The references to nursing facilities for the mentally retarded (Provider Type 71) have been removed, as Michigan no longer has any of these facilities.

The Nonlegend Drugs section has been revised to correspond to the Pharmacy (Provider Type 50) policy. This section is now titled "Over-the-Counter Products (OTCs)."

The wound dressing policy has been added to Chapter III, Supplies and Accessories.

Medicaid's policy on the attendance of a nurse aide in non-emergency transportation has been added to Chapter III.

The following policies from Chapter V have been moved to Chapter III: MARRIED COUPLES; NURSING CARE IN CHRISTIAN SCIENCE SANATORIA; RESIDENT ASSESSMENT AND REVIEW; TRANSFER TRAUMA; and TRANSFER OR DISCHARGE.

The Preadmission Screening and Annual Resident Review (PASARR) policy has been moved from Chapter VIII to Chapter III.

Information previously contained in Chapter I specific to nursing facilities has been moved to Chapter III.

The reference to Alternative Intermediate Service (AIS) homes for the Mentally Retarded has been eliminated as Michigan no longer has any AIS/MR (Provider Type 69) homes.

Chapter V

Chapter V has been eliminated as the information contained in this chapter is:

- now in Chapter III (as stated above); **or**
- previously obsolete via a Medicaid bulletin (i.e., R-19, Request for Prior Authorization of Medical Eligibility for Reimbursement for Skilled Nursing or Intermittent Care, and the MSA-1184, End of Nursing Care Notice); **or**
- already mentioned elsewhere in the manual (i.e., the Facility Admission Notice, MSA–2565-C is contained in Chapter II; CHANGE IN FACILITY CERTIFICATION is mentioned in the Nursing Facility Certification, Survey and Enforcement Chapter currently out for Public Comment); **or**
- moved to another, more appropriate chapter (i.e., the LTC Eligibility List, FM-160, is now discussed in Chapter II, Beneficiary Eligibility); **or,**
- no longer in effect.

Chapter VIIA

Chapter VIIA has been eliminated as it pertains to the reimbursement system for Alternative Intermediate Service (AIS) homes for the Mentally Retarded. As stated previously, Michigan no longer has any AIS/MR (Provider Type 69) homes.

Chapter VIII

Chapter VIII regarding PASARR has been eliminated as the information contained in this chapter is now in Chapter III (as stated above).

Appendices

Appendix I has been eliminated as the information is contained in the General Information Chapter.

Appendix K has been eliminated. The list of Psychopharmacological Drugs is now contained in Chapter III.

Appendices L, N, and O have been eliminated as the related polices are no longer in effect.

Request for Prior Authorization for a Complex Care-Memorandum of Understanding (MSA-1576)

The Michigan Department of Community Health has developed the attached MSA-1576 for requesting authorization for additional reimbursement for beneficiaries requiring complex care. The MSA-1576 will eventually be located in the Forms Appendix of the Medicaid Nursing Facility Manual. The revised Chapter III contains information on Memorandum of Understanding (MOU) - Special Agreements for Complex Care.

Request for Authorization of Private Room Supplemental Payment for Nursing Facility (MSA-1580)

The Michigan Department of Community Health has developed the attached Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580). The revised Chapter III contains policies and procedures on Coverage of Private Rooms. The information in the revised Chapter III supercedes the policies and procedures that MDCH sent under separate cover letter to nursing facilities regarding private rooms.

Manual Maintenance

The nursing facility should **DISCARD** Chapters III, V, VIIA, and VIII, and Appendices I, K, L, N, and O of the Nursing Facility Manual. The facility should **INSERT** the attached Chapter III. (The facility may discard this bulletin when manual maintenance is completed.)

The nursing facility should **DISCARD** all bulletins except those listed on the attached list. The list of bulletins that should be **RETAINED** by the facility should be filed in the front of the Nursing Facility Manual.

Questions

Any questions regarding this bulletin should be directed to Provider Support, Department of Community Health, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll free: 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

BULLETINS

The following Long Term Care (LTC) Facility, Nursing Facility (NF), MSA, and All Provider (AP) bulletins should be **retained** by the nursing facility. These bulletins contain policies and procedures that have not been incorporated into the manual.

Bulletins not listed may be **removed and discarded** from the Medicaid Nursing Facility Manual.

This list should be placed in the front of the Nursing Facility Manual.

NF Bulletin	MSA + AP Bulletin	Issue Date	Subject
	MSA 03-18	10/15/03	Clarification of Correction to New Institutional Chapter IV
NF 03-08		10/01/03	Nursing Facility Per Diem Rate Determination/Quality Programs for FY 2003-2004, Class I Rate Relief
	MSA 03-09	07/01/03	PASARR Forms – DCH-3877 and DCH-3878
	AP 03-07	07/01/03	Sanctioned Providers
	AP 03-06	06/16/03	Adult Benefits Waiver
	AP 03-05	06/01/03	Adult Benefits Waiver
NF 03-05		06/01/03	Quality Assurance Adjustment for Publicly-Owned Class III Nursing Facilities
	AP 03-04	06/01/03	Adult Benefits Waiver
NF 03-01		02/07/03	Implementation of Executive Order 2002-22; Rate Reduction
NF 02-05		12/16/02	Quality Assurance Adjustment
NF 02-03		07/15/02	Quality Assurance Adjustment
LTC 01-08		12/01/01	Implementation of FY 2002 Rates for Class I and Class III Providers/Executive Order 2001-9
LTC 01-02		02/15/01	Implementation of FY 2001 Rate Increase and Continuation of the Wage Pass-Through Program for Class I and Class III Providers
LTC 00-04		08/01/00	Nursing Home Quality Incentive Program
LTC 00-03		07/01/00	Special Rate Relief
LTC 00-02		02/16/00	Nursing Home Quality Incentive Program
	AP 00-02	02/01/00	Special Programs
	AP 99-03	02/01/99	Medicaid Program Buy-In of Medicare Part A for QMB Eligibles
LTC 99-02		01/29/99	Proportionate Share Pool
	MSA 98-05	03/02/98	Expansion of Home & Community Based Services Waiver for the Elderly and Disabled
LTC 96-07		08/30/96	Wage Pass-Through
LTC 96-01		04/1/96	Upper Limit
LTC 95-05		09/27/95	Wage Pass-Through
	AP 95-02	04/15/95	Program of All-Inclusive Care for the Elderly in Wayne County
LTC 94-09		10/1/94	Wage Pass-Through
LTC 94-01		12/15/93	Wage Pass-Through
LTC 93-05		04/15/93	Nurse Aide Training

REQUEST FOR PRIOR AUTHORIZATION FOR A COMPLEX CARE
Memorandum Of Understanding
Nursing Facility
and
Michigan Department Of Community Health

Complete this request with specific information. Include current documentation regarding the beneficiary's medical condition and any other information you feel will support this request for reimbursement.

FAX TO: MDCH-Long Term Care Services at **(517) 241-8995**

Client/Beneficiary Name	**Nursing Facility Name**
Beneficiary ID Number	**Nursing Facility Street Address**
Admission Date	**Nursing Facility City, State and Zip**
Effective Date of Current CCMOU	**Provider Contact Name**
Nursing Facility Provider ID Number	**Provider Contact Phone Number** ( ) -

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEEDS the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	$ _____ Per hour	$ _____
LPN _____ Hours Per Day	$ _____ Per hour	$ _____
Aide _____ Hours Per Day	$ _____ Per hour	$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)	$ _____ Per day	$ _____
TOTAL		$ _____

Provider Certification

The patient named above understands the necessity of prior approval for the increase in reimbursement. I understand the increase in reimbursement for the above charges requires prior authorization and, if approved and submitted on the appropriate invoice, payment and satisfaction of the approved services will be from Federal and State funds. I understand that any false claims, statements or documents, or concealment of a material fact may lead to prosecution under applicable Federal or State laws. I understand the information provided is to be held in confidence and not divulged without consent of the beneficiary.

Provider Signature | Fax Number | Date

MDCH USE ONLY:

Prior Authorization Number

APPROVED	DENIED
☐ As Presented ☐ As Amended	☐

Start Date	End Date	Units – Number of Days	Total Daily MOU Rate
			$

MDCH Signature | Date

Authority: Title XIX of Social Security Act

The Department of Community Health is an equal opportunity employer, services, and programs provider.

MSA-1576 (11-03)

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

REQUEST FOR AUTHORIZATION OF PRIVATE ROOM SUPPLEMENTAL PAYMENT FOR NURSING FACILITY

This is my written request for authorization of supplemental payment for a single room for:

Name of Beneficiary/Resident: _____

Medicaid ID Number: _____

Facility Name: _____

Facility Address: _____

_____

Facility Telephone Number: **( ) -** _____

The basis for this request is:

☐ I believe a single room is medically necessary. (If medically necessary, the Medicaid daily rate already pays for a single room.)

☐ I believe a single room is not medically necessary, but is needed for the following reason(s):

_____

_____

I understand that I must accept responsibility for paying the difference between the facility's two-person room and single room rates that are listed below. I will pay any difference in the rates that may change over time, as long as a single room is needed.

Two-person room rate: $ _____ /per day

Single room rate: $ _____ /per day

Printed Name of Requestor: _____

Address: _____

_____

Telephone Number: **( ) -** _____

Relationship to Beneficiary/Resident: _____

_____ _____

Signature of Requestor Date

MAIL TO: Long Term Care Services
Michigan Department of Community Health
P.O. Box 30479
Lansing, MI 48909-7979

FAX TO: (517) 241-8995

NOTE: If no response is received within 10 working days, contact (517) 241-4293.

Chapter III – Nursing Facilities

Table of Contents

SECTION 1 – GENERAL INFORMATION

This chapter discusses Medicaid nursing facility coverage which is intended to assist beneficiaries in attaining or maintaining the highest practical physical, mental, and psychosocial well-being and maximize independence and decision-making. The chapter outlines nursing facility requirements for beneficiary eligibility and admission, for providing services, and for informing beneficiaries of their rights and responsibilities.

Nursing facilities provide services to many of the state's most vulnerable citizens. Medicaid, as the primary payer for beneficiaries who reside in nursing facilities, adheres to all State and Federal regulations that govern care provided in these facilities. Governing regulations include, but are not limited to:

- Americans with Disabilities Act (ADA)
- 42 CFR §431, §438, §440, §441, § 448, § 483, § 485, § 488
- State Medicaid Operations Manual
- Medicare Catastrophic Coverage Act of 1988, Public Law 100-360
- Certificate of Need Commission §22215, §1819, §1905, §1902
- Social Security Act
- Omnibus Reconciliation Act of 1987 (Public Law 100-203), 1988, 1989, 1990, and 1994
- Michigan Medicaid State Plan

Only those services covered by the Medicaid Program, as outlined in this chapter, are reimbursable. Included is a full description of:

- Covered Services:
  - Services covered by the facility's per diem rate; and
  - Ancillary services that must be billed separately by the service provider.
- Non-Covered Services that the beneficiary may purchase with their patient-pay amount.

A Medicaid-certified nursing facility is defined as a nursing home, county medical care facility, or hospital long-term care unit with Medicaid certification. Also included are swing beds and nursing facilities for Mental Illness (MI) beds as defined in the Federal State Operations Manual (SOM) and/or State Medicaid Policy.

Beneficiary is defined as a Medicaid beneficiary, or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Resident is defined as a nursing facility resident (irrespective of payer source) or a person legally sanctioned to make medical decisions on his behalf (i.e., guardian, conservator, activated Durable Power of Attorney).

Individual, as used in this chapter, means any person.

SECTION 2 – QUALITY

The Michigan Department of Community Health (MDCH) is committed to a quality long-term care system that supports people with long-term care needs, regardless of the setting in which the individual receives those services, including nursing facilities, supported living settings, and their own home. Medicaid supports a system that moves away from the traditional medical model for care to one of enhanced beneficiary participation. Nursing facilities with Medicaid certification are expected to assess and plan care with resident participation and to provide services in ways that promote and support person-centered planning and quality service delivery.

2.1 QUALITY INDICATORS

Quality is indicated by the following components:

- Regular, ongoing, and systematic monitoring and revision of individualized plans of care, progress and outcomes by the beneficiary and his support system. In order to participate, beneficiaries may require support, such as regular opportunities and assistance in reviewing key considerations. Planning results should be documented in ways that are meaningful to the beneficiary and useful to people with responsibilities for implementing the plan.
- Risk and safety concerns are considered and plans developed to minimize risk of harm while promoting independence and safety.
- Behavioral interventions and medication management are used only when necessary, and are appropriately managed and monitored.
- Care coordination must support the individual's participation in his care.
- Support for personal responsibility and community relationships that avoid the unintended and detrimental consequences of organizational involvement. Facilities should minimize the disempowerment of beneficiaries or displacement of family members by professional decision-makers and/or service providers, assume the beneficiary is competent and capable of participating in his relationships and the community, and provide assistance and support only when there are unmet needs.
- Individual freedom to exercise civic rights and decision-making authority exists to the maximum extent possible.
- Individuals are free to exercise their due process and grievance rights, and are provided the information necessary to do so.
- Individuals and their support system express satisfaction and the care leads to positive outcomes.
- Diverse cultural and ethnic backgrounds are supported.
- A system of continuous quality improvement that includes input from residents and families.

Current models that utilize person-centered planning and introduce the systems/culture change to support ongoing quality in nursing facilities include, among others, The Eden Alternative™, Wellspring™, and Gentlecare™.

2.2 QUALITY OF LIFE

Nursing facilities must provide services for residents in a manner and in an environment that promotes maintenance or enhancement of the resident's quality of life. Elements of quality of life include dignity, self-determination, participation in community life and in other activities, participation in resident and family groups, and accommodation of needs through the end of life. Quality of life is defined, measured, and evaluated by residents and their support systems, and may include quality of care outcomes.

2.3 QUALITY OF CARE

Nursing facilities must meet the needs of residents in compliance with State and Federal laws, rules, codes, and established clinical guidelines and practices. (Refer to the Nursing Facility section of the Directory Appendix for specific website links for Best Practice Information.)

Complaints regarding the quality of care in any Michigan nursing facility can be made to the Health Facility Complaint Line. (Refer to the Nursing Facility Section of the Directory Appendix for contact information.)

SECTION 3 – BENEFICIARY RIGHTS

All nursing facility residents have the right to:

- A dignified existence;
- Self-determination; and
- Communication with, and access to, persons and services inside and outside the facility.

In accordance with Federal and State rules and regulations, nursing facilities are required to protect and promote beneficiary rights. These rights include, but are not limited to:

- The right to exercise their rights as citizens of the United States;
- The right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising their rights;
- The right to receive notice of their rights, rules and regulations, both orally and in writing, in a language that the resident understands;
- Access to their medical records and information;

  (In accordance with Federal regulations, a beneficiary [or his representative] must be allowed to inspect his records within 24 hours [excluding weekends and holidays] of such request. Also, in accordance with Michigan Public Health Code, a beneficiary [or his representative] is entitled to receive and examine an explanation of his bill or an itemized statement setting forth services paid for and services rendered, regardless of the source of payment.)
- The right to be informed about their health status;
- The right to refuse treatment;
- The right to non-discrimination, including non-discrimination based on payment source;
- Notification of covered and noncovered services, and any additional costs;
- Notification of any changes in room, policies, physician, health status, and treatment;
- Protection and appropriate management of resident funds;
- The right to covered services;
- Notification of transfer or relocation;
- The right to pain and symptom management at the end of life; and
- The right to re-admission to the nursing facility and to have their bed held during an emergency hospital stay, as defined in the Holding a Bed sub-section of this chapter.

