SECTION 13 - BENEFITS AND LIMITATIONS

SECTION 13-BENEFITS AND LIMITATIONS

13.1 GENERAL INFORMATION

13.1.A FUNDING SOURCES

Missouri has two programs for eligible individuals needing financial assistance in nursing homes.

One program is the "Supplemental Nursing Care Program". Under this program, if a person meets eligibility requirements as determined by the Family Support Division (FSD) and resides in a nursing home that is licensed but *not* Title XIX (Medicaid) certified, that person may receive a cash grant. The maximum cash grant is established by Missouri statute. Assistance payments to persons in this cash grant program are made entirely from state funds. These persons are also eligible for most MO HealthNet benefits.

For more information concerning the Supplemental Nursing Care (SNC) Program, contact the local FSD county office.

The other assistance program is "Vendor Nursing Care". This is a MO HealthNet program in which reimbursement is made to the provider of nursing services. Federal matching funds are available to the state for this program. The MO HealthNet Division (MHD) can reimburse a nursing home for an individual's care if:

- The nursing home is an enrolled MO HealthNet provider;
- The participant is determined by the Family Support Division to be MO HealthNet eligible;
- The participant has been screened under the Missouri Care Options process;
- The participant has been screened for a mental impairment and found appropriate for nursing home services under PASRR;
- The participant meets the medical eligibility (level of care) as determined by the Department of Health and Senior Services, Division of Regulation and Licensure, Section for Long Term Care Regulation, Central Office Medical Review Unit (COMRU); and
- The participant resides in a Title XIX certified bed.

This manual applies only to the Vendor Nursing Care Program.

13.1.B SUPPLEMENTAL SECURITY INCOME (SSI)

Supplemental Security Income (SSI) is entirely federally funded and administered by Social Security. The program provides cash assistance for disabled and elderly individuals. Individuals may be eligible to receive both a Supplemental Nursing Care cash grant and an SSI payment if they are in a nursing home that does *not* participate in the Title XIX Vendor Nursing Care Program. For participants who reside in a Title XIX bed and whose nursing care is paid by the MO HealthNet Program, SSI payments are reduced to zero ($0.00) if they have other income, or to the personal needs allowance amount established by the Social Security Administration if they have no other income.

Nursing facilities are reminded that the local Social Security Administration Office *must* be notified when a participant who receives SSI is admitted to the facility. The Social Security Office *must* update the residents address and benefit eligibility information to avoid the potential of overpayments or a delay in the receipt of benefits.

13.1.C LICENSED FACILITIES/CERTIFIED FACILITIES

All nursing homes, unless exempt by state statute 198.006, are required to be *licensed* if there are three or more residents living in the home. There are four types of long term care licenses issued: Skilled Nursing, Intermediate Care, Assisted Living and Residential Care.

In order to participate in the MO HealthNet Vendor Nursing Care Program (Title XIX), a facility *must* be licensed as a skilled nursing or intermediate care home and *must* also be *certified* as meeting federal requirements for providers of nursing facility (NF) services or intermediate care services for the intellectually disabled(ICF/ID). Provider participation in the Vendor Nursing Care Program is voluntary.

State licensing inspections and MO HealthNet certification surveys are performed by personnel within the Division of Regulation and Licensure in the Department of Health and Senior Services (DHSS). Although they are two separate procedures, they are frequently performed concurrently. Certification surveys for hospital-based nursing facilities are also performed by personnel within the Division of Regulation and Licensure. State licensing regulations may be found in 19 CSR 30-81.010 through 19 CSR 30-88.020. Federal requirements for Title XIX nursing facility participation may be found in Title 42 CFR Part 483, Subpart B; for intermediate care for the intellectually disabled, Title 42 CFR Part 483, Subpart I.

13.1.D MEDICARE NURSING HOMES

A nursing home that has been certified as a skilled nursing home may choose to execute a provider agreement with the Centers for Medicare & Medicaid Services (CMS) to provide services under Title XVIII (Medicare). The Medicare Program is administered by the Social Security Administration. Medicare homes are *not* required to participate in Title XIX (Medicaid), nor are Title XIX nursing facilities required to participate in Title XVIII (Medicare). However, many homes do have provider agreements with both programs. If a home has valid participation agreements with both Medicare and MO HealthNet, the MO HealthNet Division (MHD) reimburses the nursing home for the Medicare coinsurance for participants eligible under both programs if they reside in a Medicare/MO HealthNet certified bed. Refer to Section 16 of this manual for information on MO HealthNet billing of deductible/coinsurance.

For MO HealthNet participants who are also Medicare beneficiaries and are either a Qualified Medicare Beneficiary (QMB Only) or Qualified Medicare Beneficiary Plus (QMB Plus) and receive services covered by a Medicare Advantage/Part C plan, MO HealthNet pays the deductible, coinsurance and copayment if they reside in a Medicare/MO HealthNet certified bed.

Refer to Section 16 of this manual for a detailed explanation of these claims.

13.2 PROCEDURES FOR PROVIDER PARTICIPATION

13.2.A APPLICATION TO PARTICIPATE

The Department of Health and Senior Services (DHSS), Division of Regulation and Licensure is responsible for the certification surveys of nursing homes and the long term care wings located within a hospital. Each facility that chooses to participate in the Title XIX Program *must* complete and submit application materials to the Division of Regulation and Licensure.

13.2.B FACILITY CERTIFICATION

Upon receipt of the completed application materials by the Licensure and Certification Unit in the Division of Regulation and Licensure, Section for Long Term Care Regulation, the appropriate Section for Long Term Care Regional Office is notified to schedule a survey at the facility. The survey is normally conducted by at least a facility advisory nurse and a facility surveyor. The amount of time required to conduct a survey depends upon the size,

condition, and type of facility surveyed. Normally, an inspection to determine compliance with state licensing regulations is conducted concurrently with the Title XIX certification survey. The survey packet is submitted to the central office of the Section for Long Term Care Regulation for review. The certification decision is sent to the Missouri Medicaid Audit & Compliance Unit (MMAC). Subsequent surveys are performed no more than 15 months from the previous survey.

13.2.B(1) DISTINCT PART

A nursing home may choose *not* to have all of its licensed areas certified for participation in the MO HealthNet Program or there may be some licensed areas that do *not* meet MO HealthNet certification requirements. Federal regulations allow a facility to establish a "distinct part" provided the distinct part meets requirements for certification. The distinct part *must* be an identifiable unit such as an entire ward, floor or wing. When a facility designates a distinct part, Form DA-113, Bed Classification Listing by Category, *must* be completed showing which rooms are in the distinct part. A copy of this form is sent to the MO HealthNet Division. Vendor payments *cannot* be made for a participant residing in an area that has *not* been certified. It is the provider's responsibility to ensure that a participant for whom MO HealthNet payment is made is placed in a Title XIX certified bed. Any payments made for a participant who was *not* in a Title XIX certified bed are recouped. A request to add or change a distinct part is processed upon written notification from the facility. The request should be sent to the DHSS Section for Long Term Care Regulation/Licensure and Certification Unit for approval. The facility may make two (2) increases or one (1) increase and one (1) decrease in Medicaid beds each facility fiscal year. The effective dates may only be at the beginning of an accounting quarter or at the beginning of the fiscal year. Facilities are required to submit their request in writing no later than 45 days before the effective date. Facilities may change the location of their distinct part by submitting a request in writing no later than 30 days before the effective date.

13.2.C PROVIDER AGREEMENTS

The MMAC Unit sends a Title XIX Nursing Home Provider Agreement/Questionnaire to the facility upon request for participation and completion of the survey process. A Self-Evaluation for Compliance (MOA-10) form, which *must* also be completed, is enclosed with the agreement. The completed material should be returned to the Provider Enrollment Unit of MMAC within ten (10) days of receipt. It is a federal requirement that a facility *must* have a

signed "Participation Agreement" with the MO HealthNet Division prior to payment of MO HealthNet funds.

The provider is issued a nine-digit MO HealthNet provider number upon approval of the provider's participation agreement. That provider number is used for billing purposes.

13.3 TERMINATION, SUSPENSION OR WITHDRAWAL

13.3.A TERMINATION

If a survey by the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure finds a nursing facility out of compliance with federal standards of participation, a letter is sent to the facility notifying them of the areas that are out of compliance. The facility *must* submit to the Division of Regulation and Licensure a plan of correction with timetables for correcting those deficiencies.

If the facility has *not* corrected its deficiencies within three (3) months of the date of the survey, an alternative remedy, denial of payment for new MO HealthNet admissions, may be imposed. The Division of Regulation and Licensure makes public the fact that the denial of payment for new MO HealthNet admissions has been imposed. The facility *must* post a notice to this effect in a conspicuous location in the facility.

