/IIDs may submit requests to MSDH or the Centers for Medicare and Medicaid Services (CMS) to operate under the 1135 waiver authority during a disaster or emergency.

Source: 42 C.F.R. § 483.475; Miss. Code Ann. § 43-13-121.

History: Revised Miss. Admin. Code Part 207, Rule 3.12.D. and removed Part 207, Rule 3.12.E eff. 04/01/2018; New Rule eff. 08/01/2017.

*Rule 3.13: Facility Initiated Discharges*

- A. An intermediate care facility for individuals with intellectual disabilities (ICF/IID) must notify the resident and the resident's guardian or legal representative of a facility initiated transfer or discharge.
  - 1. The notice of transfer or discharge must be given at least thirty (30) calendar days prior to the transfer or discharge unless:
    - a) The safety or health of the individuals in the nursing facility would be endangered,

- b) The resident no longer requires the level of care provided by the nursing facility,
  - c) An immediate transfer or discharge is required by the resident's urgent medical needs, or
  - d) The resident has not resided in the nursing facility for thirty (30) calendar days.
2. The notice must be written, easily understood and include the following information:
- a) The reason for the transfer or discharge,
  - b) The effective date of the transfer or discharge,
  - c) The location to which the resident is being transferred or discharged,
  - d) A statement that the resident has the right to appeal the action to the appropriate state authorities,
  - e) The name, address and telephone number of the State long-term care ombudsman,
  - f) For residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals, and
  - g) For residents with mental illness, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals.

B. The (ICF/IID) must:

- 1. Maintain physician documentation in the medical record of transfers or discharges and the reasons for the transfer or discharge.
- 2. Develop a final summary of the resident's developmental, behavioral, social, health and nutritional status and, with the consent of the resident or legal guardian, provide a copy to authorized persons and agencies, and
- 3. Provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

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

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

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



## **Part 207 Chapter 4: Psychiatric Residential Treatment Facility**

### *Rule 4.1: General*

- A. The purpose of these regulations is to set forth the minimum requirements for providers who provide described mental health services to Medicaid beneficiaries in a Psychiatric Residential Treatment Facility (PRTF).
- B. The regulations have been prepared for the information and guidance of providers of services participating in the Mississippi Medicaid Program.
- C. Inpatient psychiatric services for beneficiaries under age twenty-one (21) must be provided before the beneficiary reaches age twenty-one (21) or, if the beneficiary was receiving the services immediately before he/she reached age twenty-one (21), before the earlier of the following: the date he/she no longer requires the services or the date he/she reaches age twenty-two (22).
- D. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.
- E. PRTF providers must adhere to applicable state and federal regulations related to their license.
- F. The facility must have a signed transfer agreement with one or more general hospitals to provide needed diagnostic and medical services to residents.
- G. The facility must have arrangements with community physicians to provide specialized medical care to residents when needed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.151 (a)(2)(ii), (c)(1)(2), 441.152 (a)(3); OBRA section 4755; 42 CFR 441, Subpart D; 42 CFR 483.52

### *Rule 4.2 Provider Enrollment*

Enrollment into the Medicaid program requires each provider to meet all of the applicable requirements outlined in Miss. Admin. Code Title 23, Part 200, Chapter 4.

Source: Miss. Code Ann. §§ 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 C.F.R. § 441, Subpart D; 42 C.F.R. § 441.151.

History: Revised eff. 08/01/2026. Revised eff. 12/01/2025.

### *Rule 4.3: Staffing*

The Division of Medicaid requires Psychiatric Residential Treatment Facilities (PRTF) have the following staff:

- A. The governing body of the PRTF must appoint an administrator to be responsible for the overall management of the facility. The administrator must have appropriate academic credentials and administrative experience in child/adolescent psychiatric treatment. The administrator must be responsible for the fiscal and administrative support of the facility's clinical program.
- B. The facility must appoint a medical director to be responsible for coordinating medical services and directing resident treatment. The medical director must be a board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry.
- C. The facility must appoint a full-time clinical director to be responsible for coordinating clinical services and implementing patient treatment. The clinical director must be one of the following:
  - 1. A board-certified child/adolescent psychiatrist,
  - 2. A psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,
  - 3. A licensed psychologist who is experienced in child/adolescent mental health treatment,
  - 4. A psychiatric mental health nurse practitioner (PMHNP) who is experienced in child/adolescent mental health treatment, or
  - 5. A licensed certified social worker who is experienced in child/adolescent mental health treatment.
- D. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry may serve as both medical director and clinical director provided that he/she is a full-time employee.
- E. The facility must employ sufficient full-time professional staff to provide clinical assessments, therapeutic interventions, ongoing program evaluations, and adequate resident supervision twenty-four (24) hours a day. At least fifty percent (50%) of the professional staff hours must be provided by full-time employees. Professional staff must be appropriately licensed and trained/experienced in providing mental health treatment. These staff members will include, but not be limited to, the following:
  - 1. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,
  - 2. A licensed psychologist,
  - 3. A registered nurse,

4. A licensed certified social worker,
  5. A certified teacher, and
  6. A recreation specialist.
- F. The PRTF must have access, through full/part-time or contract employment, the services of each of the following:
1. A licensed occupational therapist or credentialed creative arts therapist,
  2. A rehabilitation counselor, and
  3. A licensed speech-language pathologist.
- G. The PRTF must provide an adequate staff-to-resident ratio on all shifts to provide for resident and staff safety.
- H. The PRTF must notify the Division of Medicaid of changes in the Administrator, Medical Director or Clinical Director. Division of Medicaid must receive the notification in writing within seventy-two (72) hours of the effective change.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441. Subpart D; 42 CFR 441.151 (a)(2)

#### *Rule 4.4: Admission*

The Division of Medicaid covers PRTF services when a child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis.

