

PART II
POLICIES
AND
PROCEDURES
FOR
NURSING FACILITY
SERVICES



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAL ASSISTANCE

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Nursing Facility Services

**PART II - POLICIES AND PROCEDURES
FOR
NURSING FACILITY SERVICES**

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PART II - CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601 Certification from the Department of Human Resources

In order for a facility to participate in the Medicaid program, the Department of Human Resources (DHR) must provide the Division of Medical Assistance (the Division) with the following information:

- a. Certification that the facility is in compliance with the requirements for participation, the period of time covered by the certification, and any specific conditions pertaining to the certification. Certification requirements are found in the Code of Federal Regulations (CFR) at 42 CFR, Section 483.
- b. License number and effective date of license to operate a nursing facility or an intermediate care facility for the mentally retarded. Licensure requirements are found in Rules of Department of Human Resources (DHR), Chapter 290-5-8 for nursing facilities and Chapter 290-5-9 for the Intermediate Care Facilities for the Mentally Retarded (ICFs/MR).
- c. Verification that the entire facility is certified to participate in the Medicaid program.

601.1 Facility Classification

Facilities participating in the Program may be certified as Nursing Facilities (NFs) or ICFs/MR. All NFs and ICFs/MR must meet the conditions as set forth under 42 CFR, Sections 442 and 483.

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602 Enrollment

Facilities must maintain a valid provider application on file with the Division in order to be reimbursed under this program. The type of facility certified by the DHR must be noted on the nursing facility permit.

Upon the Division's acceptance of the provider application, the effective date of participation will be the same as the certification date approved by the DHR if the application package is received by the Division on or prior to the certification date. If received after the certification date, the effective date of participation will be the date the provider application is postmarked or hand-delivered to the Division.

Enrollment for facilities is subject to the following conditions:

- a. The maximum time limitations for agreements with facilities certified under Medicare (Title XVIII) shall be in accordance with the period of time prescribed by the Secretary of Health and Human Services (HHS).
- b. The maximum time limitations for the agreements with nursing facilities and intermediate care facilities for the mentally retarded shall be in accordance with the period of time prescribed by the DHR.
- c. Any enrolled provider that undergoes a change (including, but not limited to, lease, dissolution, incorporation, reincorporation, reorganization, change in ownership of assets, merger or joint venture), so that as a result, the provider either becomes a different legal entity or is replaced in the program by another provider, must give the Division at least ten days prior written notice. The successor provider simultaneously must submit a new enrollment application that includes an executed Statement of Participation to become effective at the time of the above described change. Failure of the successor to submit a new application package will prevent the Division from reimbursing services as of the date of change (see Part I Section 104 of the Policies and Procedures for Medicaid/PeachCare Manual {the Manual}). A provider that undergoes a change of ownership but does not become a different legal entity must execute a new enrollment application, and must notify the Division in writing of the change in ownership in accordance with all pertinent requirements.

A nursing facility that undergoes a change, regardless of whether or not the change creates a new legal entity, will follow the procedure described above, however, the provider number previously assigned to that facility will remain in effect.

- d. The Official Code of Georgia Annotated (OCGA), Section 31-6-45.2 provides for a monetary penalty when a proposed or existing facility that obtained a certificate of need (CON), based in part on assurances that it will participate as a provider of medical assistance, terminates its participation in the Medicaid program.

The monetary penalty amount is the difference between the Medicaid covered services the facility agreed to provide in its CON application and the amount actually provided.

The monetary penalty shall begin upon notification that a facility has terminated participation in the Medicaid program. The penalty shall be levied and collected on an annual basis for each year that the facility fails to participate.

This Code section does not apply if the following conditions exist:

- The proposed or existing facility's CON application was approved by the planning agency prior to April 6, 1992, or the planning agency's approval of such application was under appeal on or after April 6, 1992, and ultimately affirmed;
 - the facility's participation as a provider of medical assistance is terminated by the state or federal governments;
 - the facility establishes good cause for terminating its participation as a provider of medical assistance and gives 30 days written notice.
- e. When a facility voluntarily terminates participation in the Medicaid program, OCGA Section 49-4-146.2 provides that the facility develops a resident transfer plan and assist in relocation efforts. A nursing facility may voluntarily terminate participation in the program by giving 60 days written notice to the Division and complying with the following requirements.
- Provide the residents or their representatives with a contact name and information regarding appropriate facilities for placement.
 - Contact identified facilities on behalf of the residents.
 - Develop a transfer plan for each resident addressing the resident's individual needs.
 - Make arrangements for the safe and orderly transfer of residents.
 - Provide counseling to residents or their representatives regarding available community resources and appropriate state or social service organizations.
 - Enter into a limited provider agreement and continue to serve Medicaid eligible residents during the period of time from notice of termination through Decertification. Decertification occurs at such time when no Medicaid eligible residents reside in the facility.

A facility may voluntarily terminate upon 60 days written notice to the Division. The notice should include the reason for termination; the names and Medicaid numbers of all eligible residents; the names of residents with pending Medicaid applications along with names of authorized representatives; copies of notices the facility intends to provide to residents and any other information deemed necessary to process the termination.

603 Conditions of Participation

The following general conditions of participation, which were previously noted in Part I, Section 105 of the Manual, are modified for all enrolled nursing facilities (see Appendix B).

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603.1 Medicaid Payment

The facility must agree to accept the Division's payment as payment in full for covered services. The provider agrees to accept no payment from a recipient except as provided for by the county Department of Family and Children Services (DFCS) in accordance with appropriate state and federal regulations. **Under no circumstances will a recipient, relative, sponsor, or other interested party be asked or required to make payment for covered services.**

The facility will not contact Medicaid recipients for the purpose of soliciting requests for the facility's services.

Providers of nursing care, who meet conditions of participation in the Georgia Medicaid Program, are not prohibited from displaying Medicaid Approval in directories and brochures outlining services of the facility. *However, all such facility advertisements shall contain the following statement: "By its approval, the Georgia Medicaid program does not guarantee either: (1) that the quality of service offered in this facility is superior to that offered by other facilities, or (2) that all of the costs of care in this facility will be paid by Medicaid. Federal law provides that Medicaid recipients shall have freedom of choice among nursing facilities."*

General advertising to the general public, to promote an increase in the patient utilization of services, is not related to the care of patients and therefore, **not allowable as reimbursed cost. Costs of advertising should be removed from any cost reports submitted to the Department.** (See Section 1002-Reimbursement Methodology)

603.2 Certification and Re-certification for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

A physician must certify for each applicant or recipient that ICF/MR services are or were needed. The initial certification must be made at the time of admission or if an individual applies for assistance while in an ICF/MR. The certification must be signed and dated by the physician in his/her handwriting.

A physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by State law and under the supervision of a physician, must re-certify for each applicant or recipient that ICF/MR

services are needed. Re-certification must be made at least every 12 months after the initial certification.

Failure to comply with this requirement shall result in the loss of reimbursement to the facility for each day an ICF/MR recipient is not certified. The amount shall be determined by multiplying the facility's applicable billing rate by the number of days of non-compliance for each recipient not certified on that date.

603.3 Bed Registry

Nursing facilities and ICFs/MR are required to participate in the Bed Registry Program. The Bed Registry Program, administered by the Long Term Care Contractor, herein referred to as the Contractor, will provide a mechanism to monitor bed availability. It is the facility's responsibility to provide accurate information regarding bed availability as requested by the Division.

603.4 Admission Preferences

As enrolled providers in the Medicaid program, facilities are expressly prohibited by federal law from discriminating on the basis of handicap, history or condition of mental or physical disease or disability (including patients infected with the HIV Virus), race, color, or national origin. Giving preference in admissions to prospective private-pay residents over Medicaid recipients for any of the above reasons constitutes a violation of these prohibitions and subjects facilities to civil fines as well as programmatic sanctions such as termination from the Medicaid program.

Providers may not designate a certain number of beds as Medicaid beds. If a facility is certified for enrollment in Medicaid, then all of its beds are certified for use by recipients; there is no such thing as "limited certification". As long as any bed designated for a prospective Medicaid recipient's level of care is unoccupied, a Medicaid-enrolled facility may not refuse that bed to a recipient on the grounds that it is not certified as a Medicaid bed. Making the bed unavailable on such grounds will subject the facility to the same programmatic sanctions that apply in cases of discrimination on the basis of handicap or other conditions as stated above.

603.5 Private-Pay Duration-of-Stay Agreements

Providers may not engage in the practice of having prospective residents sign documents in which the prospective resident agrees to reside as a private-pay resident at the facility for a specified minimum period of time prior to becoming a Medicaid-pay resident. In some cases the prospective resident is already Medicaid-eligible; in others an application for eligibility is either pending or is to be held in abeyance until a later date.

Where a prospective resident is already Medicaid-eligible, all such agreements are illegal and unenforceable under federal law, and subject the facility to criminal prosecution and fines of up to \$25,000 plus imprisonment for up to five years. The law states that:

a. Whoever knowingly and willfully—

1) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under title XIX, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

a) as a precondition of admitting a patient to a hospital, nursing facility or intermediate care facility for the mentally retarded, or

b) as a requirement for a patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000 or imprisoned for not more than five years, or both. [42 U.S.C. Section 1320a-7b(d)]

In the cases in which a prospective resident is not already Medicaid eligible, such an agreement is unenforceable as soon as the resident becomes Medicaid-eligible. At that time, the facility must convert the resident's status from private-pay to Medicaid immediately, and return the balance of any and all fees paid by or for the recipient. The facility may not in any way solicit, encourage, or coerce any prospective recipient into delaying or abstaining from applying for Medicaid. This means that facilities are also prohibited from arranging private-pay agreements without fully disclosing to prospective residents their right to apply for and obtain Medicaid coverage at their earliest convenience. [See also OCGA 10-1-421; DHR Rule 290-5-39-03.] [Part I, 106.17.]

603.6 Responsible Party Agreements

Providers may not request or require that prospective Medicaid-eligible residents have family members or friends sign statements that they will be responsible for the recipient's financial affairs. The federal law cited in the preceding section also specifically prohibits this practice with respect to Medicaid-covered services regardless of the reason for non-payment, and carries with it the \$25,000/5 year penalty for violations. [42 U.S.C. Section 1320a-7b(d)(1)] Any such statement or agreement must be specifically restricted to services that are not covered by Medicaid. Facilities must accept Medicaid's payment as payment in full for covered services, even if that payment is zero for a specific service.

Providers may not require that prospective Medicaid-eligible residents, family members or friends sign statements that they will either give a specified time of notice before voluntary discharge, or that they will be privately responsible for any charges for days beyond the date of discharge if prior notice was not given.

604 Program Requirements for Participation

The conditions of participation and the requirements for long term care facilities are defined in 42 CFR, Section 483, Subpart B, as specified in the Omnibus Budget Reconciliation Act of 1987 as amended in 1989 and 1990.

604.1 ICF/MR Onsite Review

The Division's contractor performs on-site reviews in ICFs/MR. The conditions of participation and the requirements for ICFs/MR are defined in 42 CFR, Section 442, Subpart C and Section 483, Subpart I.

Following an on-site visit, the contractor will forward a report of its findings to the Division for appropriate action. If the Contractor's on-site report documents specific findings, the Division will notify the facility of the findings and request that the facility submit a plan of correction which identifies the actions it will take to correct the cited deficiencies and an estimated timetable for compliance with the plan.

The Division must receive this plan of correction, which is responsive to each cited deficiency, within 15 calendar days from the date of the Division's notice. If a facility's plan is not responsive to the cited deficiencies, or if the facility fails to submit the required plan of correction, the Division will issue a warning letter to the facility indicating that failure to submit a satisfactory plan of correction will render the facility subject to denial of reimbursement for future admissions and/or suspension or termination from the program.

The contractor will be requested to perform a follow-up review to determine whether the cited deficiencies have been corrected and whether the health, safety or welfare of any recipient has been damaged or endangered. Should the follow-up review demonstrate that the approved plan of correction has not been successfully implemented in its entirety, the Division may immediately deny payment for further admissions or suspend or terminate the facility's participation in the Medicaid program. Since the facility will have been given the opportunity to correct previously cited conditions, the five-day opportunity provided in Part I, Section 409 of the Manual to correct conditions will not be renewed if the follow-up review requires imposition of sanctions.

604.2 Intermediate Sanctions

If the Division finds that a facility does not or did not meet a Program Requirement governing nursing facilities, it may impose intermediate sanctions, independently or in conjunction with others, subject to provisions for notice and appeal. The Division adopted the November 10, 1994 Final Rule of the Medicare and Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities issued by the Centers for Medicare & Medicaid Services (CMS).

604.3 Advanced Directives

Nursing facilities are required to sign a letter of understanding, thereby agreeing to provide all adult individuals with information on advance directives as mandated by Section 1902 (a) (57) of the Social Security Act. (See Section 909).

604.4 Resident Assessment Instrument

Nursing facilities shall use the Centers for Medicare & Medicaid Service's (CMS) version of the Resident Assessment Instrument (RAI). Nursing facilities in Georgia may use forms with variations to CMS's Resident Assessment Instrument, provided that any RAI accurately and completely represents the CMS version. That is, it includes all and only the items on the CMS RAI with the exact wording and in the same sequence.

604.5 Nurse Aide Training and Competency Evaluation Program

Under 42 CFR, Section 483.75 and Section 483 Subpart D, effective as of 4-1-92, and the requirements of OBRA 1987, as amended in 1989 and 1990, nurse aides are required to be certified by a state approved program. The Division's Contractor has been designated to review, approve and monitor nurse aide training and competency evaluation programs.

The Contractor will maintain a registry of certified nurse aides. Information regarding an individual's certification status may be obtained by contacting the Nurse Aide Registry (see Appendix C).

Nurse aides are required to have a minimum of 12 hours of in-service education annually in accordance with federal regulations.

Rev.10/04 604.6 Dining Assistants Program

Effective October 27, 2003, new federal regulations allows a long-term care facility to employ specially trained personnel to supplement the services of certified nurse aides and licensed nursing staff. The intent of the federal regulations, which were amended in 42 CFR Parts 483 and 488, is to provide assistance to residents with feeding and hydration and to reduce the occurrence of unplanned weight loss and dehydration.