In general, beneficiaries cannot be charged for Medicaid-covered services, except for approved patient-pay amounts, co-pays or deductibles, whether they are enrolled as a fee-for-service beneficiary, MDCH is paying their Health Maintenance Organization (HMO) premium to a contracted health plan, or services are provided under Community Mental Health Services Program (CMHSP) or Substance Abuse Coordinating Agency (CA) capitation. However, beneficiaries may be charged if they choose to obtain a service from an out-of-network or non-participating provider, as long as they have prior knowledge they will be obligated to pay the entire charge and, with that knowledge, they request the service.

Medicaid beneficiaries may not be charged the difference between the provider's charge and the Medicaid payment for a service, nor can they be charged for missed appointments.

Medicaid beneficiaries cannot be charged for the copying of medical records for the purpose of providing them to another health care provider.

SECTION 4 – BENEFICIARY ELIGIBILITY AND ADMISSION PROCESS

4.1 NURSING FACILITY ELIGIBILITY

There are three components for determining participant eligibility for nursing facility reimbursement by Medicaid:

4.1.A. Verification of Medicaid Eligibility

Medicaid payment for nursing facility services for an individual requires a determination of Medicaid eligibility for that individual by the Family Independence Agency (FIA). When a Medicaid-eligible or potentially-eligible individual is admitted to a nursing facility, or when a resident becomes Medicaid-eligible while in the facility, the nursing facility must submit the Facility Admission Notice (MSA-2565C) to the local FIA office to establish/confirm the individual's eligibility for Medicaid benefits. (Refer to the Forms Appendix for a sample form.)

In order for Medicaid to reimburse for nursing facility services, the beneficiary must be in a Medicaid-certified bed.

4.1.B. Correct/Timely Pre-admission Screening/Annual Resident Review (PASARR)

The Pre-admission Screening/Annual Resident Review (PASARR) process must be performed prior to admission as described in the PASARR Process Section of this chapter.

A Level I Pre-admission Screen must be performed for all individuals admitted to a Medicaid-certified nursing facility regardless of payer source. When a Level II evaluation is required, placement options are determined through the federal PASARR screening process requirements. The Level I screening form (DCH-3877) may be found at the MDCH web site. (Refer to the Directory Appendix for website information.)

MDCH performs retrospective reviews, randomly and when indicated, to determine that the nursing facility has complied with federal PASARR requirements.

The nursing facility is required to ensure that the PASARR Level I screening has been completed and passed by the individual prior to admission. MDCH reviews retrospectively to determine that the Level I screening was performed and that the Level II screening was performed when indicated.

MDCH is required to recover any payments made to nursing facilities for the period that a participant may have been admitted to a nursing facility when the PASARR screening process was not completed.

4.1.C. Physician Order for Nursing Facility Services

A physician-written order for nursing facility admission is required. By renewing orders, the physician certifies the need for continuous nursing facility care. The order must be dated and the physician's degree must appear with the signature. The physician must initial a rubber-stamped signature.

With the exception of beneficiaries 21 years of age or under residing in a psychiatric facility, a physician (M.D. or D.O.) must approve a beneficiary's need for long-term care not more than 30 calendar days prior to the beneficiary's admission to a nursing facility.

For an individual who applies for Medicaid while a resident in a nursing facility, the physician must reaffirm the need for long-term care not more than 30 calendar days prior to the submission of the application for Medicaid eligibility.

4.2 APPEALS

4.2.A. Individual Appeals

Financial Eligibility: A determination that an individual is ineligible for Medicaid is an adverse action. Individuals may appeal such an action to FIA.

4.2.B. Provider Appeals

A retrospective determination that a participant is ineligible for nursing facility services is an adverse action for a nursing facility if MDCH proposes to recover payments made. If the facility disagrees with this determination, an appeal may be filed with MDCH. Information regarding the appeal process may be found at the MDCH website. (Refer to the Directory Appendix for website information.)

4.3 ADMISSION PROCESS

Prior to or upon admission, the nursing facility must provide beneficiaries and their representatives the following information. The information must be provided both orally and in a written language that the beneficiary understands. Beneficiaries must be provided copies of those items noted with ansterik (*).

- Rights as identified in federal regulations;
- All rules and regulations governing beneficiary conduct and responsibilities during their stay in the facility; *
- Rights as a Medicaid beneficiary and a list of Medicaid-covered services (services for which the resident may not be charged) as published in the Medicaid "Know your Rights" booklet; *
- Noncovered items and services, as well as the costs, for which the beneficiary may be charged (admission to a facility cannot be denied because the beneficiary is unable to pay in advance for noncovered services); *
- Facility policies regarding protection and maintenance of personal funds; *
- A description of the facility's policies to implement advance directives; *

- Facility policies regarding the availability of hospice care; *
- The name, specialty and contact information of the physician responsible for their care;
- Information about how to apply for Medicare and Medicaid; * and
- How to file a complaint.

Facilities must notify residents and their representatives (both orally and in a written language that the beneficiary understands) of any changes to the information listed above.

Receipt of the above information and any amendments must be acknowledged, in writing, by the beneficiary or his representative. Individual facilities may develop their own documentation protocols for this process.

4.4 PREADMISSION CONTRACTS

Nursing facilities must abide by all state and federal regulations regarding preadmission contracts.

Nursing facilities are prohibited from requiring a Medicaid-eligible person or a Medicaid beneficiary, his family, or his representative to pay the private-pay rate for a specified time before accepting Medicaid payment as payment in full. Nursing facilities violating this prohibition are subject to the appropriate penalties (e.g., revocation of their Medicaid provider agreement).

As stated in the Beneficiary Eligibility Chapter of this manual, the facility is considered to be officially notified of the beneficiary's Medicaid eligibility upon receipt of the completed MSA-2565-C, Facility Admission Notice.

SECTION 5 – MEDICAL RECORDS

Nursing facilities are required to maintain a medical record for all residents as outlined in State and Federal statutes and regulations.

Nursing facilities are required to comply with all State and Federal requirements regarding medical record confidentiality, including compliance with all Health Insurance Portability and Accountability Act (HIPAA) requirements regarding privacy.

Nursing facilities must maintain all resident assessments completed within the previous 15 months in the resident's active record. Facilities with a "paperless" system in which clinical records are electronically maintained must be able to produce a paper copy if requested for record review by State surveyors.

Nursing facilities must respect the resident's access to their medical records as required by State and Federal laws and regulations.

SECTION 6 – CARE PLANNING PROCESS

Nursing facility care planning is a continuous and ongoing process of assessment, planning, evaluation, and revision. The purpose of the care planning process is to gather information from a variety of sources, and develop a written strategy to insure that the resident receives services and supports necessary to attain or maintain the highest practical physical, mental, and psychosocial well-being. Sources of information to support care planning include the resident, his family and friends, physicians, specialists, nurses, nurse aides, dietitians, therapists and assessment tools (including the Minimum Data Set [MDS] for Nursing Facility Resident Assessment and Care Screening). A comprehensive plan identifies and addresses all aspects of the resident's health and well-being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. Using the principles and essential elements of person-centered planning, facilities are expected to involve residents and their designated support system throughout the entire process.

6.1 PERSON-CENTERED PLANNING

Person-centered planning is an ongoing process that recognizes the worth and dignity of each individual and his ability to choose how supports, services and/or treatment may be used to improve his life. The following principles apply:

- **Participation in planning** – Each individual has unique strengths, abilities and preferences and is able to express preferences and make choices. Each individual can participate in planning his life, with appropriate support if needed.
- **Support for planning** – People trusted by the individual and committed to supporting the individual's choices must be involved in planning for long-term care. The process is dependent on the participation of supportive relationships, such as family members and friends, and encourages their involvement, to the extent that the choices of the individual are reflected. These relationships support the individual's right to choose, even the right to take risks.
- **Outcome orientation** - Person-centered planning is outcome-oriented. The planning should lead to positive outcomes in the individual's life, i.e., helping to attain or maintain the highest practicable physical, mental, and psychosocial well-being. The individual determines what constitutes a positive outcome. For a younger adult with a disability, this may include building a career. For an older person near the end of life, the positive outcomes may include deciding where one dies and who is present.

Evidence of person-centered planning includes:

- An assessment process that offers the opportunity for gathering information concerning each resident's preferences, personal goals, needs and abilities, health status, and other available supports. This information should be used in developing an individualized plan of care. The individual's life plans should give direction to plans with service providers, such as discharge planning from nursing facilities into community-based settings. Nursing facilities should not exclude residents in the care planning process in order to meet facility requirements for writing care plans, obtaining signatures, and so forth.
- An assessment process that includes input from professionals and others chosen by the individual. In addition to the professionals required to participate in care planning, individuals should have support for making informed choices about the additional people and professionals they invite to their person-centered planning meetings. For example, federal guidelines require

an interdisciplinary team that includes a registered nurse who has responsibility for caring for the resident prepare care plans. In addition, the resident may choose to invite a favorite nurse aide and a former neighbor/caregiver to participate in care planning.

- A plan of care that comprehensively addresses each individual's need for health care and other services in accordance with the individual's preferences and goals.
- Services delivered in accordance with the individualized plan of care.
- Informed choice, which includes, but is not limited to, choosing among covered services and enrolled service providers, decisions about the planning process, and evaluation of the planning and its outcomes. Informed choice means knowing the options in ways that are meaningful to the individual, and having information when it is useful; not only at admission, but throughout the care process.
- Support for informed choice, which requires an organizational commitment to provide information and/or experiences that sufficiently inform an individual of their options. This commitment should be met through multiple and flexible means of providing information. These might include alternative forms of communication (e.g., Braille, sign language, audio-recorded documents), hands-on experiences with options, peer support from experienced participants, and so forth.

6.2 ASSESSMENT

In collaboration with the resident and individuals identified by the resident, appropriate facility staff must assess residents regularly and as needed to identify their preferences, wishes, goals, outcomes, capabilities, medical, and psychosocial needs. Nursing facilities should use assessment tools that are accessible (e.g., large print, verbal, appropriate language, etc.) to residents and individuals identified by the resident.

Assessment tools must include, but are not limited to, the Minimum Data Set (MDS) for Nursing Facility Resident Assessment and Care Screening. Nursing facilities are expected to use assessment tools and methods that accommodate the needs and preferences of individuals (e.g., mental health assessment tools, self-assessment tools in large print, etc.).

6.3 MINIMUM DATA SET (MDS)

Nursing facilities must conduct a comprehensive, accurate, standardized, and reproducible assessment of each resident's functional capacity. The use of the current federally specified Resident Assessment Instrument (RAI), which includes the MDS, Triggers, Resident Assessment Protocols (RAPS) and utilization guidelines is mandatory. Michigan has made a determination not to have a state-specific Section-S, but reserves the right to develop and require its data collection as need arises.

The MDS assessment must be conducted:

- Promptly upon admission, but no later than 14 days of admission;
- Promptly after a significant change in the resident's physical or mental condition or within two weeks, whichever is sooner; and
- Not less than once every twelve months.

The facility must examine each resident once every three months, revising the assessment as appropriate to ensure its continuing accuracy.

Results of the MDS assessment must be used, in addition to other information gathered and in collaboration with the resident, for developing, reviewing, and revising the resident's plan of care. The assessment must be maintained in the resident's medical record and kept confidential.

Each MDS assessment must be conducted or coordinated (with the appropriate participation of other health professionals) by a licensed, registered nurse who signs and certifies the completion of the assessment. Each person who completes a portion of the assessment must sign and certify the accuracy of that portion. Data accuracy resides with the nursing facility as the source of the data.

A facility must electronically transmit to the State, at least monthly, encoded, accurate, complete MDS data for all assessments conducted since the previous transmission. A facility that fails to transmit electronic RAI data to the State is considered out of compliance and, therefore, subject to enforcement actions. (Refer to the Nursing Facility Certification, Survey and Enforcement Chapter of this manual.)

An individual who willfully and knowingly certifies a material and false statement, or causes another individual to do so, is subject to a civil monetary penalty.

Questions about the Resident Assessment Instrument should be directed to the RAI Coordinator in the State Survey Agency. (Refer to the Directory Appendix for contact information.)

Federal regulations require that facilities coordinate the PASARR process and MDS. MDCH recommends that nursing facility administrators establish mechanisms to track completion dates of PAS and ARR evaluations so that, to the maximum extent practicable, they are coordinated with resident assessments and completion of the MDS.

6.4 Pre-admission Screening / Annual Resident Review (PASARR)

The Pre-admission Screening and Resident Review (PASARR) must be completed for all individuals seeking to enter a nursing facility regardless of payer source. Although not federally mandated, Michigan has elected to require the Annual Resident Review (ARR) for all residents in Medicaid-certified nursing facilities regardless of payer source.

The purpose of the PASARR process is to encourage community care by supporting the placement of individuals with Mental Illness (MI) or Mental Retardation (MR) in a nursing facility only when their medical needs clearly indicate that they require the level of care provided by a nursing facility. For individuals with mental illness or mental retardation, the PASARR process ensures the appropriate determination of the need for nursing facility services and the need for specialized services. The PASARR process also includes an appeals system for individuals who wish to dispute a PASARR determination.

Screening and evaluations performed under PASARR and all PASARR notices must be adapted to the cultural background, language, ethnic origin, and means of communication used by the individual being evaluated.

(Refer to the PASARR Process section of this chapter for additional information.)

6.5 PLAN OF CARE

Nursing facilities are required to provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. A written individualized plan of care must be developed in the context of a person-centered planning process in order to specify services and activities, and to accommodate individual needs and preferences. The plan outlines the goals, strengths and needs of the resident and how those will be addressed. A comprehensive plan identifies and addresses all aspects of the resident's health and well being (physical/medical, emotional, mental, spiritual), not just those services that will be provided by the facility or covered by insurance. The plan also identifies the resident's wishes and capabilities regarding the potential of relocation to a lesser level of care and includes discharge planning.

The comprehensive plan of care must be developed with direct involvement of:

- The beneficiary, family and/or his/her representative;
- The attending physician;
- An RN who has assessed the beneficiary, or who is familiar with the assessment;
- Other appropriate staff disciplines; and
- Any other trusted individuals that the beneficiary might wish to include.

Medicaid requires that a nursing facility ensure that a licensed physician supervises a beneficiary's medical care. The physician must review the entire individualized plan of care on an on-going basis. The entire plan of care may include sections for:

- Nursing care
- Rehabilitative services (if required);
- Medication;
- Treatment;
- Restorative services;
- Diet;
- Activities;
- Special plans for health and safety;
- Continuing care, measurable objectives and timetables;
- Discharge (as appropriate); and
- Mental health services.

All services rendered must be documented and consistent with the written individualized plan of care.

6.6 Evaluation/ Re-assessment / Plan Revision

Care planning is a continuous and ongoing process that requires regular re-assessment and revision of the plan of care. Federal guidelines require that the facility examine each resident not less than once every three months, and revise the resident's assessment as appropriate to ensure its continuing accuracy. Re-assessment should also occur with significant changes in the resident's condition and at the request of the resident or his representative. Once the re-assessment is completed, the current plan should be evaluated and revised to meet current goals and needs.

SECTION 7 – PASARR PROCESS

Pre-admission Screening/Annual Resident Review (PASARR) in Michigan is a two-level screening and evaluation process. The Level I screening and Level II evaluation procedures and forms are the same for Pre-admission Screening (PAS) and Annual Resident Review (ARR). The forms may be obtained from the MDCH website.

The PASARR process must be completed:

- Prior to admission to a nursing facility;
- Promptly after a significant change in a resident's physical or mental condition; and
- Not less than annually.