The facility *must* agree to repay to the MO HealthNet Division the federal portion of payments received for services after the three (3) month period if corrective action is *not* taken in accordance with the approved corrective action plan and its timetables. If the facility does *not* agree to those terms, its participation agreement in the MO HealthNet Program is terminated at the end of the three (3) month period.

If compliance is *not* achieved within six (6) months of the survey initially noting deficiencies, the facility's MO HealthNet participation is terminated. Payment for services provided after the effective date of termination may be made for up to an additional 30 days if a reasonable and timely effort is being made to transfer MO HealthNet patients.

13.3.B SUSPENSION OF PAYMENTS

Payments to a facility by the MO HealthNet Division (MHD) may be suspended for one of the following:

- Failure of the facility to comply with MHD requirements to submit requested reports and/or other necessary information; or

- Failure to repay or make arrangements for the repayment of identified overpayments within a specified time frame (13 CSR 70-3.030).

Payments held in abeyance due to the suspension may be subject to release when the facility is reinstated. The MHD reserves the right to cancel payments for such periods of time during which the facility was *not* in compliance with the terms of the participation agreement.

13.3.C WITHDRAWAL

In the event a facility finds it no longer desires to participate in Title XIX, a 30 day written notice *must* be given to MMAC and DHSS, Division of Regulation and Licensure stating the reason withdrawal is desired.

13.3.D PUBLIC DISCLOSURE

Federal regulations at 42 CFR 431.115 require that a vendor's deficiencies and plan of correction be made readily available to the public upon request. Survey information is sent to the Department of Social Services (DSS), Family Support Division (FSD) and to the District Social Security Office.

When inquiries are made by the public regarding a particular health care facility, the Family Support Division county office opens the facility file to such persons making the inquiry and also recommends they contact the DHSS, Division of Regulation and Licensure, Section for Long Term Care Regulation.

13.4 PER DIEM RATE

In accordance with state regulation 13 CSR 70-10.015 and 13 CSR 70-10.016 a per diem rate *must* be established by the MO HealthNet Division in order to reimburse a facility. A per diem is also established for ICF/ID facilities in accordance with state regulations 13 CSR 70-10.030 and 13 CSR 70-10.060. Reimbursement is based on the number of covered days multiplied by the per diem rate.

13.5 NURSING HOME ADMISSION REQUIREMENTS

There are two (2) admission requirements that *must* be performed before payment for nursing home benefits will be approved. These are:

13.5.A PREADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

A Level I screening *must* be performed for all potential residents of a MO HealthNet bed. If there is any indication of serious mental illness or intellectual disability developmental disability, a Level II screening *must* be performed prior to admission unless a special admission category applies. A physician *must* sign and date the DA-124C form prior to or on the date of admission. Payment is no earlier than the date a physician signs the DA-124C or the date of a Level II determination, if needed.

13.5.B LEVEL OF CARE DETERMINATION

If MO HealthNet benefits for nursing home services are requested, the DA-124A/B *must* be completed and submitted with the DA-124C to the Department of Health and Senior Services, Division of Regulation and Licensure, Section for Long Term Care Regulation, Central Office Medical Review Unit (COMRU). After reviewing these forms for level of care and policy compliance, the Central Office Medical Review Unit (COMRU) sends information to the DSS/FSD county office.

The DSS/FSD sends a FA-465 to the nursing facility after MO HealthNet eligibility has been established. The FA-465 is the nursing home's authorization to bill MO HealthNet. It has information concerning the earliest date of service that MO HealthNet reimburses for and the amount of surplus, if any, that is deducted from reimbursement.

Each of those two (2) requirements is discussed separately. Facilities certified as ICF/IDs are only required to meet the level of care admission requirement.

13.6 PRE LONG-TERM-CARE SCREENING

13.6.A PROCEDURES

A Pre-Long-Term Care screening (PLTC) for a preliminary evaluation of level of care and a discussion of alternative services *must* be provided to any MO HealthNet or potential MO HealthNet individual considering care in a MO HealthNet certified nursing home bed. With certain exceptions, the screening *must* be provided prior to admission to the nursing facility.

- A MO HealthNet or potential MO HealthNet individual is defined as an individual who either: (a) has already been determined by the DSS/FSD to be eligible for MO HealthNet benefits; or (b) has applied for MO HealthNet benefits or will apply in the very near future.

Step 1

- Referrals for screening are made by calling the DHSS, Division of Senior and Disability Services (DSDS) at **(**866) 835-3505**.**
- This request may be made by a hospital, family member, nursing facility, physician, ombudsman, etc.
- The minimum information the caller *must* furnish is the name, date of birth and sex of the person seeking long-term care. Other information, such as a description of the patient's condition, is helpful.
- Referrals from a hospital discharge planner to the DHSS/DSDS may result in a determination that in-home care is inappropriate for the patient at that time and that nursing home placement is necessary. No further screening is required for that individual. The Hotline worker gives the caller a screening referral number.

Step 2

- The Hotline worker contacts the DHSS/DSDS alternative services field staff person located closest to the participant.

Step 3

- The DHSS/DSDS alternative services staff person arranges to see the individual and his family, if appropriate, within one (1) working day of the call. The DHSS/DSDS worker does a preliminary level of care point count and then explains the long-term care options that are available in the patient's community.
- After an explanation of the long-term care options:

  —If alternative services are requested, the DHSS/DSDS worker makes the necessary arrangements to begin the case management and planning process for in-home services; or instead

  —If nursing home placement is still the option of choice, the DHSS/DSDS worker completes a DA-13 form. A copy of the DA-13 is in Section 14. It has the date of screening and the PLTC number on it. This information is needed to complete the DA-124A/B.

13.6.B EXEMPTIONS TO FACE-TO-FACE SCREENINGS PRIOR TO ADMISSION

Not every admission to a MO HealthNet certified nursing home bed requires a face-to-face PLTC screening prior to admission. In some instances there may be no need for a face-to-

face discussion and in other circumstances the face-to-face screening is done after the individual has entered the nursing facility. Following are the exemptions.

- An emergency admission was made. An example is one in which the caretaker had an emergency hospitalization, and no at-home support for the individual needing long-term care services was available. There is a face-to-face screening after admission.
- The resident was placed directly from out-of-state living arrangements to a nursing home. There is a face-to-face screening after admission.
- The person enters the nursing home as a private-pay resident but then applies for MO HealthNet assistance. There may be a face-to-face screening after admission.
- The person is discharged from a hospital on Friday and a DHSS/DSDS alternative staff worker *cannot* see the individual at the hospital within one (1) working day. There may be a face-to-face screening after admission.
- A participant receiving MO HealthNet nursing home benefits transferring from one certified nursing home to another home does *not* need a screening. Similarly, a transfer from a certified home to a hospital and then back to the same or different nursing home does *not* require a screening.

13.7 PREADMISSION SCREENING AND ANNUAL RESIDENT REVIEW

The Omnibus Budget Reconciliation Act (OBRA) of 1987 requires states to have in effect a preadmission screening program for mentally ill (MI) intellectual disabilities (ID) and developmentally disabled (DD) individuals who are potential residents of Title XIX certified beds. The intent of OBRA is to ensure that the MI, ID and DD participants are placed in appropriate settings and receive services appropriate for their condition.

The law states that a nursing facility *must not* place in a certified bed any new resident who is MI, ID or DD unless the State Mental Health or Division of Developmental Disabilities Authority has determined that the nursing home is appropriate for the individual. A determination for an individual in a special admission category, which is explained later in this section, does *not* have to be done prior to admission. The law applies to every applicant to a Title XIX certified bed whether or not the applicant is or will be Title XIX eligible. MO HealthNet payments are *not* made for services provided to an individual for whom a determination is required but has *not* been performed.

13.7.A PREADMISSION SCREENING PROCEDURES

The process for preadmission screening is divided into two parts: Level I and Level II. The purpose of Level I is to identify any applicant to a nursing facility who is known or suspected of being MI, ID or DD. The purpose of Level II is to evaluate if the individual with MI, ID or DD needs nursing facility level of care and, if so, whether or not the individual needs specialized services.

13.7.A(1) Level I—DA-124C

Identification of suspected MI, ID or DD individuals is made on the DA-124C form. This form is found in Section 14. Prior to a nursing home admitting any new resident to a MO HealthNet certified bed this form *must* be completed.

Not Known or Not Suspected to be MI, ID or DD

If Section B of the DA-124C form, the screening criteria for serious mental illness, or Section C of the form, the screening criteria for ID and/or related condition, indicates no further mental health evaluation is required, the person is considered "not suspected" to be MI, ID or DD. The individual may be admitted to the nursing home.

The DA-124C form *must* be filed in the patient's medical record and be available for review by state or federal surveyors.

If the individual is applying for MO HealthNet nursing home services, a DA-124A/B *must* be completed to determine level of care. The DA-124A/B form does need to be completed prior to admission. This form and instructions are found in Section 14. When submitting the DA-124 for MO HealthNet eligibility purposes, the A/B and C sections *must* be submitted together.