- A. A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry with admitting privileges must approve each admission.
- B. The goal of PRTF treatment is to help the child reach a level of functioning where less restrictive treatment will be possible.
- C. The need for PRTF admission must be supported by documentation that:
  1. The child has a diagnosable psychiatric disorder.
  2. The child can participate and process information as evidenced by an appropriate IQ for the program to which they have been admitted, unless there is substantial evidence that the IQ score is suppressed due to psychiatric illness.

3. The child's psychiatric symptoms are severe enough to warrant residential treatment under the direction of a psychiatrist.
  4. The referring psychiatrist or psychologist advises that residential treatment is needed.
  5. At least one (1) of the following:
    - a) The child has failed to respond to less restrictive treatment in the last three (3) months.
    - b) Adequate less restrictive options are not available in the child's community.
    - c) The child is currently in an acute care facility whose professional staff advise that residential treatment is needed.
  6. The admission has been certified by the UM/QIO as medically and psychologically necessary.
- D. The facility must provide the parent/guardian with contact information for the Disability Rights Mississippi, including the phone number and mailing address, and document in the record.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.152 (a)(3); 456.180(b)(1); 441.152 (a)(2); 441.152 (a)(1); 483.356 (c); 483.366 (a); 483.356 (d)

#### *Rule 4.5: Non-Covered Services*

Division of Medicaid does not cover:

- A. Admissions on the weekends. The Division of Medicaid defines weekend admissions as admission after 5:00 p.m. on a Friday. Covered days will not begin until the following Monday.
- B. Non-covered days of stay.
- C. Any days of stay not certified by the UM/QIO.

Source: Miss. Code Ann. § 43-13-121

#### *Rule 4.6: Reimbursement*

- A. Participating Mississippi facilities must prepare and submit a Medicaid cost report for reimbursement of long term care facilities.
  1. All cost reports are due by the end of the fifth (5<sup>th</sup>) calendar month following the reporting period.

2. Failure to file a cost report by the due date or the extended due date will result in a penalty of fifty dollars (\$50.00) per day and may result in the termination of the provider agreement.
- B. The Division of Medicaid uses a prospective method of reimbursement.
1. The rates are determined from cost report data.
  2. Standard rates are determined annually with an effective date of January first (1<sup>st</sup>).
  3. In no case may the reimbursement rate for services provided exceed an individual facility's customary charges to the general public for such services in the aggregate, except for those public facilities rendering such services free of charge or at a nominal charge.
  4. Prospective rates may be adjusted by the Division of Medicaid pursuant to changes in federal and/or state laws or regulations when authorized by the state legislature.
  5. Prospective rates may be adjusted by the Division of Medicaid based on revisions to allowable costs or to correct errors when authorized by the state legislature.
    - a) These revisions may result from amended cost reports, field visit reviews, or other corrections.
    - b) Facilities are notified in writing of amounts due to or from the Division of Medicaid as a result of these adjustments.
    - c) There is no time limit for requesting settlement of these amounts. This is applicable to claims for dates of service since July 1, 1993.
- C. The Division of Medicaid conducts periodic field level cost report financial reviews of selected long term care facilities, including nursing facilities, intermediate care facilities for the mentally retarded, and psychiatric residential treatment facilities, to verify the accuracy and reasonableness of the financial and statistical information contained in the Medicaid cost reports. Adjustments will be made as necessary to the reviewed cost reports based on the results of the reviews.
- D. Notwithstanding any other provision of this article, it shall be the duty of each nursing facility, intermediate care facility for the mentally retarded, psychiatric residential treatment facility, and nursing facility for the severely disabled that is participating in the Medicaid program to keep and maintain books, documents and other records as prescribed by the Division of Medicaid in substantiation of its cost reports for a period of three (3) years after the date of submission to the Division of Medicaid of an original cost report, or three (3) years after the date of submission to the Division of Medicaid of an amended cost report.
1. Providers must maintain adequate documentation including, but not limited to, financial

records and statistical data, for proper determination of costs payable under the Medicaid program.

- a) The cost report must be based on the documentation maintained by the facility.
  - b) All non-governmental facilities must file cost reports based on the accrual method of accounting.
  - c) Governmental facilities have the option to use the cash basis of accounting for reporting.
2. Documentation of financial and statistical data should be maintained in a consistent manner from one period to another and must be current, accurate and in sufficient detail to support costs contained in the cost report.
  3. Providers must make available to the Division of Medicaid all documentation that substantiates the information included in the facility cost report for the purpose of determining compliance.
    - a) These records must be made available as requested by the Division of Medicaid.
    - b) All documentation which substantiates the information included in the cost report, including any documentation relating to home office and/or management company costs must be made available to Division of Medicaid reviewers as requested by the Division.

E. Services and charges include the following:

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

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

G. Private room coverage by Medicaid is as follows:

1. The overall average cost per day determined from the cost report includes the cost of

private rooms.

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

H. The following rules apply to hospital leave:

1. A fifteen (15) day length of stay is allowed in a non-psychiatric unit of a hospital. The facility must reserve the hospitalized resident's bed in anticipation of his/her return. The bed cannot be filled with another resident during the covered period of hospital leave.
  2. A resident must be discharged from the facility if he/she remains in the hospital for over fifteen (15) days. A leave of absence for hospitalization is broken if the resident returns to the facility for twenty-four (24) hours.
  3. Facilities cannot refuse to readmit a resident from hospital leave when the resident has not been hospitalized for more than fifteen (15) days and still requires PRTF services.
- I. If a resident elopes from the facility and remains absent for twenty-four (24) hours or longer, he/she must be discharged from the facility. If further treatment at the same facility is desired after the end of the twenty-four (24) hours, the child/adolescent must go through a readmission process.