The term **"Dining Assistant"** means an individual employed or compensated by the nursing home, or who is used under an arrangement with another agency or organization, to provide assistance with feeding and hydration to residents in need of such assistance. **Such individuals shall not provide other personal care or nursing services unless certified as a nurse aide or licensed as a registered nurse or practical nurse.**

Dining assistants shall have certification of successful completion of training work under the direct supervision of a registered nurse or a licensed practical nurse. **Direct supervision means that the registered nurse or licensed practical nurse is present in the same room and available to respond to the need for assistance.**

- (a) The registered nurse directing the training program must certify successful completion by a dining assistant of the required training program. At a minimum, the certification must include the dining assistant's name, the nursing home's name, the name and signature of the registered nurse, and the date.
- (b) Such certifications are transferable from one nursing home to another provided that prior to assisting residents in the new facility to which certification is being transferred, the dining assistant satisfactorily performs a return demonstration of the minimum skills on which such dining assistant was trained in order to demonstrate competency on training program components and an understanding of the practical application of feeding and hydration skills. Such satisfactory demonstration of skills shall be documented by a registered nurse and retained by the facility in the employee's record along with a copy of the initial documentation of successful completion of the training program as specified in the Federal rules.

In addition to all other documents required by state or federal regulations, the nursing home shall maintain the following records:

- a. A copy of the nursing home's Dining Assistant Training Program
- b. Documentation of successful completion of the training program for each dining assistant.

***Dining assistants are intended to supplement, not replace, existing nursing staff requirements and as such are not considered nursing staff and are not to be included in computing the required minimum hours of direct nursing care.**

***See DHR Rules and Regulations for Nursing Homes (Chapter 290-5-8) for complete Regulations.**

605 Pre-Payments or Deposits

The following sets forth the policy on pre-payments or deposits:

605.1 Eligible Recipient

No pre-payment, application fee, or deposit may be required from an eligible recipient or his/her family by a participating facility.

605.2 Individuals with Eligibility Pending

Facilities may collect pre-payments or deposits from individuals whose Medicaid eligibility is pending, provided the funds are held in escrow until the pending application is acted upon. If an individual is declared eligible, the total deposit/ prepayment must be refunded to the patient prior to payment by Medicaid.

606 Free Will Contributions

Voluntary gifts or donations accepted by nursing facilities are not prohibited by federal regulations unless the donation is coerced and extracted on other than a purely voluntary basis. Donations may not be required as a condition of admission to the nursing facility or retention in the nursing facility. It is a violation of federal regulations to provide inferior care to those patients whose relatives or other interested parties do not make such donations.

606.1 On a monthly basis, nursing facilities are required to report all voluntary contributions made to the nursing facility by a Medicaid recipient, or by the family, guardian or sponsor of that recipient. This report must be sent to the DCH Nursing Facility Program Specialist. The listing must contain the following information:

- b. The name of the person making the contribution;
- c. The amount of the contribution;
- d. Whether the contribution was "restricted" or "unrestricted". "Restricted" contributions are funds, cash or otherwise, which must be used only for a specific purpose designated by the donor. "Unrestricted" contributions are funds, cash or otherwise, which are given to a provider without restrictions by the donor;
- e. The list of all contributions received in the prior calendar month must be approved by the administrator of the facility and submitted to the Division.

606.2 Audit and completion of payment of the claims will be delayed if the listing of contributors is not attached to, or there is no certification for, contributions included with faxed information or indicated on the certification sheet if the provider bills electronically.

606.3 Nursing facilities are prohibited from contacting recipients, their families, or other interested parties, either personally or by letter, for the purpose of coercing contributions.

606.4 Copies of the voluntary contribution reports will be made available by the Division to appropriate units of the Internal Revenue Service.

607 Reporting Interest on Recipient Funds

On a quarterly basis, the nursing facility must submit to DFCS a listing showing the resident's name, Medicaid number and the amount of interest earned on the resident's funds for the period.

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608 Freedom of Choice, see 42 CFR 431.51

Freedom to choose from among participating health care providers is a legal right of every Medicaid recipient. Freedom of choice relates to the individual's opportunity to make decisions for personal reasons free from the arbitrary authority of others. The purpose of free choice is to allow Medicaid recipients the same opportunities to choose among participating providers of covered health care and services as are generally offered to the general population. This means that Medicaid recipients are subject to the same reasonable limitations in exercising such choice as are non-recipients.

Some medical services which are usually furnished on a fee-for-service basis may occasionally be provided as part of a package of medical care. Package plans may be offered by nursing facilities and must be strictly voluntary. Once the recipient has chosen a package of medical services offered by a particular plan, he or she has exercised the right of freedom of choice for all items of medical care included in the package. The recipient retains the right of free choice of providers of any covered services not included in the package.

Recipients who were patients before a provider instituted a package plan of medical care must be afforded the opportunity to accept or reject the package and must be fully advised of their rights under the freedom of choice regulation as stated above.

If a recipient chooses to use a pharmacy other than the one contracted by the facility, the pharmacy chosen must conform to the drug delivery systems or procedures that are used by the nursing facility. This does not include the production of special reports or forms as these are duties of the consulting pharmacist that are not reimbursable under the pharmacy program.

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609 Required Nursing Hours

Nursing facilities are required to provide a minimum of 2.0 nursing hours (actual working hours) per patient day. In addition to the minimum requirement, nursing facilities must also comply with all provisions of 42 CFR, Section 483.30.

The minimum expected nursing hours are 2.50 to qualify for participation in the Quality Improvement Program and the 1% add-on. (See 1002.4).

PART II - CHAPTER 700

ELIGIBILITY CONDITIONS

701 Eligibility Criteria

In order to be eligible for Medical Assistance in a nursing facility or an intermediate care facility for the mentally retarded, an individual must meet the eligibility criteria established by the Division of Medical Assistance. In addition to the basic eligibility criteria, the Division allows a higher income for individuals who are residents in, or who are seeking admission to, a nursing facility. The Board of the Division of Medical Assistance, based on existing economic indicators, periodically establishes higher income limits for these individuals (see Part I, Section 102).

Should a recipient leave a nursing facility to return home, the higher income limit would no longer apply, and only the basic eligibility criteria would be used to determine continued eligibility for Medical Assistance.

In addition, nursing facility applicants must complete the prior approval/admissions procedures and community care assessment described in Section 800 of the manual.

702 Spousal Impoverishment

Institutionalized individuals with spouses who are not institutionalized are allowed to provide their spouses with income and resources. It is important for the Medicaid provider to refer couples to the county DFCS office for adequate assessment. DFCS will conduct assessments for these recipients on request.

PART II - CHAPTER 800

PRIOR APPROVAL/ADMISSION PROCEDURES AND COMMUNITY CARE ASSESSMENT

800 General

Rev. 07/04 All individuals seeking nursing facility admission must have pre-admission screening for mental illness and mental retardation. A physician will sign a DMA-6 or a Pediatric DMA-6A [Pediatric form for individuals under the age of 21] for those who seek Medicaid payment for nursing facility services. This DMA-6 or Pediatric DMA-6A (P6A) will serve as authorization by the physician that the resident meets the “nursing facility level of care”. See minimal requirements page VIII-3 for applicants 21 years of age and older and VIII-3A for the minimal requirements for individuals under the age of 21 years of age. The DMA-6 or P6A must be kept in the resident’s file in the nursing facility. Nursing facility staff will complete the MDS within fourteen (14) days of admission. Nursing facility staff will also continue to complete MDS documentation as required by the federal mandate.

Rev. 07/04 If at the initial MDS assessment or any time during the admission, the resident no longer meets a nursing facility level of care, the nursing facility must initiate the discharge process. All admissions will be considered permanent until the resident no longer meets a nursing facility level of care. Each nursing facility is responsible for making that decision. **Additionally, all individuals seeking nursing facility admission must be given information on options for Home and Community-Based services** (see Section 802).

Rev. 07/04 Individuals seeking Medicaid payments for services in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) must receive prior approval for the services from the Long Term Care Contractor. **These individuals must have an evaluation of continued need of care once per year.**

801 Pre-Admission/Prior Approval Procedures for Nursing Facilities

Pre-admission screening is mandatory for all individuals seeking admission to a nursing facility, regardless of payment source. Pre-admission screening procedures must be completed at the time a facility enrolls with the Division as a Medicaid provider for all individuals residing in the facility on the enrollment date.

Rev. 04/03 801.1 Pre-Admission Screening and Resident Review (PASRR) for Residents With Indicators of Mental Illness and Mental Retardation:

All nursing facilities must ensure that a person does not need Level II screening before an applicant is admitted to a nursing facility. Authorization must be received and on file. The DMA-6 or P6A and the DMA-613 are the forms that are required for nursing facility admission.

a. The form DMA-6 (Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded) (see Appendix E) or the P6A (see Appendix E-1) must be completed and signed by the physician). The dated signature of a physician on the DMA-6 or P6A must not exceed thirty (30) days prior to the DMA-613 pre-authorization (see 801.1) of a resident. ***It is the responsibility of the nursing facility to secure the signed DMA-6 or P6A prior to admission and the form is kept on file in resident's permanent chart in the facility.***

Note: A new DMA-6 or P6A is completed when a resident is discharged from one nursing facility and admitted into another facility (*transferred*), **or** if the resident is transferred out of the Hospice Program back into the nursing facility's Medicaid Program (*status change*).

A new DMA-6 or P6A **is not necessary** if the resident is transferred from the facility's Medicaid Program *into* the Hospice Program. (This is considered a status change; *however*, only the **DMA-59 is to be completed**. See 801.3).

Note: If the resident is discharged from the nursing facility **without anticipated return** (i.e., the family does not hold the bed after seven days and/or the resident is discharged with the completion of a DMA-59 to DFCS) and the resident returns to nursing facility placement, the admission process *starts over* with a new DMA-6 and a new DMA-59.

If the resident is discharged **with anticipated return**, the resident is considered a readmission; the admission process does not need to be repeated (a new DMA-6 or P6A **is not required**, a **DMA-59 is required** to report status change to DFCS. See 801.3).

The minimal requirements for an applicant to qualify for a nursing facility level of care:

LEVEL OF CARE CRITERIA

1. Intermediate care services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND a mental or functional impairment that would prevent self-execution of the required nursing care (Column B and C Mental Status, Functional Status).
2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than medical. **This individual must also have medical care needs that meet the criteria for intermediate care facility placement.** In some cases a patient suffering from mental illness may need the type of services, which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.
3. **Requirements:** One condition must exist from **Column A** medical status), one from **Column B** (mental status) or **C** (functional status) with the exception of #5, **Column C**.

| COLUMN A Medical Status | COLUMN B Mental Status | COLUMN C Functional Status |
|--|--|--|
| <ol style="list-style-type: none"> 1. Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the criteria listed immediately above, the patient’s specific medical condition must require any of the following plus one item from Column B or C. 2. Nutritional management; which may include therapeutic diets or maintenance of hydration status. 3. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. 4. Catheter care such as catheter change and irrigation. 5. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly). 6. Restorative nursing services such as range of motion exercises and bowel and bladder training. 7. Monitoring of vital signs and laboratory studies or weights. 8. Management and administration of medications including injections. | <p>Mental Status</p> <p>The mental status must be such that the cognitive loss is more than occasional forgetfulness.</p> <ol style="list-style-type: none"> 1. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement. 2. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued placement. 3. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. 4. Undetermined cognitive patterns which cannot be assessed by a mental status exam, for example, due to aphasia. | <ol style="list-style-type: none"> 1. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. 2. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and set-up help of meals. 3. Requires direct assistance of another person to maintain continence. 4. Documented communication deficits in making self-understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis addressed on MDS/care plan for continued placement. 5. Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required). |

- Rev. 10/04 801.1 b. The form DMA-613 (Level I Applicant/Resident I.D. Screening Instrument, see Appendix F) must be completed and signed by the physician. The dated signature of the physician on the DMA-613 must not exceed thirty (30) days prior to the pre-authorization of a resident. The document must be submitted to the Long Term Care Contractor, herein referred to as the Contractor via the web, phone, fax or mail for pre-admission review for Authorization (see Appendix C). An Authorization Code number is issued by the Contractor prior to a resident being admitted into a nursing facility. If the Contractor's review determines that a Level II is necessary, the Level II assessment must also be completed and an authorization code obtained *before* the applicant may be admitted into a facility.
- Rev. 07/04 c. The DMA-613 ***is not necessary*** if the physician certifies before the admission that admission is ***for an anticipated stay*** of not more than 30 days *following hospitalization for treatment of the same condition for which the individual was hospitalized.*
- Rev.07/04 d. If the resident stays more than 30 days, an annual resident review must be conducted by the State mental health and mental retardation authority *within 40 days* of the admission. ***Contact the Contractor with a completed DMA-613 to initiate process for an authorized facility stay.***
- Rev.07/04 e. The DMA-613 ***may be postponed*** for provisional admissions in *emergency situations requiring Protective Services*, with placement *not to exceed seven (7) days*. ***Contact the Contractor with a completed DMA-613 to initiate process for an authorized facility stay.***
- Rev. 7/04 f. The DMA-613 ***may be postponed*** for very brief and finite anticipated stays of *not more than 30 days* in a nursing facility, to provide *respite relief* to in-home caregivers to whom the individual with MI or MR is expected to return. ***Contact the Contractor with a completed DMA-613 to initiate process for an authorized facility stay.***
- Rev. 7/04 The Contractor will determine whether the individual may be admitted to a nursing facility utilizing the following procedures described in section 800. If the DMA-613 as determined by the Contractor's assessment does not reveal indicators for serious mental illness or mental retardation, the individual may be admitted.
- Rev. 7/04 If the DMA-613 reveals indicators for serious mental illness or mental retardation, the Contractor will initiate a Level II Assessment ***before*** a person can be admitted into a nursing facility *or upon the specified times indicated in 801.1c, e, and f.*

Note: The procedure for the DMA-613 is also a requirement if a resident is newly diagnosed with a serious mental illness or discovered to be diagnosed with mental retardation before the age of eighteen (18) or hospitalized , e.g. mental health care, emotional care, etc., for over a one year period.

Rev. 07/04

If the Level II Assessment determines that there is serious mental illness or mental retardation, the assessors will also determine whether the individual requires the level of care provided by a nursing facility and whether the individual requires specialized or rehabilitative services for the mental condition.

Rev. 07/04

If the level of care provided by a nursing facility is required, the assessors will inform the Contractor that the individual may be admitted and assign a Restricted Authorization Code (see 801.2). The assessors will also inform the Contractor if a time limit is imposed and specify the time limit when the individual may be reassessed. A new DMA-6 will need to be signed by the physician for continued stay within thirty (30) days of the time limit expiration date.

If the level of care provided by a nursing facility is not required, admission will not be granted. The decision may be appealed as specified in Appendix I. The Assessors will inform the Contractor and assign a Restricted Authorization Code indicating a denial of placement.

