



Long Term Care Provider Specific Policy

Revision Table

Revision Date	Sections Revised	Description
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
10/1/02	8.0 – 8.1.1.5	Per Transportation Policy.
11/18/02	3.4	Changing “nursing home” to “nursing facility” to make language consistent throughout the section.
10/8/03	7.0	Language is being added to Section 7.0 that will clarify how ancillary services for nursing facility residents are to be billed. This is not a new policy. It is clarification of current policy.
10/31/03	12.0	Correcting revenue center codes used by nursing facilities when billing for respiratory and therapy services. Updating the revenue codes from a 3-digit number to a 4-digit number. The order in which they appear in the table is changed so the codes are in numeric order.
12/10/03	4.5.1 and 4.5.2	“Bed-hold” days are being reduced from 14 to 7 days per hospitalization in any 30-day period. Examples in 4.5.2 are removed.
1/1/04	9.0	A Reimbursement section is being added to the manual. The information regarding the reimbursement methodology is not a new policy. It is clarification of current policy. The current Section 9.0 - 12.0 will be changed to 10.0 - 13.0
6/28/04	4.6.3	Correcting address and phone numbers for the LTC Administrator.
8/23/04	12.0 and 13.0	Providers no longer use local codes. Therefore, local codes in Appendix C are removed from the manual. Reference to 7/1/02 is removed from title in Appendix D.
8/30/04	4.5.1 and 9.1.3	Language is being added regarding the storage of medications for hospitalized residents and making the facility responsible for costs associated with replacing medications that are destroyed or misplaced. Also added is DMAP's requirement for the LTC facility to return any discontinued medications to the dispensing pharmacy that may be potentially dispensed to another client.
9/29/04	7.1.2.1.1- 7.1.2.1.4	LTC facilities use revenue code 0419 to bill the DMAP for oxygen. The oxygen policy is updated to instruct LTC facilities to bill one unit of oxygen per day.
09/18/08	Overview	Removed obsolete wording.
12/5/08	12.0	Added Nursing Home Responsibility description

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LONG TERM CARE INSTITUTIONAL PROVIDER SPECIFIC POLICY MANUAL

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Long Term Care Institutional Provider Specific Policy

Health care services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). This manual reflects the policies as they relate to Medicaid clients who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

1.0 Program Overview

The Delaware Medical Assistance Program (DMAP) provides long term care (LTC) services to those persons eligible under criteria defined in the State Plan of Medical Assistance. The State Plan is required by the Social Security Act (the Act) and by the Code of Federal Regulations (CFR). The Facility agrees to meet the standards for LTC services as described in the CFR.

1.1 Contractual Duties and Responsibilities

- 1.1.1 In accordance with the CFR, the Facility agrees to comply within 35 days of the dates of all requests from the DMAP or from the US Department of Health and Human Services for:
 - 1.1.1.1 Full and complete information concerning the ownership of any and all subcontractors with whom the Facility has had business transactions totaling more than \$25,000 during the twelve-month period ending on the date of request.
 - 1.1.1.2 Any and all significant business transactions between the Facility and any wholly owned supplier or between the Facility and any subcontractor during the five-year period ending on the date of the request (definitions of terms: “significant business transactions”, “subcontractor”, “supplier”, and “wholly-owned supplier” are in the CFR).
- 1.1.2 The Facility agrees to give thirty days written notice to the DMAP, to the Medicaid client, and to the Medicaid participant’s family when planning discharge of a Medicaid participant for other than medical reasons.
- 1.1.3 The Facility agrees to abide by all programmatic and contractual responsibilities and obligations as they appear in the Contract between the Facility and the DMAP, the General Policy and this Provider Specific Policy Manual.
- 1.1.4 The Facility must bill any third party payer that may be liable for services provided. This billing must be done prior to billing the DMAP. The facility must accept the DMAP payment as “payment in full” for services provided.
- 1.1.5 The DMAP agrees to give thirty days written notice to the Facility, to the Medicaid participant, and the participant’s family when terminating DMAP payments for a Medicaid participant remaining in the Facility. The DMAP may give less than thirty days written notice to the facility if:

- 1.1.5.1 Centers for Medicare and Medicaid Services (CMS) or the State determines that there is immediate jeopardy to resident health or safety.
- 1.1.5.2 CMS or the State determines that there are deficiencies that are non-immediate that constitute threat to residents health and safety.
- 1.1.5.3 CMS or the State determines that there are deficiencies that constitute an immediate and serious threat to resident health and safety.
- 1.1.6 The facility refuses CMS or State mandated temporary management, State monitoring, directed Plan of Correction or directed in-service training.
- 1.1.7 The DMAP agrees to reserve the right to monitor the activities of the Facility to assure that there has been compliance with the DMAP policies and procedures.
- 1.1.8 The DMAP agrees to reimburse the Facility the daily rate indicated by the Patient Index Verification Review minus any payment or contributions by the patient or on behalf of the patient unless the facility rates are renegotiated prior to the expiration of the Contract between the Facility and the DMAP.

1.2 Penalties/Suspension/Deficiencies

- 1.2.1 In accordance with the CFR, the Facility is subject to the provisions of the Act that provides federal penalties for fraudulent acts and false reporting. Copies of the pertinent sections of the Act regarding this matter are available upon request.
- 1.2.2 No facility that has been suspended or excluded may receive or retain any reimbursement from the DMAP either directly or indirectly for any service through any group practice, clinic, medical center or other facility or individual provider.
- 1.2.3 The Contract between the Facility and the DMAP will automatically cancel if identified deficiencies determined by the Certification Agency have not been satisfactorily corrected within the time phased period of the Facility's plan of correction or that the Facility has not made substantial effort and progress within such period in correcting the deficiencies and has not re-submitted in writing a revised plan of correction which has been approved by the Certification Agency.

