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CHAPTER IV
COVERED SERVICES AND LIMITATIONS

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CHAPTER IV INTRODUCTION

COVERED SERVICES AND LIMITATIONS

The duration, scope, and quality of Nursing Facility care under the Virginia Medicaid Program must not be of any less or greater duration, scope, or quality than that provided to residents not receiving state or federal assistance.

Change-of-Resident Status

The individual admitted to a Nursing Facility as Medicaid eligible (or who subsequently becomes eligible) and certified by the physician of the Pre-Admission Screening Committee or attending physician for the Nursing Facility level of care, or is certified by the attending physician at the time of application, will be considered as meeting Nursing Facility criteria until the date the attending physician, the Utilization Review (UR) Committee, or DMAS indicates the resident requires a different level of care.

Medicaid does not recognize levels of care within a Nursing Facility. Level-of-care changes will only be acknowledged to indicate that a nursing home resident no longer meets Nursing Facility criteria or that the resident requires more intensive services than can be adequately and safely provided by the Nursing Facility. There are limits to the time frames for which Medicaid payment can continue when a change in level of care is ordered or recommended. See Chapter VI for a more complete discussion of this subject.

Recipient's Financial Responsibility

A Medicaid recipient's financial responsibility toward his/her cost of care is identified as the patient pay on the DMAS-122 form. The patient pay amount must be applied to the cost of institutional care. The balance of the charge for Nursing Facility care, after the patient pay amount is subtracted from the total charge, is the responsibility of the Virginia Medical Assistance Program up to the rate allowed under the payment system.

Medicaid long term care providers cannot collect more than the Medicaid rate from a Medicaid recipient. When Medicaid eligibility is determined, it is often made retroactive to a time prior to the date that the eligibility decision was made. Federal statutory and regulatory requirements mandate that the Nursing Facility accept Medicaid payment as payment in full when a person's Medicaid eligibility begins. Thus, nursing facilities are required to refund any excess payment received from a resident or family member for the period of time that the Medicaid eligibility was pending and the resident is determined to be eligible for Medicaid.

The Patient Information Form (DMAS-122) is the document used by local Department of Social Services (DSS) offices to identify a patient's Medicaid eligibility status and to notify the facility caring for a Medicaid recipient of the amount of the individual's financial responsibility toward his/her cost of care. This form must be on file for all Medicaid recipients. Refer to Chapter II for information on responsible party requirements.

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ACCOMMODATIONS – ALL FACILITIES

Semi-Private Room

The Virginia Medicaid Program will pay for semi-private or ward accommodations (two or more bed accommodations).

Private Room

Medically Necessary

Payment may be made for a private room or other accommodations more expensive than semi-private only when such accommodations are medically necessary. Private rooms will be considered necessary when the resident's condition requires him/her to be isolated for his/her own health or that of others. Physician certification justifying the private room must be on file prior to the resident's discharge from the semi-private room. The term "isolation" applies when treating a number of physical and mental conditions. These include communicable diseases which require isolation of the resident for certain periods. Private room accommodations may also be necessary for residents whose symptoms or treatments are likely to alarm or disturb others in the same room. Reimbursement for private rooms will only be made when authorized by the Virginia Department of Medical Assistance Services (DMAS). A written request for private room reimbursement must be submitted to:

Department of Medical Assistance Services
Program Administration Supervisor II
Facility and Home-Based Services Unit
Long Term Care & Quality Assurance Division
600 East Broad Street
Richmond, VA 23219

The written request must include, at a minimum, the following:

1. Medical justification (signed and dated by the physician) for a private room;
2. A list of the facility's rooms indicating which are private and which are semi-private;
and
3. The current charges for the semi-private and private rooms.

Not Medically Necessary

When accommodations more expensive than semi-private are furnished to the resident at the time of admission because less expensive accommodations are not available at the time of admission, DMAS pays only at the rate of semi-private accommodations. If the resident is admitted to a Nursing Facility, which has only private accommodations, DMAS pays only the equivalent of semi-private accommodations in a comparable facility unless private accommodations were medically necessary.

NOTE: If a resident or resident's family requests the use of a private room which is not medically necessary, the Nursing Facility and resident or resident's family may enter into a

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separate contract for the use of this room. This becomes a contract between the resident/family and the Nursing Facility; DMAS is not involved in any way in these situations. However, a resident/family cannot be required to secure a private room.

Appropriate Bed Placement

DMAS cannot pay for care provided to a Medicaid recipient when the resident is not placed in a distinct area of the facility certified to provide services for Medicaid recipients. A Medicaid recipient who meets Medicare criteria cannot be required to be placed in a Medicare-certified bed. A recipient for whom Medicaid pays the co-pay must also be in a Medicaid-certified bed in order for reimbursement to be received.

Nursing Facility or ICF/MR Placement for Hospice Recipients

DMAS will reimburse an enrolled hospice provider for 95 percent of the daily rate that DMAS would have paid to the Nursing Facility or intermediate care facility for the mentally retarded (ICF/MR) for room and board for Medicaid-eligible hospice recipients who reside in nursing facilities and ICF/MRs. The hospice provider will bill DMAS for the stay per the instructions in the *Hospice Provider Manual* issued by DMAS. A recipient cannot be enrolled in the specialized care and hospice programs at the same time. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected and revoked simultaneously under both programs.

When an individual elects the hospice benefit and is receiving Medicaid Nursing Facility Services, § 1905(o) of Title XIX of the Social Security Act [42 U.S.C. § 1396d(o)] indicates that Medicaid payment can no longer be made directly to the Nursing Facility or ICF/MR. The individual becomes a hospice patient and is no longer a Nursing Facility or ICF/MR resident.