Rev. 10/04

NOTE: Effective July 1, 2004, Medicaid Certified Nursing Facilities must provide rehabilitative services to nursing home residents who are in the PASRR population and have a diagnosis of Mental Retardation or related condition. This change ***does not*** affect residents in the PASRR program who have a diagnosis of Mental Illness or dually diagnosed with Mental Illness and Mental Retardation (MHM will continue to provide services to these residents).
SEE (Appendix H) subtitle: NURSING FACILITY REHABILITATION SERVICES

SEE Appendix H (DIVISION OF MEDICAL ASSISTANCE MENTAL HEALTH AND MENTAL RETARDATION REHABILITATION SERVICES) for complete overview of the PASRR policy.

Rev. 07/04 801.2 Restricted Authorization Code

The Contractor will assign a Restricted Authorization Code (DMA-6, field 9A/9B) on completion of the DMA-613 review. If the applicant does meet admission criteria (see 801.1), the Contractor will assign a Restricted Authorization Code which should be recorded in the specified field 9A or 9B on the DMA-6.

The 9A field is used for recording a newly issued Authorization Code number from the Contractor. This Authorization Code designates initial admission into a nursing facility. The 9B field is for an Authorization Code number previously issued by the Contractor and designates that the resident has been previously authorized with admission privileges into nursing facility placement.

NOTE: The dated Authorization of the DMA-613 must not exceed sixty (60) days prior to the facility's admission of a resident.

Rev. 07/04 801.3 Payment/DMA-59

Effective April 1, 2003, a nursing facility is required to send the DMA 59 to the local DFCS office. The DMA-59 will serve as the DFCS notice that the resident meets a nursing facility level of care and eligibility processing should begin immediately. The nursing facility staff will mark "skilled care" on the DMA-59 form. The skilled block on the DMA 59 form is for record keeping purposes of residents meeting a nursing facility level of care. DCH and DFCS will consider the resident eligible for nursing facility admission via the physician's signature on file. No additional information is needed by DFCS to substantiate a resident's eligibility for a nursing facility level of care.

The DMA-59 will remain in force until such time the resident has a status change i.e., Hospice, transfers out to another facility, is discharged out of the facility, or dies. For any of the referenced circumstances, the nursing facility will generate a DMA-59 and advise the local DFCS office of the resident's status.

Rev.07/04

Medicaid payment can only be made for services during an approved length of stay. Medicaid payment cannot be made for services prior to the admission date. Additionally, Medicaid payment cannot be made until DFCS determines that the individual is eligible for Medicaid, and the Division is notified by Form DMA-59. (Refer to the Billing Manual for information concerning use of the DMA-59.) Medicaid payment will not be made for days the individual was not eligible for Medicaid..

Rev.07/03 801.4 Annual Updates

It is a required to update each nursing facility resident's file annually to ensure a nursing facility level of care. After reviewing the MDS, the Physician will sign an annual attestation form to attest that the resident continues to meet a nursing facility level of care. A standardized form has not been adopted. See one example for the Physician's Attestation Form, that may be used, on the following page.

PHYSICIAN’S ATTESTATION STATEMENT

Patient’s Name _____ **Medical Record No.** _____

Physician’s Name _____

(Physician must review the MDS annually, check the applicable space, sign, and indicate the date signed.) **When there is a change in physician, implement a new form**

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____, continued nursing facility placement.

Physician’s Signature *Date*

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____, continued nursing facility placement.

Physician’s Signature *Date*

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____ continued nursing facility placement.

Physician’s Signature *Date*

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____ continued nursing facility placement.

Physician’s Signature *Date*

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____, continued nursing facility placement.

Physician’s Signature *Date*

I have reviewed the most recent Annual MDS and hereby certify that this patient needs ____, does not need ____, continued nursing facility placement.

Physician’s Signature *Date*

Rev.07/04 801.5 PASRR Limited Length of Stay

If a limited length of stay was recommended by the assessors, the facility must initiate the process for pre-admission again. (Refer to Section 801.) The facility will submit a new DMA-6 to the attending physician to sign, authorizing the resident a nursing facility level of care. A new DMA-613 must be submitted to the Contractor via web, phone, fax, or mail for continued stay in the facility. If the Restricted Authorization Code begins with 1000L, the DMA-6 must be submitted at least five (5) business days prior to the expiration of the currently approved length of stay to allow time for the DHR contractor to conduct a reassessment. The attending physician may sign the DMA-6 up to thirty (30) days prior to the expiration of the currently approved length of stay, attesting to their need for continued nursing facility placement. The DMA-6 is to remain in the resident's file at the nursing facility.

Rev. 07/04 801.6 Transfer from Another Nursing Facility/ Readmissions

When a person is transferred from one nursing facility in Georgia to another, the admitting facility must secure a valid DMA-6. The physician-signed DMA-6 certifies that the resident meets a nursing facility level of care as described in 801.3. For all readmissions and transfers, enter the restricted authorization code and date assigned by the Contractor on Item 9B: State Authority (MH and MR Screening) field of the DMA-6.

Rev. 07/04 801.7 Application for Medicaid

When a person residing in a nursing facility applies for Medicaid, the facility must submit a DMA-59 to the local DFCS as described in 801.3 to obtain a payment date.

Rev. 07/03 801.8 Joint Medicare/Medicaid Recipients

As a resource within the context of 42 CFR, Section 433, Subpart D, an individual with both Title XVIII (Medicare) and the Title XIX (Medicaid) is required to utilize Medicare benefits prior to payment for services under Medicaid, but only if the Medicare services are actually available to the individual. In order to utilize Medicare benefits, the individual must be admitted to a nursing facility certified to participate in the Medicare program in accordance with Sections 1861 (i) and 1861 (j) of the Social Security Act.

In the determination of whether Medicare services are available, such factors as travel distance, family and attending physician proximity, as well as medical needs, will be considered by DFCS. For example, the State will not require use of a nursing facility which participates in both Medicare and Medicaid if the travel distance is excessive, if there are no vacancies, if the facility does not provide the kind of services needed, or

if the use of the particular nursing facility would require a change of attending physician against the wishes of the individual.

Persons eligible for Medicare Part B may be admitted directly to a nursing facility without regard to Section 1861 (i) of the Social Security Act. Prior to being admitted into a nursing facility, pre-admission approval must be obtained.

801.9 Medicare Part A Coverage for Nursing Facility Services

Residents who appear to be eligible for both Medicare and Medicaid may be admitted as Medicaid. The question frequently arises as to why an individual who apparently meets Medicare and Medicaid eligibility requirements is not covered for nursing facility services under Medicare and is admitted as a Medicaid-only recipient.

Ineligibility for Medicare Part A coverage can result from one of the following conditions:

- a. The person has not been approved (added to eligibility file) for Medicare.
- b. The person was not admitted to the nursing facility within 30 days following hospitalization.
- c. The available benefits under Title XVIII (Medicare) have been exhausted.

Rev. 07/04

802 Home and Community-Based Services Option Requirements

It is the policy of the State of Georgia that services are delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social and community integration. Based on this policy, all potential residents and/or their authorized representatives will be afforded an opportunity to make an informed choice concerning services.

It is the responsibility of the nursing facility to inform all potential and existing residents and/or their authorized representatives of home and community-based service options. This will be done for all persons who are Medicaid eligible or potentially Medicaid eligible at the time of admission and on an annual basis at the time of the annual comprehensive reassessment (i.e., RAI/MDS) required by federal regulations. If the authorized representative is unable to be physically present at the reassessment, the nursing facility must document that they have provided information about home and community-based options to the resident or the authorized representative through the mail.

Rev. 07/04

The nursing facility will advise applicants and residents of home and community-based service options using Form-385 (see Appendix F). The intent of this form is to ensure that individuals will be:

- a. advised of options available under state waiver programs
- b. provided information about these options
- c. provided information about how to seek additional information about options
- d. provided information about how to apply for services

The following process ensures that applicants/residents representatives are given the information necessary for them to make an informed choice concerning service options.

Process

- Rev. 07/04
- Step 1 **Provide each potential and existing resident (hereafter referred to as "consumer") or authorized representative with the Department of Community Health (DCH) booklet describing all home and community-based service options. *This will be done upon admission and again at the time of the annual comprehensive reassessment (RAI/MDS).*** If the authorized representative is unable to attend the reassessment, this booklet will be sent to the representative through the mail. The booklet is titled “Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia”, and can be ordered by submitting your request by FAX (404) 656-8366 attention Pamela Madden or EMAIL pmadden@dch.state.ga.us, which should include your facility representative, address (***street address only, No PO Box***), telephone number and the number of books requested. If your facility does not have the capability for the above options, you may call (404) 657-9946. Please allow up to four weeks for shipment. See the following page for request/order form for faxing or emailing as indicated above.
 - Step 2 Once information has been provided, a nursing facility representative (hereafter referred to as "informant") will verify this by placing his/her signature on Form-385 under the informant’s verification statement.
 - Step 3 The informed consumer/authorized representative acknowledges receipt of the home and community-based information. This individual then signs under the acknowledgement statement. If the authorized representative is unable to attend the annual reassessment, the informant will document on Form-385 that a copy of the booklet has been sent through the mail.
 - Step 4 Once the form is completed (signatures under appropriate statements), it must be placed in the consumer's facility record.



FACSIMILE TRANSMITTAL SHEET

RE-ORDER FORM

| | |
|---|--|
| TO: | NAME OF FACILITY |
| Attn: Pamela Madden | |
| COMPANY: | ADDRESS: (STREET ADDRESS ONLY)- NO P.O. BOX |
| DCH- Aging and Community Services | |
| FAX NUMBER: | TOTAL NO. BOOKLETS REQUESTED:----- ATTN: |
| 404.656.8366 | |
| PHONE NUMBER: | SENDER'S PHONE NUMBER: |
| | |
| RE: | YOUR FAX NUMBER: |
| "Home and Community Services, A Guide to Medicaid Waiver Programs in Georgia" | |

- Urgent For Review Please Comment Please Reply Please Recycle
-
-

Rev. 07/04 **803 Pre-Admission/Prior-Approval Procedures for Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)**

Persons seeking Medicaid payment for services in an ICF/MR must have the following information submitted to the Department of Human Resources (DHR) contractor for pre-admission review in a state owned nursing facility or to the Long Term Care Contractor for a non-state owned facility:

- a. Form DMA-6 (Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded) must be completed and must be signed by the attending physician (see Appendix E);
- b. psychological evaluation, which must have been completed within the three-month period prior to the review;
- c. social evaluation; and
- d. developmental care plan.

The contractor will determine whether the applicant requires the level of care provided in an ICF/MR.

- a. If the level of care provided in an ICF/MR is required, the contractor will complete fields 36 and 37 on the DMA-6. The length of stay will be given up to twelve (12) months . The approved time period will be specified in days. The individual may then be admitted to the ICF/MR. If the admission does not occur within 60 days, the approval will not be valid and an updated DMA-6 must be resubmitted for pre-admission review and approval. An updated psychological evaluation will be required if the one previously submitted was done more than three (3) months prior to the new review.
- b. If the level of care provided in an ICF/MR is not required, admission will be denied. This decision may be appealed (see Appendix I).

Rev. 07/04 **803.1 Payment Date**

When the person is admitted to the ICF/MR, the facility must enter the admission date on the DMA-6 (field 8) and return the forms to the Contractor. If the forms are received by the Contractor, the payment date will be the date of admission. Medicaid payment can only be made for services during an approved length of stay. No Medicaid payment can be made for services prior to the admission date. Additionally, Medicaid payment cannot be made until DFCS determines that the individual is eligible. Medicaid payment will not be made for those days the individual was not eligible for Medicaid.

803.2 ICFMR Continued Stay

The facility must submit a new DMA-6 to the contractor to obtain prior approval for continued stay in the facility beyond the designated date. The DMA-6 may be submitted up to 30 days prior to the expiration of the currently approved stay. The contractor conducts a desk evaluation of continued need of care for each Medicaid recipient in an ICF/MR in the State of Georgia once per year. Reviews are based on information submitted on the DMA-6 and a current developmental care plan. A current psychological examination must also accompany the forms if the resident is under the age of eighteen (18) every three (3) years.

If the resident continues to require ICF/MR care, the contractor will assign an approved length of stay. If the new DMA-6 is received prior to the expiration of the currently approved stay, there will not be a lapse in payment.

803.3 Transfer from Another ICF/MR

When a person is transferred from one ICF/MR in Georgia to another, the admitting facility must submit Form DMA-6 to the contractor.(see Manual Section 803.1).

803.4 Application for Medicaid

When a person residing in an ICF/MR applies for Medicaid, the procedures in the manual, Sections 803 and 803.1 must be completed before any Medicaid payment can be made.

PART II - CHAPTER 900

SCOPE OF SERVICES

901 Covered Services

- a. Nursing facility residents are allowed to retain a personal needs allowance from their income each month which can be used for clothing and other personal needs while in an institution. The personal need allowance is currently set at \$30.00 per month.
- b. Nursing facility covered services: The approved reimbursement rate established for each facility by the Division of Medical Assistance is an inclusive rate that covers the cost of the following services and items at no additional charge to the Division, the recipient, or the recipient's representative:
 - 1) Resident's room and board including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician. Insofar as possible, privacy shall be accorded a recipient with a terminal illness; however, this shall not be interpreted to require a private room.
 - 2) Laundry (including personal laundry).
 - 3) Nursing and routine services:

Routine services include all nursing services, supplies and other equipment related to the day-to-day care of the patient. Items of service which are covered under routine services (regardless of the condition of the patient) include, but are not limited to, the following:

- Nursing service (excluding private duty nurses)
- Medical social services
- Activities program
- Physical therapy
- Speech therapy
- Specialized rehabilitative services
- Restorative nursing care
- Hand feedings
- Enemas
- Assistance in personal care and grooming

i. Nursing supplies and dressings

- Extra linens
- Laboratory procedures not requiring laboratory personnel
- Tray service
- Durable medical equipment such as but not limited to beds, bedrails, walkers, wheelchairs, oxygen equipment, oxygen, and related supplies.

4) Incontinency care

- Incontinency pads, diapers, and sanitary pads
- Special mattresses and pads

5) Routine personal hygiene items and services including, but not limited, to:

shampoo, hair conditioner, comb, brush, bath soap, non-legend disinfecting soaps or specialized cleansing agents (when indicated to treat special skin problems or to fight infection), razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, petroleum jelly, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, towels, washcloths, hospital gowns, nail care, hair care, bathing, and shaving.