2.0 Long Term Care Units and Programs

2.1 Long Term Care Sites

2.1.1 To better serve the needs of the frail, elderly and disabled Delawareans, Delaware Health and Social Services (DHSS) consolidated all Division of Social Services (DSS) long-term care programs into Long Term Care sites (refer to the Index in the back of the General Policy for the addresses and telephone numbers to specific sites). These sites co-locate the three DSS long-term care units and create "one stop shopping" for our applicants. The units are Pre-Admission Screening, Financial Eligibility and Institutional Services. A description of the services provided by these units is as follows:

2.1.1.1 Pre-Admission Screening: Registered Nurses and Social Workers perform medical, psycho-social and initial financial eligibility review of all applicants seeking admission to State Institutions, Medicaid vendor payment coverage in private nursing facilities and State institutions, and all applicants applying for the Medicaid Home and Community-Based Waiver programs. Additionally, staff assesses the level of nursing care needed, develops temporary care plans, and, as appropriate, initiates the DMAP application process.

2.1.1.2 Financial Eligibility: Senior Social Workers/Case Managers perform federal financial eligibility determinations and redeterminations for coverage under the DMAP long-term care programs.

2.1.1.3 Institutional Services: Registered Nurses and Social Workers assess, on site in nursing facilities, the level of care, appropriateness and quality of care, adherence to State and Federal regulations and the level of reimbursement for every patient for whom the DMAP vendor payments are made. Each resident is visited four times per year.

2.2 Pre-Admission Screening and Financial Eligibility

2.2.1 The Pre-Admission Screening and Financial Eligibility units determine medical and financial eligibility for the following long-term care institutional programs:

2.2.1.1 Nursing Facility Program

2.2.1.1.1 This program pays for the cost of care provided in nursing facilities in Delaware that have contracts with the DMAP. These nursing facilities provide room, board, and nursing services to persons who are elderly, infirm, or disabled. An individual applying for the Nursing Facility program must require a skilled or intermediate level of care as defined by DMAP criteria. Referrals for this program must be made to the appropriate Pre-Admission Screening unit. Refer to the Index in the back of General Policy for the address and telephone number

of the Pre-Admission Screening units located in New Castle County and Kent and Sussex Counties.

- 2.2.1.1.2 Eligibility for the DMAP nursing facility program is based on both financial and medical need. Both criteria must be met in order for DMAP long-term care payments to be made on a patient's behalf.
- 2.2.1.1.3 Medical Eligibility: The Pre-Admission Screening team completes a level of care screening to determine if the applicant requires the level of care provided by the program. An individual must be in need of skilled or intermediate level of care as determined by the Medicaid Pre-Admission Screening unit in order to have DMAP nursing facility vendor payments made on his/her behalf. If the individual is found to be in need of skilled or intermediate nursing care services as defined by the DMAP, he/she is eligible medically to have DMAP payments made on his/her behalf to a long-term care provider who is enrolled with the DMAP. The provider must be certified to provide the type of care the applicant requires and hold a contract with the DMAP to provide long-term care services.
- 2.2.1.1.4 The definitions of skilled and intermediate levels of care are as follows:
 - 2.2.1.1.4.1 Skilled Care (SNF) - Skilled nursing care services are those services that must be furnished by or under the direct supervision of licensed registered nursing personnel and the general direction of a physician. A licensed registered nurse must be on-site 24 hours a day, 7 days per week.
 - 2.2.1.1.4.2 Intermediate Care (ICF) - Intermediate nursing care services are those health services that should be supervised by (but not necessarily given by) a licensed nurse.
- 2.2.1.1.5 A Level I PASARR screen (see Appendix A) is completed to identify possible mental illness or mental retardation/developmental disability and finally a reimbursement level is established which reflects the amount of nursing care required.
- 2.2.1.1.6 If the applicant is medically eligible for nursing facility care, the referral is sent to the financial unit that then assesses the applicant's financial eligibility.
- 2.2.1.2 Intermediate Care Facility for the Mentally Retarded (ICF/MR)
 - 2.2.1.2.1 The DMAP pays for the cost of care provided in facilities that are enrolled as providers with the DMAP and are certified and licensed to provide care for the mentally retarded or persons with related conditions. Qualified individuals must require an intermediate level of care and a continuous active treatment program of specialized and generic training, treatment, health services and related services that is directed toward:
 - 2.2.1.2.1.1 The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and

- 2.2.1.2.1.2 The prevention or deceleration of regression or loss of current optimal functional status.
- 2.2.1.2.1.3 Referrals should be made to the appropriate Long Term Care Medicaid financial eligibility unit. Refer to the Index in the back of General Policy for the address and telephone number of the Robscott Building in Newark and the Milford State Service Center in Milford.
- 2.2.1.3 Intermediate Care Facility in an Institution for Mental Diseases (ICF/IMD)
 - 2.2.1.3.1 DMAP vendor payments may be made for qualified individuals, age 65 or older, receiving services in an ICF/IMD.
 - 2.2.1.3.2 The individual must be found to require an intermediate level of care and inpatient psychiatric services. Referrals for this program should be made to the appropriate Long Term Care Medicaid financial eligibility unit.
 - 2.2.1.3.3 Refer to the Index in the back of General Policy for the address and telephone number of the Robscott Building in Newark and the Milford State Service Center in Milford.
- 2.2.1.4 Thirty Day Acute Care Hospital Program
 - 2.2.1.4.1 Individuals whose income does not exceed 100% of SSI standard who are hospitalized for more than 30 consecutive days may obtain DMAP coverage for their acute care hospital stay under this program.
 - 2.2.1.4.2 Individuals should apply for this program only after they have spent more than 30 consecutive days in an acute care hospital.
 - 2.2.1.4.3 The acute care hospital must have a contract with the DMAP.
 - 2.2.1.4.4 Referrals for the program should be made to the appropriate Long Term Care Medicaid financial eligibility unit. Refer to the Index in the back of General Policy for the address and telephone number of the Robscott Building in Newark and the Milford State Service Center in Milford.
- 2.2.1.5 Out-Of-State Rehabilitation Hospital Program
 - 2.2.1.5.1 Referrals for this program should be made to the appropriate Long Term Care Medicaid financial eligibility unit. Individuals applying for this program must first obtain letters from a rehabilitation hospital located in Delaware that documents that they have been denied admission to these in-state facilities.
 - 2.2.1.5.2 Medical eligibility for this program is determined by the Medicaid Medical Review Team. The individual must meet all of the following medical criteria in order to be determined medically eligible:

- 2.2.1.5.2.1 The service of a rehabilitation hospital must be reasonable and necessary (in terms of efficacy, duration, frequency and amount) for the treatment of the individual's medical condition.
- 2.2.1.5.2.2 It must be reasonable and necessary to furnish this care on an inpatient hospital basis rather than in a less intensive setting such as a nursing facility or on an outpatient basis.
- 2.2.1.5.2.3 Training or experience in rehabilitation.
- 2.2.1.5.2.4 The individual must require 24-hour rehabilitation nursing.
- 2.2.1.5.2.5 The individual must require a relatively intense level of physical therapy or occupational therapy and, if needed speech therapy, psychological services, or prosthetic-orthotic services (at least 3 hours a day of physical and/or occupational therapy, in addition to any other required therapies or services.)
- 2.2.1.5.2.6 The individual must require a multidisciplinary team approach to the delivery of the program and a coordinated program of care.
- 2.2.1.5.2.7 The rehabilitation hospital's initial assessment of the individual must document that there is reasonable expectation that the intensive rehabilitative program will lead the individual to experience significant practical improvement.
- 2.2.1.5.2.8 Realistic rehabilitative goals have been established for the individual.

3.0 Program Definitions

For purposes of this policy, the following definitions apply.

3.1 Annually

Defined as occurring within every fourth quarter after the previous pre-admission screening or annual resident review.

3.2 Applicant

An individual whose written application for Medicaid has been submitted to the agency determining Medicaid eligibility, but has not received final action. This includes an individual (who need not be alive at the time of application) whose application is filed through a representative or person acting responsibly for the individual.

3.3 Discharge

Movement from an entity that participates with the DMAP as a nursing facility, or a DMAP certified distinct part to a non-institutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

3.4 Durable Medical Equipment

Non-customized durable medical equipment, including wheelchairs, is included in the nursing facility per diem rate for both children and adults who are residents of long term care facilities. The per diem rate covers the cost of room and board, medical services and medical supplies and equipment routinely provided to nursing facility residents. Nursing facilities are expected to provide wheelchairs of varied types (standard, roll about chairs, semi-reclining, fully reclining, amputee, hemi-height, lightweight, heavy duty, etc.); and wheelchairs of different sizes (standard, standard power, extra small and extra wide size, etc.). Nursing facilities must have sufficient numbers of wheelchairs to meet the needs of their patients according to the overall medical profile of their population. Furthermore, nursing facilities are expected to provide non-permanent wheelchair accessories that can be added and removed according to the client's medical need(s), including, but not limited to: adjustable arm rests, cushions, trays, anti-tipping devices, seats, seat belts, leg rests, and positioning devices. Medicaid will not provide fee-for-service reimbursement for accessories or repairs for facility-owned durable medical equipment, including wheelchairs.

Medicaid considers durable medical equipment to be customized if it is medically necessary that the device be designed so that only the individual client can use it. In contrast, non-customized DME can be used by other clients either without modification or following the removal or attachment of accessories. In general, Medicaid does not consider a wheelchair or other durable medical equipment to be customized if the selection of the equipment and all significant adaptations can be coded using HCPCS procedure codes. However, the fact that a piece of equipment or an adaptation cannot be coded using HCPCS codes does not necessarily indicate that it meets the definition of customized DME.

It is not expected that many nursing facility residents would qualify for a custom wheelchair as the standard wheelchairs described above should meet the needs

of most residents in a nursing facility where there is continuous assistance available for indoor mobility needs. Medicaid will consider requests for fee-for-service reimbursement for custom wheelchairs for those clients who have complex medical, seating, positioning and mobility needs, and who require an individually designed wheelchair. Medicaid will also consider requests for fee-for-service reimbursement for other DME for nursing facility residents if it meets this definition for customization.

3.5 Facility

A skilled nursing facility (SNF) or a nursing facility (NF) which meets the requirements of Sections 1819 or 1919 (a), (b), (c) of the Social Security Act. For DMAP purposes (including eligibility, coverage, certification and payment), the “facility” is always the entity that participates in the program, whether that entity is comprised of all of, or a distinct part of a larger institution.

3.6 Furnished

Refers to items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual, or ordered or prescribed by a physician, (either as an employee or in his or her own capacity), a provider or other supplier of services.

3.7 Individual

A person or any legal representative of the person.

3.8 PASARR (Pre-admission Screening and Annual Resident Review)

The federally mandated screening or reviewing of all individuals with mental illness or mental retardation who apply to reside in DMAP certified nursing facility’s regardless of the source of payment for the nursing facility services, and regardless of the individual’s or resident’s known diagnoses.

3.8.1 The State’s PASARR program must identify all individuals who are suspected of having Mental Health or Mental Retardation. This identification function is termed Level I.

3.9 Level II

The function of evaluating and determining whether NF services and specialized services are needed.

3.10 Progress Notes

Written notations, dated and signed by a member of the health team, that summarizes facts about care furnished and the patient’s response during a given period of time.

3.11 Provider

Any individual or entity furnishing Medicaid services under a provider agreement with the DMAP.