Responsibilities of the Nursing Facility and ICF/MR for the Hospice Recipient

Once the individual or his/her responsible party elects the hospice benefit, the individual is considered a hospice patient. As such, the hospice is responsible for providing all services as they relate to the terminal illness. The Nursing Facility is responsible for the following:

- Room and board as defined in the *State Medicaid Manual* published by Center for Medicare & Medicaid Services (CMS):
 - Performance of Personal Care Services, including assistance with activities of daily living (ADLs) and socializing activities;
 - Administration of medications;
 - Maintaining the cleanliness of a resident's room; and
 - Supervising and assisting in the use of durable medical equipment (DME) and prescribed therapies;
- Routine care and documentation not related to terminal illness;
- Completion of Resident Assessment Instrument and care planning;
- Completion of the DMAS MI/MR Supplement Level 1; and
- Discharge tracking.

The nursing home is not required to submit a PIRS (Patient Intensity Rating System) form for hospice recipients.

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NOTE: For those individuals who are eligible for hospice benefits under Medicare and Medicaid, the hospice must bill Medicare. Unless specifically prohibited by statute, the Virginia Medicaid Program is the payer of last resort. In these instances, the routine or continuous home care charges would be billed to Medicare, and the hospice would file claims with Medicaid for the nursing home charges. For hospice recipients who are dually eligible under Medicare and Medicaid, the hospice must bill Medicare for the hospice services, even if the nursing home resident is not in a skilled bed, and must bill DMAS for room and board.

In addition, Medicaid does not make bed-hold day payments to any Nursing Facility such as when a recipient is in an acute care setting. Any arrangements to hold a bed for a hospice patient residing in a Nursing Facility would be made between the hospice and the Nursing Facility. The recipient or his/her family may elect to pay to reserve the bed while the recipient is hospitalized, but they cannot be required to do so. All residents and their families must be informed that they have the right to be admitted at the time of the next available vacancy following the recipient's discharge from the hospital.

The facility bills the hospice instead of DMAS, but the facility must deduct any patient pay amount from the bill it submits to the hospice. The Nursing Facility and ICF/MR must account for the patient pay for these individuals. The Nursing Facility or ICF/MR may bill the hospice, not DMAS, for 95 percent of the per diem rate that would normally be paid to the facility by DMAS. Hospice recipients residing in nursing homes or ICF/MRs have the same responsibility to apply their income to their cost of care as other Nursing Facility residents do. Local DSS offices will send the facility the DMAS-122 form as with any other resident.

Since dually eligible Medicare/Medicaid recipients who qualify for and are admitted to a Medicare skilled bed must dually elect their hospice benefit, Medicaid **cannot** become the primary payer for Medicare/Medicaid recipients who elect skilled nursing home placement. If a resident resides in a nursing home enrolled as a Medicaid specialized care provider, no payment for services will be made to the hospice provider by DMAS, as the Nursing Facility is required to provide all services necessary for the care of the specialized care resident.

When a skilled Nursing Facility (SNF) or Nursing Facility (NF) is the hospice patient's residence for the purposes of the hospice benefit, the facility must comply with the requirements for participation in Medicare or Medicaid. This means the hospice resident must be assessed using the RAI (Resident Assessment Instrument), have a Plan of Care (POC) and be provided with the services required under the POC. This can be achieved through cooperation between the hospice and long-term-care facility staff with the consent of the resident. In these situations, the hospice team should participate in completing the RAI (CMS MDS 2.0 User's Manual, Version 2.0, updated December 2004).

OTHER COMPENSABLE SERVICES – NURSING FACILITY

Other medical services that are necessary to the health of the residents are covered if the services are customarily provided by nursing facilities. This includes services provided by the facility, such as laboratory, X-ray, etc. Items or services that would not be included as inpatient hospital services are similarly excluded from nursing facility coverage. **For services requiring pre-authorization, all pre-authorization criteria must be met in order for the claim to be paid.**

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Physical and Occupational Therapy and Speech Language Services Furnished by the Nursing Facility or by Others under Arrangements Made by the Nursing Facility

DMAS reimburses for therapy services provided to nursing facility residents in two ways. Reimbursement for therapy services is limited to enrolled Rehabilitation Agencies. DMAS does not reimburse Home Health Agencies for therapy services provided to nursing facility residents. If a nursing facility does not have in-house therapy services and must contract with an outside agency, then the therapy services must be provided by an enrolled Rehabilitation Agency. Services provided by Home Health Agencies are not reimbursable by the Medicaid program for those individuals residing in a nursing facility at the time of service delivery.

If the nursing facility does not provide for in-house therapy services, then DMAS reimburses enrolled rehabilitation providers directly for Rehabilitative Services when such services are rendered to patients residing in nursing facilities. DMAS does not provide reimbursement for any sums that the rehabilitation provider collects, or is entitled to collect, from the Nursing Facility or any other available source, including Medicare.

If the facility has in-house therapy services such as Physical Therapy, Occupational Therapy, and Speech Language Pathology Services, these services are covered as allowable costs in the Nursing Facility. Such charges, as indicated on the invoice, will be accumulated, as are all other ancillary charges, for the purpose of establishing a per diem rate of payment and year-end cost settlement.

A provider must maintain sufficient data in its records to support the statements submitted with its cost report, and the data must be reflected in a manner to provide an adequate audit trail. These records, whether in the form of a daily log or similar day records, must be kept current, be available at all times for review by the intermediary, and contain sufficient information to allow evaluation of the reasonableness of the costs incurred for Therapy Services furnished under arrangements. The record-keeping requirement is applicable not only to Therapy Services, which are subject to the guidelines, but also to therapy services, which are evaluated under the prudent buyer concept. When a provider does not maintain records, which are sufficiently complete to determine the reasonable cost of the services in accordance with the provisions of this chapter, no payment can be made for these services in accordance with § 1815 and 1833(e) of the Social Security Act.

Nursing facilities are responsible for payment of outside resources.