6) Over-the-Counter (OTC) Drugs and Related Items:

Each nursing facility shall, as part of nursing and routine services, supply clinically necessary over-the-counter drugs and related items to be used for recipients as ordered by the attending physician without additional charge to the recipient, the recipient's representative or the Division. Each item must be available in adequate supply to assure the recipient's timely receipt of the items as ordered. These items will be provided generically or in a brand of the nursing facility's choosing, unless the doctor has a clinically necessary reason to choose a particular brand. A clinically necessary reason for choosing a particular brand is defined as a documented adverse effect or a documented lack of desired therapeutic effect with the use of the brand provided by the nursing facility.

Residents may only be charged for over-the-counter drugs if, after being informed of the options, he or she chooses to purchase a specific brand for non-clinical reasons from his or her personal needs allowance. The resident's decision to use his or her personal needs allowance for OTC drugs or supplies must be documented.

The items to be supplied by the nursing facility shall include, but shall not be limited to, the following:

Stool Softener and Laxative

Magnesium Hydroxide Liquid (Milk of Magnesia)

Glycerin Suppositories

Stool Softener

Bulk Laxative

Stimulant Laxative

Anti-diarrheal

Non-legend anti-diarrheal product

Antacid

Antacid without sodium

Analgesic/Antipyretic

Acetaminophen -tablets, liquid, suppositories

Aspirin - tablets, suppositories

Ophthalmological

Artificial tears in multi-dose containers labeled for specific patient's use

Diluents/ Irrigants

Normal saline

Sterile water

Treatment Solutions

Chlorhexidine gluconate (Hibiclens)

Rubbing Alcohol

Povidone-iodine 10% (Betadine)

Hydrogen Peroxide 3% (Peroxide)

Vaccines

Influenza Vaccine

Hepatitis B Virus Vaccine (ICF-MR only)

Other

Other clinically-necessary non-legend drugs ordered by the physician for which there is no substitute.

*Please note that the above list is not all inclusive. It is provided for illustration purposes only.

c. Drugs Eligible For Coverage By Full Dual Eligibles Receiving Medicare Part D Benefits

Effective January 1, 2006, full-dual eligible ≥ 21 years old may receive Medicaid fee for service payment for only the following drugs and/or therapeutic categories. All therapy quantity and service limits as well as prior approval requirements remain in effect.

- Generic Benzodiazepine
- Secobarbital, Phenobarbital and Mebaral
- Folic Acid 1mg
- Legend prenatal vitamins for women
- OTC iron
- Diphenhydramine
- OTC generic Loratadine and Loratadine D-
- ESRD vitamins and antacids:
Calcium Carbonate, Aluminum Hydroxide, calcium acetate. Calcium Carbonate with Glycine, Calcium Lactate, Dioctyl Sodium/Calcium Sulfosuccinate, Niacin, Pyridoxine Hydrochloride, Thiamine Hydrochloride, Vitamin B Complex (All Require Prior Approval)

Members <21 years old may receive all medications listed above as well as the following drugs and/or therapeutic categories. All therapy quantity and service limits as well as prior approval requirements remain in effect.

- Cough and cold products
- CoEnzyme Q10
- Vitamin E
- Fluoride Preparations not in combination with other vitamins
- OTC Multi-Vitamins and Multi-Vitamins with Iron (chewable or liquid drops)
- Pen-X: KLOUT.
- Meclizine
- Ibuprofen Susepension

***Note: All covered OTC's require a prescription. Please review Appendix B of the Pharmacy Manual for a description of applicable therapy limits.**

Rev. 01/06

902 Prescription Drugs

Prescription drugs are reimbursed under a separate administrative process and not otherwise included in the nursing facility per diem rate.

Effective January 1, 2006, the Medicare Modernization Act (MMA) provides for Medicare prescription drug coverage to begin. Residents are eligible for the Medicare prescription drug benefit if enrolled in Medicare Part A **and/or** Part B. For the first time, Medicare will offer prescription drug coverage (Medicare Part D). Residents with Medicare who also have Medicaid coverage should have been informed that the new Medicare prescription drug plan will cover their prescriptions beginning January 1, 2006, and that drug coverage will be provided by Medicare rather than Medicaid.

Full benefit dual-eligibles will be automatically enrolled into a Prescription Drug Plan (PDP) by the Center for Medicare and Medicaid Services (CMS). Members will have an opportunity to select a PDP of their choice once they receive notification from CMS of their assignment in November 2005.

If you have questions about the new Medicare prescription drug program and its impact on your residents, please call: **GeorgiaCares/SHIP at 1-800-669-8387**. Questions about residents' rights relative to the new prescription drug program can be directed to: **Long-Term Care Ombudsman at 1-888-454-5826**.

902.1 Requests via Telephone or Facsimile

Rev. 01/06

Requests for drugs to exceed therapy limitations or for drugs that require prior approval shall be directed to the agent, Express Scripts, Inc. by phone. Contact by fax or mail is not preferable, but allowed.

Rev. 10/04

The agent's Prior Authorization Department is staffed by associates and clinical pharmacists 24 hours/day, 365 days per year. (Clinical pharmacists are on call after normal business hours, from 7 PM - 9 AM Eastern time). Prior Authorization requests may be made telephonically, via facsimile, or in writing via U.S. mail, to:

Express -Scripts, Inc.
Prior Authorization Department
P.O. Box 390842 - BW 1040
Minneapolis, Minnesota 55439

PA Requests 1-877-650-9340, press 2
Fax Line 1-877-697-7192

902.2 Denial of Requests

Any request, which cannot be approved by the agent, will be communicated to the requester at the time of the request.

Appeals of denied requests must be submitted to the agent within ten (10) business days of the denial. The appeal must be reviewed and the requesting provider notified of the results within seven (7) business days of the receipt of the appeal, unless additional information is required. In this case, the decision must be made within seven (7) days of receipt of the additional information.

If an appeal is denied by the agent, a provider may request a 2nd level appeal by DCH within ten (10) business days.

902.3 Requests Returned for Additional Documentation

Any prior approval request that cannot be approved due to insufficient information will be returned to the physician for additional information.

902.4.1 Null and Void Authorization

Should any of the drugs approved, later become non-covered or have dispensing limitations placed on them, the authorization for the drugs will be null and void. In addition, reimbursement is contingent upon the member's eligibility at the time service is rendered.

902.4.2 Appeal of Prior Approval Denials

Residents and responsible parties shall not be liable for cost of medications where timely requests for prior approval have not been sought. Prior approval denials can be appealed in writing to the Medicaid Pharmacy Services Unit. See section 802.3 of Part II Medicaid Pharmacy Policies and Procedures for a complete description of the pharmacy secondary clinical appeals process.

Rev.10/04

903 Room Accommodations

A nursing facility must provide, as a part of routine care, room accommodations as specified in nursing facility licensure and certification requirements. A nursing facility may provide more space per bed, but an increase in reimbursement will not be provided for such extra space or for a private room. A provider of nursing facility services shall be obligated to provide a recipient of medical assistance with only semi-private accommodations which meet appropriate regulations. ***This policy does not prohibit voluntary supplementation by a relative or person other than the recipient for the specific purpose of obtaining a private room for the recipient.*** Such third party supplementation constitutes payment for non-covered services. At no time can more than 10% of nursing facility rooms be used for Medicaid recipients for whom private room supplementations have been made.

The provision of a private room to a recipient, when supplementation is provided, shall not constitute discrimination against other recipients. ***However, under no circumstances may a nursing facility discriminate with respect to accommodations on the basis of the presence or absence of such supplementation.*** If supplementation is not provided, a nursing facility must agree to accept the established reimbursement rate as payment in full for the room, regardless of whether it is private or semi-private. Payments made by relatives or persons other than the recipient to a provider for the specific stated purpose of paying the additional costs of a private room for a recipient will not be considered as income when determining the amount of patient liability toward the nursing facility's payments.

A recipient who is transferred to or admitted to a private room because of a shortage of beds in semi-private rooms ***shall not be discharged*** because of the absence of a relative or other person who is willing and able to provide supplementation.

If supplementation for a private room is available, the rate charged by the provider to the relative or other person providing that supplementation shall not

exceed the difference between the maximum rate charged by the provider for a private room for a private pay patient and the amount which the provider receives, or will receive, from the Division as reimbursement for the recipient's care in a semi-private room.

Any daily benefit payment from a long-term care insurance policy is subject to recovery by the Division even though an adult "child" may be paying the premium on behalf of the parent/recipient. This daily benefit may not be applied to the nursing facility for the additional cost of a private room.

Rev. 10/04 **904** **Reserving Nursing Facility Bed While Recipient is on Leave or Hospitalized**

Federal regulations provide that a recipient of Medical Assistance must have complete freedom of choice of providers of services. Therefore, he/she has a right to leave a facility at any time. Recipients will not be detained in a facility when competent or if a responsible member of the family wishes to remove them. Personal belongings must be released. Recipients may also obtain a leave of absence from the nursing facility as follows:

- a. Planned leave of a therapeutic nature away from the nursing facility, when authorized by the attending physician in the patient's plan of care, can be reimbursed with the facility's state payment rate (see Section 1006) under the program when a bed is held for the recipient. The Division cannot assume any portion of the cost for days exceeding the limits specified in Sections 904.1 through 904.3. Arrangements for holding a bed for a recipient for days exceeding the established limit must be made with the family or friend at a mutually agreed upon rate not to exceed the total allowable per diem billing rate that the facility would have been reimbursed had the recipient been in the facility. Any overnight stay away from the nursing facility will constitute one day. Hours away from the facility are not cumulative. All planned visits must be supported by a written order by the attending physician.
- b. The Division requires that each patient's record have an easily identifiable leave of absence form. The form should include: Patient's name, Medicaid number, level of care, the date and time the patient leaves the facility and the date and time the patient returns to the facility. The facility staff must sign or initial the form when the patient leaves and returns. The DMA-356 (Nursing Facility Leave of Absence Form) may be used to satisfy this requirement (see Appendix F).

Rev. 07/03 **904.1** **Planned Leave for Nursing Facility Residents**

Effective April 1, 2003, a nursing facility resident may spend up to eight (8) days within a calendar year with a relative or friend without a reduction in the amount of Medical Assistance payment with the facility's state payment rate (see Section 1006). The attending physician must document in the plan of care that such visits are therapeutic in nature. A recipient's total visits cannot exceed a total of eight days in any calendar

year. Payment will not be made to a facility on behalf of a recipient for any days exceeding the number of allowable visits per year.

904.2 Intermediate Care Facility for the Mentally Retarded (ICF/MR)

A recipient in an ICF/MR may visit with a relative or friend up to thirty days per calendar year without reduction in the amount of Medical Assistance payment to the facility provided that the attending physician documents in the plan of care that such visits are therapeutic in nature. There is no limit as to the number of days per visit as long as the total number of days does not exceed thirty days per calendar year. Payment will not be made to a facility on behalf of a recipient for any days exceeding the number of allowable visits per year.

904.3 Hospitalization/Bed-hold Payment

When a recipient in a nursing facility or ICF/MR who is authorized for regular vendor payment is hospitalized, the facility's state payment rate (*see Section 1006*) may be continued for seven (7) days during the hospital stay. However, it is permissible for the family or other interested party to arrange for the facility to hold the bed for a longer period of time while the recipient is hospitalized. The facility may charge a mutually agreeable rate not to exceed the total allowable per diem billing rate that the facility would have been paid had the recipient been in the facility. The Georgia Division of Medical Assistance cannot pay any portion of the cost of services in a facility for the period of time while the patient is hospitalized beyond the seven-day (7) period.

905 Reporting and Billing Days of Care

The number of days of care charged to a recipient for nursing facility services is always in units of full days. A day begins at midnight and ends twenty-four hours later. The midnight to midnight method is to be used in reporting days of care for recipients, even if the facility uses a different definition of day for internal purposes.

A part of a day, including the day of admission, counts as a full day. However, the day of discharge or death is not counted as an inpatient day. If admission and discharge or death occur on the same day, the day is considered a day of admission and counts as one inpatient day. Leave days or hospital days for which the nursing facility receives reimbursement from any source are to be counted as inpatient days.

Rev 07/03

Effective with the new GHP and MHN system implementation, Nursing Facilities will submit their claims in a UB-92 format. This may be accomplished in several ways:

- Providers may either use Billing Agents/Clearing House who must register with ACS to submit claims
- Providers may use the WINASAP software, after registering with ACS to submit claims*
- Providers may submit their claims via the Web or,
- Providers may submit paper UB-92 claims (as a final resort). Paper claims should be sent to the GHP in McRae.

Rev 04/03

Claims must be filed on the required form with appropriate information in specific blocks for payment. Claim(s) form for Nursing facilities is the **UB-92** (National Uniform Billing Form). Claim(s) must be submitted within six (6) months from the month of service. Claim(s) with third party resources must be submitted within twelve (12) months from the month of service.

Depending upon whether you are using Vendor Software, WINASAP or the Web, the fields may look different; however, the same codes should be used.