3.12 Client

An individual who has been determined eligible for Medicaid.

3.13 Resident

One who makes his/her home in any NF or any legal representative of that person.

3.14 Services

Medical care or items, such as medical diagnosis and treatment, drugs and biologicals, supplies, appliances, and equipment, medical social services, and use of hospital or SNF facilities.

3.15 Transfer

The movement from an entity that participates in the DMAP as a nursing facility or a Medicaid certified distinct part to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility.

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4.0 Financial Eligibility for all Institutional Programs

4.1 Application Process

- 4.1.1 Referrals for all the programs mentioned in Section 2.0 of this policy may be made by an applicant's family, friends, hospital, individuals in the community or a nursing home. A mentally competent individual must be aware that a referral has been made on his/her behalf. Unless a mentally competent patient agrees voluntarily to services (either at home or in an institution), DMAP payments will not be made. If the applicant is not mentally competent, the family or legal representative can act on behalf of the patient.
- 4.1.2 The applicant or representative will be asked to complete an interview with a financial unit Social Worker. The applicant or representative must complete an application form, citizenship verification, responsibility statement as well as any other required forms. The applicant or representative must also provide verification of income, resources, etc., in order for a determination of financial eligibility to be completed.
- 4.1.3 Any individual who is in receipt of SSI, who would be eligible for SSI if s/he were not institutionalized, or whose income is less than 250% of the SSI standard and who has resources that are less than \$2,000.00, and burial funds less than \$1,500 MAY be eligible financially to have DMAP payments made on his/her behalf to a nursing facility which is enrolled with the DMAP. The income limit for the Thirty-Day Acute Care Hospital program and the Out-of-State Rehabilitation Hospital program is equal to 100% of the current SSI standard. The Long Term Care Financial Eligibility Units determine financial eligibility.

4.2 Approvals

- 4.2.1 When the application for institutional long-term care has been approved, the Medicaid Financial Unit will send a notice of acceptance to the applicant, family, and facility.
- 4.2.2 The admitting long-term care facility will receive:
- 4.2.2.1 The Comprehensive Medical Report, Review and Approval of level of care for nursing homes, the Pre-Admission Screening packet, the PASARR Level I Screening Form and, if indicated, the PASARR Level II Screening Assessment. These should be retained in the patient's record for future review (PASARR Annual Resident Review and Licensing/Certification survey).
- 4.2.2.2 A notice which indicates the amount of the client's monthly income due to the facility, the amount to be retained for medical insurance and personal needs, the effective date of the Medicaid coverage and the client's Delaware Medical

Assistance ID number to be used for billing. Collection of the patient pay amount from the resident or his/her representative is the responsibility of the facility.

- 4.2.2.2.1 If the resident has no income except a SSI (Supplemental Security Income) check, there will be no patient pay amount. Generally, residents retain \$42.00 for personal needs. If they are involved in training or educational programs outside of the facility, personal needs allowances increase and will be so noted on the notice. There is no supplementation for clients who receive a \$30.00 SSI check.
- 4.2.2.2.2 If the nursing home applicant is an SSI client, the local Social Security Office should be notified that the individual is institutionalized. The nursing facility should not cash any SSI checks until authorized by the Social Security Office.
- 4.2.2.2.3 Medicaid counts income the month it is received. A Social Security check received in January will be budgeted for January's patient pay amount. Similarly, lump sums will be budgeted in the month received even if it is for a prior period.
- 4.2.2.3 A Delaware Medical Assistance card will follow shortly after the opening notices. The facility should not bill the fiscal agent until both the notice and the Medical Assistance card has been received.

4.3 Denials

- 4.3.1 If a person's application is denied, a formal denial notice will be issued stating the reason for the denial and the appeal procedures. If the applicant disagrees with the decision made, s/he can appeal that decision.

4.4 Changes

- 4.4.1 Redeterminations - Every year, per federal requirements, a re-determination of a Medicaid long-term care client's eligibility will be completed. A new application form and verifications must be provided by the client or representative. If they fail to cooperate, the facility and the client or representative will be notified in a timely manner that the DMAP coverage is in jeopardy. If DMAP coverage is terminated, the nursing facility will be notified of the termination of DMAP vendor payments. The payments may resume if the representative cooperates and provides the necessary verification. Another notice will be issued to the facility when the case is reopened.
- 4.4.2 Change In Patient Pay - Any increase or decrease in a resident's income or personal needs necessitates a change in the patient pay to the facility. When such changes occur a notice will be issued to the facility and family explaining the change and giving the effective date.
- 4.4.3 Protection Requests - In certain circumstances the DMAP may authorize a client to retain a portion of his/her income to pay for necessary medical or remedial care that is not subject to payment by a third party. This would include items,

such as; eyeglasses or repairs, hearing aids, dentures or unpaid medical bills that were incurred 30 days prior to the Medicaid eligibility date.

4.4.3.1 Requests for protection of income must be received *timely*. Protection requests for unpaid medical bills over 12 months old will not be approved. In addition, protection requests received after the client has been discharged from the facility or has expired will not be approved. Contact the regional Medicaid Long Term Care Financial Unit for details. Provider(s) will be notified of any change in the patient pay as a result of a protection of income.

4.4.4 If a provider becomes aware of any change in a client's income, receipt of resource, etc., the provider should notify the Medicaid Long Term Care Financial Unit immediately.

4.5 Temporary Absences for Hospitalization

4.5.1 If a client is hospitalized for a short period of time and is expected to return to the facility, payment may continue for a period of not more than 7 days provided that the nursing facility agrees to hold the bed for the resident. The facility must store medications until the client returns from the hospital. The facility is responsible for costs associated with replacing medications that are destroyed or misplaced.