Rehabilitation Therapists (Physical Therapists, Occupational Therapists, and Speech Language Pathologists) may not perform screenings of Medicaid residents in nursing facilities without a physician's order. Screenings are defined as an evaluation and treatment plans; the review of medical records; and participation in resident team care planning conferences. Pursuant to the Code of Federal Regulations, Rehabilitative Services provided to Medicaid recipients in nursing facilities must be ordered by a physician and must be written in the physician's POC. Nursing facilities are required to protect the rights of each resident, including the resident's rights to confidentiality of personal and clinical records. Therefore, nursing facilities should prohibit Rehabilitative Therapists from evaluating Medicaid residents or reviewing residents' records

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without the permission of the resident or his/her representative **and** an order from the attending physician.

Specialized Rehabilitative Services include, but are not limited to, Physical Therapy, Speech Language Pathology, Occupational Therapy, and Mental Health Rehabilitative Services for mental illness and mental retardation. If Specialized Rehabilitative Services are required in the resident's comprehensive POC, the facility must: 1) provide the required services or 2) obtain the required services from an outside source that is a provider of Specialized Rehabilitative Services. Specialized Rehabilitative Services must be provided by qualified personnel under a physician's written order.

Physical Therapy

A Physical Therapy program exists when the program is maintained either directly or through arrangements with qualified outside resources. To be covered as an allowable expense, Physical Therapy must be rendered according to the written orders of a physician. The level of services contemplated as constituting Physical Therapy requires the direction of a physician. The physician must determine the need for therapy, the capacity and tolerance of the resident, and the treatment objectives. Thus, for the Physical Therapy Services to be reimbursable, the physician, in consultation with a Physical Therapist, must prescribe the specific treatment to be given by the therapist and its frequency. Routine range-of-motion (ROM) exercises and other related services given to maintain function and prevent deterioration are considered part of routine nursing care administered by nursing staff and should not be included as Physical Therapy.

A qualified written POC developed in consultation with the attending physician and the appropriate therapist must be maintained, and the service must be provided in accordance with accepted professional practices by qualified therapists, assistants, or other supportive personnel under appropriate supervision and as outlined in the Medicaid *Rehabilitation Provider Manual* issued by DMAS (available online at www.dmas.virginia.gov). Such service is continued only under the attending physician's authorization and recorded in the resident's record. Authorization for service must be dated and signed by the physician ordering and providing the service.

Physical Therapy includes assistance to the physician in evaluating residents by applying diagnostic and prognostic muscle, nerve, joint, and functional ability tests and treating residents to relieve pain, develop or restore function, and maintain maximum performance using physical means, such as exercise, massage, heat, water, light, and electricity.

A qualified Physical Therapist is one who is licensed and registered by the state. Licensed Physical Therapists or Physical Therapy Assistants licensed by the Board of Medicine can provide Physical Therapy Services. The Physical Therapist's responsibilities are to evaluate a resident, plan the treatment program, and administer and document treatment within the limit of his/her professional knowledge, judgment, and skills. A licensed Physical Therapist Assistant is permitted to perform all Physical Therapy functions within his/her capabilities and training as directed by a Physical Therapist. The scope of such functions excludes the initial evaluation of the resident, initiation of new treatments, and alteration of the resident's POC.

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Speech Language Pathology Services

A Speech Language Pathology program exists when the program is maintained either directly or through arrangements with qualified outside resources. A qualified written POC developed in consultation with the attending physician and the appropriate therapist must be maintained, and the service must be provided in accordance with accepted professional practices by qualified therapists, assistants, or other supportive personnel under appropriate supervision and as outlined in the *Rehabilitation Provider Manual* issued by DMAS (available online at www.dmas.virginia.gov). Such service is continued only under the attending physician's authorization and recorded in the resident's record. Authorization for service must be dated and signed by the physician ordering and providing the service.

Speech Language Pathology Services include assistance to the physician with evaluating residents to determine the type of speech or language disorder and the rendering of appropriate corrective therapy. Reimbursement is limited to those services related to a medical diagnosis, such as stroke or post-laryngectomy. For example, Long-Term Speech Language Pathology Services, such as may be requested for a cerebral palsy child, are not covered. (Related services given to maintain function and prevent deterioration are considered part of routine nursing care administered by the nursing staff and should not be included as Speech Language Pathology Services.)

A Speech Language Pathologist is one who is certified by the American Speech and Hearing Association and licensed by the Board of Audiology and Speech Pathology, or who has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for certification.

Occupational Therapy

An Occupational Therapy program exists when the program is maintained either directly or through arrangements with qualified outside resources. A written POC developed in consultation with the attending physician and the appropriate therapist must be maintained, and the service must be provided in accordance with accepted professional practices by qualified therapists, assistants, or other supportive personnel under appropriate supervision and as outlined in the *Rehabilitation Provider Manual* issued by DMAS (available online at www.dmas.virginia.gov). Such service is continued only under the attending physician's authorization and recorded in the resident's record. Authorization for service must be dated and signed by the person ordering and providing the service.

Occupational Therapy includes assistance to the physician in evaluating the resident's level of function by applying diagnostic and prognostic tests; it also includes guiding the resident toward improving function. Related services given to maintain function and prevent deterioration are services considered as part of routine nursing care administered by the nursing staff and should not be included as Occupational Therapy.

An Occupational Therapist is registered and certified by the American Occupational Therapy Association and is a graduate of a program approved by the Council on Medical Education of the American Occupational Therapy Association or is in the process of accumulating supervised clinical experience required for registration. A certified Occupational Therapy Assistant

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(COTA) is certified by the National Board for Certification in Occupational Therapy and directly supervised by a registered and certified occupational therapist as described above.