J. The following rules apply to therapeutic leave:

1. An absence from the facility for eight (8) hours or more within one calendar day constitutes a leave day.
2. Medicaid coverage of therapeutic leave days per fiscal year, July 1 – June 30, is eighteen (18) days for a PRTF.
3. Each therapeutic leave day taken each month must be reported on the billing mechanism.
4. The attending physician must approve all therapeutic leave days. Documentation must include goals to be achieved during the leave, the duration of leave, who participated in the leave, and the outcome of the leave.

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

1. A temporary absence of a resident from a PRTF does not interrupt the monthly payments to the facility under the provisions as outlined in Part 207, Chapter 4 Rule 4.6 J.
2. Each facility is required to maintain leave records and indicate periods of therapeutic

leave days.

3. Before a resident departs on therapeutic leave, the facility must provide each resident and family member or legal representative written information explaining leave policies. The information must define the period of time the resident is permitted to return and resume residence in the facility.
4. A refund of payment will be demanded for all leave days taken in excess of the allowable or authorized number of days.

L. The PRTF must provide non-emergency transportation.

1. Effective February 1, 2019, the PRTF cannot use the Non-Emergency Transportation (NET) Broker to arrange transportation for residents. PRTFs may use NET providers that also provide NET services for the NET Broker if:
  - a) The facility arranges the transportation, and
  - b) Pays the NET provider directly.
2. Prior to February 1, 2019, the PRTF must:
  - a) Arrange and pay for non-emergency transportation and place the cost on the cost report, or
  - b) Utilize the NET Broker to arrange non-emergency transportation for residents.

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

History: Revised to correspond with MS SPA 22-0006 (eff. 05/01/2022) eff. 07/01/2022;  
Revised eff. 07/01/2021; Added Miss. Admin. Code Rule 4.6.L. eff. 09/01/2018.

#### *Rule 4.7: Active Treatment*

The use of the term “treatment” refers to the active treatment of the resident. The Division of Medicaid defines active treatment as a process comprising of the following:

- A. Multi-disciplinary diagnostic assessment,
- B. Interdisciplinary treatment planning,
- C. Therapeutic intervention,
- D. Treatment evaluation/revision, and



E. Discharge/aftercare planning.

Source: Miss. Code Ann. § 43-13-121; 142 CFR 441.154

*Rule 4.8: Assessment and Evaluation*

- A. The diagnostic evaluation must document the need for the PRTF level of care.
- B. Diagnostic evaluations must be completed within the first fourteen (14) days of admission. The assessment process must include, but is not limited to, the following:
  - 1. A psychiatric evaluation.
  - 2. A psychological evaluation signed by a licensed psychologist, which must have been completed in the sixty (60) days prior to admission. If no psychological evaluation has been conducted within the last twelve (12) months, one must be completed within fourteen (14) days following PRTF admission.
  - 3. A medical history and examination.
  - 4. A psychosocial assessment, which includes a psychological profile, a developmental profile, a behavioral assessment, and an assessment of the potential resources of the resident's family.
  - 5. A Child and Adolescent Needs and Strengths (CANS-MH) assessment.
  - 6. An educational evaluation.
  - 7. A nursing assessment.
  - 8. A nutritional assessment, if indicated.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441.155(b)(1), 441.156(b)(2)

*Rule 4.9: Treatment Planning*

- A. Treatment planning is defined by the Division of Medicaid as a collaborative venture which the members of various disciplines jointly develop a comprehensive, individualized plan of care for each individual.
  - 1. The treatment plan must be designed to achieve the individual's discharge from inpatient status at the earliest possible time.
  - 2. An initial treatment plan must be in effect within twenty four (24) hours after the resident's admission to the psychiatric residential treatment facility (PRTF).

3. The interdisciplinary treatment team must meet to discuss, approve and implement a more comprehensive treatment plan within fourteen (14) days after the individual's admission, monthly for the first six (6) months and every ninety (90) days thereafter.
  4. The treatment plan document must contain evidence that the treatment team actively partners with the individual and his/her parent or legal guardian and indicate efforts to accommodate scheduling conflicts for therapy sessions, meetings and calls to ensure active participation by all parties in the treatment planning/review/revision process.
- B. The treatment team must include the number of staff members necessary for the optimal treatment of the individual.
1. At a minimum, the team must include one of the following:
    - a) A board-certified child/adolescent psychiatrist or a psychiatrist who has successfully completed an approved residency in child/adolescent psychiatry,
    - b) A psychiatric mental health nurse practitioner (PMHNP) and a physician licensed to practice medicine or osteopathy,
    - c) A licensed clinical psychologist and a physician licensed to practice medicine or osteopathy, or
    - d) A master's level clinical psychologist and a physician licensed to practice medicine or osteopathy with specialized training and experience in diagnosis and treatment of mental illness.
  2. The team must also include one (1) or more of the following:
    - a) A licensed certified social worker (LCSW) who has a minimum of one (1) year experience in treating individuals under the age of twenty-one (21) with serious emotional disturbances (SED), or
    - b) A registered nurse who has a minimum of one (1) year experience in treating individuals with SED.
    - c) A licensed professional counselor (LPC) who has a minimum of one (1) year experience treating individuals under the age of twenty-one (21) with serious emotional disturbances (SED),
    - d) A licensed occupational therapist with specialized training or one (1) year of experience treating mentally ill individuals, or
    - e) A master's level clinical psychologist.