4.5.2 DMAP reimbursement is available for only 7 days within any 30-day period. The 30-day count begins with the first day of hospitalization or a day of hospitalization that immediately follows a previous 30-day period.

NOTE: Patient pay amount may change because of temporary absence from the facility. The facility may ask the family to pay privately to hold a bed for a patient who is hospitalized longer than 7 days.

4.6 Temporary Absence for Other Reasons

- 4.6.1 A client may be absent from the nursing home for reasons other than hospitalization for a period of 18 days per year without interruption of payment to the nursing home, as long as such absences are provided for in the client's plan of care.
- 4.6.2 If a client's physical condition is being negatively impacted by his emotional need to be in a family setting, prior approval may be obtained for a waiver of the 18-day leave of absence limitation (for other than acute care hospitalization) from the Title XIX Medical Director in order to allow the patient more time to visit with his family.
- 4.6.3 To obtain approval, a written request must be submitted by the nursing home to the Long Term Care Administrator at:

Division of Social Services Long Term Care Administrator PO Box 906 Herman S. Holloway, Sr. Campus Lewis Building New Castle, DE 19720 Phone #: (302) 255-9500 FAX #: (302) 255-4454

- 4.6.4 The request must include:
- 4.6.4.1 Reason for the request;
- 4.6.4.2 Medical summary;
- 4.6.4.3 Statement from the nursing home's medical director regarding the medical necessity of the patient being absent from the home in excess of 18 days per year;
- 4.6.4.4 Anticipated frequency of absence;
- 4.6.4.5 The number of days the patient was absent from the facility during the previous six-month period.
- 4.6.5 If approval is given, the 18-day restriction will be waived for 6 months from the date of approval.

4.6.6 A request for continuation of a waiver after the 6-month limit has lapsed must be resubmitted and approved for payments to be continued.

4.6.7 A letter will be mailed to the facility notifying it of the decision.

4.7 Discharge/Death

4.7.1 If a patient dies or is discharged from the facility, the DMAP will not pay for the day of departure or death. The patient pay amount will automatically be prorated for the last month. An Advanced Action Notice will be mailed notifying the facility of the effective date Medicaid care is terminated.

4.7.2 It is the facility's responsibility to contact the regional Medicaid unit within 24 hours of death or discharge of a patient.

4.7.3 Contact the Medicaid Long Term Care Financial Eligibility Unit or the Long Term Care Coordinator for further clarification of these procedures or policies related to openings, changes, and closings.

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5.0 Certification for ICF/MR and ICF/IMD Patients

5.1 Certification Process

- 5.1.1 Certification is the process by which a physician who has knowledge of the case attests to an individual's need for a specific type or level of institutional care. The certification must be provided by the physician on or not more than 30 days prior to an individual's admission to an institution. For an individual who makes an application for assistance while in an institution, the certification must be signed by that time or, if the certification was made earlier, not more than 30 days prior to authorization for DMAP payment. A certification loses its validity after a 30-day period and a new certification must be obtained.
- 5.1.2 Additionally, a transfer of a patient from one level of care to another is considered a new admission. Therefore, the patient must be certified for the new level of care on or before, admission to the new facility. This would include a transfer from an acute care facility even if the patient had previously been a resident in the facility to which he or she is being transferred. Transfer of a patient from one level of care to another level within the same facility, and transfer of a patient from one long-term care facility to another facility at the same level of care are both considered new admissions. Therefore, a new certification must be performed on, or before, the change. The following conditions must be met in order for the certification to be valid:
- 5.1.2.1 The certification must be in writing.
- 5.1.2.2 The certification must be signed or initialed by an individual clearly identified as a physician, "M.D." (Medical Doctor) or "D.O." (Doctor of Osteopathy), written after the signature or initials are the only acceptable acronyms. "P.A." (Physician's Assistant), "R.N." (Registered Nurse), etc. are not acceptable. The signature or initials are not acceptable if they are rubber-stamped unless the physician has initialed the stamp. The certification must be dated at the time it is signed by the physician.
- 5.1.2.3 A certification will be acceptable only if it evidences the physician's determination of the need for an ICF/IMD or ICF/MR level of care that the individual will receive or is receiving.
- 5.1.2.4 The certification must be no later than the date of admission.
- 5.1.2.5 The facility must be certified to furnish the level of care that the individual is certified as needing to receive.
- 5.1.3 The certifications for all Title XIX patients must be maintained either in the patient's/resident's medical record or in a central file in the facility where the patient/resident resides.

- 5.1.4 Examples of acceptable certification documents are as follows:
- 5.1.4.1 A statement signed and dated by the attending staff physician and/or consultant physician who has knowledge of the case that the individual is in need of a particular level or type of care (ICF/IMD or ICF/MR). To be acceptable, this statement must be signed and dated on, or not more than, 30 days before the date of admission or authorization.
 - 5.1.4.2 Physician orders which clearly indicate the need for a particular level of care which are signed and dated on, or not more than, 30 days before the date of admission or authorization.
 - 5.1.4.3 A medical evaluation which designates the level of care signed and dated by a physician who has knowledge of the case not more than 30 days prior to admission or authorization for payment.
 - 5.1.4.4 A referral or transfer form indicating the level of care to which the patient is being transferred and other necessary data (patient's name, transferring facility) which is signed and dated by a physician who has knowledge of the case on, or not more than, 30 days before the date of admission or authorization.
 - 5.1.4.5 An admission review form signed and dated by an attending or staff physician who has knowledge of the care. This admission review form must have been forwarded to the Central Medicaid Office. The date of the evaluation cannot have been more than 30 days before the date of admission or authorization for payment.
- 5.1.5 If the certification is not signed on the date of admission but later, the vendor payments will not begin on date of admission but on the date signed.
- EXAMPLE: Mrs. Smith is admitted to Delaware State Hospital's ICF/IMD section from the hospital on 10/5. Her physician does not complete the certification until 10/10. The vendor payments will not begin 10/5 but on 10/10.