The PASARR process is not required in the following situations:

- When an individual is admitted to an Intermediate Care Facility for the Mentally Retarded (ICF/MR-Provider Type 65).
- When an individual is admitted to and resides in a hospital swing bed. However, the PASARR process must be completed prior to admission if the individual transfers to a nursing facility.
- When an individual is readmitted to a nursing facility after a hospital stay. If the Annual Resident Review date occurs during a period of hospitalization, the screening must be completed within 30 days of admission or readmission to the nursing facility.
- For an individual transferring from one nursing facility to another, with or without an intervening hospital stay, unless a Level I screen has not been performed previously.
- For an individual returning to the nursing facility from therapeutic leave, unless the resident's condition has changed. Therapeutic leave does not change the due date for Annual Resident Review. Advance planning may be necessary to ensure timeliness of review.

The following table outlines screening requirements.

Pre-admission Screening (PAS)	A Level I screening is required for all individuals seeking to enter a nursing facility regardless of payer source, except as noted above. The Level I screening, and the Level II evaluation when indicated, must be completed prior to admission to a nursing facility.
Annual Resident Review (ARR)	All residents in Medicaid-certified nursing facilities must be reviewed at least annually to determine if the resident is in need of mental health services and/or continued nursing care. Annually means within every fourth quarter after the previous Level I screening or Level II evaluation, whether it was completed for admission, condition change, or annual review. The Level I screening must be completed for all residents, and a Level II evaluation must be performed if indicated. If a resident was hospitalized when an ARR was due, the Level I screening must be completed within 30 days of readmission, and any subsequent Level II evaluation must be completed within the quarter following readmission to the nursing facility.

Condition Change	A Level I screening must be completed immediately or, at most, within 14 days when there is a significant change in the resident's mental health, or a physical change that may impact the resident's mental health needs. Federal regulations defines a "significant change" as a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan or both. A Level II evaluation must be completed when indicated.
30-Month Rule	During the PASARR process, a nursing facility resident may be identified as no longer in need of nursing services but in need of specialized services. In this situation, if the resident has lived in a nursing facility for 30 continuous months, the CMHSP must advise the individual of their options, which may include community placement with specialized services or continued residence in the nursing facility with specialized services. Under these circumstances, no appeal needs to be filed in order to maintain nursing facility residency. The individual's status as a long-term resident must be evident in their nursing facility medical record. Individuals determined to need specialized services, who have resided in a nursing facility for less than 30 months, and who are found to no longer need nursing services must be assisted to transition to a more appropriate setting.
Transfer Trauma	Transfer trauma protections (see Transfer Trauma sub-section in this chapter) apply to mentally ill or mentally retarded individuals determined not to need nursing facility services during PASARR Level II evaluations.

7.1 LEVEL I SCREENING

The purpose of the Level I Screening is to identify individuals who may be mentally ill or mentally retarded. Level I Screening is documented on the "Preadmission Screening (PAS)/Annual Resident Review (ARR) (Mental Illness/Developmental Disability Identification)" form (DCH-3877). (Refer to the Forms Appendix for a sample form.) The DCH-3877 must be completed and signed by a registered nurse, certified or registered social worker, psychologist, physician's assistant, or physician.

The professional who completes the Level I Screening must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (For the distribution of forms and documentation, refer to the Distribution of PASARR Documentation sub-section later in this section.)

The following table contains a list of psychopharmacological drugs that may indicate the presence of a mental illness. Included are examples of antidepressant and anti-psychotic medications. The list is not meant to be all-inclusive.

Antidepressant Medications	
Generic Name	**Brand Name**
Amitriptyline Hydrochloride	Elavil
Bupropion Hydrochloride	Wellbutrin
Citalopam	Celexa
Doxepin Hydrochloride	Sinequan

Anti-Psychotic Medications	
Generic Name	**Brand Name**
Chlorpromazine Hydrochloride	Thorazine
Clozapine	Clozaril
Fluphenazine Hydrochloride	Prolixin
Haloperidol	Haldol

Antidepressant Medications	
Generic Name	**Brand Name**
Fluoxetine Hydrochloride	Prozac
Fluroxamine	Luvox
Imipramine Hydrochloride	Tofranil
Mirtazapine	Remeron
Netazodone Hydrochloride	Serzone
Nortiptyline Hydrochloride	Aventyl, Pamelor
Paroxitine	Paxil
Sertraline Hydrochloride	Zoloft
Trazodone Hydrochloride	Desyrel
Venlafaxine Hydrochloride	Effexor

Anti-Psychotic Medications	
Generic Name	**Brand Name**
Loxapine Hydrochloride	Loxitane
Mesorldazine Besylate	Serentil
Olanzapine	Zyprexa
Quetiapine Fumarate	Seroquel
Risperidone	Risperdal
Thioridazine Hydrochloride	Mellaril
Thiothixene	Navane
Trifluoperazine Hydrochloride	Stelazine
Ziprasidone	Geodon

Miscellaneous Products	
Generic Name	Brand Name
Lithium Citrate	Cibalith-S
Lithium Carbonate	Eskalith, Lithobid

7.2 LEVEL II EVALUATION

The purpose of the Level II Evaluation is to assess individuals who are identified as mentally ill or mentally retarded to determine the need for nursing facility services, specialized services, and/or mental health services. All individuals identified by Level I screening as possibly mentally ill or mentally retarded (a "yes" response to any question on the Level I screening form, DCH-3877) must receive a Level II evaluation, unless it is documented that they meet one of the exemption criteria outlined in the next sub-section, or the MDCH/CMHSP finds that the individual does not meet the criteria for a serious mental illness under the PASARR provisions. The CMHSP is responsible for providing the nursing facility and the individual and/or legal representative with written documentation that the individual does not meet the PASARR criteria for a serious mental illness. If the individual is seeking admission to a nursing facility, the Level II evaluation, when indicated, must be completed prior to admission.

7.3 LEVEL II EVALUATION EXEMPTION

Level II Evaluation Exemption Form (DCH-3878) is used to claim an exemption to Level II evaluations. If the individual qualifies for an exemption to the Level II evaluation based on the criteria outlined below, the DCH-3878, "Mental Illness/Developmental Disability Exemption Criteria Certification" form must be completed. (Refer to the Forms Appendix for a sample form.) The DCH-3878 may be completed by a registered nurse, a certified or registered social worker, psychologist, physician's assistant, or physician and must be signed by a physician.

Exemptions to the Level II evaluation may be requested based on the following criteria:

- The individual is in a coma. If the individual is in a coma at the time the Level II evaluation is to be performed, the individual may be exempted from the Level II evaluation process. A physician must certify that the individual is in a coma. The individual may then be admitted to the nursing facility without a Level II evaluation. When the individual is no longer in a coma, the nursing facility must complete a Level I screening and refer for a Level II evaluation, if indicated.
- The individual has a primary diagnosis of dementia (such as Alzheimer's disease or another dementing illness). An exemption due to dementia cannot be claimed for any individual who is also identified as being mentally retarded or having a related condition, or for any individual with another primary psychiatric diagnosis. For example, an individual with dementia alone may be exempted. An individual diagnosed with dementia and depression may not be exempted. A physician must certify that the individual meets the clinical criteria for dementia and does not have another primary psychiatric diagnosis, or mental retardation or a related condition.
- The individual is convalescing after hospitalization for an acute illness and meets all of the following conditions:
  - The individual will be admitted to a nursing facility directly from a hospital after receiving acute inpatient care at the hospital. Treatment in an emergency room is not considered a hospital stay. An individual who received inpatient treatment in a psychiatric facility cannot be admitted to a nursing facility claiming this exemption, nor can an individual who comes directly from home or any other community placement.
  - The individual requires nursing facility services for the condition for which they received care in the hospital.
  - The attending physician has certified before admission to the nursing facility that the individual is likely to require less than 30 days nursing facility services.

Medicaid approves payment for a hospital discharge/convalescent care stay up to 30 days only. If the individual needs nursing care beyond 30 days, the nursing facility must notify the local CMHSP at least five working days before the end of the 30-day stay that a Level II evaluation is needed. The local CMHSP completes the Level II evaluation within 14 days of the date of notification and forwards the evaluation to MDCH. The entire determination process must be completed within 40 days of the individual's admission from the hospital. If MDCH determines that the individual no longer requires nursing facility services, Medicaid reimburses up to five days beyond the date of the determination to allow for appropriate discharge planning. It is expected that a nursing facility will begin discharge planning for residents at the time of admission from the hospital and discontinue this planning only when a determination is made that the resident will not be discharged from the nursing facility.

The person completing the Level II evaluation exemption must provide a copy of the DCH-3877 to the prospective nursing facility resident or their legal representative. Notification must also be adapted to the cultural background, language, ethnic origin and means of communication of the person being evaluated. (Refer to the Distribution of PASARR Documentation sub-section.)

7.4 Level II Evaluation Completion

Individuals who are identified on the Level I screening as having a mental illness or mental retardation, and who do not meet exemption criteria outlined previously must be referred to the local CMHSP for a

Level II evaluation. Level II evaluations are conducted by mental health professionals through the local CMHSP, under contract with MDCH. The evaluation involves an interview with the individual, review of medical records, and consultation with nursing facility and/or hospital staff. The mental health professional must conduct the Level II evaluation in accordance with the MDCH OBRA Operations Manual. A copy of this manual may be requested from the MDCH OBRA office or the local CMHSP.

When a Level II Evaluation is required, it must be completed prior to nursing facility admission.

When a Level II evaluation is indicated for an Annual Resident Review (ARR), the nursing facility must notify the local CMHSP of the need for the Level II evaluation at least 30 days prior to the due date of the ARR by sending them a new DCH-3877 (Level I screening form). For example, if the initial Level II evaluation was completed on April 15, 2002, the ARR is due April 15, 2003, and the facility must notify the local CMHSP that a new Level II is due by March 15, 2003. The local CMHSP is responsible for timely completion of Level II evaluations and for providing facilities with written documentation of PASARR determinations in a timely manner.

Once completed, the CMHSP forwards all documentation of the Level II evaluation to MDCH. Based on this documentation, MDCH determines whether the individual requires nursing facility services or can be served in an alternate setting. MDCH also determines whether specialized services or other mental health services are needed to treat the individual's mental illness or mental retardation.

MDCH's decision regarding the need for nursing facility services and the need for specialized services is forwarded to the referring CMHSP. It is the responsibility of the CMHSP to explain the evaluation and determination to the individual and his legal representative within 30 days. The CMHSP must provide a copy of the evaluation and the MDCH determination letter to the individual and his representative and explain the appeal rights to the individual and their legal representative. This information must also be adapted to the cultural background, language, ethnic origin and means of communication of the individual being evaluated.

The local CMHSP notifies the attending physician, nursing facility, and discharging hospital of the results of the evaluation and the MDCH determination in writing within 30 days of the review. A copy of this notification must be retained in the individual's record. (Refer to the Distribution of PASARR Documentation sub-section.)

Given that all other admission criteria outlined in this chapter are met, a nursing facility may admit an individual on the basis of a verbal Pre-admission Screening determination from MDCH. This determination may be communicated to the nursing facility by the CMHSP.

If the facility does not receive a written determination as follow-up to a verbal determination within 30 days of an admission, the facility must send a written reminder to the CMHSP and the MDCH OBRA Office within 45 days of the admission. (Refer to the Directory Appendix for contact information.)

The nursing facility is responsible for verifying that required PAS and ARR processes are completed and documented in the resident's record. The nursing facility medical record must include the determinations of the level of care, the need for specialized services, the original DCH-3877 and DCH-3878 forms, and the Level II evaluation report and supporting documents.

7.5 DISTRIBUTION OF PASARR DOCUMENTATION

The following chart shows the correct distribution of copies of PASARR forms (DCH-3877, DCH-3878) and Level II evaluation documentation. All originals must be fully completed and signed.

Level I Screening Documentation (DCH-3877)		
Original	Nursing facility record	All nursing facility admissions
Copy	Individual or their representative	All nursing facility admissions
Copy	CMHSP	If "yes" answer(s)
Copy	MDCH via local CMHSP	If "yes" answer(s) and no exemption criteria met

Documentation of Exemption to Level II Evaluation (DCH-3878)	
Original	Nursing facility record
Copy	Individual or their representative
Copy	CMHSP
Copy	MDCH via local CMHSP

Level II Evaluation Documentation	
Original	MDCH OBRA Office
Copy	CMHSP
Copy	Individual or their representative
Copy	Nursing facility
Copy	Hospital, attending physician

MDCH Determination	
Original	CMHSP
Copy	MDCH
Copy	Individual or their representative
Copy	Hospital, attending physician
Copy	Nursing facility

7.6 COMPLIANCE

Failure of a nursing facility to comply with OBRA PASARR requirements will result in the loss of Medicaid reimbursement to the facility for services provided for that resident for any period during which a correct and timely screening or review was not completed for that resident. A claim should not be submitted for dates of services provided during periods for which required Pre-admission Screening or Annual Resident Review has not been completed.

The resident or parties responsible for the resident cannot be charged for the loss of reimbursement caused by the facility's failure to meet PASARR requirements.

The Level I screening is considered completed when the DCH-3877 has been filled out, signed, and distributed or, if exemption criteria are met, both the DCH-3877 and DCH-3878 have been filled out, signed, and distributed. The Level II evaluation process is completed when the CMHSP has completed the evaluation and the individual has been notified of the MDCH determination.

For a screening or evaluation to be correct, the completed forms must contain information consistent with documentation in the resident's nursing facility medical record.

Compliance is monitored through the survey process, complaint investigations, and audits. Retrospective payment adjustments through interim gross adjustments and/or final settlements are made to recover funds as necessary. A nursing facility is not penalized for failures to meet PASARR provisions for which it is not responsible and/or could not prevent.

7.7 APPEALS OF PASARR DETERMINATIONS

Individuals adversely affected by PASARR determinations may appeal the determination or another person may appeal the determination on their behalf. Examples may include the determination that the individual no longer requires specialized services when they have received those services in the past and wish to continue. An individual may decline nursing facility admission or specialized services without appeal.

Information regarding the MDCH administrative hearing (appeal) process is available on the MDCH website. (Refer to the Directory Appendix for website information.)

7.8 COMPLAINTS

Complaints or concerns regarding a nursing facility's implementation of the PASARR regulations should be directed to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

Complaints or concerns about local CMHSP implementation of PASARR policy should be sent to the MDCH OBRA Office. (Refer to the Directory Appendix for contact information.)

SECTION 8 – MEDICAID COVERED AND NON-COVERED SERVICES

Determination of medical necessity and appropriateness of Medicaid services is the responsibility of the attending physician (M.D. or D.O.) and is subject to MDCH review. Services must be within the scope of currently accepted medical practice, limitations of the Medicaid Program, and State and Federal requirements.

8.1 MEDICARE-COVERED SERVICES

For Medicare-covered services, MDCH only pays up to a Medicare-enrolled beneficiary's obligation to pay (i.e., coinsurance and deductibles), or the Medicaid fee screen, whichever is less. This limitation also applies if the beneficiary is eligible for, but not enrolled in, Medicare. In addition, Medicaid covers the coinsurance and deductible amounts on any Medicare-covered service not normally covered by Medicaid.

If the beneficiary has a Medicare benefit available, that benefit must be utilized before Medicaid pays any portion of the claim. If a beneficiary who has Medicare coverage is receiving services under CMHSP or CA capitation, the CMHSP/CA assumes the MDCH payment liability described in this section.