- C. The treatment plan delineates all aspects of the individual's treatment and includes, at a minimum:
1. A diagnostic evaluation that includes examination of the medical, psychological, social, behavioral, and developmental aspects of the individual's situation and reflects the need for inpatient psychiatric care.
  2. An assessment of the individual's immediate therapeutic needs.
  3. An assessment of the individual's long-range therapeutic needs.
  4. An assessment of the individual's personal strengths and liabilities.
  5. Identification of the clinical problems that are to be the focus of treatment.
  6. Measurable and realistic treatment goals for each identified problem.
  7. Observable, measurable treatment objectives that represent incremental progress towards goals, coupled with target dates for their achievement.
  8. An integrated program of therapies, activities, and experiences designed to meet each objective.
    - a) Special procedures, as defined in Miss. Admin. Code Title 23, Part 207, Rule 4.12, cannot be included in the treatment plan as a treatment modality.
    - b) The treatment plan must document and address any interventions that may be contraindicated or inappropriate for the individual.
    - c) If special procedures become necessary, the treatment plan must be amended or modified within one (1) working day of the first incident to reflect the use of the least restrictive necessary measures. The effectiveness or ineffectiveness of interventions must be evaluated and revised therapeutic measures should be incorporated into the individual's treatment plan to be used as a basis for future interventions.
  9. The clinician identified as responsible for each aspect of treatment.
  10. Identification of goals, objectives and treatment strategies , and include feedback from the individual and his/her parent or legal guardian regarding the discussion of treatment options available in the community. If a geographically distant therapist will be utilized, this must be specified in the treatment plan.
  11. An individualized discharge plan that includes:
    - a) Discharge criteria, indicating specific goals to be met,

- b) An estimated discharge target date, and
  - c) No later than seven (7) days prior to discharge, the discharge plan must also include an aftercare plan that addresses coordination of family, school/vocational and community resources, including recommendations and/or arrangements for further treatment, to ensure continuity of care for the individual.
- D. The treatment team must meet to review, and revise if necessary, the individual's treatment plan a minimum of every thirty (30) days or more often when necessary to provide optimum treatment. The treatment review team must assess the individual's progress in treatment by:
- 1. Noting treatment successes, discussing which objectives and/or goals have been achieved and when, and explaining treatment failures.
  - 2. Making changes in the treatment plan, as needed.
  - 3. Re-assessing the individual's need for continued residential care, as opposed to less restrictive treatment.
  - 4. Noting the individual's measurable progress towards discharge, reviewing/revising the discharge criteria and/or target date as needed.

Source: Miss. Code Ann. §§ 43-13-117, 43-13-121; 42 CFR 441.154(a)(b); 441.155(b)(2); 441.155(c)(1)(2); 441.156(b)(1)(3)(4)(5); 441.156(c)(1)(2); 441.156(d)(1)(2).

History: Revised eff. 05/01/2022.

*Rule 4.10: Therapeutic Interventions*

- A. Psychotherapy is defined as the intentional, face to face interaction between a mental health professional and a client, either an individual, family, or group, in which a therapeutic relationship is established to help resolve symptoms of the resident's mental and/or emotional disturbance.
- B. Individual therapy is defined as psychotherapy that takes place between a mental health therapist and a resident. Individual Therapy must be provided a minimum of one (1) hour each week unless its contraindication is documented in the treatment plan. Individual Therapy must be provided by master's level mental health therapists.
- C. Family therapy is defined as psychotherapy that takes place between a mental health therapist and a resident's family members or guardians, with or without the presence of the resident. If a resident is in the custody of the Department of Human Services (DHS), family therapy may also include others, including DHS representatives and foster family members, acting in loco parentis. Family Therapy must be at least twice a month, unless its contraindication is documented in the treatment plan.

1. Each resident's family, guardian, or person acting in loco parentis must participate in the family therapy sessions.
  2. If the resident's family is more than a two (2) hour drive from the PRTF, one (1) face-to-face family therapy session and one (1) therapeutic conference call is acceptable.
  3. Family Therapy must be therapeutic in nature to include discussing the resident's functioning, treatment progress, goals and objectives.
  4. Social visits or phone calls are not considered family therapy.
  5. Family Therapy must be provided by master's level mental health therapists.
  6. Residents who are in the custody of the Department of Human Services (DHS) must complete one (1) face-to-face family therapy session with the social worker in the county of the PRTF, unless the social worker in the home county is available, and complete the second (2nd) family therapy session via telephone with the social worker in the home county.
  7. A geographically distant therapist may provide family therapy when there are family issues that must be resolved or ameliorated before face-to-face sessions that include the resident can be productive and therapeutic.
    - a) Distance alone is not justification for prescribing off-site therapy.
    - b) When off-site therapy is appropriate, the treatment plan must identify the off-site therapist, indicate the goals for such therapy, and specify how information will be exchanged between the PRTF and the off-site therapist.
    - c) Collaboration between therapists is the responsibility of the PRTF and must be documented in the clinical record.
- D. Group therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2), but not more than eight (8) residents at the same time.
1. Possibilities for groups include, but are not limited to, those which focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.
  2. Each resident must participate in a minimum of three (3) hours of group therapy, provided in at least three (3) sessions, each week unless contraindication is documented in the treatment plan.
  3. The length, frequency and timing of sessions in which services are delivered must be determined by what is developmentally appropriate for each resident.