Social Services to Meet the Resident's Social Needs

Social Services are designed to promote preservation of the residents' physical and mental health and to prevent the occurrence or progression of personal and social problems. There must be an evaluation of each resident's social needs and a plan for providing such care recorded in the resident's record. This must be updated quarterly and evaluated in conjunction with the resident's total POC.

A facility with more than 120 beds must employ a full-time qualified Social Worker as defined by 42 CFR 483.15. The Nursing Facility must have a qualified Social Worker or have a written agreement with a qualified Social Worker for consultation and assistance on a regularly scheduled basis sufficient to meet resident needs. A qualified Social Worker is an individual with a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling, and psychology. In addition, the individual must have one year of supervised experience in a health care setting working directly with individuals.

Facilities with fewer than 120 beds must assure that the facility provides medically related Social Services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. In the absence of such a qualified individual, there must be a designated staff member with suitable training and experience who is responsible for arranging for Social Services and for the utilization of Social Services with other elements of the POC.

Resident Activities Program

Each Nursing Facility must have a qualified Activities Director (as defined by 42 CFR §483.15) or have a written agreement for consultation with a qualified Activities Coordinator. Certification through the National Certification Council for Activity Professionals (NCCAP) is an acceptable qualification for Activities Directors. The frequency of consultation must be sufficient to meet the needs of the residents.

A Resident Activities program includes recreational activities for the residents' participation and is designed to encourage normal activity through physical exercise, intellectual and sensory stimulation, and social interaction. There must be a written outline for group and independent activities of sufficient variety to meet the needs of various types of residents under the direction and supervision of a staff member, qualified through experience and training, in directing group activity as required.

Independent and group activities must be planned for each resident as a matter of record and provided in accordance with his/her needs and interest. Activity plans must be written and included in the overall POC. The plan must be reviewed quarterly with the resident's participation and changed as needed. The Activities Director must be able to evaluate and determine the effectiveness of the programming for residents and make changes according to the interest and response of each resident.

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In-Service Education

In-Service Education includes a planned program conducted for the development and improvement of skills of all the facility's personnel. This includes training related to problems and needs of the population served by the facility. Records shall be maintained which indicate the content and participation in all staff development programs.

Covered expenses include those for persons providing such training and training materials, including the cost of outside courses designed to further educate employees in their specific areas of responsibility.

Supplies and Equipment

Supplies and equipment, which are medically necessary for the direct care and treatment of inpatients are covered Nursing Facility Services. These include, but are not limited to, wheelchairs, walkers, trapeze bars, egg-crate and other specialized mattresses, dressing catheter trays, suture sets, incontinence supplies, etc. Coverage of resident-specific, customized items must be made through the DMAS-122 adjustment process described later in this chapter.

Certain medical supplies required to facilitate discharge are covered as allowable costs. These supplies do not include items such as hospital beds and wheelchairs. Deductible and co-insurance amounts will be paid when Medicare covers these items. Pharmacy items are covered for nursing home residents. Items such as antiseptics (including hydrogen peroxide), Band-Aids, adhesive tape, and gauze are classified as supply items and are not covered under the pharmacy program.

Ventilators and Associated Supplies

Prior approval by DMAS will be required for all ventilators and associated supplies furnished to Nursing Facility residents who are not residing in a Nursing Facility that has a contract with DMAS to provide Specialized Care Services. DMAS will not negotiate a special rate with a Nursing Facility so that it may admit a ventilator-dependent individual if the Nursing Facility does not have a contract with DMAS to provide Specialized Care or Long-Stay Hospital Services.

For those residents who reside in a Nursing Facility that does not have a contract with DMAS to provide Specialized Care Services, DMAS will pre-authorize and make direct reimbursement to durable medical equipment (DME) vendors for the following items for Nursing Facility use:

- Ventilator rental;
- Portable back-up suction machine;
- Heated Cascade humidifier system;
- Ventilator circuits;
- Tracheotomy tubes;
- Tracheotomy care kits;
- Tracheotomy dressing;
- Suction machine;
- Suction catheter;
- Sterile water;
- Oxygen and oxygen equipment;
- Manual resuscitator; and
- I.V. pole or other suitable support for circuits.

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The reimbursement to the vendor includes the services, consultation of, and teaching by a Respiratory Therapist to the Nursing Facility.

Medicaid payment requests for ventilators for recipients expected to be placed in nursing facilities, which do not have a contract with DMAS for Specialized Care Services, should be sent to:

Department of Medical Assistance Services
Program Administration Supervisor II
Facility and Home-Based Services Unit
Long Term Care & Quality Assurance Division
600 East Broad Street
Richmond, VA 23219

The written request must include:

- The recipient's Medicaid number;
- The present location of the individual;
- The proposed nursing home placement;
- The current medical status;
- A written statement from the attending physician justifying need and including the type of equipment required; and
- An itemized list of equipment required; the rental cost of machine-associated supplies and services; and the name, address, and phone number of the respiratory equipment supplier.

Therapeutic Beds

Prior approval by DMAS will be required for all therapeutic beds (Low Air Loss or Air Fluidized) furnished to nursing home residents who have a documented Stage IV pressure ulcer (*RAI MDS Classification – Stage IV: A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone*). Residents enrolled in Specialized Care Services are not eligible for the \$10-a-day reimbursement for the therapeutic bed. The facility is required to submit via fax the DMAS-258 form (Specialized Treatment Bed Pre-Authorization Form) to 1-804-371-4986. Please see the billing instructions in Chapter V for the specific revenue code, which has been designed for this program.

The \$10-a-day reimbursement for the therapeutic bed will begin from the date of the physician order plus one day for up to 82 consecutive days. For example, an order received on January 1, 2005, would be authorized through March 24, 2005. (NOTE: Dates will be adjusted to include leap year.)