Known or Suspected to be MI, ID or DD

If Section B or C of the DA-124C form indicates a serious MI, ID and/or related condition, the person is considered a "suspected" MI, ID or DD, and a Level II evaluation *must* be performed prior to the person's admission to the home unless a special admission category applies.

The following are terms used on the DA-124C:

- Dementia

An individual with a primary diagnosis of dementia (including Alzheimer's disease or a related disorder) is *not* considered seriously mentally ill for the purpose of PASRR and does *not* require a Level II evaluation. This person may be admitted to a nursing home without further screening. However, if a person with a diagnosis of dementia also has a diagnosis of ID, a Level II is required prior to admission.

- Special Admission Categories

  Special Admission Categories only apply for persons who are suspected of being MI, ID or DD. There are five such categories.

  With two of the categories, Terminal Illness and Serious Physical Illness, the Level II evaluation is *not* performed prior to admission. The Level II is evaluated immediately following admission.

  Each of the other three (3) categories has a strict time period and is described below.

  —Respite Care: An individual may be admitted and remain in a facility for 30 consecutive days or less in order to provide respite for the caregiver. A Level II is *not* required. The DSS/FSD controls the nursing home authorized payment dates by means of a form they send to state office. *No payment can be made to the nursing facility beyond the 30 days.* If a situation arises in which the respite care is longer than 30 days, the nursing home *must* contact the DHSS, Division of Regulation and Licensure. If continued stay is authorized, a Level II is performed. The Family Support Division is notified if vendor payments may continue and they will change the nursing home dates to allow payment.

  —Emergency Provisional Admission: This category is for the situation in which an individual needs placement to protect the individual from serious physical harm to self or others. The nursing home *must* contact the DHSS, Division of Regulation and Licensure. This type stay *must* be prior authorized by the DHSS, Division of Regulation and Licensure as an emergency. No more than seven (7) days is allowed for an emergency admission. Again, the DSS/FSD manages those dates based on information from the DHSS, Division of Regulation and Licensure. If the resident stays in the home longer than seven (7) days, the home *must* immediately notify DHSS,

Division of Regulation and Licensure to determine continued stay. A Level II may be performed after the initial seven (7) day period, depending on the circumstances.

—Direct Transfer from a Hospital: Under the final PASRR rule a transfer from a hospital for a stay of 30 days or less is exempt from the PASRR process. If a physician attests that the individual is likely to need 30 days nursing home care or less for the condition for which the individual has been hospitalized, no Level II is necessary. Nursing home payment is made for no more than 30 days. If it becomes apparent that the individual needs longer than 30 days, the home *must* immediately notify the DHSS, Division of Regulation and Licensure. If continued stay is approved, a Level II is performed.

13.7.A(2) Level II

In order to begin the process for a Level II review, the DA-124A/B form *must* also be completed. Both forms, the DA-124A/B and DA-124C should be mailed to:

Missouri Department of Health and Senior Services
Division of Regulation and Licensure
Section for Long Term Care Regulation
Central Office Medical Review Unit
P.O. Box 570
Jefferson City, MO 65102

The DHSS, Division of Regulation and Licensure performs the level of care and sends the information to the Department of Mental Health who is responsible for completing the Level II review.

For individuals suspected of being ID or of having a related condition, the Division of Developmental Disabilities Regional Center conducts the required Level II screening activities.

For individuals suspected of having MI, the Division of Comprehensive Psychiatric Services contracts with an independent agent who conducts Level II screening activities.

If an individual is suspected of having a MI and an ID or related condition, the Level II reviews are completed by the state mental health authority and/or the contract agent of the state mental health authority.

Possible Outcomes of Level II Review

- An MI, ID or DD person who does *not* need the level of service provided by a nursing facility is inappropriate for placement there.
- An MI, ID or DD person who needs the level of services provided by a nursing facility and needs less intensive specialized services that can be provided by the NF is appropriate for placement in a Title XIX certified nursing bed.
- An MI, ID or DD person who needs the level of service provided by a nursing facility but needs specialized services that *cannot* be provided in the nursing facility is inappropriate for placement in Title XIX certified bed.
- Applicants of advanced years who are *not* a danger to themselves or others and who are in need of specialized services may choose *not* to receive them. The individual may be admitted to the nursing home.

13.7.B POLICY ISSUES REGARDING PREADMISSION SCREENING

- Preadmission screening is required for any resident who is placed in a MO HealthNet certified bed without respect to payment source. This includes private pay and Medicare beneficiaries as well as MO HealthNet residents.
- Nursing homes or hospitals are responsible for the PASRR Level I (DA-124C) screening process, which *must* be completed prior to a resident's admission to a certified bed.
- If an individual transfers from a noncertified bed to a certified one, whether or not the transfer is made within the same facility or a different one, the nursing home *must* complete the Level I screening process. If a Level II evaluation is needed, this *must* be performed prior to transfer.
- There is no need to complete a second DA-124C form when:
    1. A participant transfers from a certified bed in one facility to a certified bed in another facility;
    2. A participant is discharged from a certified bed to a hospital and returns to a certified bed, whether same or different nursing home;

3. A participant is discharged from a certified bed to home but returns to a certified bed in the same or a different nursing home in less than 60 days. If length of stay is more than 60 days, another Level I (DA-124C) *must* be performed.

NOTE: There *must* be a DA-124C in a resident's file. Be sure to obtain a copy when a person transfers. If a copy of the DA-124C is *not* obtained for one reason or another, complete a new DA-124C and submit it to the DHSS, Division of Regulation and Licensure. Attach a note to the form saying why another "C" form is being submitted.

- If there is a significant change in the mental health status of an individual, the provider completes another DA-124C form and submits the form to DHSS, Division of Regulation and Licensure, COMRU.
- The revised DA-124C has been designed so that upon its completion, the provider should know if the individual can be admitted to the home or if a Level II evaluation *must* be performed before admittance.
- An individual transferred from an out-of-state nursing facility to one in Missouri *must* be screened under this state's plan if Missouri is going to pay for services. Therefore, a Level I and Level II, where applicable, *must* be performed before payment is authorized.
- The physician signature and date are required in Section F of the DA-124C form. The date is very significant for a resident applying for MO HealthNet nursing home benefits because *eligibility for nursing home benefits can be no earlier than the date shown in Section F.*
- For those individuals who are seriously mentally ill or ID/related condition and require a Level II evaluation, *MO HealthNet nursing home benefits can be no earlier than the date a Level II determination is made.*
- If MO HealthNet benefits for nursing home services are requested by the resident, the DA-124A/B *must* be completed and submitted with the DA-124C to the Department of Health and Senior Services, Division of Regulation and Licensure, COMRU, P.O. Box 570, Jefferson City, Missouri 65102.
- A Pre-Long-Term Care Screening (PLTC) by the DHSS, Division of Senior and Disability Services *must* be provided to any MO HealthNet or potential MO HealthNet individual prior to admission to a certified bed, unless exemptions apply. Authorization for nursing home payments *cannot* be made until a PLTC number has

been assigned. This admission requirement is separate from the PASRR process. Both the PASRR and the PLTC processes are required.

13.7.C RESIDENT REVIEW

P.L. 104-315 amended Title XIX of the Social Security Act to repeal the requirement for annual resident review. The amendment was effective on October 19, 1996. In addition, the legislation adds a requirement for a nursing facility to notify the State mental health authority promptly after a significant change in the physical or mental condition of a resident who is MI or ID. A review and determination *must* be done promptly after a nursing facility has notified the State mental health authority that there has been a significant change in the resident's physical or mental condition.

The Division of Developmental Disabilities through its Regional Centers is responsible for reviews for ID and DD residents. The Division of Comprehensive Psychiatric Services through its contract agent is responsible for reviews of MI residents. For seriously mentally ill residents, the Department of Mental Health has contracted with Emeritus Corporation, d.b.a. Bock Associates to perform Level II screenings and resident reviews.

Nursing facilities *must* make charts available to the evaluator who will send the facility a copy of the full evaluation for each resident reviewed upon completion. The evaluation informs the facility of mental health services that the facility is required to include in the plan of care and to provide.

A completed copy of Level II screenings and resident reviews are sent to the facility. The evaluation informs the facility of mental health services that the facility is required to include in the plan of care and to provide.

13.7.C(1) Possible Outcomes of Change of Condition (Status) Resident Review

There are a number of possible outcomes after a Change of Condition (Status) Resident Review is performed.

- The individual needs the level of services provided by a nursing facility but does *not* require specialized services. The resident may remain in the facility; no further action is required.
- The individual needs the level of services provided by a nursing facility and needs specialized services for his/her mental illness or mental retardation.

Whether the resident may remain in the facility depends on whether the facility can provide or arrange for the active treatment the resident needs.