4. Group therapy must be provided by master's level mental health therapists although larger groups up to twelve (12) participants can be co-led by a person with a lesser level of training.
- E. Psychotherapy notes must be documented for each therapy session and include the following essential elements:
1. The date and time in and time out of the session,
  2. The type of therapy, either individual, family or group,
  3. The person(s) participating in the session,
  4. The length of the session,
  5. Clinical observations about the resident including their demeanor, mood, affect, mental alertness, thought processes or risks,
  6. The content of the session,
  7. Therapeutic interventions attempted and the resident's response to the intervention(s),
  8. The resident's response to any significant others who may be present in the session,
  9. The outcome of the session,
  10. A statement summarizing the resident's degree of progress toward the treatment goals,
  11. Reference at least monthly to the resident's progress in relation to the discharge criteria and the estimated discharge date,
  12. The signature and printed name, if needed for clarity, of the therapist, and
  13. Monthly summaries are not acceptable in lieu of psychotherapy session notes.
- F. Milieu therapy is defined as residential psychiatric treatment that occurs in the total environment of the closed setting, also referred to as the "therapeutic community." Milieu therapy must be provided twenty-four (24) hours a day by all PRTF staff.
1. Emphasis is placed on clear, healthy, respectful communication between resident/resident, staff/staff, and staff/resident, and on shared problem-solving and decision-making.
  2. The entire environment, not just the limited time spent with an identified therapist, is considered vital to the treatment process. The physical environment of the facility must reflect a warm, child-friendly atmosphere with treatment-oriented information including,

but not limited to, motivational/educational posters, schedules of activities, requirements for level systems and rules for unit, written in positive terms and age appropriate language. Materials must be posted in a manner that is highly visible and easily accessible to residents.

3. Milieu notes must be documented daily and:
  - a) Present a clear picture of the resident's participation and interactions in the therapeutic community.
  - b) Describe the resident's actions, staff interventions, and the resident's response to those interventions.
  - c) Are usually completed by direct care staff.
  - d) If a checklist is used, it must be accompanied by at least a brief narrative.
  - e) Must be behaviorally focused.
  - f) Behavior and events should be described rather than labeled.
  - g) Must reflect a pattern of clear, respectful communication between staff and resident, with emphasis on the resident's involvement and collaboration in his/her own treatment.
4. The community meeting is a required element of milieu therapy. This is a time when all residents and most, if not all, professional and direct care staff meet together to discuss and solve problems that arise in community living, make community decisions, set goals, resolve conflicts and discuss ideas that may enhance treatment.
5. Documentation that community meetings are held at least daily and are attended by all residents and most, if not all, professional and direct care staff.
6. Documentation that the focus of community meetings is good communication and collaboration among residents and staff to solve problems, make community decisions, and introduce/discuss ideas/suggestions that will enhance treatment.
7. Documentation that residents are knowledgeable about their treatment and actively participate in goal-setting and treatment evaluation.
8. Community meeting notes must be clearly identifiable.
9. Each resident's participation must be documented, or his/her absence justified, in a minimum of one (1) community meeting per day.
10. Notes must reflect that the community meetings are therapeutic in nature and address

treatment issues including, but not limited to:

- a) Problem identification,
- b) Goal-setting,
- c) Problem-solving,
- d) Conflict resolution,
- e) Behavioral observations/evaluation,
- f) Problems in community living.

11. The nature of each resident's participation must be described.

12. If a checklist is used, it must be accompanied by at least a brief narrative.

G. Therapeutic Pass/Therapeutic Leave is defined as those times when a resident is permitted time "away" from the PRTF to practice skills learned in treatment or to work on significant relationships in a setting that is less structured and controlled.

1. Therapeutic Pass refers to "away" time of less than eight (8) hours.

- a) If a resident leaves the facility on a therapeutic pass accompanied by PRTF staff, no documentation is required.
- b) If a resident leaves the facility on a therapeutic pass with anyone other than staff, including relatives or representatives of DHS, therapeutic goals for the pass must be identified and documented. At the conclusion of the pass, documentation must indicate whether or not the therapeutic goals were met.

2. Therapeutic Leave refers to "away" time of eight (8) hours or more in the same calendar day. A single day of therapeutic leave is determined by the resident's absence from the facility for eight (8) hours or more between the hours of 12:01 a.m. and 11:59 p.m. on any given day.

- a) Therapeutic Leave is not allowed during the fourteen (14) day assessment period following admission.
- b) The attending physician or PMHNP must approve all therapeutic leave days.

3. Documentation at the time a resident leaves the facility must include:

- a) The date/time of check-out,



- b) The required time of return,
  - c) The name(s) of the person(s) with whom the leave will be spent,
  - d) The resident's physical/emotional condition at the time of departure including vital signs,
  - e) The types and amounts of medication being provided and instructions in lay terms for taking them,
  - f) Therapeutic goals for the leave, as related to the goals established in the treatment plan,
  - g) The name and signature of the person with whom the resident is leaving, and
  - h) The signature of the staff person checking the resident out.
4. Documentation at the time of the resident's return must include:
- a) The date and time of check-in,
  - b) The resident's physical/emotional condition at the time of return including vital signs and notation of any physical injury or complaint,
  - c) Whether or not any contraband was found,
  - d) The types and amounts of medication being returned, if any, and explanation of any missed doses,
  - e) An explanation of any early or late return from leave,
  - f) A brief report on the outcome of the leave by the parent or guardian,
  - g) The name and signature of the person returning the resident's to the facility,
  - h) The signature of the staff person checking resident in, and
  - i) An assessment of the outcome of the leave must be conducted by the resident's therapist within seventy-two (72) hours of the resident's return from leave.
- H. Creative arts therapies is defined as those therapies, including art, movement/dance, music and poetry, which a qualified professional uses the creative process and the resident's response to the created product to help the resident resolve emotional conflicts, increase self-awareness, develop social skills, manage behavior, solve problems, reduce anxiety, improve reality orientation, and/or increase self-esteem.