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A request for the bed may be made up to three times annually for a total of 246 non-continuous days. The annual period begins with the first day of use of the bed. A recipient may qualify for use of the bed if the following situations are met:

- The recipient has been off the therapeutic bed for 30 days; and
- The recipient has developed a new Stage IV ulcer. Facilities must report all Stage IV ulcers a patient has the first time a request for a therapeutic bed is made.

The pre-authorization will be based on the following documentation. The faxed request must include:

- Facility name;
- Facility provider number;
- Date of request (This is the date the form is filled out.);
- Facility contact name;
- Facility contact number;
- Facility fax number;
- Type of request:
 - Initial (82 days) - Check “Initial” if this is the first request for this resident.
 - Previously Approved/New Ulcer - Check “Previously Approved/ New Ulcer” if the resident has been authorized for a bed previously. The patient must have a new Stage IV Ulcer on a different area of the body and there must have been at least 30 days between the requests.
 - Surgical Flaps Are Approved For 41 Days - The recipient has received a surgical flap for their Stage IV pressure ulcer and needs to be placed on a therapeutic bed. This is for new post-surgical requests, not for recipients who were on a bed and then received a flap;
- Recipient’s name;
- The recipient’s Medicaid number;
- Location of Stage IV ulcer or surgical flap - May attached extra sheet if needed for information on wounds;
- Date of onset of the Stage IV ulcer or surgical flap;
- Width, depth, and length of the Stage IV ulcer or surgical flap;
- Description of the ulcer or surgical flap;
- Date of physician order for the therapeutic bed. The order does not need to be submitted but must be available during an on-site utilization review (UR); and
- Check Type of Bed - Low Air Loss or Air Fluidized. These must be beds, not overlays.

Facilities will receive, by fax and through Virginia Medical Management Information Systems (VAMMIS), notification of approval or denial.

Facilities will receive their forms back along with a correction notification by fax if DMAS is:

- Unable to identify the recipient name;
- Unable to identify the recipient Medicaid number;
- Unable to identify the provider name;

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- Duplicate Request/Admission **approved** under PA# _____
(No need to resubmit); or
- Duplicate Request/Admission **denied** under PA# _____
(No need to resubmit).

You are required to resubmit your form if you receive a correction notification, with the exception of the “Duplicate Request/Admission Approved” or “Duplicate Request/Admission Denied” reasons.

If you receive a denial, you may request reconsideration within 30 days of receiving notification by writing and sending supporting documentation to:

Department of Medical Assistance Services
Program Administration Supervisor II
Facility and Home-Based Services Unit
Long Term Care & Quality Assurance Division
600 East Broad Street
Richmond, VA 23219

DMAS-122 ADJUSTMENTS

Definition of a DMAS-122 Adjustment

Federal regulations require that the Virginia Medicaid Program’s payment to nursing facilities, intermediate care facilities for the mentally ill, and long-stay acute care hospitals be reduced by the amount of the patient’s income, less certain deductions (the patient pay amount). One required deduction is an amount “for medical or remedial care not subject to payment by a third party,” including necessary medical or remedial care not covered under the *Virginia State Plan for Medical Assistance*. Medicaid uses the patient pay amount to determine the amount of the facility’s monthly billing that the patient will pay. Patient pay plus Medicaid contribution equals the amount due to the facility for the patient’s care for that month.

Usually, the patient pay is the recipient’s income, minus \$30.00, which is set aside in the resident fund for such things as personal items. (Chapter VII describes items that may and may not be charged to the resident fund.) Any excess above that is paid to the facility as the patient’s share of the cost of care. Medicaid pays the balance between the amount of the patient pay and the amount of the per diem allowance for a patient in that Nursing Facility. Patient pay can be Social Security or other retirement income, an annuity, etc.

The amount of the patient pay is determined by the local DSS office as calculated on the DMAS-122 form (Patient Information Form). The DMAS-122 form is initially completed when the recipient is found to be eligible for Long-Term-Care Services. If a resident requires medical services not covered by Medicaid (e.g., dental, eye, or hearing services or transportation costs incurred to receive medical or remedial services not covered by Medicaid), the responsible local DSS office may be requested to prepare a DMAS-122 form (for a specified period of time) that allows for funds normally available for Nursing Facility care to be available to pay for the non-covered medical services. Such medical services must not be covered by Medicaid or be subject to third-party payment.

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When payment for a non-covered service is requested, the patient (his/her representative, Power of Attorney, or the facility) contacts the local DSS office and requests a DMAS-122 adjustment. Neither DMAS nor DSS can authorize a DMAS-122 adjustment if the recipient does not have a patient pay amount.

LIMITATIONS

A DMAS-122 adjustment request must always be used as the last source of payment. If the recipient has other sources of possible payment (e.g., Medicare, major medical insurance, prescription insurance, dental insurance, etc.), payment must be requested from those other sources first. When the facility submits a request for a DMAS-122 adjustment, a statement must be included that it has been determined that the service is not covered under any other third-party insurance or that third-party coverage is exhausted or paid to its maximum amount.

Only the cost of medically necessary, resident-specific, customized, or non-covered items or services may be deducted from patient pay. This includes electric, motorized, or customized wheelchairs and other equipment not regularly supplied to residents as part of the cost of care. Supplies, equipment, or services used in the direct care and treatment of residents are covered services and must be provided by the nursing home. These include, but are not limited to, standard wheelchairs, recliners, geriatric chairs, special mattresses, humidifiers, cots, incontinent supplies, and routine podiatry care. The facility is responsible for providing these items and services to recipients; their cost cannot be deducted from patient pay. (Note: Extenuating circumstances will be considered for the provision of podiatry care when the patient has a documented systemic condition that would require the services of a podiatrist. In this case, the facility is not responsible for providing podiatry care.)

In addition, DMAS-122 adjustments may be allowed for medically or remedially necessary services that were incurred prior to Medicaid eligibility and prior to admission. One example of an expense, for which the patient pay amount may be adjusted, is for expense incurred for hospitalization over 21 days in duration.