The resident may have a choice as to whether or not to participate in active treatment depending on the resident's age and mental capacity.

- The individual does *not* need the level of services provided by a nursing facility and does *not* require specialized services. Arrangements *must* be made for the resident's discharge.
- The individual does *not* need the level of services provided by a nursing facility but does require specialized services that *cannot* be provided by the NF. Whether the resident may remain in the facility depends on the length of time that the individual has continuously resided in a nursing facility.

  a. If the individual has continuously resided in a nursing facility for at least 30 months before the date of review, the resident is given the choice of remaining in the facility or of receiving services in an alternative setting. Regardless of the participant's choice, specialized services *must* be provided or arranged to meet the individual's needs.

  b. Residents of a nursing facility for fewer than 30 months do *not* have an option; they *must* be discharged, but arrangements to meet their specialized services needs in an alternative setting are made by the Department of Mental Health.

     NOTE: The 30 month rule is based on continuous residence in a nursing facility. The stay need *not* be in one facility as long as the residency in a nursing facility is continuous. A hospitalization is *not* considered a break in a continuous stay if the person is admitted to an acute care facility from a nursing facility and upon discharge returns to a nursing facility. It is *not* considered a break in a continuous stay if a person leaves a nursing home for no more than 12 days per six (6) calendar months.

13.7.D DEFINITIONS OF MENTAL ILLNESS AND DEVELOPMENTAL DISABLITY

- Mental Illness

  Individuals are considered to have mental illness if they have a current primary or secondary diagnosis of a serious mental disorder, as defined by the Secretary of Health and Human Services, such as schizophrenia, paranoia, major affective,

schizoaffective disorders and atypical psychosis, and do *not* have a primary or secondary diagnosis of dementia (including Alzheimer's disease or a related disorder).

- Developmental Disability (DD) and Related Conditions

Individuals are considered to have a DD if they have a level of disability defined under Missouri Revised Statutes 630.005 (9).

DD refers to significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

The provisions of this section also apply to persons with "related conditions," as defined by 42 CFR 435.1009 that states: "Persons with related conditions" means individuals who have a severe, chronic disability that meets any of the following conditions:

a. It is attributable to—
   1. Cerebral palsy or epilepsy; or
   2. Any other condition*, other than mental illness, found to be closely related to a DD. This condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with a DD, and requires treatment or services similar to those required for a DD.

b. It is manifested before the person reaches age 22.

c. It is likely to continue indefinitely.

d. It results in substantial functional limitations in two (2) or more of the following areas of major life activity:
   1. Self-care;
   2. Understanding and use of the language;
   3. Learning;
   4. Mobility;
   5. Self-direction; and
   6. Capacity for independent living.

* Any other condition includes autism.

13.7.E DEFINITION OF SPECIALIZED SERVICES

- Specialized Services for Individuals with Mental Illness:

A continuous and aggressive implementation of an individualized plan of care developed by a physician and an interdisciplinary team of qualified mental health professionals. The plan prescribes therapies and activities for the treatment of persons experiencing an acute episode of severe mental illness that requires supervision by trained mental health personnel. It is directed toward reducing the resident's psychotic symptoms and improving his level of independent functioning.

- Specialized Services for Individuals with DD:

  A continuous program for each client, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

  1. the acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
  2. the prevention or deceleration of regression or loss of current optimal functional status.

  In order to benefit from specialized services, an individual *must* have potential for learning. Specialized services do *not* include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous treatment program. Individuals requiring specialized services are generally only able to benefit from training programs that are under the direction of trained ID/DD disabilities personnel, available 24 hours per day.

  Specialized services *must* include an Individualized Support Plan (ISP) developed and implemented by appropriate disciplines. The ISP *must* be reviewed and revised as necessary but at least annually by a qualified ID professional or qualified mental health professional.

13.8 PROCEDURES FOR DETERMINING PARTICIPANT'S LEVEL OF CARE

13.8.A MEDICAL ELIGIBILITY—FORM DA-124A/B

The Nursing Facility Program requires that there *must* be prior authorization or certification of need for nursing facility level of care before a nursing home payment can be made on behalf of a participant. There are established guidelines for determining level of care. These can be found in State Regulation 19 CSR 30-81.030. A nurse consultant in the Division of Regulation and Licensure makes a certification of level of care based on the guidelines established in regulation and the information given on the DA-124A/B form. If the DA-124

report is completed at the nursing home, it is important that every effort is made to have the report reflect the patient's condition and plan of care. There is an explanation of the DA-124A/B form in Section 14. This form is supplied by the county Family Support Division (FSD).

13.8.A(1) Levels of Care

- Nursing Facility: Nursing Facility (NF) services are physician-directed services provided by a facility certified as a Nursing Facility to individuals whose physical or mental condition requires health-related services on an inpatient basis.

  To qualify for NF care, a participant *must* have an assessed point level of at least 21 using the assessment procedure as described in State Regulation 19 CSR 30-81.030.

- Intellectually Disabled or Persons with Related Conditions: Intermediate care facility for the intellectually disabled or related conditions (ICF/ID) are services provided in a certified facility whose primary purpose is to provide health or habilitative services for ID individuals or persons with related conditions.

  To qualify for ICF/ID services a person *must* have mild, moderate or a profound developmental disability (DD) or a related condition and be receiving active treatment.

13.9 DETERMINING PATIENT SURPLUS (LIABILITY)

It is a federal requirement that the MO HealthNet payment to a nursing home be reduced by a participant's income less certain deductions; i.e., personal allowance, medical insurance and any allotments to a spouse and/or eligible dependents. This income is called "patient liability" or "patient surplus" and is computed by a FSD caseworker.

The surplus amount is automatically deducted from the provider's reimbursable amount by the claims processing system. With electronic billing, the provider is *not* required to enter a surplus amount on the electronic claim.

13.9.A SURPLUS AND MONTH OF ADMISSION

Patient surplus is *not* collected by the nursing home the first month a participant is admitted if admission is after the first day of the month. If admission is the first day of the month, then patient surplus is charged to the participant for the first month.

13.9.A(1) Medicare and MO HealthNet days in the same Month

When there are Medicare days and MO HealthNet days in the same month, surplus is applied to the MO HealthNet days. Surplus is *not* applied to the MO HealthNet days when the individual was *not* a resident of the nursing facility on the first day of the month.

If the participant is in the hospital on the first day of the month, and Medicare covers the cost of the remainder of the month, then no surplus is due. For any month following the month of readmission in which there are Medicare and MO HealthNet days, the surplus is applied to any MO HealthNet days in the month regardless of the date of readmission.

13.9.B SURPLUS AND READMISSION

If a participant enters a hospital during one month and is *not* readmitted to the nursing home until after the first day of the following month, surplus is to be billed to the participant or the participant's representative (responsible party) for the month of readmission. If a participant is out of a nursing home for more than 30 days, the FSD caseworker informs the nursing home and the participant or the participant's representative if surplus should be collected for the month of readmission.

13.9.C SURPLUS WHEN STAY IS FOR A PARTIAL MONTH

Patient surplus is *not* prorated. If a participant is in the nursing home for only part of a month, it is possible that the patient surplus is greater than the covered days times the per diem amount. The MO HealthNet payment in this case is $000.00 (zero). If the surplus amount is greater than the charge for the number of days in the nursing home, the difference *must* be refunded to the participant's account. The provider should bill MO HealthNet for a participant even though the reimbursement is zero in order to receive credit for those patient days.

13.10 AN FA-465 FORM—A FACILITY'S AUTHORIZATION TO BILL MO HEALTHNET

The FSD caseworker completes an FA-465 form for each eligible resident after financial and medical eligibility has been determined. This form is sent to the participant with a copy to the facility. The FA-465 is important to the provider as it establishes three items:

1. The earliest date of service for which MO HealthNet vendor payment is made;
2. The participant's level of care, which *must* be shown on the claim; and
3. The patient liability (surplus) amount to be collected from the participant or his representative and the effective date that the surplus amount is first due.

The FA-465 form is a nursing home's authorization to submit claims for MO HealthNet payment on behalf of the participant named on the form. A claim for MO HealthNet payment *must not* be submitted until the provider has a copy of an FA-465 for the resident. If an FA-465 is *not* received within a reasonable time, contact the participant's caseworker. There is an explanation of this form in Section 14.

When a participant transfers from one nursing home to another, the receiving facility *must* have a new FA-465 from FSD before billing MO HealthNet.

13.10.A WHEN TO BILL THE PARTICIPANT FOR SURPLUS

It is recommended that providers collect surplus at the beginning of the month for that month's services. This avoids the situation in which a Social Security check, which would have been used to pay surplus, *must* be returned to SSA because the beneficiary died the previous month.