- I. Occupational therapy is defined as the use of purposeful activity, designed and guided by a qualified professional, to help the resident achieve functional outcomes that promote the highest possible level of independence.
- J. Recreation therapy is defined as a process that utilizes recreation services for purposive intervention in physical, emotional and/or social behavior to bring about a desired change in that behavior and to promote the growth and development of the resident.
- K. Speech-Language Pathology is defined as remedial assistance with speech and/or language problems provided by a licensed speech-language pathologist.
- L. When other therapies such as art therapy, recreational therapy, occupational therapy, dance/movement therapy, music therapy, speech/language therapy, are employed, their use must be documented in the clinical record in much the same manner as psychotherapy including date, length, type of session, together with a summary of the session's content, process, outcome and the therapist's name/signature.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 441.155(b)(1)(4)(5)

*Rule 4.11: Medical Treatment and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Requirements*

- A. The Division of Medicaid covers medically necessary Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for EPSDT-eligible beneficiaries in accordance with Miss. Admin. Code Part 223, without regard to service limitations and with prior authorization.
- B. A psychiatric residential treatment facility (PRTF) must ensure that every individual receives medically necessary EPSDT services regardless of whether such services are identified in the individual's plan of care.
- C. Each PRTF must have written policies and procedures and a designated area for responding to an individual's physical and/or medical needs in the PRTF.
- D. EPSDT services in a PRTF must be provided by:
  - 1. The PRTF,
  - 2. Under arrangement between the PRTF and a qualified Mississippi Medicaid enrolled non-facility provider, and/or
  - 3. By a qualified Mississippi Medicaid enrolled provider in the community not affiliated with or under arrangement with the PRTF.
- E. The Division of Medicaid reimburses for medically necessary EPSDT services:

1. On the PRTF's cost report if services are provided directly by the PRTF or under arrangement with the PRTF, or
  2. Directly to the provider directly if EPSDT services are provided by a qualified Mississippi Medicaid enrolled provider in the community not affiliated with or under arrangement with the PRTF.
- F. The Division of Medicaid does not reimburse a provider for any duplicative psychiatric service that the PRTF is responsible for providing.
- G. PRTF providers must document all EPSDT services provided in the medical record.

Source: U.S.C. § 1396d; 42 C.F.R. §§ 431.107; 455.1; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 04/01/2019.

*Rule 4.12: Special Procedures*

- A. The Division of Medicaid defines special procedures as seclusion and restraint and must be used as an immediate response only in emergency safety situations when needed to help a resident regain control of his/her behavior. At all times, the least restrictive effective intervention must be used. The potential therapeutic effects of prevention of self and other injury and reinforcement of behavioral boundaries must be weighed against the counter-therapeutic effects.
1. Seclusion is defined as the involuntary confinement of a resident in an area from which she/he is physically prevented from leaving. It is used to ensure the physical safety of the resident or others and to prevent the destruction of property or serious disruption of the milieu.
  2. Restraint is defined as the restriction of a resident's freedom of movement or normal access to his/her body through physical, mechanical or pharmacological means, in order from the least to the most restrictive method. It is used to ensure the resident's physical safety.
    - a) Personal restraint is defined as the restraint of a resident through human physical action using a standard technique or method designed and approved for such use. It is used to prevent a resident from causing harm to self or others or to prevent destruction of property.
    - b) Mechanical restraint is defined as the restraint of a resident through the use of any mechanical device, material or equipment attached or adjacent to the resident's body that s/he cannot easily remove.
    - c) Pharmacological restraint is defined as the use of a medication, which is not a

standard part of the resident's treatment regimen, to control or alter the resident's mood or behavior or to restrict freedom of movement. Pharmacological restraint is used to insure the safety of the resident or others through a period of extreme agitation when less restrictive measures have not been effective. Standing PRN orders for pharmacological restraints are prohibited.

- B. Seclusion or restraint must only be used in situations where less restrictive interventions have been determined to be ineffective. Any use of seclusion or restraint must be:
  - 1. In accordance with appropriate techniques,
  - 2. Applied by staff trained and approved to use such techniques,
  - 3. Implemented in the least restrictive manner possible,
  - 4. In a room that is safe and sanitary, with adequate lighting, ventilation and temperature control, and
  - 5. Evaluated on a continual basis and ended at the earliest possible time based on the assessment and evaluation of the resident's condition.
- C. Seclusion or restraint cannot be used as a method of coercion, discipline or retaliation as compensation for lack of staff presence or competency, for the convenience of staff in controlling a resident's behavior, or as a substitute for individualized treatment.
  - 1. Restraint and seclusion must not be used simultaneously.
  - 2. Any personal or mechanical restraint of a resident in a face-down position is prohibited.
  - 3. Any personal or mechanical restraint of a resident in a spread-eagle position with legs and arms apart is prohibited.
  - 4. Standing, or "as needed" (PRN), orders for seclusion or restraint are prohibited.
- D. The following actions are required for any form of special procedure with the exceptions as noted below:
  - 1. Only a physician or a PMHNP may order the seclusion or personal/mechanical restraint of a resident.
  - 2. If seclusion or personal/mechanical restraint is initiated without orders from a physician or PMHNP, a verbal or telephone order must be obtained from the physician or PMHNP by an RN or LPN no later than one (1) hour after the start of the procedure. If the physician's or PMHNP's order cannot be obtained within the one (1) hour, the procedure must be discontinued.