6.0 Recertification of ICF/MR and ICF/IMD Patients

6.1 Recertification Process

- 6.1.1 Recertification is the process by which a physician who has knowledge of the case attests to an individual's need for continued placement at a specific type or level of care. General conditions which must be met for a recertification to be valid are as follows:
- 6.1.1.1 The recertification must be in writing.
 - 6.1.1.2 The recertification must be signed or initialed by an individual who has knowledge of the case and is clearly identified as a physician. "M.D." (Medical Doctor) or "D.O." (Doctor of Osteopathy) written after the signature or initials are the only acceptable acronyms. "P.A." (Physician's Assistant), "R.N." (Registered Nurse), etc., are not acceptable. The signature or initials are not acceptable if they are rubber-stamped unless the physician has initialed the stamp. The recertification must be dated at the time it is signed by the physician.
 - 6.1.1.3 A recertification will be acceptable only if it evidences the physician's determination that continual care is required at a particular level.
 - 6.1.1.3.1 Examples of acceptable recertifications are as follows:
 - 6.1.1.3.1.1 A signed and dated statement by the physician who has knowledge of the case that the continuation of the specific level of care is necessary.
 - 6.1.1.3.1.2 Signed and dated orders by the physician who has knowledge of the case which clearly indicate a need for continuation of care at a specific level.
 - 6.1.1.3.1.3 Signed and dated progress notes by the physician who has knowledge of the case that clearly indicates the need for continuation of care at a specific level.
 - 6.1.1.3.1.4 A signed and dated report that a physician might use in caring for the patient which clearly indicates the need for continuation of care at a specific level.
 - 6.1.1.3.1.5 Utilization review committee minutes or forms indicating that the patient's care was reviewed by a physician who has knowledge of the case and that continued care at a specific level is necessary. The physician's signature and date must appear on the minutes and/or form.
 - 6.1.1.4 The facility must be certified to furnish the level of care the individual is recertified as needing.
 - 6.1.1.5 The recertification for all Title XIX patients must be maintained in the patient's medical record or in a central file in the facility where the patient resides.

6.1.2 ICF/IMD Recertifications

- 6.1.2.1 Recertification of ICF/IMD Medicaid patients will be performed at 60 and one hundred 180 days after admission and at 12, 18, and 24 months after admission. Thereafter, recertification can be performed annually.

EXAMPLE:

Mrs. Smith, an ICF/IMD Medicaid patient, is admitted to the Delaware State Hospital on January 7, 2000. Her original certification, as usual, must be dated January 7, 2000, or no more than 30 days prior to January 7, 2000. Assuming her original certification is performed on January 7, 2000, her recertification would be as follows:

March 8, 2000 - 1st recertification 60 days after admission and date of original certification

July 6, 2000 - 2nd recertification 180 days after admission and date of original certification

January 7, 2001 - 3rd recertification 12 months after admission and date of original certification

July 6, 2001 - 4th recertification 18 months after admission and date of original certification

January 7, 2002 - 5th recertification 24 months after admission and date of original certification

- 6.1.2.2 Thereafter, recertifications would be due annually (i.e., January 7, 2003; January 7, 2004; etc.). Again, note that this schedule would be followed only if there is no break in intermediate level coverage. If a break does occur, a new original certification must be performed and the recertification cycle would have to be started anew.

6.1.3 ICF/MR Recertifications

- 6.1.3.1 For ICF/MR patients, the recertification must be no later than the 365th day after the previous certification or recertification.

- 6.1.3.2 As stated previously, a break in coverage means that a new original certification must be performed and the recertification cycle started anew. The following situations constitute a break in coverage:

- 6.1.3.2.1 The patient is not placed in a nursing home within 30 days of the completion of the original certification.

- 6.1.3.2.2 The patient is transferred from one level of care to another.

- 6.1.3.2.3 The patient is transferred from an acute care hospital to nursing home. Even if the patient had previously been a resident of the facility to which he is transferred, a new original certification must be completed. This would apply even if a patient only spent one overnight in an acute care hospital.
- 6.1.3.2.4 The patient is transferred from one level of care to another level with the same facility.
- 6.1.3.2.5 The patient is transferred from one nursing home to another nursing home at the same level of care.
- 6.1.3.2.6 See Appendix A for examples of Recertification Forms.

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7.0 Nursing Facility Ancillary Charges

Only the nursing facility may bill for ancillary services for a nursing facility resident. The nursing facility may either provide the services directly or through a contractual arrangement.

7.1 Covered Charges

7.1.1 The DMAP will reimburse private nursing facility providers for some ancillary charges that are separate from the facility's per diem rates. These ancillary services may include:

7.1.1.1 Physical therapy, by RPT only;

7.1.1.2 Occupational therapy;

7.1.1.3 Speech therapy; and

7.1.1.4 Oxygen.

7.1.2 Facilities will be paid at the median cost for each service (cap) or their actual cost, whichever is lower. A further explanation of covered ancillaries follows:

7.1.2.1 Oxygen

7.1.2.1.1 The facility may only bill one (1) unit of oxygen per day.

7.1.2.2 Physical Therapy

7.1.2.2.1 Physical Therapy Evaluation - The DMAP will reimburse for the initial evaluation performed by Registered Physical Therapist. The DMAP will pay for one evaluation per treatment course. Date of service is the actual day evaluation was performed. If facility bills for more than 1 evaluation in 6 months, supporting documentation must be attached to the claim to justify the need for the new evaluation and new course of treatment.

7.1.2.2.2 Physical Therapy Treatment - The DMAP will reimburse for one treatment per session provided by Registered Therapist only. The DMAP will not reimburse for physical therapy treatment delivered on the same day as a physical therapy evaluation. The DMAP will reimburse for maintenance as well as restorative therapy if doctor ordered and if monthly progress notes are completed by the therapist indicating what treatment was rendered at each session and the progress of the patient.