Example:	Participant enters nursing home on January 15 and dies on April 20.
Jan. 15–31	No surplus collected (Admitted after the first day of the month)
Feb. 1–29	Surplus collected at beginning of February for February services (February 3 SSA check)
March 1–31	Surplus collected at the beginning of March for March services (March 3 SSA check)
April 1–19	Surplus collected at beginning of April for April services (April 3 SSA check)
April 20	Participant Expired

May 3 SSA check received *must* be returned to SSA.

13.10.B EFFECT ON SURPLUS WHEN SOCIAL SECURITY INCREASES

If Congress approves a Social Security increase, the participant surplus is adjusted. FSD supplies a listing showing all MO HealthNet participants, their old surplus, and their new surplus and effective date. The county FSD caseworker issues an FA-465 form reflecting the correct surplus amount for participants who have more than one source of income, i.e., Railroad Retirement, Veterans Benefits, or private retirement plans. A new FA-465 is *not* generated for any participant who appears with the correct amount on the listing.

Social Security benefits are normally increased January 1 and listings distributed to facilities in the latter part of December. It should be noted that the adjusted surplus amount is effective for January dates of service.

13.11 SPOUSAL IMPOVERISHMENT

A provision of the Medicare Catastrophic Coverage Act of 1988 commonly known as *"spousal impoverishment"* was implemented for admissions to MO HealthNet certified beds on and after September 30, 1989. Its purpose is to prevent forcing a married couple to deplete their savings in order for one spouse receiving nursing care to qualify for MO HealthNet. In the past, this often left the spouse who remained at home impoverished.

The law seeks to reduce that threat by protecting a portion of the income and/or resources of a couple for maintenance of a community spouse. The following instructions explain the treatment of resources for MO HealthNet eligibility and the actions a nursing home *must* take.

When one (1) member of a married couple enters a MO HealthNet certified bed in a nursing home and the other remains in the community, all countable assets held by either or both spouses are considered available equally to both spouses in determining MO HealthNet eligibility. Their home and most personal goods are excluded from such countable assets.

The spousal impoverishment provisions allow the community spouse to keep the greater of $22,728 or half the combined assets *not* to exceed $113,640 as of January 1, 2012. The amounts are adjusted upward every January.

In determining the spousal share (what the community spouse can keep), the assets held at the beginning of the first continuous 30 day period of institutionalization are assessed. The

institutionalized spouse can qualify for MO HealthNet when the remaining portion of countable resources is at or below the eligibility limit of $999.99 ($2,000.00 if case eligibility is based on blind criteria).

The Family Support Division completes an assessment and documentation of a couple's joint assets at the first continuous period of institutionalization whenever requested by either member of the couple or their representative. An assessment should be requested even when there are no immediate plans for the institutionalized spouse to apply for MO HealthNet benefits.

Section 1919(c) (1) (B) (1) of the Act requires nursing homes to advise new admissions to certified beds of MO HealthNet eligibility and, also, that resource assessments are available from FSD upon request. The Department of Social Services monitors nursing homes to ensure that they advise individuals of the opportunity for assessments.

The pamphlet MO HealthNet Payment for Nursing Home Care, which contains the above information, may be copied and distributed to new admissions, or a facility may develop its own pamphlet with this information. To obtain a supply of this pamphlet, a facility may: write to the Family Support Division at the address on the back of the pamphlet, call 573-751-2549, fax a request to 573-526-4837, or contact the local Family Support Division office.

13.12 PROGRAM POLICIES

13.12.A REIMBURSEMENT

- The MO HealthNet Program reimburses an enrolled nursing facility based on the eligible participant's days of care multiplied by the facility's Title XIX per diem rate less any patient surplus amount.
- MO HealthNet pays for the day of admission but does *not* pay for the day of hospice election, transfer, discharge or death. The day of hospice election, transfer, discharge, or death may *not* be billed to the participant or his representative.
- If a participant dies on the day of admission, contact MO HealthNet Division, Program Relations Unit, at (573) 751-2896 for special handling.
- MO HealthNet does *not* pay for any day a participant is *not* in the facility except for therapeutic home reserve and, under certain circumstances, hospital leave days. To determine a "day," a bed count performed at 11:59 PM is most acceptable. If a participant is receiving outpatient hospital services that span midnight but is *not* admitted to the hospital, the nursing home may bill for that day.

- If the participant has both Medicare Part A and MO HealthNet coverage, the Medicare Part A benefit *must* be utilized until it has been exhausted. During a Medicare Part A coverage period, only claims reflecting Medicare days, revenue code 0189, are to be submitted. Nursing facilities are *not* to submit claims for room and board charges, revenue codes 0110, 0119, 0120, 0129, 0190, 0191, 0192, 0193, 0194 and 0199, during Part A coverage periods.

13.12.B THERAPEUTIC HOME RESERVE DAYS

The MO HealthNet Program reimburses the facility for therapeutic home reserve days provided the attending physician has documented approval in the patient's plan of care. The coverage of a temporary leave of absence includes those periods when a participant is away from the nursing home visiting a friend or relative. It does *not* apply to any days during which the participant is hospitalized except for the provision under hospital reserve days.

The number of days allowed for home leave is 12 days for the first six (6) calendar months and twelve (12) days for the second six (6) calendar months of the year.

13.12.C HOSPITAL RESERVE DAYS

Payment to a nursing facility for hospital reserve days is made under the following specific conditions only:

1. The nursing home is licensed by the Department of Health and Senior Services.
2. The Department of Health and Senior Services has *not* taken any legal action to terminate the home's participation in MO HealthNet or deny payments for new admissions as a result of noncompliance with federal standards.
3. The nursing home has 97% occupancy of the MO HealthNet certified area in the prior calendar quarter in which the first hospital reserve day occurs. Determination of occupancy is based on the quarterly survey report submitted by every nursing facility to the Department of Health and Senior Services.
4. The inpatient hospital stay is three (3) days or less.
5. The resident has enough unused therapeutic home reserve days to use two (2) home reserve days when one (1) hospital reserve day is requested.
6. The resident or the resident's responsible party notifies the nursing facility that the resident intends to return to the nursing home following the hospital stay.

A resident is *not* required to use therapeutic home reserve days when those hospital reserve days are applicable. The resident has several choices. The resident may choose *not* to reserve a room at all. In that case under OBRA 1987 the nursing home is obligated to place the resident in the first available semiprivate room with a certified bed upon the participant's discharge from the hospital. Another choice is that the resident may pay the nursing home to reserve the bed during the hospitalization period instead of using the participant's therapeutic home reserve days. If that is the situation, the nursing home should have a statement on record signed by the resident or resident's guardian that the resident chooses *not* to use therapeutic home reserve days to cover the hospital leave day's charge and understands that in order to hold a specific bed the resident is financially responsible.

13.12.D BED-HOLD POLICY

Neither a resident nor the responsible party is required to pay a nursing facility to hold a bed. If the resident/responsible person chooses to, he/she may pay a nursing facility in order to reserve the same bed the participant is leaving. A nursing home has an obligation to inform a resident or the responsible person that paying them to hold a bed is voluntary.

When a resident is transferred to a hospital, the nursing home is required, both by federal statute and by federal regulation, to readmit the resident immediately upon the first availability of a bed in a semiprivate room.

13.12.E PRIVATE ROOM

The MO HealthNet per diem includes reimbursement for a semiprivate room and board. MO HealthNet per diem also covers a private room when necessary to isolate a participant due to a medical or social condition. A MO HealthNet participant or responsible party may elect a private room subject to availability and pay the difference between a facility's private pay semiprivate rate and the private pay private rate.

A MO HealthNet participant may *not* be placed in a private room and charged any additional amount above the facility's MO HealthNet per diem rate unless the participant or responsible party specifically requests a private room in writing prior to placement in a private room and acknowledges that an additional amount *not* payable by MO HealthNet will be charged.

13.12.F DEPOSITS

Upon acceptance of a participant's MO HealthNet benefits, and under the terms of the provider agreement and federal and state regulations, a facility may *not* require MO HealthNet residents to pay a deposit as a condition of admission. It is a felony and grounds

for termination from the Title XIX Program to charge money as a precondition of admission or as a requirement for continued stay. The following is a section from 1128B(d) of the Social Security Act:

(d) Whoever knowingly and willfully—

(2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State Plan approved under this title (42 USCS section 1396 et seq.), any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

(A) As a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) As a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State Plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000, or imprisoned for not more than five (5) years, or both.

If a resident is admitted as private pay and a deposit has been collected, this deposit *must* be returned to the resident or to the resident's representative if the individual later becomes MO HealthNet eligible.

13.12.G PARTICIPANT NONLIABILITY

13.12.G(1) Covered Services

MO HealthNet covered services rendered to an eligible participant are *not* billable to the participant if MO HealthNet would have paid had the provider followed the proper policies and procedures for obtaining payment through the MO HealthNet Program as set forth in 13 CSR 70-4.030.