3. Pharmacological restraint may be initiated only by medical staff acting on a physician's or PMHNP's orders. At the time of the order, the physician or PMHNP must identify a specific time when the procedure is expected to end and/or the expected duration of the medication's effects, at which time the resident's condition must be assessed and the incident must be processed with the resident.
4. The physician's or PMHNP's order for seclusion or personal/mechanical restraint must be for a time period not to exceed one (1) hour for residents younger than nine (9) years of age, or two (2) hours for residents nine (9) to twenty one (21) years of age.
  - a) The original order may be renewed, if clinically justified, in accordance with these limits for up to a total of twenty four (24) hours.
  - b) After the renewal limits of the original order are reached, a physician or PMHNP must see and assess the resident before issuing a new order.
5. The staff person responsible for terminating seclusion must be physically present in or immediately outside the seclusion room throughout the duration of the procedure.
6. The staff person responsible for terminating a mechanical restraint must be physically present throughout the duration of the procedure.
7. Within one (1) hour of the initiation of the emergency safety intervention, a physician, PMHNP or RN must conduct a face-to-face assessment of the physical and psychological well-being of the resident.
8. Even if the emergency safety intervention is terminated in less than one (1) hour, the face-to-face assessment must be conducted within an hour of its initiation.
9. The health and comfort of the resident must be assessed every fifteen (15) minutes by direct observation, and staff must record their findings at the time of observation.
10. Vital signs must be taken every hour unless contraindicated and documented in the resident's record.
11. There must be clear criteria for ending the special procedure and the resident must be made aware of them when the procedure is initiated and at follow-up intervals as appropriate.
12. A physician, PMHNP, or RN must evaluate the resident's well-being immediately after the seclusion or restraint is terminated.
13. At an appropriate time, but no later than twenty-four (24) hours following the conclusion of the special procedure, the resident must be given the opportunity to discuss with all staff involved in the procedure the antecedents, emotional triggers, and consequences of his/her behavior and any learning that occurred as a result of the intervention.

- E. All staff who have direct resident contact must have ongoing education, training, and demonstration of knowledge of the proper and safe use of seclusion/ restraint and alternative techniques/methods for handling the behavior, symptoms, and situations that traditionally have been treated through seclusion and restraint. Training in the application of physical restraint must be a professionally recognized method, which does not involve restraining a resident in a face-down or spread-eagle position with legs and arms apart.
- F. If a facility provides for the use of seclusion/restraint, it must inform the prospective resident and the parent/guardian at the time of admission of the circumstances under which these special procedures are employed. The facility must provide the parent/guardian with a copy of its policy regarding seclusion/restraint and obtain a signed acknowledgment from the parent/guardian documenting that the policy was explained and a copy given to them. This acknowledgment must be filed in the resident's record. In the event that a resident requires either seclusion or restraint, the PRTF must notify the parent/guardian as soon as possible, but no later than twenty-four (24) hours after the initiation of the procedure.
- G. Documentation of each incident of seclusion or restraint must be part of the resident's permanent record.
  - 1. Documentation of each incident of seclusion or restraint, including personal, mechanical and pharmacological restraint, must include, but not be limited to, the following information:
    - a) The date and time the procedure started and ended,
    - b) The name of the physician or PMHNP who authorized it, the name(s) of staff who initiated the procedure, were involved in applying or monitoring it, and/or were responsible for terminating it,
    - c) Whether or not the resident returned from therapeutic leave within the preceding twenty-four (24) hours,
    - d) The reason the procedure was used,
    - e) Which less restrictive options were attempted, and how they failed,
    - f) Criteria for ending the procedure,
    - g) The results of the face-to-face assessment conducted by a physician, PMHNP or RN within one (1) hour after initiation of the procedure including:
      - (1) The resident's physical and psychological status,
      - (2) The resident's behavior,

- (3) The appropriateness of the intervention measures, and
  - (4) Any complications resulting from the intervention.
- h) The resident's condition at the time of each fifteen (15) minute reassessment and at the end of the procedure,
  - i) The signature of the person documenting the incident,
  - j) A record of both staff/resident and staff only debriefing sessions, which must take place within twenty-four (24) hours of the use of seclusion/restraint, and must include the names of staff present for or excused from the debriefing and any changes to the resident's treatment plan that resulted from the debriefings, and
  - k) Notification of the resident's parents/guardians within twenty-four (24) hours of the initiation of each incident, including the date and time of notification and the name of the staff person providing the notification.
- 2. A separate log documenting all episodes of seclusion/restraint in the PRTF must be maintained. A multi-disciplinary team, including at least nursing personnel, physician or PMHNP, therapist, and quality management personnel, must review incidents of seclusion/restraint monthly. These meetings must be documented.
  - 3. Information regarding the number of times seclusion or restraint have been employed by a facility must be included each month as part of the facility's census report to the UM/QIO.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 483.364(b)(1)(2); 483.356(a)(1)(2)(3)(4); 483.366(a); 483.356(a)(3)(ii); 483.358(d)(e)(f); 483.364(a); 483.362(a)(c); 483.370(a)(b).

#### *Rule 4.13: Medication*

- A. Documents pertaining to medication must be accurate and readily located. When medication is a prescribed intervention for a problem identified in the resident's treatment plan, it must be noted as such in the treatment plan. Medication changes must be made during treatment planning meetings whenever possible. When circumstances preclude this, the changes must be reviewed for all team members' update at the next available staffing opportunity.
- B. When medications are prescribed or changed, a member of the professional staff must review, with each resident's parent/guardian, the following:
  - 1. The name/class of medication,
  - 2. The method of administration,
  - 3. The symptoms targeted,

4. Possible side effects of the medication,
  5. Possible long-term effects of the medication,
  6. Treatment alternatives, and
  7. Likely outcomes of using/not using the medication.
- C. When a face-to-face encounter cannot be held with a parent/guardian prior to starting a medication regimen, the "informed consent" conference must be held by telephone, with the parent's/guardian's responses noted and dated.
1. Two (2) PRTF staff must witness the form after talking with the parent/guardian.
  2. The informed consent must be signed by the parent/guardian within thirty (30) days after the telephone consent.
- D. Documentation must substantiate that medications have been accurately administered in accordance with the physician's or PMHNP's orders. Any variances must be justified in the record by medical staff.
- E. An instrument for monitoring medication side effects must be identified and routinely administered to each resident who is prescribed psychoactive medication upon admission, at least every sixty (60) days during his/her stay and again at discharge.
- F. Medication adjustment is defined as the use of a resident's routine medication in a non-routine way to help the resident through a period of heightened stress or agitation. Medication adjustment is not considered to be a special procedure. Medication adjustments must not be sedating, must be administered orally, and must be taken voluntarily by the resident. Standing PRN orders for medication adjustments are acceptable.