Prior authorization is not required for billing the Medicare deductible and coinsurance amounts, even if the service would require prior authorization if Medicaid were the payer. However, if the facility is uncertain of Medicare coverage, prior authorization from Medicaid should still be obtained. This allows the facility to render the service, bill Medicare and then, if appropriate, bill Medicaid for its share of the service. If Medicare Part B covers an item or service that is included in the Medicaid per diem, the nursing facility is responsible for any coinsurance or deductible, even when billed by an ancillary provider.

Services for which Medicare has made a payment may not be used to offset the patient-pay amount. Coinsurance amounts are charged to the patient-pay amount, and Medicaid reimburses any applicable difference between the patient-pay amount and the coinsurance rate.

If a beneficiary has Medicare Part B coverage, and Medicare does not cover a service, Medicaid considers the service to be included in the Medicaid reimbursement for routine nursing care.

8.2 OTHER INSURANCE

Many Medicaid beneficiaries have insurance coverage (either traditional health insurance or an HMO) through private and/or employer-based commercial policies. That insurance is always primary, and the rules of that insurer must be followed. This includes, but is not limited to, prior authorization requirements, qualifications of providers, and providing services through the insurer's provider network. MDCH does not pay for services denied by the primary insurer because the primary insurer's rules were not followed.

MDCH pays appropriate copays and deductibles up to the beneficiary's financial obligation to pay or the Medicaid fee screen, whichever is less. If the primary insurer has negotiated a rate for a service that is lower than the Medicaid fee screen, MDCH cannot be billed more than the negotiated rate. Medicaid-covered services not included in the primary insurer's plan are reimbursed by MDCH up to the Medicaid fee screen if all MDCH coverage rules are followed. If a beneficiary with other insurance coverage is enrolled in a MHP, or is receiving services under CMHSP or CA capitation, the MHP/CMHSP/CA assumes the MDCH payment liabilities described in this section.

8.3 PAYMENT FOR NON-COVERED SERVICES

For necessary medical or remedial care recognized under the State law but not covered by the Medicaid Program, the Medicare Catastrophic Coverage Act of 1988, Public Law 100-360, allows nursing facility beneficiaries to access their patient-pay amount to pay for these services. If Medicare covers the medical service, then Medicaid will continue to cover the Medicare deductible and coinsurance in the event it does not exceed the Medicaid fee screen.

SECTION 9 - MEDICAID SERVICE DESCRIPTIONS

The following table outlines those services that are included in the facility's per diem rate or are an ancillary service that may be provided to beneficiaries in a nursing facility. Following the table is a more detailed description of each service.

All services required as a condition of licensure/certification are included in the per diem rate.

The nursing facility should contact the ancillary provider or Medicaid Provider Inquiry Line to confirm Medicaid coverage of ancillary services.

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Administrative Services	X		
Admission Kits			X
Alcohol Abuse Treatment (See Substance Abuse Services and Treatment description)		X	
Ambulance Services – Emergency and non-Emergency (See Transportation description)		X	
Ancillary Services			X (Some)
Beauty and Barber Services			X
Chiropractic Services		X	
Daily Oral Hygiene and Supplies (See Dental Services description)	X		
Dental Services		X	
Dietary Services and Food (including enteral tube feeding formula, supplies and equipment)	X		
Drug Dependency Treatment (See Substance Abuse Services and Treatment description)		X	
Dry Cleaning (See Laundry Services description)			X
Durable Medical Equipment – customized equipment		X	
Durable Medical Equipment – standard equipment	X		
End of Life Care	X		
Enrichment Programs	X		
Family Planning Services		X	
Food (See Dietary Services and Food description)	X		
Foot Care – Routine (See Podiatry Services description)	X		
Hearing Services		X	
Hospice Services – Nursing Facility Responsibility	X		
Hospice Services – Hospice Responsibility		X	

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Hospital Services (Inpatient and Outpatient)		X	
Housekeeping and Maintenance	X		
Intravenous Therapy – nursing supplies, equipment (including IV infusion pump, but not drug infusion pump)	X		
Intravenous Therapy – pharmaceuticals		X	
Laboratory Services – routine	X		
Laboratory Services Requiring Special Laboratory and Professional Laboratory Staff		X	
Laundry Services	X		
Medically-Related Social Services	X		
Medication Reviews (See Pharmacy description)	X		
Mental Health Services – facility provided	X		
Mental Health Services – local CMHSP and referrals		X	
Nurse Aide Attendance for Medical Appointments (See Transportation description)	X		
Nursing Care – routine	X		
Orthotics		X	
Oxygen - intermittent and infrequent	X		
Oxygen – daily use		X	
Personal Comfort Items			X
Personal Hygiene Items	X		
Pharmacy – Medicaid Covered Over-the-Counter Drugs		X	
Pharmacy – Routine Over-the-Counter Drugs	X		
Pharmacy— Prescription Drugs		X	
Physician Services		X	
Podiatry Services		X	
Private Duty Nursing in a Nursing Facility			X
Private Room (if medically necessary)	X		
Private Room (no medical necessity)			X
Prosthetics		X	
Radiology		X	
Supplies and Accessories	X		
Therapies – Routine maintenance	X		
Therapies – Non-routine		X	
Total Parenteral Nutritional Formula, Equipment and Supplies (See Dietary Services and Food description)		X	
Transportation Services - non-emergency	X		
Vaccines	X		

Service Description	Covered		Non-Covered
	Included in Per Diem	Ancillary Service	
Vision Services		X	
Wound Dressings (see Supplies and Accessories)	X	X (some)	

9.1 ADMINISTRATIVE SERVICES

Nursing facilities must be administered in a manner that effectively and efficiently uses its resources to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in compliance with all applicable State and Federal licensure and certification laws, codes and regulations. Services rendered in the general administration of the facility are included in the facility's per diem rate. Services include, but are not limited to:

- Arranging appointments;
- Building, equipment, and grounds maintenance;
- Development, adoption, and posting of patient rights;
- Development of disaster plans;
- Development of patient councils;
- Infection control;
- Insect and vermin control;
- Management of patient trust funds;
- Nursing care determinations;
- Quality control;
- Record keeping; and
- Utilization control.

9.2 ADMISSION KITS

Admission kits are not covered by Medicaid. The beneficiary may purchase the kit from personal funds; however, the facility may not require the beneficiary to obtain such a kit as a condition of admission. A beneficiary's patient-pay amount may not be used to cover this cost.

9.3 ANCILLARY SERVICES

Ancillary services (i.e., services other than daily care services) must be ordered and documented, in writing, by the beneficiary's attending physician, and the documentation must be retained in the beneficiary's medical record. The physician's signature on prior authorization forms, treatment plans, etc., certifies the necessity of ancillary services. The physician must review the beneficiary's progress resulting from the ancillary service not less than every 60 days and summarize the progress resulting from the ancillary service provided.

The orders must be for a specific beneficiary (no blanket orders) and prior to the service being rendered. Orders may be received by telephone but must be written in the beneficiary's medical record. Such services must be provided and billed by the appropriate enrolled provider. It is suggested that the facility contact the ancillary provider or the Medicaid Provider Inquiry Line to ascertain whether the service is covered prior to arranging for the provision of the service. (Refer to the Directory Appendix for contact information.)

The facility is responsible for arranging all ancillary and non-covered medical services. Arranging appointments and transportation for these services is included in the per diem rate.

The beneficiary or beneficiary's representative may choose to purchase non-covered services directly from an ancillary provider. The beneficiary pays the ancillary provider directly for the services provided. The nursing facility must retain, in the beneficiary's fiscal record, receipts showing that the beneficiary paid for the particular non-covered service. Medicaid post-payment reviews will be conducted to assure that the beneficiary's fiscal record contains the receipts.

Nursing facilities may not bill Medicaid for ancillary services except for therapies, oxygen, pharmacy, and the Medicare coinsurance or deductible for ancillary services. Otherwise, the ancillary provider must bill for the service. Some nursing facilities are exempt from billing certain ancillary services (e.g., only a Provider Type 62-Hospital Long Term Care Unit can bill for pharmacy). The Billing & Reimbursement for Institutional Providers Chapter contains the allowable nursing facility provider types that can bill for ancillary services.

Therapies may be billed by the facility regardless of coverage by Medicare. However, Medicaid remains the payer of last resort.

Ancillary services (e.g., physical therapy) provided to a beneficiary on the day of discharge may be billed to Medicaid, even if the beneficiary was admitted and discharged on the same date.

9.4 Beauty and Barber Services

Services of a professional beautician or barber are not included in the per diem rate and are not covered by the Medicaid Program. The beneficiary may purchase such services from personal funds. A beneficiary's patient-pay amount may not be used to cover these costs.

9.5 Chiropractic Services (Medically-necessary)

Chiropractic services, such as x-rays and treatment, are an ancillary service and are not included in the facility's per diem rate.

9.6 Dental Services

The facility's per diem rate includes providing assistance with, and supplies for, daily oral hygiene. Dental supplies include, but are not limited to:

- Dental floss
- Mouthwash
- Mouthwash cups
- Denture adhesive
- Denture cleaner
- Denture cups
- Toothbrushes
- Toothpaste

Routine and emergency dental services are an ancillary service and are not included in the facility's per diem rate.

9.7 DIETARY SERVICES AND FOOD

Residents must be provided nourishing, palatable, well-balanced meals that meet their daily nutrition and special dietary needs. Dietary services must also meet the preferences of residents and offer substitutes of similar nutritional value.

Nutrition appropriate for each resident's condition is included in the facility's per diem rate. This includes, but is not limited to:

- Daily nutritious meals and snacks
- Reasonable food substitutes of a similar nutritive value
- Dietary supplements
- Enteral formulas, supplies, equipment, and associated nursing services
- Infant formulas
- Nursing services associated with total parenteral nutrition (TPN) *
- Special diets
- Therapeutic diets
- Water solutions

* The formula, equipment, and supplies required for the TPN feedings are an ancillary service and are not included in the facility's per diem rate.

Medicaid reimburses non-profit nursing facilities that incur costs resulting from the purchase of raw food and food preparation associated with special dietary needs for religious reasons. (Refer to the Nursing Facility Reimbursement chapter of this manual for more information.)

9.8 DURABLE MEDICAL EQUIPMENT

9.8.A. Standard Equipment

Standard, non-customized durable medical equipment is included in the facility's per diem rate. The durable medical equipment supplier and the nursing facility must make arrangements for purchasing or renting required equipment. Standard durable medical equipment includes, but is not limited to:

- Adaptive ADL equipment
- Air mattresses
- Autoclaves
- Bed boards
- Bed cradles
- Bed pans
- Bed rails
- Beds (including hospital beds)
- Bedside safety rails
- Bedside stands
- Blood pressure apparatus
- Canes

- Comfortable cushioned chair
- Commodes
- Crutches
- Emesis basins
- Food pumps
- Foot boards
- Foot rails
- Foot stools
- Freestanding trays for meals
- Geriatric chairs
- Infrared lamps
- Lifts
- Oxygen equipment and supplies
- Positioning pillows
- Reading lights
- Sitz baths
- Splints
- Suction machines
- Traction equipment
- Trapeze equipment
- Tub lifts
- Urinals
- Walkers
- Wash basins
- Wheelchairs

Such equipment must be available for all the residents demonstrating need. Previously acquired equipment should be adapted to meet the beneficiary's needs, if appropriate.

The facility is required to repair/maintain standard, non-customized equipment, and this expense is included in the per diem rate. This may not be billed separately to Medicaid, the beneficiary, his family, or representative.

Replacement, repair and maintenance of standard equipment owned or rented by the beneficiary is not a Medicaid-covered benefit.

9.8.B. Customized Equipment

For customized equipment, the durable medical equipment provider must request prior authorization. Once purchase or rental of the equipment is authorized, the DME/Medical Supply provider may provide the service and bill Medicaid directly.

Prior authorization is approved if the following conditions are met:

- The attending physician (M.D. or D.O.) must order the equipment in writing. These orders must be signed by the attending physician and retained in the beneficiary's medical record. The orders must include the estimated period of months that the beneficiary will need such equipment, the medical/functional need, and an explanation of why standard, non-customized equipment is not suitable. A copy of the physician's orders must be attached to the durable medical equipment provider's prior authorization request.
- The equipment is medically necessary and specifically customized for the exclusive use of the beneficiary.
- The equipment offers physical/restorative function to the beneficiary.
- The facility is not the direct supplier of durable medical equipment.

Repairs to customized equipment by the durable medical equipment provider are covered only when it is necessary to make the equipment serviceable. Extensive repairs and maintenance by authorized technicians are covered if the warranty has expired. The durable medical equipment provider may bill for authorized repairs. Routine periodic

servicing, such as cleaning, testing, regulating, and checking of the equipment, is not separately reimbursable.

9.9 End of Life Care

Facilities are expected to have systems and policies in place to address appropriate advance care planning and end of life care. Facilities must notify residents at admission of their policies regarding the implementation of advance directives and the availability of hospice care. Residents are entitled to adequate and appropriate pain and symptom management as a basic and essential part of their medical treatment. Best Practice Information for end-of life care and pain management for nursing homes and hospital LTC units is available on the Michigan Department of Consumer & Industry Services website. (Refer to the Directory Appendix for website information.)

9.10 Enrichment Programs

Facilities are required to provide or arrange for an ongoing program of activities designed to meet the interests and physical, mental and social well-being of each resident. An individualized program may be developed as part of the person-centered care planning process. Programs designed to maintain the resident's quality of life are included in the facility's per diem rate. Such services include, but are not limited to:

- Social services;
- Books;
- Current periodicals (e.g., newspapers, magazines) [If the beneficiary personally subscribes to a periodical (e.g., newspaper, magazine) for his own use, he is responsible for payment of that subscription.];
- Diversional programs;
- Motivational programs;
- Reality-oriented programs; and
- Recreational programs.

9.11 Family Planning Services

Family planning services are an ancillary service and are not included in the facility's per diem rate.

9.12 Hearing Services

Hearing evaluations are an ancillary service and are not included in the facility's per diem rate.

A Medicaid co-payment is not required for nursing facility beneficiaries.

9.13 Hospice Services

Upon admission to a nursing facility, residents must be advised of the facility's policies regarding the availability of hospice care.

Nursing facility beneficiaries [including Memorandum of Understanding (MOU) Special Agreements for Complex Care cases] are eligible for Medicaid hospice services if determined by a hospice provider to meet hospice level of care. Additionally, in certain situations (such as lack of a caregiver in the home), a hospice beneficiary, in consultation with the hospice provider, may elect to enter a nursing facility to receive end of life care. Medicare beneficiaries receiving or eligible for the 100-day skilled nursing benefit have the right to choose hospice instead. This decision should not be influenced by differences between hospice and Medicare skilled nursing facility reimbursement rates.

If the beneficiary is enrolled in a MHP and is admitted to the nursing facility with the hospice benefit, the MHP is responsible for reimbursement of hospice services.

For nursing facilities that elect to contract with hospice providers, MDCH encourages a written contract between the hospice provider and the nursing facility that specifically outlines the responsibilities of each. Additionally, the contract must specify how the hospice provider will reimburse the nursing facility for room and board.

Nursing facilities cannot bill Medicaid directly for room and board or any other services for hospice beneficiaries. A hospice is responsible for all costs for a person receiving hospice care. The hospice bills Medicaid for room and board, then reimburses the nursing facility at the rate specified in the contract between the providers.

MDCH reimburses the hospice for its daily rate and for room and board for beneficiaries in Medicaid or Medicaid/Medicare certified beds. The room and board rate is 95% of the facility's Medicaid per diem rate, which is the minimum established by Centers for Medicare and Medicaid Services (CMS). Although the rate paid to the hospice by Medicaid is set, it is not necessarily the rate that the hospice must pay the facility. It is expected that some services may be purchased or traded between the facility and the hospice, so the negotiated room and board rate must be stipulated in the contract.