13.12.G(2) Retroactive Coverage

The Social Security Act at 1919(c)(5) specifies admission practices a MO HealthNet nursing facility *must* follow regarding a participant's right to MO HealthNet benefits. A resident *cannot* be required to waive his rights to benefits under MO HealthNet. Therefore, if a resident is *not* eligible for MO HealthNet at time of admission but is eligible retroactively to the time of admission, the resident is *not* responsible for payment of those days. Those days can be billed to the MO

HealthNet Program. If the resident or his family paid for those days until eligibility was established, that money *must* be returned after MO HealthNet eligibility is established. Failure to return the money after MO HealthNet eligibility has been established is a MO HealthNet Program violation under 13 CSR 70-3.030.

13.12.H REMAINING PERSONAL FUNDS FOR A DECEASED PARTICIPANT

Nursing facilities are required to submit a written account of the remaining personal funds for any deceased resident who has received aid, care, assistance or services paid by the Department of Social Services (Section 198.088(7), RSMo [Cum. Supp. 1993]). For the purpose of this policy, personal funds of the deceased resident include all of the resident's remaining funds held by the nursing home, in whatever title the account or accounts may be known. The residents personal funds account balance must be submitted on the Personal Funds Account Balance Report form within 60 days from the date of the resident's death. A copy of this form can be found at http://manuals.momed.com/forms/Personal_Funds_Account_Balance_Report[TPL-PF].pdf

Providers must send this form to the MO HealthNet Division, Cost Recovery/Third Party Liability Unit, PF Recovery, P. O. Box 6500, Jefferson City, MO 65102-6500. The nursing home must include on the form the name and address of the resident's estate or the individual designated to receive the resident's quarterly accounting of all financial transactions.

13.12.H(1) Cost Recovery/Third Party Liability Unit

Providers may contact the Cost Recovery/Third Party Liability Unit at (573) 751-2005 during regular business hours to ask any questions regarding this matter, including verifying if a resident has received aid or assistance, or to request additional reporting forms.

13.12.H(2) Funeral Expenses

Funeral expenses may be paid from a resident's personal funds held by a facility if no other funds are available to cover the cost. If personal funds are used for this purpose, complete the Personal Funds Account Balance Report form indicating that funds were used to pay funeral expenses, the payee and the amount applied toward the funeral expenses.

13.12.H(3) Aid and Assistance Paid by DSS

Upon receipt of the reporting form, the MO HealthNet Division (MHD) determines the amount of aid, care, assistance and services paid on behalf of the deceased resident by the Department of Social Services. Within 60 days of receipt of the Personal Funds Account Balance Report form, MHD notifies the nursing home of the amount determined to have been paid by the Department on behalf of the deceased participant. The nursing home *must* pay to the Department any remaining personal funds, up to the amount of aid and assistance that was paid by the Department. The nursing home *must* send a check payable to the Department of Social Services within 60 days of the facility's receipt of the notification for payment. Instructions for payment appear on the Department's notification letter.

If a balance remains in the residents personal fund account after payment has been issued to the Department of Social Services, then the deceased resident's remaining personal funds should be treated in the same manner as the nursing home does for residents who do *not* receive aid and assistance.

Providers are in violation of MO HealthNet Program regulations under 13 CSR 70-3.030 if, within 60 days of the death of the resident, they fail to submit a complete accounting of the remaining personal funds of a deceased resident who has received aid, care, assistance or services paid by the Department of Social Services.

13.13 INCLUDED SERVICES, ITEMS AND SUPPLIES

All supplies, items and services included in the calculated per diem rate *must* be provided to the resident. Supplies and services that would otherwise be covered in a per diem rate but that are also billable to the Title XVIII Medicare Program *must* be billed to that program for facilities participating in the Title XVIII Medicare Program. Included supplies, items and services may *not* be billed to the resident or his responsible party. Covered services in the per diem rate include but are *not* limited to the following:

- Services, items and supplies required by federal or state law or regulation that *must* be provided by long term care facilities participating in the Title XIX Program;
- Semi-private room and board;
- Private room and board when it is necessary to isolate a participant due to a medical or social condition; examples are contagious infection, loud irrational speech, etc.;

- Therapeutic home leave days for MO HealthNet participants, *not* to exceed 12 days for the first six (6) calendar months and *not* to exceed 12 days for the second six (6) calendar months;
- Hospital leave days when all criteria are met;
- Provision of nursing services;
- Provision of routine personal hygiene and routine care services;
- Basic hair care, including haircuts, shampoo, and sets as necessary. Only services that are performed by other than nursing home personnel at the election of the participant may be billed to the participant. Included in basic hair care is any over-the-counter shampoo;
- All general personal care services that are furnished routinely and relatively uniformly to all residents for their personal use for purposes of cleanliness and appearance; e.g., necessary clipping and cleaning of fingernails and toenails, and shaves to the extent necessary for reasonable personal hygiene. The provider shall *not* bill the patient or his representative for this type of personal service or supplies.
- All laundry services, including personal laundry;
- All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;
- All consultative services required by federal or state law or regulation;
- All therapy services required by federal or state law or regulation;
- All routine care items, including disposables and including but *not* limited to those items specified herein;
- All nursing care services and supplies, including disposables, and including but *not* limited to those items specified herein;
- Any and all non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins and minerals. Providers may *not* elect which non-legend drugs in any of the four categories to supply; any and all *must* be provided to residents as needed and are included in a facility's per diem rate.

NOTE: The following list is taken from state regulation 13 CSR 70-10.015.

PERSONAL CARE

Baby powder

Bedside tissues

Bibs, all types

Deodorants

Disposable underpads of all types

Gowns, hospital

Hair care, basic including washing, sets, brushes, combs, non-legend shampoo

Lotion, soap and oil

Oral hygiene including denture care, cups, cleaner, mouthwashes, tooth brushes and paste

Shaves, shaving cream and blades

Nail clipping and cleaning-routine

EQUIPMENT

Arm slings

Basins

Bathing equipment

Bed frame equipment including trapeze bars and bedrails

Bed pans, all types

Beds, manual, electric

Canes, all types

Crutches, all types

Foot cradles, all types

Glucometers

Heat cradles

Heating pads

Hot pack machines

Hypothermia blanket

Mattresses, except those authorized by MHD Exception

Patient lifts, all types

Respiratory equipment, compressors, vaporizers, humidifiers, IPPB machines, nebulizers, suction equipment and related supplies, etc.

Restraints

Sand bags

Specimen container, cup or bottle

Urinals, male and female

Walkers, all types

Water pitchers

Wheelchairs, standard, geriatric, and rollabout

NURSING CARE/PATIENT CARE SUPPLIES

Catheter, indwelling and non-legend supplies

Decubitus ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads and/or turning frames, heel protectors, donuts and sheepskins

Diabetes blood and urine testing supplies

Douche bags

Drainage sets, bags, tubes, etc.

Dressing trays and dressings of all types

Enema supplies

Gloves, non-sterile and sterile

Ice bags

Incontinence care including pads, diapers and pants

Irrigation trays and non-legend supplies

Medicine droppers

Medicine cups

Needles including but *not* limited to hypodermic, scalp, vein

Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel

Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A & D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings, and bandages of all types, cotton balls, and aerosol merthiolate, tongue depressors

Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags

Suture care including trays and removal kits

Syringes, all sizes and types including ascepto

Tape for laboratory tests

Urinary drainage tube and bottle

THERAPEUTIC AGENTS AND SUPPLIES

Enteral feedings (including by tube) and all related supplies
Nutritional supplements

- I.V. therapy supplies: arm boards, needles, tubing and other related supplies
- Oxygen, (portable and stationary), oxygen delivery systems, concentrators and supplies
- Special diets
- Drugs, stock (excluding insulin)
- Any and all non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins and minerals. Providers may not elect which non-legend drugs in any of the four categories to supply; and all must be provided to residents as needed and are included in a facility's per diem rate.

13.14 FACILITIES FOR THE MENTALLY ILL

Facilities that care primarily for residents with mental disease are considered "institutions for the mentally ill." By federal rule, at Title 42 CFR 440, MO HealthNet *cannot* reimburse an institution for the mentally ill for participants who are between the ages of 21 and 65. In general, an institution for mental diseases means a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the intellectually disabled is *not* an institution for mental diseases.

13.15 PARTICIPANT COPAY

Services of the Nursing Home Program described in this manual are *not* subject to a copay amount. Residents of nursing homes licensed by the Department of Health and Senior Services are exempt from the cost sharing or copay amount. Reference Section 13.10 of this manual for information on patient surplus/liability, which is different than a copay amount.

13.16 MO HEALTHNET PROGRAMS THAT HAVE SPECIFIC BENEFITS AND LIMITATIONS FOR NURSING HOME RESIDENTS

13.16.A AMBULANCE SERVICES

Ambulance services are covered if they are of an emergency nature and if the participant is transported to the nearest hospital with appropriate facilities.