The facility is responsible for monitoring proper care of the resident's medical supplies and equipment. Requests for adjustment made because an item is lost or broken by facility staff must include documentation on the resident's interdisciplinary POC regarding proper care and treatment of the item. When loss or breakage is incurred as a result of facility staff following improper practices, the facility must assume responsibility for replacement of the item. If repeated adjustments are requested for the same repairs or the repair is costly, the facility may be requested to submit its POC. In such cases, DMAS will review the request and determine whether authorization should be made.

Services Not Allowed

Types of services that CANNOT be deducted from patient pay include:

- Medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as: diabetic and blood or urine testing strips, bandages, and

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wound dressing; standard wheelchairs; air or egg-crate mattresses; I.V. treatments; splints; and certain prescription drugs;

- Ted stockings;
- Acupuncture Treatment;
- Massage Therapy;
- Personal care items, such as special soaps and shampoos;
- Physical Therapy;
- Speech Therapy;
- Occupational Therapy; and
- Transportation costs to covered Medicaid services.

DMAS-122 ADJUSTMENTS FOR ITEMS OR SERVICES AUTHORIZED BY DSS

A facility must submit a request for a DMAS-122 adjustment directly to the patient's local DSS office. Faxes are not accepted. If the facility submits an adjustment request directly to DMAS, the request will be returned to the facility for submission to DSS. Items and services for which DSS may authorize a DMAS-122 adjustment without securing DMAS pre-authorization cost less than \$500 and include the following:

- Routine dental care, necessary dentures, and denture repair for recipients 21 years of age and older (should the dental treatment plan indicate services that will require a total cost of \$500 or more, DMAS must pre-authorize);
- Routine eye exams, eyeglasses, and eyeglass repair;
- Hearing aids (when medically necessary), hearing aid batteries, and hearing aid repair;
- Batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- Chiropractor Services, except for Medicare recipients (Medicare covers Chiropractor Services, and Medicaid covers the Medicare deductible and co-insurance amounts);
- Dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician; and
- Transportation costs incurred to receive medical/remedial services not covered by Medicaid. All non-emergency transportation must be pre-authorized by the appropriate Medicaid transportation broker.

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The request submitted by the facility to the local DSS office for the above items or services must include:

- The recipient's correct Medicaid identification number;
- The current physician's orders or standing order for the non-covered service;
- Medical justification for the service being requested;
- The service description;
- Actual cost information;
- Documentation that the recipient continues to need the equipment for which a repair, replacement, or battery is requested; and
- A statement of denial or non-coverage by other insurance. It is the facility's responsibility to obtain verification that the requested service or item is not-covered by any other source. Either an official denial from a third party carrier or a written statement by the facility staff that the insurance company was contacted, and the item or service is, in fact, non-covered is acceptable. In either case, the statement must include identification of the third party payer(s), the policy number, the name of the insured, the date that the third party payer was contacted, and the full name of the third-party-payer contact person.

If the request submitted by the facility does not include all of the required information, the package will be returned to the facility, and authorization will not be made until all required information has been provided to DSS.

DMAS-122 ADJUSTMENTS FOR ITEMS REQUIRING AUTHORIZATION BY DMAS

Effective as of August 1, 2003, MAP-122 adjustments for all wheelchairs and medical or remedial care greater than \$500.00 are limited to no more than the prevailing Medicaid or Medicare rate. This change was mandated in the 2003 Virginia Appropriations Act (Item 325 BBB). Patient pay adjustments not requiring DMAS approval will continue to be reimbursed at 100% of the provider's charges regardless of their enrollment with Medicaid.

Because many of the services received by Nursing Facility residents are from providers not enrolled with Virginia Medicaid, the facility residents could be balance-billed the difference between what DMAS reimburses and the provider's charges. In the case of Medicaid participating providers, they will be required to accept Medicaid's reimbursement as payment in full and cannot bill the patient. We are requesting that the facilities inform residents of this requirement when medical or remedial services are medically necessary and, whenever possible, a Medicaid-enrolled provider should be utilized. Once again, this change in reimbursement only applies for services that require approval from DMAS.

Requests for adjustments to patient pay for services or expenses, which exceed \$500, must be submitted by the local DSS worker. The DSS worker sends the request and documentation from

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the facility, along with the patient income and patient pay information, to DMAS for authorization. Faxes are not accepted. The request submitted to DMAS must include:

- The current or most recent patient pay information (MAP-122);
- The recipient's correct Medicaid identification number;
- The current physician's orders (may be a standing order) for a non-covered service (the orders must be signed);
- The written medical justification for the service being requested (see below for specific requirements);
- The service description;
- The provider's usual and customary charges;
- The Minimum Data Sheet (MDS) (for hearing aid, wheelchair, and communication device requests only);
- A statement of denial or non-coverage by other insurance. It is the facility's responsibility to obtain verification that the requested service or item is not-covered by any other source. Either an official denial from a third party carrier or a written statement by the facility staff that the insurance company was contacted, and the item or service is in fact non-covered, is acceptable. In either case, the statement must include identification of the third party payer(s), the policy number, the name of the insured, the date that the third party payer was contacted, and the full name of the third-party-payer contact person.

NOTE: The maximum amount of reimbursement for non-covered medical or remedial goods and services for Nursing Facility residents shall not exceed the higher of the Medicaid or Medicare rate for such goods or services.

Medical documentation provides a visual image of the resident's needs. Documentation for medical justification must include the following:

- The physician's prescription;
- The diagnosis and medical findings that relate to the reason for the request;
- Identification of the resident's functional limitation;
- Identification of the quantity needed, frequency of use, estimated length of use; and
- Identification of how the service will be used in the resident's environment.