Because Medicaid is making a payment for room and board (even though it is paid to the hospice), beneficiaries must be treated as all other Medicaid beneficiaries. For example, the facility cannot seek or accept additional or supplemental payment from the beneficiary, his family, or representative in addition to the amount paid for the covered service, even when a beneficiary has signed an agreement to do so.

9.13.A. Nursing Facility Responsibilities

Nursing facilities must adhere to all State licensure requirements, even though some of the components of care are provided by the hospice rather than the nursing facility. An example of a licensure component completed by the hospice is that, upon admission, the hospice provides the facility with copies of the beneficiary's history and physical, interdisciplinary assessment, and plan of care. For purposes of licensure, these copies are accepted as appropriate.

If a beneficiary is already receiving hospice services and elects admission to a nursing facility, the nursing facility should note that the beneficiary has elected hospice on the Facility Admission Notice (MSA-2565-C) sent to the local FIA office. This should result in a Level of Care 16 on the beneficiary's **mihealth card**. If the **mihealth card** does not indicate a Level of Care 16, the beneficiary or their designated representative should contact the local FIA to request a correction.

Hospice staff cannot be utilized to meet staffing patterns required for licensure (i.e., the facility cannot include hospice staff on staffing reports).

Although the hospice is responsible for developing the coordinated plan of care, the nursing facility, as well as the beneficiary, must be an active participant in its development.

If the hospice beneficiary in a nursing facility has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

Services that must be provided by the nursing facility include:

- Room and board;
- Laundry (including facility items as well as personal items); and
- All other non-terminal illness-related services afforded other Medicaid beneficiaries (e.g., services included in the per diem rate).

Hospice covered beneficiaries residing in the nursing facility must not experience any lack of nursing facility services or personal care due to their status as a hospice beneficiary. Facilities must offer the same drugs, services, medical supplies and equipment to all beneficiaries who have elected the hospice benefit in the same manner that services are provided to other beneficiaries in the facility who have not elected hospice care. If a service is normally furnished as part of the facility's per diem rate, the service must also be provided to hospice beneficiaries. If services are provided for needs associated with a non-terminal illness and are normally furnished and billed by another provider, that practice would continue.

9.13.B. Hospice Responsibilities

Hospice must certify/re-certify the beneficiary's need for hospice care.

If a beneficiary already living in a nursing facility elects the hospice benefit, it is the responsibility of the hospice to submit to MDCH, Enrollment Services Section, a Hospice Membership Notice form (DCH-1074). MDCH will assign a Level of Care code 16 on the Eligibility Verification System (EVS).

The hospice, in collaboration with the beneficiary and/or family and nursing facility, will establish a coordinated plan of care for the beneficiary. The plan must specify the overall care to be provided and indicate, in detail, which services will be provided by the hospice and which will be provided by the facility.

If the hospice beneficiary has a patient-pay amount, it is the hospice's responsibility to collect that amount from the beneficiary. The nursing facility cannot collect the patient-pay amount from a hospice beneficiary unless the contract with the hospice specifically delegates that responsibility to the facility.

9.13.C. Service Provision

The following is intended for use as a guideline only. It identifies services for which the hospice is responsible, services that the hospice may arrange, and services that are "negotiable."

9.13.C.1. SERVICES THAT HOSPICE MUST PROVIDE (RELATED TO THE TERMINAL ILLNESS)

- A coordinated plan of care outlining the responsibilities of each provider;
- Intermittent (i.e., less than eight hours per day) nursing care of the hospice beneficiary;
- Counseling (defined as bereavement, nutritional, and spiritual); and
- Social work services.

9.13.C.2. SERVICES THAT HOSPICE MAY ARRANGE (RELATED TO THE TERMINAL ILLNESS)

- Spiritual care; and
- Home health aide/homemaker services. This applies only for services not provided during the facility's normal provision of care. For example, if the facility normally provides baths five times a week but the hospice plan of care calls for a bath each day, the hospice aide would provide baths on the days the facility does not.

9.13.C.3. NEGOTIABLE SERVICES

Services that must be available for hospice beneficiaries but appropriate contracted providers may render, as related to the terminal illness and as included in the patient plan of care, include the following. <u>These services are the responsibility of the hospice, and **cannot** be billed to Medicaid by the contracted provider.</u>

- Inpatient care for acute episodes of pain and symptom control;
- Inpatient respite care (not available for beneficiaries residing in a nursing facility);
- Laboratory;
- Pharmacy;
- Durable medical equipment;
- Radiology;
- Medical;
- Up to 24 hours of continuous care (at least eight hours of which must be nursing care) during periods of crisis;
- Physical therapy;
- Occupational therapy;
- Speech/language pathology; and

- Emergency ambulance transportation (if the service is included as part of the hospice plan of care).

9.14 HOSPITAL SERVICES

A nursing facility must have in effect a transfer agreement with one or more hospitals.

9.14.A. Planned Inpatient Hospital Admission

When a hospital admission is planned, the beneficiary must be discharged from the nursing facility. The nursing facility must not count the day of discharge as reimbursable by Medicaid. This day is included on the hospital's claim when billing. The facility may not bill Medicaid for hospital leave days for a planned admission. (See the Holding a Bed [Hospital Leave and Therapeutic Leave] sub-section of this chapter for more information.)

9.14.B. Emergency Inpatient Hospital Admission

When a resident is admitted to the hospital on an emergency basis, the nursing facility may receive Medicaid reimbursement for holding their bed. (See the Holding a Bed [Hospital Leave and Therapeutic Leave] sub-section of this chapter for more information.)

9.14.C. Outpatient and Emergency Room

Outpatient and emergency room services are an ancillary service and are not included in the facility's per diem rate.

A beneficiary who goes to the hospital for outpatient or emergency room services is not discharged from the nursing facility because the beneficiary is not admitted to the inpatient hospital. The beneficiary should be included in the census of the nursing facility, even if the beneficiary was being treated at midnight in the hospital outpatient or emergency room.

9.15 HOUSEKEEPING AND MAINTENANCE

Facility and room/bed maintenance necessary to maintain a sanitary, orderly, and comfortable environment are a required service and included in the nursing facility's per diem rate.

9.16 INTRAVENOUS THERAPY

Intravenous therapy nursing services, supplies and equipment (including IV infusion pump, but not drug infusion pump) are included in the facility's per diem rate.

Pharmaceuticals used in IV therapy are an ancillary service and are not included in the facility's per diem rate.

9.17 LABORATORY SERVICES

Any nursing facility that performs laboratory services must be certified/accredited under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

Laboratory tests that are listed as waived tests under CLIA are included in the facility's per diem rate (e.g., Testrip). A list of these tests and the instrumentation needed to perform them can be found on the FDA website: www.fda.gov/cdrh/CLIA.

Laboratory services that can only be performed with special laboratory equipment by professional laboratory staff may be provided and billed by the appropriate enrolled ancillary provider (e.g., independent laboratory, outpatient hospital). Such services are not included in the facility's per diem rate.

Drawing, collecting and delivery of laboratory specimens are routine nursing services. As such, they are included in the facility's per diem rate regardless of who actually performs the service (i.e., nursing facility or ancillary provider).

9.18 LAUNDRY SERVICES

Facilities are responsible for general laundry services (e.g., bedding) and the beneficiary's personal laundry (e.g., clothing). Such services are included in the facility's per diem rate.

Dry cleaning services may be billed to the beneficiary if the beneficiary requests the service in writing, he has prior knowledge that the service is not covered by Medicaid, and he agrees to accept the cost. A beneficiary's patient-pay amount may not be used to cover these costs.

9.19 MEDICALLY-RELATED SOCIAL SERVICES

Nursing facilities must provide medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. These services may include, for example, information and referral, resident and family support, discharge planning, and are included in the facility's per diem rate.

9.20 MENTAL HEALTH SERVICES

Nursing facilities are required to have a written agreement with the local CMHSP outlining their working relationship to provide screening, evaluation and specialized services to nursing facility residents. The agreement must include a description of the process to be used to ensure the annual review of residents previously identified as mentally ill or mentally retarded. The agreement must also specify the means through which the facility and the CMHSP will deliver mental health services for nursing facility residents.

Completion of required Pre-admission Screening and Annual Resident Review is included in the facility's per diem rate. Prior to admission to a nursing facility, all individuals, regardless of payment source, must receive the Level I Pre-admission Screening (PAS) to identify the need for mental health and specialized services. Additional screening for mental health and specialized services is done as an Annual Resident Review (ARR), or more frequently in response to a change in a beneficiary's condition. (See the PASARR Process section of this chapter for more information.)

Mental health services provided by the nursing facility staff, as specified in the resident's plan of care, are included in the facility's per diem rate. Nursing facilities must provide mental health and/or mental retardation services that are of lesser intensity than specialized services to all residents who need such services.

9.20.A. Specialized Services

Specialized services are those identified by the PASARR Level II and are provided or arranged by the CMHSP. These services must be available to nursing facility individuals regardless of whether they are identified and required by the PASARR process, or whether the individual is determined to require additional services to be provided or arranged for by the State as specialized services. Individuals with a primary diagnosis of dementia are also covered by this requirement, even though the PASARR process exempts individuals with a primary diagnosis of dementia.

The PASARR Level II evaluation may provide recommendations regarding the specialized services and programs needed by the resident. Recommendations are based on evaluation of the resident's impairment in functional skills and the severity of those deficits. Nursing facilities must meet the responsibilities as outlined in this section for providing specialized services.

"Specialized Services" are defined as those mental health services for residents who are mentally ill or mentally retarded which are:

- Of greater intensity than those normally required from a nursing facility;
- Provided in conjunction with usual nursing facility services;
- Determined through the PASARR process;
- Provided or arranged for by the local CMHSP acting on behalf of the State; or
- Result in the continuous and aggressive implementation of an individualized plan of care.

Specialized services for residents with **mental illness** may include, for example, individual, group and family psychotherapy, crisis intervention services, and formal behavior modification programs.

Specialized services for residents with **mental retardation** include specialized professional involvement because the service need is related to the resident's mental retardation. Evaluators must carefully distinguish between those service needs that require the involvement of a mental retardation professional, and those which are "generic" and do not require specifically-trained professionals. For example, administering medication is a "generic" service, while teaching a resident to self-administer may be a "specialized service" because it requires the involvement of a mental retardation professional to design and monitor the program.

For residents with **multiple diagnoses**, such as mental retardation and mental illness or mental retardation and dementia, evaluators may recommend either specialized services or other mental health services, depending on the interrelationship of the two diagnoses.

9.20.B. Nursing Facility Responsibilities

Responsibilities of the nursing facility include:

- Providing all of the usual and customary services (see Medicaid Covered Services sub-section) and as required by licensing and certification. This includes specialized mental health rehabilitation services as defined in 42 CFR 483.120.
- Monitoring the need for PASARR evaluations and ensuring that they are completed on time (see the PASARR Process section). The nursing facility must notify the CMHSP when a Level II evaluation is indicated.
- Collaborating with the resident or his legal representative and the CMHSP to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Coordinating the identified services (which may be obtained from the local CMHSP) and implementing and monitoring the services recommended in the individualized plan of care. Nursing facilities must also provide interventions which complement, reinforce and are consistent with any specialized services the individual is receiving or is required to receive by the State through the CMHSP. The individualized plan of care must specify how the facility will integrate relevant activities throughout all hours of the day at the facility to achieve consistency and enhancement of the goals identified in the individualized plan of care.

9.20.C. CMHSP Responsibilities

Responsibilities of the CMHSP include:

- Performing the comprehensive evaluation (Level II evaluation) when required by the PASARR Screening.
- Collaborating with the resident or his legal representative and the nursing facility to develop an individualized plan of care for specialized services based on the needs identified during the PASARR Level II evaluation. The plan of care must outline the responsibilities of each provider for the specialized services.
- Providing specialized services to nursing facility residents who have been determined to need them through the PASARR process. MDCH has allocated funds to local CMHSPs for this purpose.
- Providing training to nursing facility direct care staff to implement and monitor the programs as designed, and participating in the evaluation and modification of the plan of care as needed.
- Providing services to nursing facility residents on the same basis as to all other persons in the region. A nursing facility may use the local CMHSP as a mental health service provider in order to fulfill the nursing facility's obligation to provide specialized mental health rehabilitation services. Services for residents with a primary diagnosis of dementia are also available from a local CMHSP on the same basis.

In 1991, funds were made available to local CMHSPs to provide specialized services and other mental health services to individuals residing in nursing facilities. Priority for use of these funds is for individuals with the most severe mental health problems who need specialized services. To the extent there are funds remaining after this priority group is served, MDCH has given local CMHSPs authorization to serve individuals who need mental health services other than specialized services.

Ancillary providers of mental health services may bill Medicaid directly.

9.21 NURSING CARE

Nursing facilities must have nursing staff sufficient to provide nursing and other related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Nursing care includes the responsibility for development, implementation and oversight of a plan of care that remains consistent with on-going observation, assessment and intervention by licensed nurses. The following are examples of custodial and rehabilitative nursing care that may be performed by, or under the supervision of, licensed nurses and are included in the per diem rate. Nursing services include, but are not limited to:

- Observing vital signs and recording the findings in the beneficiary's medical record;
- Administration of topical, oral, or injectable medications, including monitoring for proper dosage, frequency, or method of administration, including observation for adverse reactions;
- Treatment of skin irritations or small superficial or deep skin lesions requiring application of medication, irrigation, or sterile dressings;
- Routine changing of dressings in chronic, non-infected skin conditions and uncomplicated postoperative incisions;
- Nursing observation and care of beneficiaries with unstable or complex medical conditions which can only be provided by, or under the immediate direction of, licensed nursing personnel;
- Proper positioning in bed, wheelchair, or other accommodation to prevent deformity and pressure sores;
- Provision of bed baths;
- Routine prophylactic and palliative skin care (e.g., application of creams and lotions) for the prevention of skin irritation and pressure sores;
- Administration of intravenous solutions on a regular and continuing basis;
- Administration of tube feedings;
- Nasopharyngeal aspiration required for maintenance of a clear airway;
- Care of a colostomy or iliostomy during early postoperative period, on an on-going basis, and conducting colostomy training;
- Use of protective restraints, bed rails, binders, and supports (if ordered by a physician and in compliance with state and federal regulations) provided in accordance with written patient-care policies and procedures;
- Use of intermittent positive pressure breathing equipment and nebulizers;

- Care of catheters;
- Care of tracheostomies, gastrostomies, and other indwelling tubes;
- Administration of oxygen or other medicinal gases on a regular and continuing basis in the presence of an unstable medical condition or when nursing assessment is required to determine frequency and necessity of administration;
- Identifying the need for, and insuring arrangements for, prompt and convenient clinical, laboratory, x-ray, and other diagnostic services;
- Use of heat as a palliative and comfort measure, such as whirlpool and hydrocolator;
- Training and assistance in transfer techniques (bed to wheelchair, wheelchair to commode, etc.);
- Training, assistance, and encouragement of self-care as required for feeding, grooming, toileting activities (including toilet routine to encourage continence), and other activities of daily living;
- Normal range-of-motion exercises as part of routine maintenance nursing care; and
- Pain assessment and management.

9.22 ORTHOTICS

Orthotics are an ancillary service and are not included in the facility's per diem rate.

9.23 OXYGEN

The administration of oxygen and the related nursing services are included in the per diem rate.