Ambulance service to a physician's office, a dentist's office, a patient's home or to a nursing home is not a MO HealthNet ambulance covered service. Refer to section 22 of this manual for information on Non-Emergency Medical Transportation (NEMT).

13.16.B CLINIC SERVICES

MO HealthNet covers clinic services. However, MO HealthNet is prohibited from covering such services when the clinic is located on the premises of a nursing home, regardless of any office space leasing arrangement a practitioner may have with a nursing home. Whether the services are provided in the long term care facility itself or in the clinic physically situated on the long term care facility premises, those services are *not* covered by MO HealthNet. Clinic services provided off the facility premises are covered by MO HealthNet.

13.16.C DENTAL SERVICES

Routine dental services performed in a nursing home do *not* require prior authorization. For further information on dental services and dentures, refer to Section 13 of the Dental Provider Manual.

13.16.D EXCEPTIONS

A group two (2) or three (3) pressure support surface is the only nursing facility item that may be considered by the Exception Process for payment outside the per diem.

Requests for group two (2) and three (3) pressure support surfaces may be submitted by fax to 573-522-3061. In addition to the MO HealthNet Exception Request form, prescribers must also complete the Air Fluidized/Low Air Loss Therapy form

Section 20 of the Nursing Home Provider Manual contains a full discussion of the Exception Process. For further assistance, the Exceptions Process may be contacted at (800) 392-8030.

13.16.E HEARING AID SERVICES

Requests for audiometric testing and hearing aids *must* originate with the participant and *must* proceed with the participant's full knowledge and consent.

Prior authorization is required for all hearing aid services provided in a nursing home except for post-fitting adjustments, post-fitting evaluations and repairs to hearing aids no longer under warranty. A Report of Hearing Aid Evaluation (RHAE) form completed to the extent possible *must* be attached to all prior authorization requests for hearing aid services to be provided in a nursing home. The hearing aid provider is responsible for completing the form and obtaining the required signatures. The participant or legal guardian *must* sign Section D of the RHAE form certifying that he/she initiated the request for the service. The nursing home administrator *must* also sign Section D of the RHAE form to certify that the participant initiated the request for a hearing aid.

Separate prior authorization requests are required for the testing and the hearing aid if the testing *or* dispensing is to be provided in the nursing home.

13.16.F HOSPICE SERVICES

MO HealthNet covers hospice services. The hospice benefit is designed to meet the needs of patients with a life-limiting illness and to help their families cope with the problems and feelings related to this difficult time. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative to palliative care.

When providers verify participant eligibility, the hospice participant is identified by the lock-in provider's name and phone number. Eligibility may be verified by calling the interactive voice response (IVR) system at (573) 751-2896 or using the Internet at www.emomed.com. Reference Sections 1 and 3 of this manual for more information.

MO HealthNet eligible individuals residing in MO HealthNet certified nursing facilities who meet the hospice eligibility criteria may elect MO HealthNet hospice care. When a participant in a nursing home elects hospice services, the hospice provides or arranges for all

care, supplies, equipment and medicines related to the terminal illness. MO HealthNet reimburses the hospice provider who then reimburses the nursing facility (NF) for room and board services. The nursing home *must* agree to accept the hospice's negotiated per diem rate as payment in full since *it cannot bill MO HealthNet for nursing home services on behalf of the hospice patient.* The room and board services provided by the nursing facility include the performance of personal care services that a care-giver would provide if the individual were at home. These services include assistance in the activities of daily living: washing and grooming, toileting, dressing, meal services, socializing (companionship, hobbies, etc.), administration of medication, maintaining the cleanliness of the resident's bed and room, and supervising and assisting in the use of durable medical equipment and prescribed therapies (such as range of motion exercises, speech and language exercises).

There *must* be a written agreement between the hospice and the nursing facility under which the hospice takes full responsibility for the professional management of the individual's hospice care, and the nursing home agrees to provide room and board to the individual.

Payment for hospice NF room and board is determined in accordance with rates established under 1902(a) (13) of the Social Security Act.

13.16.F(1) Payment of Surplus

It is a federal requirement that hospice patients in a MO HealthNet certified bed *must* use any income they receive, less certain deductions such as medical insurance, for their room and board (hospice care). The procedure to determine the amount of surplus for hospice patients is performed by the Family Support Division (FSD).

When the nursing home and the hospice have agreed to the placement (admission) of a hospice patient in the nursing home, the home *must* notify FSD of the placement, and request that the hospice patient or the responsible party apply for vendor services. The DA-124A/B and DA-124C *must* be completed and sent to the Division of Regulation and Licensure. When FSD receives these forms from the Division of Regulation and Licensure, the caseworker calculates the surplus amount and completes the FA-465. The FA-465 is sent to the resident, the responsible party and the nursing home. The nursing home should give a copy of the FA-465 to the hospice.

It is between the hospice and the nursing home to decide which of them bills for and collects the surplus amount, if any, from the patient. MO HealthNet payment

for nursing home services is made to the hospice. This payment is reduced by any surplus amount shown in the file for that individual. The nursing home *must not* bill MO HealthNet for these days. The hospice is responsible for reimbursing the nursing home.

When a participant elects or revokes hospice in the middle of the month, surplus is applied to the appropriate provider's claim for the first of the month. The remaining surplus balance, if any is carried forward and applied to the subsequent provider's claim until it is satisfied in full.

EXAMPLE: Participant, Jane Doe, is a resident of a nursing home and elects hospice on June 15 then later revokes hospice on August 3. She has a monthly surplus of $800.

June 1-14	Nursing home submits a claim for room and board. Payment is deducted by Jane's $800 surplus.
June 15-30	Hospice submits a claim for the nursing home room and board. Payment is made in full to the hospice at 95% of the nursing home's per diem.
July 1-31	Hospice submits a claim for the nursing home room and board. Payment is deducted by the $800 surplus and the remaining is paid to the hospice at 95% of the nursing home's per diem.
August 1-3	Hospice submits a claim for the nursing home room and board. The allowed amount of 95% of the nursing home's per diem for the three (3) days is only $300. The hospice receives a $0.00 payment from MO HealthNet.
August 4-31	Nursing home submits claim for the room and board. Payment is reduced by the remaining $500 surplus and the rest is paid at 100% of the nursing home's per diem.

Remember it is important for both nursing home and hospice providers to submit claims for each day the participant is under their care, even if no money is received from MO HealthNet for that claim. Surplus can only be correctly applied if all days have been submitted

Providers should note that Missouri Care Options and the PASRR process apply to hospice admissions.

13.16.G OPTICAL SERVICES

Optical services performed in a nursing home are subject to precertification requirements as described in Section 13.7 of the Optical Provider Manual. Routine optical services performed in a nursing home do *not* require prior authorization. The participant, participant's family, personal representative or legal guardian *must* have full knowledge of and consent to requests for all optical services.

For further information on optical services, refer to Section 13 of the Optical Provider Manual.

13.16.H PHARMACY SERVICES

All drug products produced by manufacturers that have entered into a rebate agreement with the Federal Government are reimbursable under the MO HealthNet Pharmacy Program, with the exception of Drug Efficacy Study Implementation (DESI) drugs and drugs specified in Section 13, Benefits and Limitations, of the manual.

A list of manufacturers that have entered into an agreement with the Federal Government (along with the first five digits of the NDC number by which products may be identified), can be found in Drug Company Contact Information. Products for which the first five digits of NDC numbers are not included on the list are not reimbursable under the MO HealthNet Pharmacy Program and are not available through any prior authorization program. The federal Centers for Medicare & Medicaid Services (CMS) has required that participating manufacturers identify products which are affected by the Drug Efficacy Study Implementation (DESI). CMS has instructed state Medicaid programs that products identified as such are not subject to federal financial participation and are therefore not reimbursable under the MO HealthNet Pharmacy Program. All prescriptions filled for eligible participants must be filled in accordance with Chapter 338 of the Missouri Board of Pharmacy statues.

To comply with the Deficit Reduction Act of 2005 (DRA) states must now collect the 11-digit National Drug Codes (NDC) on all outpatient drug claims submitted to the MO HealthNet program for rebate purposes. Providers are required to submit their claims for all medications administered in the clinic or outpatient hospital setting, with the exact NDC that appears on the product dispensed or administered. Should a dispute arise between MO HealthNet utilization data and a manufacturer’s estimation of product sold, data is supplied to the manufacturer to resolve the dispute. If necessary, zip code or provider-specific utilization data is provided. Should data indicate that a provider is billing fraudulently by using NDCs

other than those identifying the actual product dispensed, the information is referred to the Missouri Medicaid Audit & Compliance (MMAC) Unit and may result in legal action, provider sanctions and possible termination from the program.