APPROVED OMB NO. 0938-0279

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|--|----------------------------|-----------------------------------|---|-----------------------|--|
| <p style="font-size: 2em; text-align: center;">1</p> | 2 | 3 PATIENT CONTROL NO. | 4 TYPE OF BILL | | |
| 5 FED. TAX NO. | | 6 STATEMENT COVERS PERIOD FROM TO | 7 COVD. 8 N-C.D. 9 C-ID. 10 L.R.D. 11 | | |
| 12 PATIENT NAME | | 13 PATIENT ADDRESS | | | |
| 14 BIRTHDATE | 15 SEX 16 MS 17 DATE | 18 HR 19 TYPE 20 SSG | 21 D.HR 22 STAT 23 MEDICAL RECORD NO. 24 25 | | |
| 26 27 28 29 30 31 | CONDITION CODES | | | | |
| 32 OCCURRENCE DATE 33 CODE | 34 OCCURRENCE DATE 35 CODE | 36 OCCURRENCE DATE 37 CODE | OCCURRENCE SPAN FROM THROUGH | | |
| 39 VALUE CODES AMOUNT | | 40 VALUE CODES AMOUNT | | 41 VALUE CODES AMOUNT | |
| a | | b | | c | |
| b | | a | | b | |
| c | | b | | c | |
| d | | c | | d | |

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|-------------|----------------|------------------|---------------|----------------|------------------|------------------------|----|
| 1 | | | | | | | 1 |
| 2 | | | | | | | 2 |
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|----------------------------------|-----------------------------|-------------------------------|-------------------|------------------------|---------|-----------------------|---------|---------|-------------------|-----------|----|
| 50 PAYER | 51 PROVIDER NO. | 52 REL INFO 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 | | | | | | |
| A | | | | | | | | | | | |
| B | | | | | | | | | | | |
| C | | | | | | | | | | | |
| DUE FROM PATIENT ▶ | | | | | | | | | | | |
| 57 | | | | | | | | | | | |
| 58 INSURED'S NAME | 59 P. REL | 60 CERT. - SSN - HIC - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. | | | | | | | |
| A | | | | A | | | | | | | |
| B | | | | B | | | | | | | |
| C | | | | C | | | | | | | |
| 63 TREATMENT AUTHORIZATION CODES | | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION | | | | | | | |
| A | | | | A | | | | | | | |
| B | | | | B | | | | | | | |
| C | | | | C | | | | | | | |
| 67 PRIN. DIAG. CD. | 68 CODE | 69 CODE | 70 CODE | 71 CODE | 72 CODE | 73 CODE | 74 CODE | 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78 |
| 79 PC. | 80 PRINCIPAL PROCEDURE DATE | 81 OTHER PROCEDURE DATE | | OTHER PROCEDURE DATE | | 82 ATTENDING PHYS. ID | | | | | |
| | | A | | B | | | | | | | |
| | | C | | D | | | | | | | |
| 84 REMARKS | | 83 OTHER PHYS. ID | | OTHER PHYS. ID | | | | | | | |
| a | | A | | B | | | | | | | |
| b | | a | | b | | | | | | | |
| c | | a | | b | | | | | | | |
| d | | X | | 86 DATE | | | | | | | |

UB-92 HCFA-1450 OCR/ORIGINAL I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-92 Form

Completion of the National Uniform Billing Claim Form (UB-92)

A universal Billing Manual is available. However, fields that must be completed for Nursing Facility claims to be paid are:

FL 4. Enter a code indicating the specific type of bill (e.g., interim, final).

| <u>TYPE OF BILL</u> | <u>First and Second Digits</u> | <u>Third Digit*</u> |
|---------------------|--------------------------------|---------------------|
| Skilled Care | 21 | 1, 2, 3 or 4 |
| Intermediate Care | 21 | 1, 2, 3 or 4 |
| ICF/MR | 66 | 1, 2, 3 or 4 |

***The Third Digit Codes are:**

1 = Admit through Discharge

2 = Interim – First Claim

3 = Interim –Continuing Claim

4 = Interim – Last Claim

Note: For routine continuous stay bills, the TYPE of Bill should be 213 or 663

FL 5. Federal Tax Number

FL 6. Statement Covers Period
Enter the beginning and ending service date(s) of the period included on this bill.

FL 7. Covered Days
Enter the number of days covered by the primary payer. This should be the total number of accommodation units reported in #46.

FL 12. Patient Name
Enter last name, first name, and middle initial of the patient. If the name on the Medicaid card is incorrect, the recipient or the recipient's representative should contact the local DFCS to have it corrected immediately.

FL 14. Patient Birthdate
Record date of birth exactly as it appears on the Medicaid Card. An unknown birth date is not acceptable. If the date on the Medicaid Card is incorrect, the recipient or the recipient's representative should contact the DFCS to have it corrected immediately.

FL 17. For inpatient services, the date of admission is considered to be the date the patient began receiving care, including the observation period. Preadmission testing must be included on the inpatient claim.

FL 19. Type of Admission
Use Code 3- Elective

Elective – the patient’s condition permits adequate time to schedule the availability of a suitable accommodation.

FL 20. Source of Admission
Use Code 1. Physician Referral

FL 21. Discharge Hour
Enter the hour (00-23) that the patient was discharged from inpatient care if there is a discharge code in field 22.

FL 22. Patient Status

Use Code 30. PATIENT STATUS CODES

Still a Patient

30 - (Replaces old patient status code “T”)

Note: Unless the patient is being discharged from the facility with no expectation of a return, please use status code “30”

Discharge

- 01 – Discharged to home or self care**
- 02 – Discharged/Transferred to another short-term general hospital for inpatient care (Replaces old patient status code “B”)**
- 03 – Discharged/Transferred to Skilled Nursing Facility**
- 05 – Discharged/Transferred to another type of institution for inpatient care**
- 04 – Discharged/Transferred to Intermediate Care Facility**
- 06 – Discharged/Transferred to home under care of organized home health service organization**

Deceased

20 – (Replaces old patient status code “G”)

EXAMPLES:

Example 1

Billing for Members still in the facility.

Billing Period: 04/01/2003 through 04/07/2003

FL 6 - From/Through Dates: 04/01/2003 – 04/07/2003

FL 7 - Covered Days: 7

FL 22 - Status: 30

Note: Unless the patient is being discharged from the facility with no expectation of holding the bed, please use a status of 30 for “Still a Patient”.

Note: In the past, providers have often used a Patient Status of “B” when a patient is discharged to a hospital with the expectation that the hospital stay will be an extended one

(i.e. one well beyond the 7 bed hold days). If you are billing for that situation, use a **Discharge Status 02 (FL 22)**. Medicaid does not pay for the Date of Discharge nor the Date of Death, so bill your claim accordingly, using valid UB-92 Discharge or Death Status Codes.

FL 42 Revenue Code

Enter the appropriate Revenue Code

190-Accommodations

182- Planned Leave

185- Hospital Leave

Rev. 01/01/06

Effective January 01, 2006, Revenue Code 190 is to be used to bill nursing facility accommodation charges. Providers must bill only the days the member is in the facility.

In addition, please be informed that if you are billing for patient leave days, whether planned, or hospital stays, you must bill a Revenue Code 190. This line must only include the days the member is in your facility for that billing period. Then bill the appropriate Leave Day Revenue Code with a beginning date of service and the total number of days the patient is away from the facility. If you are billing more than one Leave segment during a month, you must bill each segment on a separate line with the correct beginning date of service. Both Revenue codes, (190 and/or 182, 185) should total the covered days on the claims.

Example 2

Dates of service: 01/01/2006 – 01/16/2006 (covered days 16)

Line 1 – 190 Revenue Code – 01/01/06 - (10 units)

Line 2 – 185 Revenue Code – 01/10/06- (6 units)

Total = Line 1 and line 2 totaled = 16 days

Example 3

Dates of service: 01/01/06 – 01/16/06 (16 covered days)

Line 1 – 190 – 01/01/06 – (12 units)

Line 2 – 185 – 01/08/06 – (4 units)

Total lines= Line 1 and line 2 totaled= 16 days

Example 4

Dates of service: 01/01/06 – 01/31/06 (31 covered days)

Line 1 – 190 –01/01/06 (20 days)

Line 2 – 185 – 01/08/06 (6 days)

Line 3 – 185 – 01/21/06 (5 days)

Total lines = Line 1, 2 and 3 totaled= 31 days

The system will price the Revenue code 182 and 185 lines automatically and separate from the 190 Revenue code. These lines will be priced according to the leave rates in the system for each facility.

If you are billing more than one leave segment, you must enter another line with Revenue Code 182 or 185.

***PLEASE BE SURE YOU COMPLETE ALL REQUIRED INFORMATION ON THE CLAIM FORM.**

- FL 46. Units of Service
Enter the number of days associated with Revenue Codes in FL 42.
- FL 47. Total Charges (by Revenue Category)
Enter the total charges pertaining to the related revenue code for the current billing period as entered in the statement covers period. Only charges relating to the covered eligibility dates should be included in total charges.
- FL 50. Payer
Enter payer name and carrier code* of any liable third party payer other than Medicare. (*Carrier codes are located in the Third Party Insurance Carrier listing).
- A reasonable effort must be made to collect all benefits from other third party coverage. Federal regulations require that Medicaid be the payer of last resort. (See Chapter 300 of the *Policies and Procedures Manual applicable to all providers*).
- When a liable third party carrier is identified on the card, the provider must bill the third party,
- FL 51. Provider Number
Enter the number assigned to the provider by the payer indicated.
- FL 54. Prior Payments
Enter the amount that the hospital has received toward payment of this bill from the carrier.
- FL 55. Estimated Amount Due
This is field where the total charges will be captured.
- FL 58. Insured's Name
Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the Medicaid card. If the name on the Medicaid card is incorrect, the recipient or the recipient's representative should contact the local DFCS to have it corrected immediately.
- FL 60. Certification/SSN/HIC/ID No.
Enter the Medicaid Recipient Client Number *exactly* as it appears on the Medicaid card.
- FL 61. Insured Group Name
Enter the name of the group or plan through which the insurance is provided to the insured if the patient has a third party. Medicaid requires the primary payer information on the primary payer line when Medicaid is secondary.
- FL 62. Insurance Group Numbers
Enter the identification number, control number, or code assigned by the carrier or payer if the patient has Third Party.

- FL 67. Principal Diagnosis Code
Enter the ICD-9-CM code for the *principal* diagnosis
Codes prefixed in “E” or “M” are not accepted by the Department. A limited
number of “V” codes are accepted
- FL 76. Admitting Diagnosis
Enter the ICD-9-CM diagnosis code provided at the time of admission as stated
by the physician.
- FL 85. Provide Representative Signature
An authorized signature is required.

Submit to the Contractor/ Fiscal Agent:

ACS/Georgia Health Partnership
PO Box 5000
McRae, GA 31055-5000

Phone: 1-800-766-4456 or (404) 298-1228

906 Discharge Date

Neither the Medicaid program, the recipient nor the sponsor may be charged any monies for the date of discharge or death regardless of the time the patient departs the facility. Additionally, the facility may not charge the Division, the recipient or the responsible party for days subsequent to the discharge date (except when bed is being held as explained in Section 904).

907 Nursing Facilities with Residents Having Diagnoses of Mental Disease

Reimbursement is not available to a facility classified as an Institution for Mental Diseases (IMD).

The criteria below are to be considered when determining the overall character of a facility and when making a determination on non-payment to a facility. These criteria are to be considered in evaluating the facility's overall character; no single criterion will be sufficient to classify the facility as an IMD.

1. Facility location within a 25-mile radius of an existing mental hospital. If it is physically adjacent or near an existing mental hospital, and the facility regularly accepts a majority of its patients as transfers from a mental hospital, this is one indication that the facility is an IMD.
2. The age distribution of the patients. The age distribution should be substantially younger than the Georgia nursing facility average.
3. The facility's license as a mental health care facility.
4. The types of services and treatments the facility provides. If it provides psychological therapy and counseling on a regular basis to a majority of patients as part of an ongoing plan of care, this is another indication that the facility is an IMD.
5. The backgrounds, specialties and training of the facility's employees and medical staff. If the facility requires its employees to have a psychiatric background, this would indicate that the facility could be an IMD.
6. The diagnoses of the patients. If 50% or more of the patients have a primary diagnosis of mental disease, this is an indication that the facility is an IMD.

The criteria listed below will be used to determine whether a patient has a primary diagnosis of mental disease.

- 1) A patient with a physical problem necessitating nursing facility care who has no mental disability is considered a physical patient.
- 2) A patient with mental disability necessitating nursing facility care who has no significant physical problem is considered a mental patient.
- 3) A patient with physical problems that would not independently necessitate nursing facility care, but who has a mental disability that would preclude the proper handling of this physical problem outside a nursing facility and for whom nursing facility care is necessary due to the mental disability in functioning, is considered a mental patient.
- 4) A patient with a mental disability and physical problem, either of which would independently require nursing facility care, will generally fit into one of the following groups:

- a) A patient with long-standing mental disability who develops major physical problems and vice-versa. When it is clear that nursing facility care resulted from one or the other, the patient will be classified according to the original basis for admission, physical or mental.
 - b) A patient for whom no clear-cut distinction is possible, as in group (1), will be considered a physical patient.
- 5) A patient not fitting into categories (a) through (d) who was admitted to a nursing facility from an inpatient psychiatric facility (i.e., state mental hospital) and who cannot be discharged because of his or her need for mentally or physically-related care, is considered a mental patient.
 - 6) Mental diseases are those listed under the heading of mental disorders in the International Classification of Diseases, 9th Revision - Clinical Modification (ICD-9), except for mental retardation.
 - 7) Organic brain syndrome, senile dementia and mental retardation are excluded from the definition of mental disease.

908 Clinic Services to Residents in Nursing Facilities and ICFs/MR.

Clinic services are defined as services that are provided to outpatients. An outpatient is defined as a patient who is receiving professional services at an organized medical facility, or distinct part of such a facility, neither of which is providing the patient with room and board and professional services on a continuous 24-hour-a-day basis.

The definition of outpatient does not exclude residents of Title XIX long term care facilities from receiving clinic services either through an arrangement between the facility and the clinic or from a clinic which is chosen by the resident. The clinic from which they receive services may not provide them with room and board and professional services on a continuous 24-hour-a-day basis. Since clinic services must be provided on an outpatient basis, eligibility for clinic services is limited to the following patients:

- a. who for the purpose of receiving necessary health care go to a clinic, or other sites where the clinic staff is available; and
- b. who on the same day leave the site from which the services are provided.

This requirement precludes residents of nursing facilities and ICFs/MR from receiving clinic services that are provided in the long-term care facility. Therefore, these services must be provided at a location which is not a part of the long-term care facility. If provided at the location of the facility, these services may not be covered as clinic services; they could be covered as long-term care services if included in the package of institutional services provided to the residents of the facility.

909 Advance Directives

In compliance with Section 1902 (a) (57) of the Social Security Act, nursing facilities must:

- Provide written information to residents regarding their rights under State law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;
- Provide written information to individuals regarding the institution's written policies respecting the implementation of the right to formulate advance directives;
- Document in the medical record whether or not an advance directive has been executed;
- Comply with all requirements of State law respecting advance directives;
- Provide (individually or with others) education for staff and the community on issues concerning advance directives;
- Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

PART II - CHAPTER 1000

BASIS FOR REIMBURSEMENT

Rev. 01/01/2006

1001 General

This chapter provides an explanation of the Division's reimbursement methodology.

1002 Reimbursement Methodology

A facility's Actual Reimbursement Rate is the amount the Division will reimburse to a facility for nursing services rendered to a particular eligible patient for one patient day and is calculated by subtracting Patient Income from Total Allowed Per Diem Billing Rate. The Actual Reimbursement Rate is always subject to prospective adjustment to effectuate the policies described in this chapter. In addition, it is subject to retroactive adjustment according to the relevant provisions of Part I, Chapter 400 of the Manual and Appendix I.