Oxygen gas, equipment, and supplies for intermittent and infrequent use are included in the facility's per diem rate.

If a beneficiary requires frequent or prolonged oxygen on a daily basis (i.e., at least 8 hours per day):

- As a resident in the Nursing Facility (Provider Type 60), the oxygen gas, equipment, and supplies must be billed by an enrolled medical supplier, not the nursing facility.
- As a resident in a County Medical Care Facility (Provider Type 61) or a Hospital Long Term Care Unit (Provider Type 62), the oxygen gas, equipment, and supplies are billable by the facility.
- (Refer to the Billing and Reimbursement for Institutional Providers Chapter in this manual for billing instructions.)

Oxygen services (i.e., gas, equipment, and supplies) are not covered by Medicaid if **Medicare** is paying for the stay. Medicare's per diem reimbursement rate includes the oxygen services.

9.24 PERSONAL COMFORT ITEMS

Medicaid does not cover individual personal comfort items (e.g., telephone, television, radio, guest trays). Such services are not included in the facility's per diem rate. Beneficiaries may purchase individualized services with personal funds. A beneficiary's patient-pay amount may not be used to cover these services.

If the facility provides personal comfort items to all its beneficiaries (e.g., a television in the recreation room), the service is included in the facility's per diem rate.

9.25 PERSONAL HYGIENE ITEMS

Items needed for personal hygiene are included in the facility's per diem rate. Such items include, but are not limited to, the following:

- Bacteriostatic soaps
- Body lotions
- Combs and brushes
- Cotton swabs
- Deodorant/antiperspirant
- Facial tissues
- Hair conditioners (as appropriate)
- Incontinence supplies
- Medicine cups
- Oral hygiene supplies
- Patient gowns
- Personal hygiene preparations
- Safety razors
- Sanitary napkins
- Shampoo
- Shaving cream
- Soaps

9.26 PHARMACY

Nursing facilities must provide pharmaceutical services to meet the needs of each resident.

Prescriptions must be ordered and documented, in writing, in the beneficiary's medical record by the attending physician.

A Medicaid co-payment is not required for prescription pharmaceuticals for nursing facility beneficiaries.

The Michigan Pharmaceutical Product List (MPPL) contains the over-the-counter and prescription pharmaceutical products covered by Medicaid and any restrictions placed on those products, including when prior authorization is required. The prior authorization process is outlined in the MPPL and may be obtained by the physician or their designee. The Michigan Pharmaceutical Products List is available online. (Refer to the Directory Appendix for website information.)

Only Hospital LTC Units may bill Medicaid directly for pharmacy items. Pharmaceuticals dispensed in all other types of nursing facilities must be billed through a pharmacy (unless pharmacy is included in the per diem rate, i.e., ICF/MR).

9.26.A. Over-the-Counter Products (OTC's)

- The MPPL designates when an OTC drug is included in the facility's per diem rate. It is the responsibility of the facility to provide these products. Examples of OTCs in the per diem include mouthwash, topical antiseptics, analgesics, cough and cold preparations, ointments, and vitamins and minerals. The pharmacy or supplier must make arrangements with the nursing facility for reimbursement.

- OTCs not included in the per diem rate that may be billed to Medicaid, as outlined in the MPPL, are reimbursable to Pharmacy (Provider Type 50) for nursing facility beneficiaries. Examples include Diphenhydramine and Insulin.

9.26.B. Medication Reviews

Medication reviews, as required by federal regulations, are the responsibility of the facility and are included in the per diem rate. The pharmacist must make arrangements with the facility for reimbursement of such services.

9.27 PHYSICIAN SERVICES

Physician services must be provided and are an ancillary service. Such services are not included in the facility's per diem rate. In accordance with federal requirements, residents have the right to choose an attending physician.

A physician must initially examine a resident within 48 hours of admission to the nursing facility. If the admission occurs on a Friday, the exam must be completed within 72 hours.

A physician must evaluate a beneficiary every 30 days for the first 90 days after admission. The resident must then be evaluated every 60 days unless otherwise justified and documented by the physician. At a minimum, the resident must be evaluated at least once every 90 days on an ongoing basis.

A physician visit is considered timely if it occurs no later than ten days after the required visit. After the initial visit, the physician may alternate personal visits between the physician and a physician assistant or nurse practitioner.

9.28 PODIATRY SERVICES

Palliative treatment and routine foot care (e.g., trimming of the nails, removal of corns and calluses) are included in the facility's per diem rate.

Medically necessary podiatry physician services are an ancillary service and are not included in the facility's per diem rate.

9.29 PRIVATE DUTY NURSING

Private duty nurses are not covered in a nursing facility by the Medicaid Program nor are they included in the facility's per diem rate. The beneficiary may use personal funds to purchase private duty nursing services. A beneficiary's patient-pay amount may not be used to cover the cost of private duty nursing.

9.30 PRIVATE ROOM

When a Medicaid beneficiary requires a private room due to medical necessity, the nursing facility is reimbursed at the usual per diem rate. Private rooms required for medical necessity are included in the facility's per diem rate. Written documentation of medical necessity must be part of the beneficiary's medical record.

Medical necessity is defined as a documented medical condition that creates the need to isolate the resident for his safety and/or the safety of others (i.e., infection control). This also includes behavioral

conditions related to a medical condition (i.e., aggression related to dementia). The medical necessity must be documented, as well as addressed, in care planning and treatment.

If a beneficiary requests a private room and there is no medical necessity, the beneficiary may elect to pay privately. The nursing facility must advise the beneficiary that a private room is not a Medicaid-covered service unless it is medically necessary, and that the beneficiary or family is responsible for paying the difference between the cost of a semi-private and private room. The facility may only charge the difference between what it would normally charge a private-pay resident for a semi-private and a private room. Facilities may not charge beneficiaries the difference between the Medicaid per diem rate and the rate charged a private-pay resident for a private room. For example, if the facility charges $98.00/day for semi-private room and $112.00/day for a standard private room, the charge is $14.00/day. The beneficiary's patient-pay amount may not be used for this purpose.

If the beneficiary agrees to pay the difference between the semi-private and private room rate, the beneficiary or family member must request permission, in writing, from the MDCH. The Request for Authorization of Private Room Supplemental Payment for Nursing Facility form (MSA-1580) is used to obtain the permission. The MSA-1580 is completed by the beneficiary or family member. (Refer to the Directory Appendix for downloading the MSA-1580 and other contact information.) Requests to supplement the cost of a private room are reviewed for cost and reason for request on a case-by-case basis. A response will be sent to the requestor, the beneficiary (if different), and the facility within ten working days.

This response must be retained as part of the beneficiary's medical record. Subsequently, these charges are subject to audit by MDCH, CMS or designated representatives of either of those entities. These charges must be reported by the nursing facility as revenue received. This response, however, does not guarantee that the beneficiary will be provided a private room. The agreement to provide a private room is given by the nursing facility.

9.31 PROSTHETICS

Prosthetic services are an ancillary service and are not included in the facility's per diem rate.

9.32 RADIOLOGY

Radiology services are an ancillary service and are not included in the facility's per diem rate.

9.33 SUBSTANCE ABUSE SERVICES AND TREATMENT

Services rendered for the treatment of alcohol and drug abuse are an ancillary service are not included in the facility's per diem rate.

9.34 SUPPLIES AND ACCESSORIES

Supplies, accessories, and equipment necessary to achieve the goals of the beneficiary's plan of care are included in the facility's per diem rate and must be available to the beneficiary. Medical supplies, accessories, and equipment include, but are not limited to:

- Atomizers
- Bandage products

- Bed linens
- Bib or protective cover
- Catheters/accessories and irrigation solution
- Cloth diapers
- Cotton balls
- Cotton swabs
- Deodorizers
- Diagnostic agents (e.g., Testape, Kyotest)
- Disposable diapers
- Disposable gloves
- Dressings (e.g., surgical pads, cellulose wadding, tape)

  Note: Some supplies for complex wound care are not included in the per diem rate and must be obtained through a medical supplier or pharmacy (Provider Type 87 and 50). Supplies that must be billed by a medical supplier, including information for interpreting the list of supplies, are on the MDCH website. (Refer to the Directory Appendix for additional information.)
- Elastic hose
- Enema kits
- Finger cots
- First aid trays
- Flameproof cubicle curtains
- Foot soaks
- Hot water bottles
- Hypodermic needles/syringes
- Ice bags
- Incontinence pads, pants, and liners
- IV supplies and equipment; related supplies (including IV infusion pump)
- Minor medical/surgical supplies
- Miscellaneous applicators
- Nebulizers (hand-held or used with a compressor)
- Ostomy supplies
- Plastic waste bags
- Recreational/therapeutic equipment and supplies to conduct ongoing activities
- Safety pins
- Sheepskin, devices and solutions for preventing/treating decubiti
- Slings
- Stethoscopes

- Straws
- Syringes/needles
- Thermometers
- Tongue blades (depressors)
- Towels/washcloths
- Tracheostomy care kits and cleaning supplies
- Trochanter rolls
- Water carafes/glasses

Note: This list is not complete. Generic equivalents and products in the same family (i.e., same general use) are also included in the facility's per diem rate.

9.35 THERAPIES

Nursing facilities must provide or obtain specialized rehabilitative services if required by the beneficiary's plan of care.

Routine maintenance therapy consists of the repetitive services required to maintain function. The development of the therapy and treatment are included in the per diem rate. Such therapy does not require the therapist to perform the service, nor does it require complex and sophisticated procedures.

Non-routine occupational therapy (OT), physical therapy (PT) and speech/language/ pathology (ST) are ancillary services that are covered if prior authorization is obtained and the following conditions are met:

- The therapy must be billed by the facility;
- There must be a written order by the attending physician for each calendar month of therapy; and
- The written orders must be signed by the attending physician and retained in the beneficiary's medical record.

Federal regulations require the facility to have a valid contract with the OT, PT, or ST provider. A valid contract allows the facility to retain professional and administrative control over the services provided. Therefore, an agreement that stipulates only the use of facility space does not constitute a valid contract.

If Medicaid funds have inappropriately been paid to a facility for OT, PT, or ST services when a facility did not possess a valid contract, the funds may be recovered by gross adjustment or at the time of cost settlement, as appropriate.

The following clarifies the professional responsibilities of the nursing facility, the physician, and the therapist in the provision of OT, PT or ST services for Medicaid beneficiaries.

- The facility has administrative and professional responsibility for the management of the total health care needs of the beneficiary as outlined in the plan of care. The facility must assure that appropriate OT, PT, or ST services are available to the beneficiary as needed. In situations where the therapist is not an employee of the facility, the facility must establish a valid contract

with a therapist/speech pathologist who meets applicable licensure/certification/accreditation requirements.

- The attending physician is responsible for determining the medical necessity and appropriateness for services and preparing the written orders for OT, PT or ST evaluation and treatment. These are reviewed and approved/disapproved by the MDCH Prior Authorization Division.
- The therapists are responsible for evaluating the beneficiary's needs; developing a written plan of treatment, including goals and objectives; and providing or overseeing the appropriate services. A copy of the treatment plan must be retained in the beneficiary's medical record.

The facility's responsibilities, as described above, are not meant to conflict in any way with the professional responsibilities of OTs, PTs or STs in the evaluation and treatment of the beneficiary.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy program is included in the reimbursement for the therapy/speech pathology.

Therapies provided to nursing facility beneficiaries outside the nursing facility premises must be provided in the outpatient department of a general hospital or medical care facility.

Therapies provided to county medical care facility, hospital long term care unit or hospital swing bed beneficiaries outside their respective facilities must be provided in the outpatient department of a general hospital. ST may also be provided by a hearing and speech center. Prior authorization must be obtained by the facility regardless of where the service is to be provided.

Note: Therapy provided by a physician (M.D. or D.O.) is not a covered benefit for beneficiaries in a nursing facility.

9.35.A. Occupational Therapy (OT)

Occupational therapy (OT) must be active and restorative. A registered occupational therapist or a certified occupational therapy assistant must render the services. If the assistant renders the service, the therapist must be on the premises when the service is provided.

The following are examples of occupational therapy services that may be covered by Medicaid:

- Training in activities of daily living;
- Fabrication of adaptive equipment;
- Perceptual motor training;
- Splinting;
- Testing;
- Therapeutic exercises; and
- Prosthetic and orthotic training.

OT services that are provided and billed simultaneous with PT are not covered. Also, diversional OT, reality orientation, and restorative nursing functions are considered part of the per diem rate, and not separately reimbursable.

9.35.B. Physical Therapy (PT)

Active, restorative, or specialized maintenance physical therapy (PT) programs, as explained below, are benefits of the Medicaid Program. There must be the expectation that the beneficiary's condition will improve significantly in a reasonable and generally predictable period of time.

A licensed physical therapist (temporary permit is acceptable), physical therapy assistant, or physical therapy aide must provide the services. If the assistant or aide renders the services, the therapist must be on the premises when services are provided.

The following are examples of restorative PT services which may be covered by Medicaid:

- Hot pack, ice pack, infrared treatment, or whirlpool bath is covered when provided as a prerequisite to a skilled physical therapy procedure;
- Gait training is covered when provided to a beneficiary whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality;
- Prosthetic and orthotic training is covered when instructing the beneficiary in using the prosthetic or orthotic device; and
- Range of motion exercises are covered when provided as part of the treatment of a specific disability which has resulted in a loss or restriction of mobility.

For specialized maintenance physical therapy, the therapist's initial evaluation of the beneficiary's needs and designing of the program are covered. The program must be appropriate to the beneficiary's capacity, tolerance, and treatment objectives. The instructions to the beneficiary or to other members of the health team (e.g., nursing personnel) in carrying out such an individualized treatment plan and infrequent re-evaluations, as may be required, are also covered.

9.35.C. Speech Pathology/Therapy (ST)

The services must be for active, restorative treatment and must be rendered by a speech pathologist certified by, or possessing a "Letter of Equivalency" from, the American Speech and Hearing Association. For speech pathology evaluations, a copy of the speech pathologist's certification or "Letter of Equivalency" must accompany the first prior authorization request for that pathologist.

The following are examples of conditions that may warrant speech pathology services:

- Cerebral vascular accident (CVA) or trauma;
- Neurological disease, such as Parkinsonism or multiple sclerosis;
- Laryngectomy;

- Voice disorders caused by conditions such as nodules, polyps, papilloma, ulcers, cysts, or cord damage (the exact diagnosis must be included in the physician's order); or
- Maxillofacial abnormalities with traumatic or surgical excision of the tongue, lips, or hard or soft palate.

When properly documented, other diagnoses and conditions may be covered if they meet the above requirements and are prior authorized.

Since the purpose of speech pathology services is restorative rather than habilitative, these services are not covered for:

- Speech problems due to symptoms of organic brain syndrome or chronic brain syndrome; or
- Speech problems due to mental retardation.

Medicaid does not cover ST when another public agency (e.g., local or intermediate school district special education program) can assume the responsibility of services for the beneficiary.

9.35.D. Prior Approval for Therapies

The Occupational/Physical Therapy – Speech Pathology Prior Approval – Request/Authorization (MSA-115) is used to request prior authorization. The MSA-115 must be reviewed and signed by the attending physician. When making the initial request for therapy, the facility must attach a copy of the initial evaluation and written treatment plan.

Initial prior authorization is valid until the end of the calendar month in which treatment begins. Prior authorization to continue therapy must be obtained for every calendar month thereafter.

The initial evaluation does not require prior authorization and cannot be provided more often than twice in a 12-month period (and at least six months apart).

Exception: Evaluation of oral pharyngeal swallowing cannot be provided more than four times in a 12-month period.