For wheelchair and other assistive mobility item requests, medical documentation must describe mobility impairments, postural impairments, cognitive ability, and how the needs were

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previously met. Requested wheelchair components must be matched to the resident's functional limitations. In addition, wheelchair requests must include a recent evaluation (within the last three months) of the chair by a Physical Therapist or Occupational Therapist.

For communication device requests, medical documentation must also describe the speech limitation; the diagnosis related to the speech limitation and prognosis for improvement; speech therapy interventions; how the communication needs are currently being met; the resident's ability and motivation to use the equipment; and why the particular device was selected. In addition, requests for communication devices must include an evaluation by a Speech Language Pathologist, as well as how training on the use of the device will be provided.

For hearing aids, medical documentation must include a written audiological evaluation and interpretation (i.e., findings and recommendations).

For eyeglasses, medical documentation must include an ophthalmologic or optometric written evaluation. In addition, if the resident has cataracts or has had cataract surgery, this must be identified.

For drugs and biologicals, medical documentation must identify the correct National Drug Code (NDC) and the condition for which the product is being used.

EMERGENCY SERVICES

DMAS will provide telephonic pre-authorization for medical services that are of an emergency nature (e.g., a dental abscess or a fractured tooth). This pre-authorization will be based on the information provided to DMAS from the patient representative or provider. If the Program Operations Division (call the Payment Processing Unit at 804-786-3357) gives telephonic pre-authorization, DMAS will send a written response to the requestor pre-authorizing the patient pay adjustment for the emergency medical condition. The telephonic pre-authorization does not bypass the normal procedures for the DMAS-122 adjustment request, nor does it supersede the requirements of the local DSS office or DMAS. A copy of DMAS' written response must be attached to the DMAS-122 adjustment package that is required to be sent to the local DSS office so that final authorization can be made by DMAS.

APPEALS

Copies of approval and denial letters will be sent to the recipient, the facility, the local DSS eligibility worker, and Financial Operations at DMAS. Denial letters will include a statement of appeal rights. In pended cases, a letter will be sent to the facility and a copy to the recipient requesting additional information needed to review the request. When procedures are not followed or the request is incomplete, the request will be rejected and sent back to the local DSS office.

A recipient has the right to appeal whenever Medicaid-covered services are proposed to be terminated, reduced, or suspended. The authorizing agent (DMAS or DSS) will notify the recipient or his/her representative, in writing, of the right to a hearing and the procedure for requesting a hearing at the time of application and at the time of any action by either agency.

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NON-COMPENSABLE SERVICES

“Sitters” in Nursing Facilities

“Sitter” or Companion Service provided to Medicaid residents in nursing facilities is not a Medicaid-covered service. Another person or organization may purchase this service on behalf of the resident. This is allowable and not countable as income available to the resident if:

- The service provided by the “sitter” is not part of the facility’s usual service;
- The “sitter” is not employed to provide a service that should be part of the nursing care rendered by the facility;
- Payment is made directly to the provider of the service and not to the Medicaid resident or to the Nursing Facility; and
- The Nursing Facility maintains on file a statement as to the “sitter” payment being made, its amount, who is making it, and for what service or services.

Otherwise, any money received by the resident or paid to the Nursing Facility on the resident’s behalf must be considered as income and could require an adjustment in the patient pay as recorded on the Patient Information Form (DMAS-122).

Private Duty Nurses

It should be noted that the services of a Private Duty Nurse or Private Duty Attendant are neither covered nor allowed. Private Duty Nurses, Private Duty Attendants, Registered Professional Nurses, Licensed Practical Nurses (LPNs), or other trained attendants, whose services are restricted to a particular resident by arrangement between the resident or relative and the Private Duty Nurse or Attendant, are not covered or allowed. The Nursing Facility is required, and the payment structure is computed, to cover the nursing care needs of the recipient.

PHARMACY COSTS

Nursing Facilities Without Licensed In-House Pharmacies

These facilities may not include the cost of drugs as an expense item in the Medicaid cost report.

Medicaid payment will be made to the pharmacy dispensing the drugs. Therefore, pharmacy charges for legend and non-legend drugs are not to be included on the Nursing Facility’s billing invoices.

Nursing Facilities With Licensed In-House Pharmacies

Nursing facilities that operate in-house pharmacies must enroll the pharmacy with DMAS as a pharmacy provider and must submit all billings for drugs on the pharmacy invoice.

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Medical Supplies Purchased From a Pharmacy

These supplies may be shown on the Nursing Facility billing invoice as an ancillary charge. Pharmacies cannot bill DMAS for medical supplies.

RESERVATION OF BEDS

Therapeutic Leave

A Nursing Facility bed may be held for therapeutic leave when the resident's POC provides for such leave and is so noted on the resident's chart. Therapeutic leave includes visits with relatives and friends, or admission to a rehabilitation center for up to seven days for an evaluation. It does not include admission to an inpatient hospital. Such leave is limited to 18 days in any 12-month period (with no restriction as to the duration or time of leave, except in the case of admission to a rehabilitation center for an evaluation, which is restricted to no more than seven days per evaluation). Therapeutic leave is resident-specific and is counted from the first occurrence of overnight leave that a resident takes. From that date, a resident has 18 days of leave available for the next 365 days. Therapeutic leave days also apply to ICF/MRs.

When a Nursing Facility resident is admitted to a rehabilitation center for an evaluation and uses up to seven days of therapeutic leave for this purpose, the Nursing Facility must notify the DMAS Long-Term Care Section by telephone of the date of admission to the rehabilitation center and the date of re-admission to the Nursing Facility. Only by providing this information to DMAS can uninterrupted payment for these days be assured to the Nursing Facility.