1002.1 Definitions

- a. Patient Income is that dollar amount shown on the Summary Notification letter issued by the Department of Family and Children Services (DFCS). Refer to the Billing Manual for Nursing Facility Services for information about the Summary Notification letter. The patient's income is deducted in full from the Medicaid reimbursement rate until the income has been exhausted.
- b. Total Allowed Per Diem Billing Rate is the amount derived from the rate setting process, as defined in Sections 1002.2 and 1002.3.
- c. A nursing facility is an institution licensed and regulated to provide nursing care services or intermediate care services for the mentally retarded in accordance with the provisions of this Manual. For reimbursement purposes, nursing facilities including hospital based facilities are divided into two types based upon the mix of Medicaid patients residing in the facilities. The type classification of a nursing facility may change as described in this chapter. The types are described below:
 - 1) Nursing Facilities - These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital.
 - 2) Intermediate Care Facilities for the Mentally Retarded (ICF-MR) - These facilities provide care to patients that are mentally retarded.

Rev 01/06

- d. Cost Center refers to one of five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported in Column 3 of the Schedule as Routine and Special Services (Lines 17 and 77), Dietary (Line 89), Laundry and Housekeeping and Operation and Maintenance of Plant (Lines 109 and 123), Administrative and General (Line 169), and Property and Related (Line 186). See hospital-based and state institutions cost reports for appropriate cost center expense groupings.
- e. Distinct Part Nursing Facilities are facilities in which a portion operates as a nursing facility and another portion operates separately as an intermediate care facility for the mentally retarded.
- f. Total Patient Days are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.
- g. Hospital-Based Nursing Facilities - A nursing facility is hospital-based when the following conditions are met:
 - 1. The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.
 - 2. The facility is subordinate to the hospital and operated as a separate and distinct hospital division that has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.
 - 3. The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of the hospital, must be responsible to the hospital's governing board.
 - 4. The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

Section A

- a) employee benefits
- b) central services and supply
- c) dietary
- d) housekeeping

- e) laundry and linen
- f) maintenance and repairs

Section B

- a) accounting
- b) admissions
- c) collections
- d) data processing
- e) maintenance of personnel

Facilities must provide organizational evidence demonstrating that the above requirements of (4) have been met. This evidence will be used to determine which facilities will be hospital-based.

Evidence that the required number of services in Sections A and B are shared with the hospital must be included in the hospital's Medicare cost report.

Appropriate costs should be allocated to the nursing facility and the Medicare cost report must be approved by the Medicare intermediary.

In making the determination that a long-term care facility is hospital-based, collocation is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents.

The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

- 1) Only one hospital-based nursing facility per hospital is allowed.
- 2) Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed

Medicare cost report is used to file the Medicaid cost report to set a per diem rate.

Nursing facilities classified as hospital-based prior to July 1, 1994, will be exempt from the above additional requirements. Hospitals, which currently have more than one hospital-based nursing facility, will not be allowed to include any additional hospital-based facilities.

- h. Property Transaction is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger). For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship, or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all of the following events that are applicable to the transaction:
1. The effective date of the sale or the lease.
 2. The first day a patient resides in the facility.
 3. The date of the written approval by the Division of Health Planning of the relevant proposal.
 4. The effective date of licensing by the Georgia Department of Human Resources Standards and Licensure Unit.
 5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.
 6. The date on which physical construction is certified complete by whichever agency(s) is/are responsible for this determination.
 7. The date of the approval of a Certificate of Need by the Division of Health Planning.
- i. Gross Square Footage is the outside measurement of everything under a roof, which is heated and enclosed. When the Division issues the provider a rate under the Dodge Index Property System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of a facility is subject to audit review (along with other parameters which

affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc..

- j. Age is the original date a building was completed counted by years through December 1983 with no partial year calculations. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.
- k. Cost is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. **A definition of cost and a discussion of allowable and non-allowable costs are contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in CMS-15-1, *the costs listed below are non-allowable.***

Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials;

Memberships in civic organizations;

Out-of-state travel paid by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care;

Vehicle depreciation or vehicle lease expense in excess of the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable. For purposes of this provision, patient care staff includes only those who are transported in order to provide direct medical care to an individual patient.

Fifty percent (50%) of membership dues for national, state, and local associations;

Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgment or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable;

Advertising costs that are (a) for fundraising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement, or (e) related to government relations or lobbying.

Funds expended for personal purchases.

1002.2 Total Allowed Per Diem Billing Rate for Facilities for Which a Cost Report is Used To Set a Billing Rate

For dates of service beginning July 1, 2005, the 2002 Cost Report is the basis for reimbursement.

For these facilities the following formulas apply:

Total Allowed Per Diem Billing Rate =

Allowed Per Diem + Efficiency Per Diem + Growth Allowance + Other Rate Adjustments.

Allowed Per Diem =

Summation of the (Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available) for each of the four Non-Property Cost Centers plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is limited to the standard (90th percentile) per diem in this cost center will be based upon the standard per diem calculated from the cost reports for the year ending June 30, 1981.

Efficiency Per Diem =

Summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers.

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Growth Allowance =

Summation of 5.067% of the Allowed Per Diem for each of the four Non-Property and Related cost centers.

Further explanation of these terms is included below:

- a. In general, the Net Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern: mathematical calculation errors; limitations placed on allowable costs by the Nursing Facilities Manual, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; or other parameters placed on reasonable cost by the Division. These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses that are attributable to care. See Appendix I for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule references are to the Cost Report):

See Section 1002.5 of the Nursing Facility Manual for additional description of such limitations.

Allowable Home Office salary costs are limited to an appropriate maximum.

Fringe benefits are also limited to an appropriate maximum. (A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a \$100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of \$100,000 to be applied only to owners of nursing facilities and related parties.)

Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

Routine and Special Services Net Per Diem =

Nursing Facilities Net Per Diem =

(Historical Routine and Special Services (Schedule B, Lines 5 plus 7, Column 4) divided by (Total Patient Days, Schedule A, Line 13, Column 8); for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period.

ICF-MR Net Per Diem =

(Historical ICF-MR Routine and Special Services (Schedule B, Lines 6 plus 7, Column 4) divided by (Total ICF-MR Patient Days, Schedule A, Line 13, Column 8).

When costs for State Distinct Part Nursing Facilities can be identified, be they routine services or special services, the costs will be allocated as identified. Where costs have not been identified, the patient days method will be used to allocate costs.

Dietary Net Per Diem =

Historical Dietary, Schedule B, Line 8, Column 4, Divided By Total Patient Days.

Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem =

Historical Laundry, Housekeeping, Operation and Maintenance of Plant, Schedule B, Lines 9 plus 10, Column 4, Divided By Total Patient Days.

Administrative and General Net Per Diem =

Historical Administrative and General, Schedule B, Line 11, Column 4, Divided By Total Patient Days.

Property and Related Net Per Diem =

For a facility with a Property and Related Net Per Diem in excess of the Property and Related Standard Per Diem, the Net Per Diem will be reduced to the Standard Per Diem. For any facility having a property transaction after May 6, 1981, (excluding leases for which the Division had approved rates on or before that date) the total Property and Related Net Per Diem, shall not exceed the Standard Per Diem.

Costs for property taxes and property insurance, as defined in the Uniform Chart of Accounts, are included but are not subject to the property and related cost center Standard Per Diem. Historical Property & Related, Schedule B, Line 12, Column 4, Divided By Total Patient Days.

The Return on Equity Percent is 0% for all facilities.

Facilities reimbursed as of June 30, 1994, and June 30, 1995, for actual arm's length property and related costs will be reimbursed at the Dodge Index rate if a change in the audited reimbursement rate results in a per diem increase.

Facilities reimbursed as of June 30, 1994, and June 30, 1995, at actual arm's length property and related costs including those subject to standards, will not be reimbursed at the Dodge Index rate if a change in audited reimbursement results in a per diem decrease, unless a property transaction occurs as described in Section 1002.5(a) in which case the Dodge Index will apply. Until the Dodge Index applies to these facilities, reimbursement will continue at actual arm's length property and related costs.

Facilities reimbursed for actual property and related costs will be reimbursed at the Dodge Index rate as described in Section 1002.5(a) through (f) below, if actual property and related costs per diem become less than the Dodge Index rate or if there is a property transaction according to Section 1002.5(a).

Facilities reimbursed at the Dodge Index rate will remain at Dodge Index rate for all subsequent periods.

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- b. Standard Per Diem for each of the five cost centers is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem. The number of facilities in the applicable group shall be multiplied by the Maximum Percentile, or a median net per diem may be chosen, with the Maximum Cost per day being determined as a

percentage of the median. The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for an efficiency incentive payment is 105% of the median cost per day within each peer group. The Maximum Percentile is the eighty-fifth for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, and the Property and Related cost centers. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for the Hospital-Based Nursing Facility group and the ninetieth percentile for the Free Standing Nursing Facility group and the Intermediate Care Facility for the Mentally Retarded group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation.

The grouping will be done using Net Per Diem for each cost center that has been reported by the facility, and calculated by the Division on June 30, 2005. Standards effective July 1, 2005, will not be recalculated based upon changes in rates due to subsequent determination of additional allowable cost, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center.

There are several instances where a facility could fall in more than one group. Intermediate care facilities for the mentally retarded that also are nursing facilities are classified as intermediate care facilities for the mentally retarded.

For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type facility it is as of June 30, 2005.

If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

Routine and Special Services Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded
Dietary Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Free Standing Nursing Facility

Hospital-Based Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Administrative and General Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped as follows:

Nursing Facility

Intermediate Care Facility for the Mentally Retarded

Property and Related Standard Per Diem

For this Standard Per Diem, all nursing facilities shall be grouped by the age of the facility as follows:

All facilities constructed five or less than five years ago

All facilities constructed ten or less than ten years ago, but more than five years ago

All facilities constructed more than ten years ago

The age of the facilities as of October 1976. For facilities with buildings constructed in different years, the composite age of the facility is computed using the number of square feet contained in each unit to produce a weighted average age.

- c. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the five cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero (\$0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by .75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums:

| | |
|--|--------|
| Routine and Special Services Maximum Efficiency Payment | \$0.53 |
| Dietary Maximum Efficiency Payment | \$0.22 |
| Laundry and Housekeeping and Operation and Maintenance of Plant Maximum Efficiency Payment | \$0.41 |
| Administrative and General Maximum Efficiency Payment | \$0.37 |
| Property and Related Maximum Efficiency Payment | \$0.40 |

1002.3 Total Allowed Per Diem Billing Rate For Facilities For Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

If the Division determines that a cost report cannot be used to set a billing rate the per diem rate will be established, as follows:

- a. When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. (See Appendix D2(h).)
- b. Newly enrolled facilities will be reimbursed the lower of: projected costs; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate.
- c. In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing

Rate will be resolved as described in the provisions discussed below for unauditible cost reports.

The Total Allowed Per Diem Billing Rate for facilities with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to either the Dodge Index Rate as determined under Section 1002.5(a) through (g), or the lesser of projected costs or the maximum allowable costs as determined by Section 1002.5(a) divided by that number of patient days which represents a 95% rate of occupancy.

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- d. In all other instances where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for unauditible cost reports. If the Division determines that a cost report which was to be used to set a reimbursement rate is unauditible (i.e., the Division's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk review or on-site audit), or unreliable (See Appendix D2(h).), the Division may reimburse the facility the lower of the following:

The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by the unauditible cost report;

The Total Allowed Per Diem Billing Rate calculated from the unauditible cost report; or

The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem.

Once a cost report becomes auditable and appropriate, the Total Allowed Per Diem Billing Rate will then be calculated using the audited cost report as a basis. The resulting reimbursement rate will then be applied to the appropriate period.

Effective April 1, 1982, the Property and Related cost center reimbursement for those facilities whose cost reimbursement is limited to the Standard (90th percentile) Per Diem in this cost center will be based upon the Standard Per Diem calculated from the cost reports for the year ending June 30, 1981.

- e. If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department may elect to use the average score for all facilities.

1002.4 Other Rate Adjustments

A staffing adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services may be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1. The Division also requires that a facility participate in Division-sponsored quality improvement initiatives in order to receive this adjustment. Facilities must enroll in the Quality Improvement Program by the deadline of September 30, 2003.

For the most recent calendar quarter for which MDS information is available, Cognitive Performance Scale (CPS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor may be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose CPS scores are moderately severe to very severe. The adjustment factors are as follows:

| % of Medicaid Patients | Adjustment Factor |
|------------------------|-------------------|
| <20% | 0% |
| 20% - <30% | 1% |
| 30% - <45% | 2.5% |
| 45% - 100% | 4.5% |

Effective July 1, 2003, under the Nursing Home Provider Fee Act, all facilities may be required to pay a fee for each patient day of care provided. An adjustment equal to the fee payable for each Medicaid patient day may be added to a facility's rate. During the quarter beginning July 1, 2003, the adjustment amount may be estimated by the Division; any difference between the estimated and actual fee will be corrected by changes to rates for a subsequent quarter. For periods beginning October 1, 2003, the adjustment amount will be based on the fee applicable for the prior quarter.

1002.5 Property and Related Reimbursement Limitations

The Division has established additional criteria to determine the reasonableness of property and related costs.

Property Transactions after June 14, 1983

- a. For any facility having a property transaction, including a renewal of a lease, with an effective date after June 14, 1983, excluding additions, expansions and renovations, the steps described in paragraphs (b) through (f) of this subsection comprise the Dodge Index method of property and related reimbursement which will be performed to set the property and related net per diem for a facility. Facilities reimbursed for actual property and related costs will be reimbursed at the Dodge Index rate if actual property and related costs per diem become less than the Dodge Index rate or if there is a property transaction according to this section. Facilities reimbursed at the Dodge Index rate will remain at the Dodge Index rate for all subsequent periods. This will be referred to as the property rate component for the remainder of this subsection. The property rate component is then used in the computation of a facility's Allowed Per Diem as defined in Sections 1002.2 and 1002.3.

The Division does not recognize the termination of a lease prior to its stated expiration date as a property transaction. It will be presumed that the termination of a lease prior to its stated expiration date was done to increase Medicaid reimbursement; provided, however, that the presumption is rebuttable if the provider can demonstrate by clear and convincing evidence that the lease was terminated for some other legitimate purpose. In the event of the termination of a lease prior to its stated expiration date, the facility's Property and Related reimbursement rate will then be based upon historical costs or the Dodge Index Rate, whichever applies.