The therapist or speech pathologist must keep appropriate notes that include the date of treatment, the name of the therapist, the type and length of treatment, and the resident's response to treatment. These notes must be maintained in the beneficiary's medical record.

Prior authorization requests for group therapy require documentation that group therapy is in the best interest of the beneficiary's treatment.

9.35.D.1. INITIAL REQUEST

When making the initial request for prior authorization of therapy, the facility must attach a copy of the initial evaluation and the written treatment plan. The initial evaluation and treatment plan must include the following information:

- Statement of the problem (i.e., the specific physical entity and functional incapacity involved or the specific speech and/or language diagnosis based upon results of formal/informal testing);
- Baseline condition at initial evaluation, measured in units appropriate to the problem (for speech pathology, this would include the baseline description of clinical and functional performance in all language modalities);
- Short-term goals appropriate to the beneficiary's diagnosis, level of severity, prognosis, and functional needs;
- Proposed technique for reaching goals, including the planned progression from the baseline condition to the goal; and
- Method by which progress will be measured.

This and any other supplemental documentation must include the beneficiary's name and Medicaid ID Number, the date, and the facility's name and ID Number.

The MSA–115 is used to obtain authorization for therapy prior to the provision of the service.

9.35.D.2. CONTINUED REQUEST

Authorization of the initial service does not guarantee authorization of continued service. The therapist must submit the MSA-115 for continued therapy with documentation of the most recent progress. The progress notes must be concise and refer to the baseline established in the initial evaluation. Progress must be objective and measurable.

9.35.D.3. DISTRIBUTION OF FORM

The prior authorization form is a four-part, snap-out form. The original, first, and second copies of the form must be submitted to the MDCH Prior Authorization Division. (Refer to the Directory Appendix for contact information.)

The facility should retain a copy for its records until the approved or disapproved form is returned by the MDCH. If the facility does not receive a response regarding the original prior authorization form within 15 days of the date of its submission, a new request should be submitted. (The reason a second prior authorization form is being submitted should be included, i.e., no response to the first request.) The facility must not bill until authorization is received and the services are rendered.

9.35.D.4. PROCESS

The MDCH consultant will make a determination and assign a prior authorization number to approved requests. The originals will be returned to the facility. If a portion of the request is denied, Medicaid will only reimburse for the authorized services. The nine-digit Prior Authorization Number must be entered on the claim when billing. The facility must retain a copy of the approved request as part of the beneficiary's medical record.

Approval of the request confirms that a beneficiary is in need of services that can be covered by the Program. It does not verify beneficiary eligibility, level of care, nor guarantee the fee charged. The facility is responsible for verifying the beneficiary's Medicaid eligibility prior to providing the service.

Whenever a beneficiary is admitted to the facility directly from a general hospital or from another nursing facility where the beneficiary was receiving reimbursable therapy services, the name of that facility and the date of discharge from that facility should be included on the prior authorization request. In order to assure continuity of the treatment regimen in such instances, retroactive authorization may be requested if the request is filed within ten days following admission. Retroactive authorization may be granted when the service is rendered within Program guidelines for coverage (e.g., is restorative in nature).

Facilities participating in Medicare are not required to obtain prior authorization for the deductible and/or coinsurance amounts when Medicare approves the services.

9.35.D.5. BILLING

The Invoice Processing System is programmed to match the services authorized with the services billed. Services billed must not exceed the services authorized.

Completion Instructions

The following instructions pertain to the completion of the MSA-115. All prior authorization forms must be typewritten to facilitate processing.

Item 1 - Control Number

The **control number** is used by MDCH for identification purposes. The facility must **NOT** mark in this item.

Item 2 through Item 4 - Consultant's Use Only

These items are for the MDCH **Consultant's use only.** These items are not to be completed by the facility.

Item 5 - Prior Authorization Number

If all or part of the service is authorized, a **nine-digit Prior Authorization Number** will be entered in this item. The facility must enter this number on the claim when billing.

NOTE: In the event the facility is approved for both an MOU and therapy services, one prior authorization number will be issued for both the MOU and therapy.

If the service is disapproved, no number will be assigned.

Item 6 through Item 8 - Facility Identification Data

The **facility's name, provider type code, and seven-digit identification number** must be entered as they appear on the Medical Assistance Provider Enrollment Turn-around Form, page 2.

Item 9 - Facility Reference Number

The facility may enter a **reference number or the beneficiary's name**, not to exceed 10 alpha and/or numeric characters, to comply with its individual filing system.

Item 10 through Item 11 - Facility Identification Data

The facility's **mailing address** (including an attention line if appropriate) **and telephone number** (including area code) assists the Consultant in resolving inquiries and returning the prior authorization form to the facility.

Item 12 through Item 15 - Client Identification Data

The **beneficiary's name** (last, first, and middle initial), **sex** (M or F), **ID Number, and birth date** (in the six-digit format: month, day, year) must be entered exactly as they appear on the **mihealth card**.

Item 16 - Admission Date

This is the date the beneficiary was **most recently admitted** to the facility.

Item 17 through Item 18 - Diagnosis and Onset Date

The **diagnosis** for which the beneficiary requires the services and the **onset date of the diagnosis** indicate the primary reason the beneficiary requires the requested services must be entered.

If the beneficiary has a chronic disease (e.g., arthritis) and recently suffered an exacerbation, the approximate date of such exacerbation must be cited.

Item 19 through Item 21 - Therapist Identification Data

The **therapist's/pathologist's name, office telephone number** (including area code), **address**, and **certificate number** identifying the therapist/pathologist must be entered. (Speech pathologists must attach a copy of the Certificate of Clinical Competency or Letter of Equivalency to the first prior authorization involving an individual speech pathologist.)

The therapist/pathologist wishing to add any comments may do so by attaching a separate sheet which must contain the beneficiary's name and identification number, date, and the facility's name and identification number.

Item 22 - Treatment Authorization Request

The **Treatment Authorization Request** must be checked to indicate whether this is the initial prior authorization request for this beneficiary for this treatment plan, a continuing request for an additional calendar month of service, or a revision of a previously authorized treatment plan.

Item 23 - Service Given By

This indicates **who is to provide the service**: therapist/ pathologist, assistant, or aide (this does not refer to a nurse's aide).

Item 24 - Treatment Month

The **calendar month(s) in which treatment is to be rendered** must be shown in a two-digit format (e.g., April should be shown as 04).

Item 25 - Date Started

The **date treatment was started** for the given diagnosis must be entered.

Item 26 - Last Authorized

The **date the MDCH Consultant signed the last approved prior authorization request** for the given diagnosis must be entered.

Item 27 - Number Sessions

This is the number of **sessions rendered up to the date the form was completed** for the given diagnosis. The facility must not indicate the number of sessions previously authorized for a different diagnosis.

Item 28 - Rehabilitation Potential

This is a brief assessment of the beneficiary's **rehabilitative potential** and factors that contribute to this determination (e.g., "good potential, patient's attitude is positive and persistent, progress depends upon the reduction of pain").

Item 29 - Line Number

The **line number** is to be used as a reference. **NOTE:** A separate Line Number must be used for each different CPT/HCPCS Code that is used.

Item 30 - Number per Month

This is the **number of times** the service is to be provided. Services may be prior authorized on a weekly basis.

Item 31 - Procedure Code

This is the CPT/HCPCS code(s) as listed in the Billing Code Appendix which describes the service(s). **NOTE:** For each different CPT/HCPCS code, a separate Line Number must be used.

Item 32 - Consultant Use Only

The facility is not to complete this item. The **MDCH Consultant** will use this area to indicate any amendments on approved services. The facility should always review this area to see if any changes are necessary for delivery of services and/or accurate billing.

Item 33 - Goals

The **expectations** for the beneficiary's ultimate achievement and the **length of time** it will take must be stated (e.g., ambulation unassisted for 20 feet, able to dress self within 15 minutes, oral expression using 4-5 word phrases to express daily need).

Item 34 - Progress Note/Discharge Plan

This is the documentation of the beneficiary's **progress** from the prior month to the current time in reference to the measurable and functional goals stated in the treatment plan. Documentation of beneficiary nursing and family education may be included. The final month of anticipated treatment should include the **discharge plan** for the carry-over of achieved goals to supportive personnel.

Item 35 - Complications Causing Extension of Treatment

Any **condition or complication that might require an extension of services** (e.g., decubiti, urological complications, or fractures) should be fully described.

Item 36 - Physician Certification

The **attending physician** must indicate if this is an **initial certification or a recertification** and **sign** and **date** the prior authorization form. The attending physician's signature is required each time a request is made.

Item 37 - Provider Certification

The facility's **certification** is required to validate the form. This is accomplished by the facility's authorized representative's **signature** on the form and the form must be **dated**. All unsigned requests will be returned to the facility for signature.

Item 38 through Item 43 - Consultant Use Only

These items will be **completed** by the consultant. The consultant will indicate that the service is approved as presented, approved as amended, or disapproved. If all or part of the plan is authorized, the consultant will assign a nine-digit Prior Authorization Number in Item 5.

The therapist/speech pathologist must keep progress notes. Such notes include the:

- date of treatment,
- name of the individual who rendered treatment,
- type and length of treatment, and
- beneficiary's response to the treatment.

The progress notes must be included in the beneficiary's medical record.

The cost of supplies and equipment (e.g., plate guards) used as part of the therapy/speech pathology program is included in the reimbursement for the therapy/speech pathology.

The following illustrates an MSA-115 as it might be completed in a usual situation.

OCCUPATIONAL/PHYSICAL THERAPY - SPEECH PATHOLOGY
PRIOR APPROVAL - REQUEST/AUTHORIZATION

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTE: FOR INITIAL AND REVISED REPORTS ONLY, YOU **MUST** ATTACH A COPY OF THE INITIAL EVALUATION AND TREATMENT PLAN.

1. CONTROL NUMBER

CONSULTANT USE ONLY
2. 3. 4.

5. Prior Authorization Number

6. TREATMENT SITE Hills Nursing Home	7. TYPE 60	8. I.D. NUMBER 6143500	9. PROVIDER'S USE ONLY Good
10. ADDRESS (NUMBER, STREET, CITY STATE, ZIP) 5 Main Street, Ada, Michigan 49441			11. PHONE NUMBER (616) 243-9170
12. RECIPIENT NAME (LAST, FIRST, MIDDLE INITIAL) Good, Sam	13. SEX M	14. I.D. NUMBER 11000047	15. BIRTHDATE 04/01/37
16. ADM. DATE 02/01/02			18. ONSET DATE
17. DIAGNOSIS TO BE TREATED/EVALUATED CVA with resultant left hemiparesis			
19. THERAPIST/PATHOLOGIST NAME (LAST, FIRST, MIDDLE INITIAL) O'Malley, Sue R.		20. OFFICE PHONE NUMBER (616) 432-7620	21. LICENSE/CERTIFICATION NUMBER 843714
22. TREATMENT AUTHORIZATION REQUEST ☐ INITIAL ☐ CONTINUING ☒ REVISED	23. SERVICE GIVEN BY THERAPIST/ ☒ PATHOLOGIST ☐ ASST ☐ AIDE	24. TREATMENT MO. 08	25. DATE STARTED 12/01/02
26. LAST AUTH. 11/24/02	27. NO. SESSIONS 1		

28. REHABILITATION POTENTIAL

33. GOALS
Gait Training

ESTIMATED TIME

34. PROGRESS NOTE/DISCHARGE PLAN

Patient is exhibiting some hesitation in moving outside the Parallel bars. Does two lengths with stand-by assistance before rest. Trying to get outside of bars within next week.

29. LINE NO.	30. NUMBER PER MONTH	31. PROCEDURE CODE	32. CONSULTANT USE ONLY
01	20	97116	
02			
03			
04			
05			
06			

35. COMPLICATIONS CAUSING EXTENSION OF TREATMENT

36. PHYSICIAN CERTIFICATION
I certify ☐, re-certify ☒ that I have examined the patient and determined that therapy is necessary; that service will be furnished on an in/out-patient basis while the patient is under my care; that I approve the above treatment plan or evaluation and will review it every 30 days or more often if the patient's condition requires.

James P. Pike, M.D. — PHYSICIAN NAME (TYPE OR PRINT)
James P. Pike M.D. — PHYSICIAN SIGNATURE
01/03/02 — DATE

37. PROVIDER CERTIFICATION
The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and if approved, and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

Peta Reece — PROVIDER SIGNATURE
08/03/02 — DATE

CONSULTANT USE ONLY

38. CONSULTANT REMARKS

39. APPROVED AS	40. DISAPPROVED	41. CONSULTANT SIGNATURE	42. DATE	43. MONTH
☐ PRESENTED ☐ AMENDED	☐			

9.36 TRANSPORTATION

9.36.A. Non-emergency Transportation

The nursing facility is responsible for all non-emergency transportation for beneficiaries, including non-emergency transportation to medical appointments/treatment not available in the facility (i.e., dialysis treatment). The facility must either arrange or provide transportation. Reimbursement for non-emergency transportation is included in the facility per diem rate. The per diem rate also includes transportation for newly-admitted beneficiaries from a hospital or another residence.

Travel to out-or-state medical providers (other than Michigan Medicaid-enrolled "borderland" providers as defined in the General Information for Providers chapter of this manual) is not the responsibility of the facility and must be prior authorized by MDCH.

The facility must select the most appropriate, cost-effective mode of transportation. Whenever possible, a facility-owned vehicle should be used. This vehicle must comply with the Americans with Disabilities Act (ADA).

In rare situations, the condition of a beneficiary needing non-emergency transport requires an attendant in addition to the driver. In such cases, it is appropriate for a nurse aide to accompany the beneficiary and this cost should be reflected in the annual cost report as "staffing costs associated with providing needed medical care." Sending a nurse aide or other staff member with the beneficiary being transported must not negatively impact the care of residents remaining in the facility.

The need for a nurse aide to accompany a beneficiary must not be confused with the responsibility of the family or legal guardian "to attend the beneficiary if escort is needed to sign consent forms, decide treatment options, sign insurance forms, provide histories, etc." A nurse aide is not to be responsible for these legal and medical decisions and knowledge.

9.36.B. Emergency Ambulance

Nursing facilities must have contractual arrangements for ambulance services for emergencies. When there is an emergency, an ambulance provider renders the service and bills Medicaid.

9.36.C. Non-emergency Ambulance

When a physician issues a written order for non-emergency ambulance transportation, usually due to the need for a stretcher or other emergency equipment, the ambulance provider may bill Medicaid directly and must maintain the physician's order as documentation of medical necessity. If non-emergency ambulance transport is not ordered by the beneficiary's physician, arrangements for payment must be between the facility and the ambulance provider, and cannot be charged to the beneficiary, beneficiary's family or used to offset the patient-pay amount.

9.37 VACCINES

Reimbursement for any vaccination ordered by the attending physician and administered in the nursing facility is included in the per diem rate. The invoiced purchase cost of the vaccine should be included as an allowable medical supply expense on the facility's cost report.

9.38 VISION

Vision services (examinations and glasses) are ancillary services and are included in the facility's per diem.

A Medicaid copayment is not required for nursing facility beneficiaries.

SECTION 10 – SPECIAL PLACEMENTS AND AGREEMENTS

10.1 DEMENTIA UNITS

A nursing facility may elect to designate beds or units to address the special needs of beneficiaries with Alzheimer's disease or other dementing illnesses. Care for Medicaid beneficiaries in dementia specialty beds is reimbursed as defined for any other nursing facility bed.