13.16.H(1) Excluded Drug Products

The pharmacy provisions of OBRA 90 list specific drugs and categories of drugs that state Medicaid programs may exclude from coverage. The specific and up-to-date listing of the drugs and categories of drugs that are excluded from coverage under the MO HealthNet Pharmacy Program may be found on the MO HealthNet website by referencing "Drugs with Coverage Limitations," or by accessing the following link: http://www.dss.mo.gov/mhd/cs/pharmacy/pdf/druglist.pdf.

Drugs falling outside the definition of a covered outpatient drug, as defined in Section 1927(k)(2),(k)(3) and (k)(4) of the Social Security Act, are excluded. Active Pharmaceutical Ingredients (APIs) and excipients may be considered pharmacy covered services. For questions regarding a denied claim, pharmacies may call the Clinical Services Pharmacy Help Desk at (800)392-8030.

13.16.H(2) Clinical Edit, Preferred Drug List and Drug Prior Authorization Process

As specified in OBRA 90, any MO HealthNet drug prior authorization process *must* meet certain criteria. Such a process *must*:

- Provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization.

- Provide for the dispensing of at least a 72-hour supply of a covered outpatient drug in an emergency situation, except with respect to the drugs on the list of drugs permissible for exclusion.

In accordance with OBRA 90 requirements, patient-specific drug prior authorization requests are accepted and responded to via telephone (800)392-8030 or by faxing the Drug Prior Authorization form to (573) 636-6470, Monday through Friday, 8:00 am. to 9:00 p.m., Saturday, Sunday and major national holidays 8:00 a.m. to 6:00 p.m. Requests for drug prior authorization *may* be initiated by either pharmacy or prescriber staff. All requests *must* include all required information. Requests received that have sufficient information and are initiated by a physician's office or pharmacy staff receive a response either

during the requestor's call or by return FAX or phone call. Requests received with insufficient information for review do *not* initiate a prior authorization review or the 24-hour response period.

The following information *must* be supplied with each patient-specific drug prior authorization (PA) request:

- Participant DCN
- Participant name
- Drug, strength, dosage form and dosing schedule requested
- Diagnosis may be required
- Requested duration of approval

Providers are reminded that no prior authorization process exists for products of manufacturers that have *not* signed the national rebate agreement.

For up-to-date information on drug products that require edit authorization, reference the "Clinical Edit and PDL Documents" tab of the MO HealthNet website or by referencing the following link: http://www.dss.mo.gov/mhd/cs/pharmacy/pages/clinedit.htm. The provider may review the specific policy requirements to expedite processing of requests. These policies are dynamic and revised as necessary to remain current.

13.16.H(3) Prescribing Long-Term Maintenance Drugs

Maintenance medications are drugs taken on a regular basis for an ongoing condition such as but not limited to diabetes, high blood pressure, cholesterol, heart disease or asthma. Maintenance medications are required to be prescribed/billed for no less than a one-month supply when, in the prescriber's professional judgment, the patient's diagnosis has been established, the condition stabilized, and the drug has achieved the desired effect and may be safely prescribed ongoing. Maintenance medications can also include but not be limited to medication for long term pain relief and supplements such as but not limited to vitamins, fiber, and laxatives, etc. Pharmacy providers are to dispense in the manner prescribed. Regardless of the dispensing system utilized, long term care, PRN and all maintenance medications may be billed no more frequently than one time per month. The MO HealthNet Pharmacy Program will not allow refill of

medications for weekend passes, leaves of absence or utilization of reserve days. There will be no exceptions for these circumstances beyond those required to implement a change in the prescribed dosage.

13.16.H(4) Pharmacy Products Covered Under the Nursing Home Per Diem

Products reimbursed under the nursing home per diem are *not* to be billed to MO HealthNet by providers. These services *cannot* be billed to the participant. All routine care items are considered included in the MO HealthNet reimbursement methodology to long term care facilities. Pharmacy providers *MUST NOT* bill the MO HealthNet Program or the participant for items or services included on this list. The list of items and services covered under the nursing home per diem can be found in section 13.14 of this manual.

13.16.I PHYSICIAN SERVICES IN NURSING HOMES

Following is a summary of physician services that are required for MO HealthNet residents in a Title XIX facility and usually performed in a nursing home. It includes both federal and state licensing requirements.

- The physician *must* see the resident at least once every 30 days for the first 90 days and at least once every 60 days thereafter. The physician must examine the resident as often as necessary to ensure proper medical care.
- For each medical examination, the physician *must* review the resident's care, including medications and treatments; write, sign and date progress notes, and sign and date all orders.
- All physician telephone orders *must* be signed and dated within seven (7) days of the original telephone order.

13.16.J DURABLE MEDICAL EQUIPMENT

Some services or equipment are *not* included in the nursing facility per diem and may be covered through the Durable Medical Equipment Program.

13.16.J(1) Wheelchairs

Standard, geriatric and roll-about wheel chairs *must* be supplied by the nursing facility without charge to the participant. Customized wheelchairs, however, may be available through the MO HealthNet Durable Medical Equipment (DME)

Program. The term "customized wheelchair" is defined as those chairs that are tailor-made for one participant and *cannot* be used by anyone else.

Wheelchairs that are categorized as "custom" should be requested through a MO HealthNet participating durable medical equipment supplier. The DME provider *must* request prior authorization as instructed in Section 8 of the Nursing Home Provider Manual.

Customized wheelchairs that are purchased by the MO HealthNet Program become the property of the participant. If the participant transfers from one facility to another, the custom wheelchair *must* accompany the participant.

13.16.J(2) Home Parenteral Nutrition

Home parenteral nutrition (HPN) is covered through the Durable Medical Equipment Program. HPN requires pre-certification through Mo HealthNet's Web tool CyberAccess[SM], Additional information regarding CyberAccess[SM] and the medical criteria documents established by MO HealthNet may be found at http://dss.mo.gov/mhd/cs/index.htm

13.16.J(3) Volume Ventilator Rental

Ventilators are covered through the Durable Medical Equipment Program. Back-up ventilators are *not* approved for participants in a nursing home.

13.16.K PSYCHIATRIC SERVICES IN A NURSING HOME

MO HealthNet will allow a Psychiatric Diagnostic Interview Examination, procedure code 90801, for participants in a Skilled Nursing Facility (nursing home) when performed by a Psychiatrist, Psychiatric Clinical Nurse Specialist (PCNS), or Psychiatric Mental Health Nurse Practitioner (PMNHP). The Psychiatric Diagnostic Interview Examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

13.17 EMERGENCY SERVICES

Emergency services are services required when there is a sudden or unforeseen situation or occurrence or a sudden onset of a medical condition manifesting itself by acute symptoms of

sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

13.18 OUT-OF-STATE, NONEMERGENCY SERVICES

All nonemergency, MO HealthNet covered services that are to be performed or furnished out-of-state for eligible MO HealthNet participants, and for which MO HealthNet is to be billed, *must* be prior authorized before the services are provided. Services that are *not* covered by the MO HealthNet Program are *not* approved.

Out-of-state is defined as *not* within the physical boundaries of the State of Missouri nor within the boundaries of any state that physically borders on the Missouri boundaries. Border-state providers of services (those providers located in Arkansas, Illinois, Iowa, Kansas, Kentucky, Nebraska, Oklahoma and Tennessee) are considered as being on the same MO HealthNet participation basis as providers of services located within the State of Missouri.

A Prior Authorization Request *form* is *not* required for out-of-state nonemergency services. To obtain prior authorization for out-of-state, nonemergency services, *a written request must* be submitted by a physician to:

MO HealthNet Division
Participant Services Unit
P.O. Box 6500
Jefferson City, MO 65102

The request may be faxed to (573) 526-2471.

The written request *must* include:

1. A brief past medical history.
2. Services attempted in Missouri.
3. Where the services are being requested and who will provide them.
4. Why services can't be done in Missouri

NOTE: The out-of-state medical provider *must* agree to complete an enrollment application and accept MO HealthNet reimbursement. Prior authorizations for out-of-state services expire 180 days from the date the specific service was approved by the state.

13.18.A EXCEPTIONS TO OUT-OF-STATE PRIOR AUTHORIZATION (PA) REQUESTS

The following are exempt from the out-of-state prior authorization requirement:

1. All Medicare/MO HealthNet crossover claims.
2. All Foster Care children living outside the State of Missouri. However, nonemergency services that routinely require prior authorization continue to require prior authorization by out-of-state providers even though the service was provided to a Foster Care child.
3. Emergency ambulance services.
4. Independent laboratory services.

13.19 CATASTROPHES/DISASTERS

Facilities needing to temporarily relocate residents to another facility due to a catastrophe or a disaster related situation may continue to bill MO HealthNet for those residents as normal, but that facility is personally responsible for entering into a reimbursement agreement with the other facility.

END OF SECTION

TOP OF PAGE