If a resident in a Nursing Facility is in a Specialized Care category and that resident needs to be transferred to a rehabilitation hospital for up to a seven-day evaluation, the resident must be discharged from Specialized Care and admitted to regular Nursing Facility Services. DMAS cannot pay the Specialized Care rate unless the resident is physically occupying the Specialized Care bed.

Bed Reservation ("Bed Hold") - Hospitalized Residents

DMAS will not make bed-hold day payments to any Nursing Facility. All residents and their families must be informed that they have the right to be re-admitted at the time of the next available vacancy following the resident's discharge from the hospital. This information must be read and signed by the resident or his/her relative. Families may elect to pay to reserve the bed while the recipient is hospitalized, but the facility cannot require that the bed be held. This applies to residents that are actually admitted to the hospital by a physician.

According to 42 CFR § 483.12(b)(3), a nursing facility must establish and follow a written policy under which a resident, whose hospitalization or therapeutic leave exceeds the bed-hold

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period under the State Plan for Medical Assistance, is readmitted to the nursing facility immediately upon the first availability of a bed in a semi-private room if the resident: 1) requires the services provided by the nursing facility, and 2) is eligible for Medicaid nursing facility services.

A nursing facility may **not** refuse to readmit a resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the State Plan for the following reason:

- The resident (at the time of re-admission) has an outstanding payment to the nursing facility for which he/she is responsible in accordance with Medicaid regulations and the facility has not complied with the required 30-day discharge notification requirements. Discharge notification requirements include given residents appropriate appeal rights as described in the Nursing Facility Manual.

The facility is required to conform with the following in order to document its compliance with this requirement:

- Post in a conspicuous place accessible to residents and families, a notice that residents must be given an opportunity to be re-admitted to the facility at the time of the next available vacancy;
- Include in the resident's record a statement signed by the resident or his/her representative that he/she has been fully informed of his/her right to be re-admitted and the reasons for failure to afford him/her this right as set forth in this section; and
- Document for each resident discharged the disposition of each resident and the follow-up to ensure re-admission as required. This documentation must be on file at the Nursing Facility and be made available to DMAS staff on demand. At a minimum, the documentation must include the following:
 - The date of admission to a hospital;
 - The date of discharge from a hospital;
 - The discharge destination;
 - If the discharge destination is different from the pre-admission location, and the reason the resident was not re-admitted when discharged from the hospital;
 - If the resident was placed in another Nursing Facility or alternate setting following discharge from the hospital, indicate: (1) the dates of follow-up contact to ensure that the resident is offered the next available vacancy, and (2) the date the resident was re-admitted. The offer of the next available vacancy must be made in writing and signed by the resident or his/her representative; and
 - If the resident is not re-admitted at the time of the next vacancy, fully document the reason. If the resident is not re-admitted for a reason other than resident refusal, the facility must notify the resident or his/her representative in writing.

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(An example of a form which can be used to document compliance with this regulation is included in the “Exhibits” section at the end of this chapter.)

When a resident, who has been discharged from the Nursing Facility, or a relative is contacted by the facility to be offered a vacancy, the offer made by telephone must be followed up with a letter documenting the acceptance or rejection of the offered vacancy. The facility may proceed to fill the vacancy if the resident or his/her relative has verbally refused the vacancy without waiting for the written response from the resident or relative. The purpose of the written follow-up is the facility’s protection against accusation that it has not clearly informed the resident or his/her relative of the availability of a vacancy.

Any Nursing Facility that routinely holds beds for a minimum of 12 days for residents who are discharged to hospitals may be excused from the documentation requirements for hospitalized recipients. It must, however, submit a letter to DMAS indicating that the facility will reserve the recipient’s bed **whether or not** anyone pays for the bed. After the facility letter has been received, a specific waiver of the tracking responsibility will be issued.

AUTHORIZATION OF SERVICES

The receipt of an authorization from DMAS for services that require authorization does not guarantee reimbursement. DMAS reimbursement is contingent upon the continued Medicaid eligibility of the recipient and is subject to all DMAS Utilization Review (UR) activities.

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NOTICE

MEDICAID-ELIGIBLE RESIDENTS,
WHO LEAVE THIS NURSING FACILITY
TO ENTER A HOSPITAL
AND ARE ADMITTED TO ACUTE CARE,
MUST BE GIVEN AN OPPORTUNITY
TO BE RE-ADMITTED
TO THIS NURSING FACILITY
AT THE TIME OF THE NEXT
AVAILABLE VACANCY
WITH THE FOLLOWING EXCEPTIONS:

1. The resident does not meet Nursing Facility criteria or has medical needs that cannot be provided by the Nursing Facility;
2. A physician judges the resident to be a danger to himself/herself or to others; or
3. The resident, at the time of re-admission, owes the Nursing Facility an outstanding payment for which he/she is responsible under Medicaid regulations.

SAMPLE COMPLIANCE FORM

I. Resident Name _____

Identification Number _____

II. Level of care PRIOR to hospital admission: _____

A. Date admitted to hospital: _____

B. Date discharged from hospital: _____

III. Hospital Discharge Plan

A. Self/Home Care _____

B. Home for Adults _____

C. Geriatric Treatment Facility _____

D. Death _____

E. Return to same NF _____

F. Other NF _____

Same bed _____
Different bed _____
Reason: _____

Reason: _____

IV. If resident is placed in another nursing facility following discharge from the hospital, please indicate the dates of follow-up calls and the status of the client below:

A. Date of follow-up call: _____

Resident status: _____
(e.g. in residence, in hospital, in another NF, etc.)

B. Date of follow-up call: _____

Resident status: _____
(e.g. in residence, in hospital, in another NF, etc.)

C. Date of follow-up call: _____

Resident status: _____
(e.g. in residence, in hospital, in another NF, etc.)

V. Date of Readmission: _____

If not readmitted, state reason: _____

Attach documentation that resident was offered and refused admission. Use reverse side if more space is needed.