7.1.2.2.2.1 The DMAP will reimburse for up to 23 sessions in a month. If more than 23 sessions are required in a month, prior authorization must be requested of the

Long Term Care Coordinator. Payment will *not* be made for more than 23 sessions if they have not been prior authorized.

- 7.1.2.2.2.2 If therapy continues for longer than 90 days, claims must have supporting documentation attached justifying need for therapy after 90 days. Supporting documentation would include a copy of the physician's order for therapy and copies of the therapist's progress notes indicating that the resident is still making progress.
- 7.1.2.3 Speech Therapy
 - 7.1.2.3.1 Speech Therapy Evaluation - The DMAP will reimburse for the initial evaluation for a course of treatment. The evaluation must be performed by a MSCCCSLP (Master of Science Certification Clinical Competency Speech Language Pathologist). The facility should bill for actual date of service. If the facility bills for more than one evaluation in a year, supporting documentation must be attached to the claim to justify the need.
 - 7.1.2.3.2 Speech Therapy Treatment - The DMAP will reimburse for one treatment per session. Therapy must be provided by a MSCCCSLP. Monthly progress notes must be written by MSCCCSLP. Reimbursement will not be made for speech therapy treatment delivered on the same day as a speech therapy evaluation.
 - 7.1.2.3.2.1 The DMAP will reimburse for a maximum of 23 sessions per month. If more than 23 sessions are required in a month, prior authorization must be requested of the Long Term Care Coordinator. Reimbursement will *not* be made for more than 23 sessions if they have not been prior authorized.
 - 7.1.2.3.2.2 If therapy continues for more than 90 days, the facility must attach supporting documentation to the claim to justify continuing need. Supporting documentation would include copies of the physician order for therapy and the therapist's progress notes. Notes must indicate what treatment was rendered in each session and progress or outcome of the session.
- 7.1.2.4 Occupational Therapy
 - 7.1.2.4.1 Occupational Therapy Evaluation - The DMAP will reimburse for one evaluation per treatment course. Evaluation must be performed by a Registered Occupational Therapist (ROT). The facility should bill actual date evaluation was completed. If the facility bills for more than one occupational therapy evaluation in a year, supporting documentation must be attached to the claims to justify the need for a new evaluation and new course of treatment.
 - 7.1.2.4.2 Occupational Therapy Treatment - The DMAP will reimburse for one treatment per session performed by a Registered Occupational Therapist or by a Certified Occupational Therapy Aide under the direct supervision of a Registered Occupational Therapist. The therapy must be ordered by a physician. Monthly progress notes must be completed by the therapist indicating what treatment was rendered at each session and progress made by the patient. Reimbursement will

not be made for therapy treatments provided on the same day as an occupation therapy evaluation.

- 7.1.2.4.2.1 The DMAP will reimburse for up to 23 sessions per month. If more than 23 sessions are required in a month, prior authorization must be requested of the Long-Term Care Coordinator. Reimbursement will *not* be made for more than 23 sessions if they have not been prior authorized.
- 7.1.2.4.2.2 If therapy continues for longer than 90 days, claims must have supporting documentation attached justifying need for therapy after 90 days. Supporting documentation would include copies of the physician's order for therapy and the therapist's progress notes.

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8.0 Non-Emergency Ambulance Transportation

8.1 Non-Emergency Ambulance Transportation for Medicaid Clients Residing in a Nursing Facility

8.1.1 Effective October 1, 2002, DMAP utilized a "broker" system to facilitate all non-emergency transportation (NET) services. Under the new system, the Broker is responsible for verifying client eligibility for DMAP services, assessing the client's need for NET services, selecting the most appropriate transportation to meet the client's needs, and educating clients about NET services. The Broker serves as a single point of contact for ALL NET services.

8.2 Nursing Facility Responsibility

8.2.1 The nursing facility is expected to transport Medicaid clients to and/or from medical services if the facility has vehicle(s) utilized for patient transportation.

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9.0 Reimbursement

9.1 Methodology

- 9.1.1 Skilled nursing facilities are reimbursed prospectively determined per diem rates based on reported costs and a patient based classification system.
- 9.1.2 Skilled nursing facilities should have procedures in place to receive over-the-counter (OTC) products for their residents that are covered under the per diem.
 - 9.1.2.1 OTC products and all supplies (such as, but not limited to, lancets, syringes and diagnostic strips) for patients who are residents of certified and licensed intermediate or skilled care facilities are reimbursed through the secondary patient care cost component of the per diem rate. OTC products and all supplies are NOT reimbursed directly.
- 9.1.3 Facilities are required to return to the dispensing pharmacy any medications that have been discontinued if those medications are potentially able to be dispensed to another client.

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	<h2 style="color: #800000; margin: 0;">Medicaid Recertification (ICF/IMD Level of Care)</h2>
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10.0 Appendix A – Medicaid Recertification (ICF/IMD Level of Care)

Intermediate Recertification

Any Revised: Diagnosis: _____

I certify that I have reviewed the patient’s comprehensive Plan of care and determined that INTERMEDIATE nursing care Services are required because _____

Date Due 60 Days After Admission

Signature of Physician Date

Recertification

Any Revised: Diagnosis: _____

I certify that I have reviewed the patient’s comprehensive plan of care and determined that INTERMEDIATE nursing care services are required because _____

Date Due 180 Days After Admission and 120 Days After Preceding Recertification

Signature of Physician Date

Recertification

Any Revised Diagnosis: _____

I certify that I have reviewed the patient’s comprehensive plan of Care and determined that INTERMEDIATE nursing care services are required because _____