Source: Miss. Code Ann. § 43-13-121.

*Rule 4.14: Discharge Aftercare*

- A. No later than seven (7) days prior to the resident's projected discharge date, the treatment team must develop a provisional aftercare plan for the resident. The plan's content must include, but not be limited to:
1. The planned discharge date,
  2. The date of the resident's admission and discharge,
  3. The name of the person/agency expected to assume care and custody of the resident,
  4. The physical location/address where the resident is expected to reside,



5. A list of the resident's psychiatric diagnoses,
6. Behavior management recommendations for parents and any other suggestions which might contribute towards the resident's successful participation in family life,
7. Educational summary and practical recommendations/suggestions for teachers which might contribute towards the resident's success at school, and
8. Treatment recommendations or observations/comments for follow-up mental health clinicians which may increase the likelihood of success in therapeutic aftercare.

B. At the time of the resident's discharge the facility must:

1. Amend the provisional aftercare plan to include:
  - a) The dates of the resident's admission and discharge,
  - b) The name of the person/agency expected to assume care and custody of the resident,
  - c) The physical location/address where the resident is expected to reside,
  - d) A list of the resident's psychiatric diagnoses,
  - e) Detailed information about the resident's medications the names, strengths and dosage instruction in lay terms for all medications prescribed for the resident, as well as any special instructions such as lab work requirements,
  - f) Behavior management and other pertinent recommendations for parents/caregivers,
  - g) Names, addresses and telephone numbers of the agencies/persons who will provide follow-up mental health services, the date and time of initial aftercare appointments, and treatment recommendations for the providers of those services,
  - h) Place where the resident will be attending school, a summary of the resident's educational progress while at the PRTF, his/her current educational standing, and recommendations for the resident's teachers,
  - i) Other recommended resources, if applicable, including recreational, rehabilitative, or other special programs believed to offer benefit to the resident,
  - j) The parent/guardian's signed acknowledgment that she/he was provided:
    - 1) A copy of the resident's aftercare plan,
    - 2) A minimum of a seven (7) day supply of the resident's medications, and

- 3) Prescriptions for a thirty (30) day supply of the resident's medications.
2. Provide the parent/guardian with:
  - a) A written copy of the final aftercare plan.
  - b) A supply of all current medications prescribed for the resident, equal to the amount already stocked for that resident by the PRTF but not less than a seven (7) day supply or more than a thirty (30) day supply.
  - c) Prescriptions for a thirty (30) day supply of all medications prescribed for the resident.
3. Seek the parent's/guardian's consent to release copies of the resident's educational summary and recommendations to the resident's school. If this consent is obtained, the educational information must be mailed to the resident's school within one working day following the resident's discharge. The school must not be sent the resident's complete aftercare plan, but only the part pertaining to education.
4. Seek the parent's/guardian's consent to release copies of the resident's aftercare plan and discharge summary to the providers of follow-up mental health services. If this consent is obtained, the aftercare plan and discharge summary must be mailed to mental health aftercare within two (2) weeks following the resident's discharge.

Source: Miss. Code Ann. § 43-13-121; 42 CFR 441, Subpart D

*Rule 4.15: Reporting Requirement*

- A. The PRTF must keep the Division of Medicaid informed of serious occurrences involving residents of the PRTF.
  1. The death of any resident or a serious incident involving any resident, regardless of whether or not those involved were Medicaid beneficiaries, must be reported to the Division of Medicaid.
    - a) The death of any resident must be reported to the Division of Medicaid as soon as possible, but no later than close of business the same day.
    - b) Serious incidents must be reported by fax to the Division of Medicaid by close of the next business day.
  2. The Division of Medicaid defines serious incidents as:
    - a) Serious injury of a resident, defined as any significant impairment of the physical condition of the resident as determined by qualified medical personnel.

- 1) This includes, but is not limited to, burns, lacerations, bone fractures, substantial hematoma, and injuries to internal organs, whether self-inflicted or inflicted by someone else.
- 2) All serious injuries that require medical intervention are to be reported.
- b) Suicide attempt by a resident.
- c) Elopement of a resident.
- d) Allegations of sexual contact between residents.
- e) Allegations of maltreatment, like abuse and/or neglect of a resident.
- f) Any injury of a resident sustained in the course of a seclusion or restraint.
3. Each report must include:
  - a) The name of the resident, if she/he is a Medicaid beneficiary,
  - b) A description of the occurrence, and
  - c) The name, street address, and telephone number of the facility.
- B. Serious incidents must also be reported to the appropriate agencies or entities according to applicable state and federal regulations. These include, but are not limited to:
  1. Department of Human Services (DHS).
  2. Mississippi State Department of Health, Bureau of Health Facilities Licensure and Certification (MSDH).
  3. Disability Rights Mississippi (DRM) formerly known as the State Protection and Advocacy office.
  4. Regional Office of the Center for Medicare and Medicaid Services (CMS)
  5. Medicaid Fraud Control Unit, Attorney General (MFCU)
  6. Utilization Management and Quality Improvement Organization (UM/QIO) for the Division of Medicaid.

Source: Miss. Code Ann. § 43-13-121; 43-21-353; 42 CFR 483.374

*Rule 4.16: Maintenance of Records*

Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.

Source: Miss. Code Ann. § 43-13-121; 43-21-353