10.2 HOLDING A BED (HOSPITAL LEAVE AND THERAPEUTIC LEAVE)

Medicaid reimburses the nursing facility for holding a bed while the beneficiary is admitted to a hospital for emergency medical treatment (hospital leave) or takes a therapeutic leave from the facility for non-medical reasons.

Prior to therapeutic leave or transfer to a hospital, providers must give written notice of the facility's bed hold and readmission policy to the beneficiary and a family member or legal representative. This must include information about Medicaid coverage for therapeutic and hospital leave. In an emergency, notice must be given to the resident and family or legal representative within 24 hours. If the beneficiary refuses to have a family member notified, this must be documented in the beneficiary's record.

The written notice must specify:

- The Medicaid bed hold policy under which the beneficiary is permitted to return and resume residence in the facility; and
- The facility's written policy under which a beneficiary is readmitted to the facility when their absence is in excess of the Medicaid-reimbursed leave days. The beneficiary must be readmitted immediately to the first available bed (if the beneficiary still requires nursing home services and still is Medicaid eligible).

10.2.A. Hospital Leave Days

Medicaid reimburses a nursing facility to hold a bed for up to ten days during a beneficiary's temporary absence from the facility due to admission to the hospital for emergency medical treatment. The facility must hold the bed and may bill Medicaid if there is reasonable expectation by the attending physician at the point of admission to the hospital that the beneficiary will return to the nursing facility by the end of the tenth day. The hospital admission must be for emergency medical treatment, as documented by the attending physician in the beneficiary's medical record.

An "emergency medical condition" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the beneficiary (or, with respect to pregnant women, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

The beneficiary must return to the nursing facility in ten or fewer days in order for the nursing facility to bill Medicaid for hospital leave days.

If the beneficiary is in the hospital for more than ten days, the nursing facility is released from its obligation to hold the bed and cannot bill Medicaid for **any** hospital leave days. The resident may be charged to hold the bed for those days if they agree in advance. (See Medicaid Non-Covered Leave Days sub-section.) The facility is encouraged to monitor the resident during the hospital stay to determine the likely length of hospitalization.

If the resident is expected to be in the hospital for ten days or fewer and dies while in the hospital, the nursing facility may bill Medicaid for the hospital leave days up to the day before the resident died.

If the resident returns to the nursing facility under Medicare coverage, the facility may bill Medicaid for the hospital leave days if the emergency hospitalization was for ten days or fewer.

A resident is counted in the facility census if they are in the facility at midnight. If the resident is out of the facility on hospital leave at midnight, that day must be counted as a hospital leave day. If the resident returns to the nursing facility from the hospital, then is re-admitted to the hospital for the same condition that they were hospitalized for previously, the 10-day period of Medicaid reimbursed hospital leave days continues if the resident was not counted in the facility census for that day. If, given the circumstances above, the resident was counted in the facility census, a new 10-day period of Medicaid reimbursed hospital leave days may begin.

The resident need not be shown on the Medicaid claim as discharged from the nursing facility unless the hospital admission was a planned admission (not an emergency) or was longer than 10 days.

Patient-pay amounts and billing methods are not affected by this hospital leave day policy. The nursing facility should continue to collect any patient-pay amount, typically on the first day of the month, and indicate the amount collected on the Medicaid claim. The Medicaid Claims Processing System automatically deducts the patient-pay amount and reimburses the provider for the balance. If the facility bills Medicaid for hospital leave days that occur at the beginning of the month, then the nursing home should collect the patient-pay amounts as usual. The facility should charge the amount against the patient-pay that Medicaid will pay for that day. For example, if a resident has a patient-pay of $200 and is in the hospital for an emergency condition for the first 5 days of the month (the stay is 10 days or fewer), the nursing facility should collect the patient-pay amount from the resident, then submit a Medicaid claim. Medicaid would reimburse the facility the hospital leave day per diem rate, minus the patient-pay amount. Using 2002 figures, the facility reimbursement would be $150.30 [($70.06 x 5)-$200].

There is no limit to the number of hospital leave days per resident that may be billed to Medicaid annually as long as there are no more than 10 consecutive leave days per hospital stay.

Hospital leave days are not included in the Medicaid census statistics.

10.2.B. Therapeutic Leave Days

If the beneficiary has a temporary absence from the nursing facility for therapeutic reasons as approved by a physician, Medicaid reimburses the facility to hold the bed open for up to a total of 18 days during a 365-day period. Therapeutic leave is for non-medical reasons, such as overnight stays with friends or relatives. A resident is counted in the facility census if they are in the facility at midnight. If the beneficiary is out of the facility on therapeutic leave at midnight, that day must be counted as a therapeutic leave day.

The Medicaid Program covers up to 18 therapeutic leave days in a 365-day period for each beneficiary if:

- The facility reserves the bed for the beneficiary during his absence; and
- The beneficiary's written plan of care provides for out-of-facility visits; and
- The beneficiary returns to the facility.

There is no limit to the number of therapeutic leave days that may be reimbursed at one time as long as the total does not exceed 18 days in a 365-day period (not the calendar year). For example, if a resident goes on a 5-day family vacation beginning April 10, 2003, that resident has 13 therapeutic leave days remaining until April 9, 2004.

If a beneficiary does not return from a therapeutic leave, the beneficiary must be discharged on the date he left the facility. The date of admission and the date of discharge may not be billed as therapeutic leave days.

Therapeutic leave days must be included in the Medicaid census statistics.

10.2.C. Medicaid Non-Covered Leave Days

Medicaid does not reimburse providers to hold a bed for reasons other than emergency transfer to a hospital (10-day maximum per hospital admission), or therapeutic leave (18-day maximum per 365-day period). However, the facility may hold the beneficiary's bed for other reasons and for leave days not covered by Medicaid, and bill the beneficiary if the beneficiary:

- Has prior knowledge that the service is not a Medicaid benefit; and
- Desires to have the bed reserved; and
- Agrees, in writing, to pay the facility to hold the bed at a specified rate. (The beneficiary's patient-pay amount may not be used for this purpose.)

If the beneficiary elects to not pay privately, the beneficiary has the option to return to the next available, equivalent bed. A beneficiary cannot be involuntarily transferred/discharged after a temporary absence, including discharge to obtain acute care in an inpatient hospital, unless the appropriate criteria are met and the appropriate regulations, policies, and procedures are followed.

Except for Medicaid-covered leave days and when beneficiaries have paid to hold a bed, the beneficiary must be discharged from the facility, then readmitted upon return to the first available bed.

All bed hold days (excluding hospital leave days) must be included in the Medicaid census statistics.

10.3 INVOLUNTARY TRANSFER OR DISCHARGE

10.3.A. Conditions

A nursing facility must not involuntarily transfer or discharge a beneficiary unless:

- It is necessary for the welfare of the beneficiary, and the beneficiary's needs cannot be met in the facility; *
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; *
- It is necessary to protect the safety of individuals in the facility;
- It is necessary to protect the health of individuals in the facility; *
- The beneficiary has failed, after reasonable and appropriate notice, to pay (or to initiate payment under Medicaid) for a stay at the facility; or
- The facility ceases to operate.

The facility must include documentation in the beneficiary's clinical record for any of the above circumstances. * Items require documentation of medical necessity by the attending physician.

10.3.B. Transfer Trauma

For certain residents (defined below), transfer trauma must be considered when that resident may be moved due to a change in the level of nursing need.

Transfer trauma is defined as "any adverse psychological and/or physical effects occasioned by the transfer of a nursing home patient that would be materially detrimental to the physical or mental health of the patient."

Residents for whom transfer trauma must be considered include all those who have resided in the current nursing facility for at least one year, or who have been involuntarily transferred within the previous year. (A discharge to obtain acute care in an inpatient hospital, followed by an immediate readmission within three weeks to the same nursing facility, does not interrupt the continuity of a resident's stay).

The State Survey Agency evaluates transfer trauma. This evaluation considers the social, mental and emotional adjustment of the resident, including the length of time that the resident has been in the nursing facility and the relationships that the resident has

formed in the facility. This evaluation may also consider the resident's age, history and success of previous placements, and history of adapting to change. Consideration must also be given to the opinion of the attending physician regarding the resident's social and emotional adjustment and the physical effects of the proposed transfer.

Transfer trauma must be considered before the resident is notified of a nursing level of care change. When Medicaid is the payer source, Medicaid payment at the current level continues while transfer trauma is being considered.

If Medicaid was not the payer source immediately prior to the transfer trauma issue being raised, then Medicaid payment is not made until a decision is reached.

If the transfer trauma decision upholds the beneficiary's medical need to remain in a bed not certified for his present level of care, then the beneficiary's prior level of care will be retained to provide for continued Medicaid coverage.

If it is determined that there is no issue of transfer trauma, the beneficiary must be transferred to a bed or setting appropriate for the new level of care. MDCH will change the level of care code. The beneficiary or representative can appeal the level of care decision.

Concerns about involuntary transfer and/or transfer trauma should be reported to the Health Facility Complaint Line. (Refer to the Directory Appendix for contact information.)

10.3.C. Beneficiary Notification

Nursing facilities must give beneficiaries a 30-day written notice regarding transfer unless:

- The transfer or discharge is a health care emergency;
- The safety or health of beneficiaries or staff is endangered;
- The beneficiary agrees to the transfer/discharge.
- The beneficiary's health has improved sufficiently so the beneficiary no longer needs the services provided by the facility; or
- The facility ceases to operate.

The notice must include:

- The reason for the transfer or discharge;
- The effective date of the transfer or discharge;
- The location to which the beneficiary will be transferred or discharged;
- The name, address, and (toll-free) telephone number of the State Long Term Care Ombudsman;
- For beneficiaries with developmental disabilities (DD), the mailing address and telephone number of the agency responsible for the protection and advocacy of DD individuals, established under the Developmental Disabilities Assistance and Bill of Rights Act;

- For nursing facility beneficiaries with mental illness (MI), the mailing address and telephone number of the agency responsible for the protection and advocacy of MI individuals, established under the Protection and Advocacy for Mentally Ill Individuals Act; and
- Appeal rights.

The facility must also provide:

- Sufficient preparation and orientation to beneficiaries to ensure safe and orderly transfer or discharge from the facility, as required by state and federal regulations; and
- Notice of the facility's bed-hold and re-admission policy, including the Medicaid bed-hold policy.

If a nursing facility elects to discontinue operations (voluntary closure) or withdraw from the Medicaid program, the facility must provide notice to the beneficiary as outlined above not less than 30 days before the closure or withdrawal. The notice must be sufficient to allow for suitable relocation arrangements.

10.4 Married Couples

When married beneficiaries or blood relatives live in the same Medicaid nursing facility, they may share a room if both spouses or their relatives consent. (This policy applies only to beneficiaries who both require nursing facility services. It does not apply when one beneficiary does not require nursing facility services. For example, if a husband and wife wish to share a room in a nursing facility, in order for Medicaid to cover both of them in the facility, they must both require nursing facility services. If only one of them requires nursing facility services, Medicaid only covers services for that person.)

10.5 Memorandums of Understanding (MOU) - Special Agreements for Complex Care

A beneficiary who is being discharged from the hospital to a nursing facility may require specialized care beyond services covered by the usual Medicaid nursing facility per diem rate (e.g., ventilator care; complex care that requires extensive and intensive services upon discharge from a hospital).

Beneficiaries must be at the point where the nursing facility stay will be covered by Medicaid alone, and must have three or more individually complicated medical problems requiring extensive equipment, supplies, and personnel in order to meet their needs. Identified problems are usually a result of expanded medical technology and the concomitant long-term care needs of the beneficiary. MOU's are not given to cover the cost of a private room when privacy is required for medical reasons.

These special placements must be prior authorized before nursing facility admission, and are reviewed on an individual basis by the MDCH Long Term Care Services. (Refer to the Directory Appendix for contact information.) The hospital must initiate this authorization process. Detailed medical information regarding the individual will be requested and reviewed. Once all the information requested is received, a decision is forwarded to the hospital within three weeks.

Once the nursing facility has agreed to the admission, MDCH and the facility will negotiate an MOU that specifies a per diem rate that includes the increased cost of care for the resident. The mutually agreed upon reimbursement rate is all-inclusive, including all usual Medicaid reimbursed services. The MSA-1576 (Request for Prior Authorization for Complex Care) is used to authorize the MOU reimbursement. (Refer to the Forms Appendix for a copy of the form.)

10.6 ONE-DAY STAY

A nursing facility is reimbursed for a one-day stay if a Medicaid beneficiary is admitted to the facility and, the same day, is discharged from the facility due to death, return home, or transfer to another institution that is not a Medicaid-enrolled provider. The one-day stay does not apply to a beneficiary admitted to a nursing facility if, later that day, the beneficiary is discharged and transferred to another nursing facility or an inpatient hospital and, at midnight, the second facility or hospital claims the beneficiary in its daily census.

10.7 RELIGIOUS NON-MEDICAL HEALTH CARE CENTER

Religious Non-medical Health Care Centers may be licensed as nursing facilities and certified for Medicaid. Beneficiaries in Medicaid-certified facilities, under the care of a practitioner, may be determined to be in need of nursing care and, therefore, covered by Medicaid.

SECTION 11 – SPECIAL PROVIDER TYPE COVERAGES AND LIMITATIONS

11.1 HOSPITAL SWING BEDS (PROVIDER TYPE 63)

In order to address the shortage of rural nursing facility beds, federal requirements allow rural hospitals to provide post-hospital extended care services. Such a hospital, known as a swing bed hospital, can "swing" beds between hospital and nursing facility levels of care on an as-needed basis. In order to receive Medicaid reimbursement, hospital swing beds must meet all applicable state and federal requirements and provide all required services.

Providers of hospital swing bed services may bill Medicaid for hospital swing bed days only when the combined length of stay in the acute care bed and swing bed exceeds the average length of stay for the Medicaid inpatient diagnosis related group (DRG) of the admission. The total number of Medicaid-reimbursed hospital swing bed days is limited to 100 days per beneficiary per calendar year.

Medicaid does not require the MDS for clinical assessment purposes or reimbursement for beneficiaries in hospital swing beds. The PASARR process must be completed, as outlined earlier in this chapter, prior to placement in a nursing facility.

(Refer to the Billing & Reimbursement Chapter of this manual for additional swing bed billing instructions.)

11.2 NURSING FACILITIES FOR MENTAL ILLNESS (NF/MI) (PROVIDER TYPE 72)

Medicaid reimburses NF/MI for services provided to qualified beneficiaries age 65 and older.

In order to be admitted to a NF/MI, a beneficiary must require specialized nursing care, in addition to having a psychiatric diagnosis requiring care.

In order to receive Medicaid reimbursement, NF/MI providers must meet all applicable state and federal requirements and provide all defined services.

Medicaid reimburses NF/MI providers at a per diem rate, which includes all of the usual covered nursing facility services as outlined in this chapter. In addition, ancillary services are also included in the per diem rate for NF/MI providers, e.g., laboratory, x-rays, medical surgical supplies (including incontinent supplies), hospital emergency room, clinics, optometrists, dentists, physicians, pharmacy. Therapy/speech pathology provided to these beneficiaries is included in the facility's per diem rate.

11.3 VENTILATOR-DEPENDENT CARE UNITS

Medicaid provides nursing and respiratory care to residents in a qualified special long-term care unit or nursing facility Ventilator-Dependent Unit. The targeted population is adults aged 18 and over who are ventilator-dependent and meet specific medical criteria. The beneficiary must be currently Medicaid-eligible. These placements must be prior authorized and are reviewed on an individual basis by MDCH, Long Term Care Services prior to placement in the nursing facility. (Refer to the Directory Appendix for contact information.)