Date Due 12 Months After Intermediate Admission and 180 Days After Preceding Recertification

Signature of Physician Date

Recertification

Any Revised Diagnosis: _____

I certify that I have reviewed the patient’s comprehensive plan of Care and determined that INTERMEDIATE nursing care services are required because: _____

Date Due 18 Months After Admission And 180 Days After Preceding Recertification

Signature of Physician Date

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	<h2 style="color: red; margin: 0;">PASARR Level I Analysis</h2>
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11.0 Appendix B – PASARR Level I Analysis

Client: _____
 Social Security Number: _____
 Date of Birth: _____
 Payment Type: _____
 Review Requirements: _____

Section I

	<u>Yes</u>	<u>No</u>
Needs skilled nursing care & related services?	___	___
Needs Rehabilitative services?	___	___
Regularly needs health related care and services?	___	___
Has been referred to, or evaluated by, Medicaid PAS team?	___	___

NOTES:

Section II

	<u>Yes</u>	<u>No</u>
Has written diagnosis of mental illness?	___	___
Has history of mental illness?	___	___
Has been prescribed neuroleptic, major tranquilizer, antipsychotic or antidepressant medication on regular basis?	___	___
Presenting evidence of possible mental illness, including disturbance of mood, affect or orientation?	___	___

NOTES:

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Section III

Yes

No

Has diagnosis of mental retardation or a related condition?

Is being referred by, or eligible for services by, an agency which serves people with mental retardation or related conditions?

Has history or presenting signs or symptoms of mental retardation or related conditions?

NOTES: _____

Preliminary Analysis:

Final Analysis:

Date: _____

Worker: _____

Determination: _____

Date of Printing: _____

Printed By: _____

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Nursing Home Responsibilities

12.0 Appendix C – Nursing Home Responsibilities

The following is a list of what Medicaid pays for and what the nursing home is required to supply.

1. The Facility Will Provide:
 - a. Medical Supplies
 1. Adhesive tape and Band-Aids
 2. Cellucotton, cotton, and cotton balls
 3. Disposable diapers and/or incontinent pads
 4. Gauzes and lamswood
 5. Paper handkerchiefs
 6. Thermometers
 7. Water proof sheets
 - b. Medical Equipment
 1. Bed pans, urinals, and commodes
 2. Catheters
 3. Crutches
 4. Emesis basins and enema bags
 5. Hot water bottles and ice bags
 6. Invalid rings
 7. Nasal atomizers
 8. Rectal tubes
 9. Rubber gloves and finger cots
 10. Syringes and needles
 11. Wheelchair and walkers
 - c. Non-Medical Supplies
 1. O.T. Supplies
 2. R.T. Supplies
 - d. Non-Legend Drugs and Medications
 1. Analgesic (aspirin, aspirin compounds, Tylenol, etc.)
 2. Antiseptics (mercurochrome, merthiolate, zephiran, betadine, etc.)
 3. Dental and oral (dentifrice's, denture adherents, mouthwash, etc.)
 4. Dermatologics (phisohex, rubbing alcohol, soap, talcum powder, hydrogen peroxide, petrolatum, lotions, creams, ointments, etc.)

5. Diagnostics (acetest tablets, clinitest tablets, taptest, etc.)
6. Laxatives, enemas, lubricants, (cascara, milk of magnesia, mineral oil, prepared enemas, etc.)
7. Dietary supplements (sustagen, meritene, vitamins, etc.)

e. Services

1. Shave
2. Shampoo given by facility employees
3. Laundering of linens
4. Hand feeding
5. Incontinence care and training
6. Cost of billing procedures
7. Personal laundry

The Patient and/or Family May be Billed for:

a. Personal Items


1. Cosmetics
2. Cologne, perfume, aftershave, etc.
3. Letter paper, stamps, and greeting cards
4. Newspaper and magazine subscriptions
5. Clothing
6. Cigarettes

b. Services

1. Shampoo given by beautician
 2. Hair cut or set
 3. Permanent
 4. Personal dry cleaning
2. Federal law prohibits nursing homes from charging Medicaid clients or their families for items and services covered by Medicaid.
 3. Nursing homes that accept Medicaid cannot ask Medicaid clients or their families for contributions as a condition of admission or charge fees to supplement the Medicaid rate.
 - a. Federal regulations prohibit the displacement of a resident once admitted to a nursing home participating in the Medicaid program on the basis of a change in source of payment for the resident. One example of a prohibited action would occur when a Medicaid participating nursing home refuses to continue to care for a resident because the individual's source of payment has changed from private fund to Medicaid. A second example would be when a nursing home terminated one or more services to a resident who goes on Medicaid. It is important to note there should be evidence that the nursing home's termination of service was based on a medical rather than a financial reason.
 - b. Federal laws prohibit a nursing home from requiring a Medicaid eligible client or the legal custodian or guardian of a resident to supplement Medicaid coverage for basic care and

services. This includes requiring continuation of a “private pay contract” once the resident becomes eligible for Medicaid; and/or asking for contributions, donations, or gifts as a condition of admission or continued stay.

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	<p>Nursing Facility Ancillary Services</p> <p>Revenue Codes</p> <p>Private Nursing Facilities Only</p>
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13.0 Appendix D – Revenue Codes

The following Revenue Center codes are used when billing the DMAP for ancillary services provided on and after 7/1/02.

Code	Description
0419	Respiratory services – Other services (NOTE: This revenue code replaces codes YY001-YY003) Providers should not use this revenue code for clients identified and reimbursed at a super-skilled rate.
0421	Physical therapy – visit charge
0424	Physical therapy, evaluation or re-evaluation
0431	Occupational therapy – visit charge
0434	Occupational therapy – evaluation or re-evaluation
0441	Speech-language pathology – visit charge
0444	Speech-language pathology/evaluation or re-evaluation

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