- b. b. The property rate component is comprised of four sub-components:
 - 1) Building and Building Equipment
 - 2) Major and Minor Moveable Equipment
 - 3) Motor Vehicle Equipment
 - 4) Land

The method of calculating the rate for each of these sub-components is described in the following paragraphs.

- c. The Building and Building Equipment sub-component is calculated by dividing the reasonable construction acquisition cost by total patient days.

Reasonable construction acquisition cost is determined as follows:

- 1) For all existing facilities, multiply the regional Dodge Construction Index from the April - September, 1982 issue for the calendar year preceding the prospective rate year by the average construction multiplier for Atlanta. For facilities less than 30,000 square feet the cost range of 20,000 - 30,000 square feet will be used and for facilities 30,000 square feet or greater the cost range will be based on the 30,000 - 40,000 square foot indicator. All facilities having their first property transaction after June 14, 1983 (i.e., newly constructed facilities) will use the 30,000 - 40,000 square foot range.
- 2) Multiply the product from (i) by 108%.
- 3) Multiply the product from (ii) by the gross square footage of the facility with a maximum of 300 square feet per bed allowed. (New facilities will use 300 square feet per bed regardless of actual square footage. Existing facilities will use actual footage up to the maximum allowable. New facilities for which a subsequent property transaction occurs will use actual square footage up to the maximum.
- 4) Multiply the result of (iii) by the depreciation factor. The depreciation factor is calculated by subtracting the age of the facility in years from 40 and dividing the result by 40. Where the facility is more than 20 years old, a value of 20 is used such that the facility is never more than 50% depreciated based on a 40 year life.
- 5) Multiply the result of (iv) by an amortization factor which is determined according to the formula below:

$$\frac{1}{r \times [1 - 1/(1+r)^n]}$$

r represents the return rate and n is the remaining years of life of the facility based on a 40 year life.

Total Patient Days equals 90% of the maximum number of available patient days for a given facility per year.

For facilities having their property transaction after June 14, 1983 (i.e., newly constructed facilities), the building and building equipment component will be determined in accordance with the effective date of that property transaction as defined in Section

1002.1(h). The regional Dodge Construction Index from April-September of the calendar year preceding the property transaction will be used to determine a building rate component. The return rate for Dodge Index facilities is 11%.

Return Rate - This percentage will be reviewed and set by the Division.

- d. The Division will calculate a Moveable Equipment (major and minor) cost per bed at current replacement cost. For 1983 the value has been set at \$1,600.00 per bed.

Effective April 1, 1990, this Moveable Equipment value was increased to \$2176.00 per bed and effective July 1, 1993, will be increased to \$2430.00 per bed. A composite life of twelve years will be used to compute the amortization factor. The major and minor moveable equipment sub-component is calculated by multiplying the cost per bed by the amortization factor and dividing the product by total patient days. The current replacement cost will be reviewed by the Division of Medical Assistance and may be indexed utilizing the medical equipment price index published by the Centers for Medicare and Medicaid Services or another appropriate proxy for moveable equipment cost.

- e. The Division will calculate a reasonable allowance for Motor Vehicle Equipment. For 1983, the value has been set at \$8,000.00 per 100 beds or fraction thereof. A life of four years will be used to compute the amortization factor. The motor vehicle equipment sub-component as calculated by multiplying the reasonable allowance by the amortization factor and dividing the product by total patient days.

The reasonable allowance will be reviewed by the Division and may be indexed utilizing the transportation component of the Consumer Price Index or another appropriate proxy for motor vehicle equipment cost.

- f. In calculating the Land sub-component, acreage will be screened for cost reasonableness and limited to the lower of actual acres or the maximum established for the facility. The maximum varies according to the number of beds and facility location (rural or urban).

For a facility in an urban area (i.e., a Metropolitan Statistical Area-MSA-county), land is limited to three acres for a 100 bed facility plus one acre for each additional 100 beds or fraction thereof. The maximum cost allowed per acre is \$70,800. For any provider which applies for an adjustment to its Property and Related Net Per Diem on or after April 1, 1987, due in any part to costs associated with the

acquisition of land (including, but not limited to purchases and leases), such land acquisition costs shall be allowable only to the extent that they do not exceed \$70,800 per acre. In a rural area (non-MSA), land is limited to five acres for a 100 bed facility plus one acre for each additional 100 beds or fraction thereof. The maximum cost allowed per acre is \$42,480. For any provider which applies for an adjustment to its Property Related Net Per Diem on or after April 1, 1987, due in any part to costs associated with the acquisition of land (including, but not limited to, purchases and leases), such land acquisition costs shall be allowable only to the extent that they do not exceed \$42,480 per acre.

Reimbursement for additional land for facilities in urban and rural locations will be allowed to meet requirements such as local codes for sewage disposal, parking, and density.

Original land cost should be documented by original accounting records, county records, or an acceptable reasonable basis such as an allocation procedure. If the original land cost cannot be properly documented, no allowed rate will be calculated.

- 1) To calculate the rate for facilities with land areas exceeding the maximum allowable:
 - a. Divide the allowable original land acquisition cost by the total acreage.
 - b. Multiply the average acquisition cost per acre by the maximum allowable land areas as determined by the rules outlined above.
 - c. Multiply the result in (i)(b) by the return rate.
 - d. Divide the result from (i)(c) by the number of patient days.
- 2) To calculate the rate for facilities with land areas at or below the maximum allowable:
 - a) Multiply the allowable land and acquisition cost by the return rate.
 - b) Divide the result from 2(ii) by the number of patient days.

The property rate component will be set at the sum of the building and building equipment, moveable equipment, motor vehicle equipment and land rate subcomponents.

- g. For any facility having an Initial Transaction after July 13, 1978, and which has a subsequent transaction on or after June 15, 1983, by the

same party, a related party, or a different operator within ten years after the initial transaction, reimbursement is defined in subparagraphs 1) and (2) below.

- 1) During the ten years following an initial transaction prior to June 15, 1983, reimbursement will be the lesser of:
 - a) reported costs of the subsequent transaction (the most recent lease, sale or change of ownership occurring within 10 years of the initial transaction),
 - b) the Standard Per Diem, if the initial transaction occurred after May 6, 1981, but before June 15, 1983, or
 - c) costs as determined by paragraphs (b) through (f) as the date of the lease, sale, or change of ownership that gave rise to the application of this paragraph.
 - 2) During the ten years following an initial transaction after June 14, 1983, reimbursement will be the lesser of:
 - a) costs as determined by paragraphs (b) through (f) at the date of the initial transaction, or
 - b) costs as determined by paragraphs (b) through (f) at the date of the subsequent transaction.
- h. For a facility having an addition, expansion, or renovation after June 14, 1983, reimbursement will be determined as follows:
- 1) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement will not be increased as the result of renovation unless all of the following conditions are satisfied:
 - the renovation is mandated by state or federal law as implemented through policies and procedures of the Georgia Department of Human Resources Standards and Licensure Unit
 - the additional reimbursement is determined by a replacement cost appraisal (however, at the Division's discretion, for capital items not affecting the entire facility, multiple, competitive arm's length bids by contractors can be used instead of replacement cost appraisals).

the provider could not with reasonable diligence ascertain that the renovation would be required by the Georgia Department of Human Resources Standards and Licensure Unit. Reasonable

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diligence will include but is not limited to obtaining an inspection and its resulting report by the Architect of the Standards and Licensure Section specifically for the purpose of determining what repairs, renovations or other actions will be required of the facility to meet all applicable physical plant requirements, as well as all other inspections and deficiency reports on file at the Georgia Department of Human Resources Standards and Licensure Unit for that facility.

- 2) If the facility was being reimbursed under the provisions of paragraphs (a) through (g), reimbursement for additions and expansions will be subject to limitations described in paragraphs (b) through (f). If the addition or expansion does not add beds, there will be no additional reimbursement. If beds are added, the addition will be treated in a manner similar to a new facility to determine a separate property rate sub-component for the addition.

1002.6 Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.7 Payment in Full for Covered Services

The facility must accept as payment in full for covered services the amount determined in accordance with Section 1002, Nursing Facility Manual.

1002.8 Adjustments to Rates

Payment rates for state-owned nursing facilities will be adjusted to 100% of service costs. This provision will apply in addition to all others in this chapter and will supersede those that are in direct conflict only to the extent that they are not capable of simultaneous application.

1003 Additional Care Services

1003.1 Required Nursing Hours

The **minimum required** number of nursing hours per patient day for all nursing facilities is 2.00 actual working hours. The **minimum expected** nursing hours are 2.50 to qualify for the 1% add-on. (See 1002.4)

1003.2 Failure to Comply

- a. The **minimum standard** for nursing hours is **2.00**.
- b. Facilities found not in compliance with the 2.00 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients, or suspension or termination whichever is appropriate as determined by the Division.
- c. The **minimum expected** for nursing hours is **2.50** for participation in the Quality Improvement Program.

1004 Medicare Crossover Claims

The maximum allowable payment for Medicare nursing facility coinsurance (crossover) claims will be the nursing facility's Medicaid specific per diem rate in effect for the dates of service of the crossover claims. The crossover claims will not be subsequently adjusted due to subsequent per diem rate adjustments. This section is also included in Chapter 1100 of the Manual.

1005 Upper Payment Limit Rate Adjustments for Government Owned or Operated Nursing Facilities

For payments on or after January 1, 2001, State government –owned or operated facilities and non-State government owned or operated facilities will be eligible for rate payment adjustments, subject to the availability of funds. A facility's status as government owned or operated will be based on its ability to make direct or indirect intergovernmental transfer payments to the State. The rate payment adjustments will be subject to federal upper payment limits and will be based on amounts that would be paid for services under Medicare payment principles. These rate payment adjustments will be made on a monthly, quarterly or annual basis in a manner that will not duplicate compensation provided from payments for individual patient claims.

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07/05 1006 Payments Rates for Patient Leave Days or Bed Hold Days

Effective for dates of service on and after July 1, 2004, payments for patient leave days or for bed hold days during a patient's hospitalization will be made at 75% of the rate paid for days when a patient is onsite at a facility. Because patient leave days and bed hold days are not subject to the nursing home provider fee, the payment rate for patient leave days and bed hold days will exclude any compensation for the provider fee.

PART II - CHAPTER 1100

CLAIMS PROCESSING

1101 General

In order to facilitate timely and correct payment of claims, the Division has developed and implemented a Management Information System. This computer system utilizes automated processing and auditing steps in lieu of lengthier and less efficient manual processing steps. The nursing facility billing forms currently in use were developed so as to capture the necessary data to employ the System. The volume of claims received by the Division is such that we must rely on the computer system to audit all claims. Therefore, it is essential that the billing forms be completed correctly by the nursing facility to prevent delays in payment, denial or rejection of claims.

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1102 Form DMA-59 "Authorization For Nursing Facility Reimbursement"

The Form DMA-59 (see Appendix E) is used by nursing facilities and intermediate care facilities for the mentally retarded (ICFs/MR) in requesting vendor payments. All initial admission requests, continued stay requests, and terminations/discharges require a Form DMA-59 to be initiated by the facility. The form must be sent to DFCS. The form MUST BE LEGIBLE when submitted by the facility. Any illegible forms will be returned by the county to the facility for resubmission.

If the person is not a Medicaid recipient (does not have a Medicaid number), the facility must instruct the individual's family or representative to make application at DFCS in the county where the nursing facility is located. The Form DMA-59 is then completed and sent to DFCS with a letter identifying the family member or representative as having made an application. The Form DMA-59 will not be processed by DFCS until an application is filed.

Form DMA-59 will allow a patient to be admitted, changed, and terminated on one form.

Instructions for completing Form DMA-59 are included in Appendix E. A sample of the form is included in Appendix F.

Rev.07/01 1102.1 All Form DMA-59's are completed by the facility in duplicate. The copy is kept by the facility and placed in the recipient's case folder. The original is sent to DFCS.

Rev. 04/03 1102.2 The DFCS will use the information reported on the DMA-59 to process the changes reported by the facility including new admissions.

- 1102.3 **The DMA-6 is no longer sent to DFCS.** *The DMA 59* will serve as the evidence that the resident meets an approved nursing facility level of care.
- Rev.07/01 1102.4 At this point, the assistance payment worker takes action based on the individual's eligibility. If the individual is determined ineligible, DFCS will issue a Summary Notification letter to the facility reporting denied eligibility. Conversely, if the individual is determined eligible for Medicaid, DFCS will issue a Summary Notification letter to the facility reporting the effective date of eligibility. The DFCS will not return the Form DMA-59 to the facility.
- Rev.07/01 1102.5 The DFCS will retain their copy of the Form DMA-59 as documentation of information reported by the facility.
- Rev.07/01 1102.6 When DFCS has a need to update the recipient's data such as Income and Status (ineligibility), the DFCS will issue a Summary Notification letter to the facility reporting changes to patient liability or eligibility.
- Rev.04/03 1102.7 **A change from one level of care to another in the same facility is no longer necessary.** The nursing facility staff will mark “skilled care” on the DMA-59 form. The skilled block on the DMA -59 form is for record keeping purposes of residents meeting a nursing facility level of care. DCH and DFCS will consider the resident eligible for nursing facility admission via the admitting physician’s signature on file within the facility. ***No additional information is needed by DFCS to substantiate a resident’s eligibility for a nursing facility level of care.***

1103 Electronic Media Billing

As an alternative to billing claims on paper, Electronic Media Claims (EMC) provide a means of submitting weekly nursing facility claims electronically. The benefits of this process include faster payment of claims, fewer errors since the provider keys his own claims, reduced provider costs and less paper forms are mailed which eliminates the risk of lost claims.

Once a recipient is entered into the (EMC) software the recipient will never have to be added again. Each week the facility will simply make the necessary changes to dates of service, patient's status, level of care and total days billed. These claims are then transmitted to the fiscal agent for processing and payment. If a problem occurs, prior to the fiscal agent's weekly deadline with the facility's claims transmission the fiscal agent will contact the nursing facility to correct their error(s).

Electronic Media Billing is available for nursing facility providers who have data processing equipment or who contract for data processing services. Three methods of electronic media billing are available: dial-up transmission, magnetic tape and diskette 3 1/2 and 5 1/4. Please refer to Chapter 9000 of the Billing

Manual for Nursing Facility Services for additional information about enrolling in electronic billing.

1104 Nursing Home Remittance Advice

A complete description of the Remittance advice, please refer to the fiscal agent's Billing Manual for Nursing Facility Services Section.

1105 Mailing Addresses for Completed Forms

- a. Form DMA-59 is mailed to the appropriate Department of Family and Children Services.
- b. Forms DMA-295 and DMA-296 are mailed to the fiscal agent.

APPENDIX A

Medicaid Member Identification Card Sample

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Medicaid

Member ID #: 123456789012
Member: Joe Q Public
Card Issuance Date: 12/01/02

Primary Care Physician: Dr. Jane Q Public
285 Main Street
Suite 2859
Atlanta, GA 30303
Phone: (123) 123-1234 X1234

Plan: Georgia Better Health Care
After Hours: (123) 123-1234 X1234

www.ghp.georgia.gov

For out-of-state prior approval call 800-766-4466 (Toll Free)
Customer Service: 770-570-3373 (Local) or 866-211-0950 (Toll Free) TDD: 866-211-0951 (Toll Free)

| | |
|--|--|
| Payor: ACS, Inc. Member: Box 3000 Provider Enrollment: Box 4000 Provider: Box 5000 Prior Authorization: Box 7000 McRae, GA 31055 | To All Providers: Possession of this card is not a guarantee of coverage. If unable to use swipe card function, please verify eligibility at 404-298-1228 (Local) or 800-766-4466 (Toll Free). |
| Payor: ESI, Inc. Rx BIN: 003858 Rx PCN: A4 Rx GRP: GMEA | Mail Drug Claims To: ESI-GDCH Paper Claims P.O. Box 390863 Bloomington, MN 55439 RX Provider Help Line 877-650-9340 |

PeachCare for Kids Member Identification Card Sample

| | |
|--|--|
| GEORGIA DEPARTMENT OF COMMUNITY HEALTH | |
| PeachCare for Kids | |
| Member ID #: 123456789012 | |
| Member: Joe Q Public Card Issuance Date: 12/01/02 | |
| Primary Care Physician: Dr. Jane Q Public 285 Main Street Suite 2859 Atlanta, GA 30303 Phone: (123) 123-1234 X1234 | Plan: Georgia Better Health Care After Hours: (123) 123-1234 X1234 |

| | |
|---|--|
| www.ghp.georgia.gov | |
| <p>For out-of-state prior approval call 800-766-4456 (Toll Free) Customer Service: 770-570-3373 (Local) or 866-211-0950 (Toll Free) TDD: 866-211-0951 (Toll Free)</p> | |
| <p>Payor: ACS, Inc. Member: Box 3000 Provider Enrollment: Box 4000 Provider: Box 5000 Prior Authorization: Box 7000 McRae, GA 31055</p> | <p>To All Providers: Possession of this card is not a guarantee of coverage. If unable to use swipe card function, please verify eligibility at 404-298-1228 (Local) or 800-766-4456 (Toll Free).</p> |
| <p>Payor: ES1, Inc. Rx BIN: 003858 Rx PCN: A4 Rx GRP: GMEA</p> | <p>Mail Drug Claims To: ES1-GDCH Paper Claims PO Box 390863 Bloomington, MN 55439 RX Provider Help Line 877-650-9340</p> |

APPENDIX B

Provider Enrollment

You may request a Provider Enrollment Application/enrollment documents or submit inquiries by one of the methods listed below:

Mail: ACS
Provider Enrollment Unit
Post Office Box 4000
McRae, GA 31055

Phone: (800) 766-4456 or in metro Atlanta, (404) 298-1228

Download: <http://ghp.georgia.gov>, click on “Provider Information”, then “Documents and Forms”

E-mail: <http://ghp.georgia.gov>, click on “Contact Us”

Apply Online: <http://ghp.georgia.gov>, “Provider Information” then “Enroll as an Individual”

Facsimile: 1-866-309-0935

APPENDIX C

DIRECTORY FOR INQUIRY INFORMATION AND/OR FORM REORDERING

Long-Term Care Contractor - Noted throughout the Manual as the "Contractor"

ACS/Georgia Health Partnership
PO Box 7000
McRae, GA 31055-7000

Phone: 1-800-766-4456 or (404) 298-1228

Nurse Aide Registry

ACS/Georgia Health Partnership
PO Box 7000
McRae, GA 31055-7000

1-800-414-4358 or 678-527-3010

Nurse Aide Training Programs

ACS/Georgia Health Partnership
PO Box 7000
McRae, GA 31055-7000

Phone: 1-800-414-4358 or 678-527-3010

Billing Rates/Cost Reports

Division of Medical Assistance
Director of Reimbursement
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

Phone: (404) 656-4273 Fax: (404) 656-9655

Policies and Procedures for Nursing Facility Services

Department of Community Health
Program Specialist
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

Phone: (404) 657-9946 Fax: (404) 656-8366

Provider Enrollment

ACS/Georgia Health Partnership
PO Box 88030
Atlanta, GA 30356

Phone: 1-800-766-4456 or (404) 298-1228

Billing Questions

ACS/Georgia Health Partnership
PO Box 5000
McRae, GA 31055-5000

Phone: 1-800-766-4456 or (404) 298-1228

Forms Request and Reorders

Forms DMA-6, DMA-59, DMA- 292, DMA-296, DMA-355, DMA-356, DMA-385,
DMA-501, DMA-520, DMA-613.

PASRR

Fiscal Agent

ACS/Georgia Health Partnership
PO Box 5000
McRae, GA 31055-5000

Phone: 1-800-766-4456 or (404) 298-1228

APPENDIX D

UNIFORM CHART OF ACCOUNTS, COST REPORTING, REIMBURSEMENT PRINCIPLES AND OTHER REPORTING REQUIREMENTS

Revised 01/01/2006

General

This appendix discusses the use of a uniform chart of accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

1. Uniform Chart of Accounts

The Georgia Division of Medical Assistance requires that all nursing facilities participating in the Medicaid Program utilize the classification of accounts shown in the Uniform Chart of Accounts in reporting its financial operations in the cost reporting system. While it is not mandatory that books of original entry or ledgers be maintained in accordance with the Uniform Chart of Accounts, facilities are strongly encouraged to do so. The Uniform Chart of Accounts has been designed to meet management needs for budgeting information, information flow, internal control, responsibility accounting and financial reporting. Also, it has been designed in such a manner that accounts may be added or deleted to tailor the financial information to the facility's needs.

Should a facility elect to maintain its books of original entry or ledgers in a manner other than that specified in the Uniform Chart of Accounts, the facility is required to have available a detailed description of how its accounting system differs. This description of differences must be used by the facility for converting the output of its reporting system into the format specified in the Uniform Chart of Accounts. This description of differences and conversion of reporting information into the proper format are considered to be essential components of a facility's accounting records. When such information is needed but not maintained, a facility's cost report will be determined to be unacceptable for fulfilling reporting requirements and penalties described in Section 2.b and 2.g of this appendix will be imposed.

2. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through the mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during

the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

- a. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be e-mailed to the Division on or before September 30th. (See Hospital-based facility exception in 2(d) below.)
- b. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of \$50.00 per day for the first thirty days and a penalty of \$100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services prior to September 30.
- c. If a cost report is received by the Division prior to September 30th but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.
- d. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections b. and c. also apply to hospital-based facilities' cost reports.

Approval for extensions beyond the September 30 or November 30 deadline, where applicable, will be granted only if the provider's operations are "significantly adversely affected" because of circumstances beyond the provider's control (i.e., a flood or fire that causes the provider to halt operations). Each provider must submit a written request specifying the hospital-based facility and the reason for the extension.

- e. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book column for Schedules B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B-1A, by an amount resulting from revenue received from sources other than the Division for these services.

Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

- f. All nursing facilities are required to submit to the Division any changes in the amount of or classification of reported costs made on the original cost report within thirty days after the implementation of the original cost report used to set reimbursement rates. Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.
- g. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.
- h. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

For ownership changes effective with at least six months of patient day data on the applicable June 30 fiscal year cost report, the initially submitted cost report will be used to establish the new owner's rate when the comparable cost reports are used to set rates. For the periods prior to the use of the new owner's cost report, the new owner will receive rates based on the previous owner's approved cost report data, with the appropriate Dodge Index property rate. If the new owner's initial cost report contains less than six months of patient day data, when the initial cost report period reports are used to set rates, the new owner will receive a rate based on the previous owner's last approved cost report inflated to current costs, as determined by the Division, or the costs from the new owner's initial cost report, whichever is lower. If the ownership change is between related parties, when the initial cost report period reports are used to set rates, the old owner's cost report and new owner's cost report for the year of the ownership change may be combined and considered in determining the minimum rate for the new owner.

- i. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be

required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

- j. For audit examinations described in (i) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.
- k. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate work papers or letters of explanation should be attached.
- l. All cost reports are to be emailed to nhcostreport@dch.state.ga.us. Correspondence concerning the cost reports may be mailed to the following address:

Program Manager
Nursing Home Services Unit
39th Floor
Division of Financial Management
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

3. Reimbursement Principles

The objective of a system of reimbursement based on reasonable costs is to reimburse the institution for its necessary and proper expenses incurred related to patient care. As a matter of general reimbursement principle, costs with respect to individuals covered by the Medicaid Program will not be borne by those not covered and costs with respect to individuals not covered by the Medicaid Program will not be borne by the Program. The principles of cost reimbursement require that institutions maintain sufficient financial records and statistical data for proper determination of costs payable under the Program. Such records and data must be maintained for a period of at least three years following the date of submission of the cost report

4. Case Mix Index Reports

- a. MDS Data for Quarterly Patient Listing - Using Minimum Data Set (MDS) information submitted by a facility, the Division will prepare a Case Mix Index Report, listing information for patients in a facility on the last day of a calendar quarter. A preliminary version of the report will be distributed to a nursing facility about the middle of the following quarter after each calendar quarter end. The preliminary version of the report will be distributed with instructions regarding corrections to patient payer source information that a nursing facility may submit for consideration before the final version of the report is prepared and distributed.

- b. RUG Classification - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Resource Utilization Group (RUG) classification. Version 5.12, with 34 grouper and index maximizer, the RUG classification system will be used to determine a patient's RUG category.
- c. Payer Source - For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.4.a, a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.
- d. Relative Weights and Case Mix Index Scores for All Patients - For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for all patients in a facility.
- e. Relative Weights and Case Mix Index Scores for Medicaid Patients - For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Exhibit D-1 identifies the relative weights for each RUG category. This data will be used to determine a case mix score for Medicaid patients in a facility.
- f. CPS Scores - For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Cognitive Performance Scale (CPS) score.
- g. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

5. Nursing Hours and Patient Day Report

Except for ICF-MR and state owned facilities, each facility must submit a Nursing Hours and Patient Day Report for each calendar quarter, within one month after the end of the quarter. The required information will be submitted in accordance with a format and instructions as distributed by the Division. A facility's request to correct or amend a nursing home provider fee report will be limited to a 30 day period following the report's due date. Corrections to nursing hours and patient day data used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

If a facility does not submit a report or does not submit a report when due, a late fee of \$10 per day may be assessed.

EXHIBIT D-1

| | Category | Classification | Code | Case Mix Index for All Patients | Case Mix Index for Medicaid Patients |
|----|---------------------|--|-------------|--|---|
| 1 | Extensive | Extensive Special Care 3 / ADL > 6 | SE3 | 2.839 | 2.896 |
| 2 | Extensive | Extensive Special Care 2 / ADL > 6 | SE2 | 2.316 | 2.362 |
| 3 | Rehabilitation | Rehabilitation All Levels / ADL 17-18 | RAD | 2.284 | 2.330 |
| 4 | Extensive | Extensive Special Care 1 / ADL > 6 | SE1 | 1.943 | 1.982 |
| 5 | Rehabilitation | Rehabilitation All Levels / ADL 14-16 | RAC | 1.936 | 1.975 |
| 6 | Special Care | Special Care / ADL 17-18 | SSC | 1.877 | 1.915 |
| 7 | Rehabilitation | Rehabilitation All Levels / ADL 9-13 | RAB | 1.772 | 1.807 |
| 8 | Special Care | Special Care / ADL 15-16 | SSB | 1.736 | 1.771 |
| 9 | Special Care | Special Care / ADL 4-14 | SSA | 1.709 | 1.743 |
| 10 | Rehabilitation | Rehabilitation All Levels / ADL 4-8 | RAA | 1.472 | 1.501 |
| 11 | Clinically Complex | Clinically Complex with Depression / ADL 17-18 | CC2 | 1.425 | 1.454 |
| 12 | Clinically Complex | Clinically Complex / ADL 17-18 | CC1 | 1.311 | 1.337 |
| 13 | Clinically Complex | Clinically Complex with Depression / ADL 12-16 | CB2 | 1.247 | 1.272 |
| 14 | Physical | Physical Function with Nursing Rehab / ADL 16-18 | PE2 | 1.188 | 1.212 |
| 15 | Clinically Complex | Clinically Complex / ADL 12-16 | CB1 | 1.154 | 1.177 |
| 16 | Physical | Physical Function with Nursing Rehab / ADL 11-15 | PD2 | 1.095 | 1.117 |
| 17 | Impaired Cognition | Cognitive Impairment with Nursing Rehab / ADL 6-10 | IB2 | 1.061 | 1.082 |
| 18 | Clinically Complex | Clinically Complex with Depression / ADL 4-11 | CA2 | 1.043 | 1.064 |
| 19 | Physical | Reduced Physical Function / ADL 16-18 | PE1 | 1.077 | 1.077 |
| 20 | Behavioral Problems | Behavior Problem with Nursing Rehab / ADL 6-10 | BB2 | 1.021 | 1.041 |
| 21 | Physical | Reduced Physical Function / ADL 11-15 | PD1 | 0.990 | 0.990 |
| 22 | Impaired Cognition | Cognitive Impairment / ADL 6-10 | IB1 | 0.938 | 0.957 |
| 23 | Physical | Physical Function with Nursing Rehab / ADL 9-10 | PC2 | 0.937 | 0.956 |
| 24 | Clinically Complex | Clinically Complex / ADL 4-11 | CA1 | 0.934 | 0.953 |
| 25 | Behavioral Problems | Behavior Problem / ADL 6-10 | BB1 | 0.866 | 0.883 |
| 26 | Physical | Physical Function with Nursing Rehab / ADL 6-8 | PB2 | 0.824 | 0.841 |

| | Category | Classification | Code | Case Mix Index for All Patients | Case Mix Index for Medicaid Patients |
|----|---------------------|---|-------------|--|---|
| 27 | Physical | Reduced Physical Function / ADL 9-10 | PC1 | 0.865 | 0.865 |
| 28 | Impaired Cognition | Cognitive Impairment with Nursing Rehab / ADL 4-5 | IA2 | 0.777 | 0.777 |
| 29 | Behavioral Problems | Behavior Problem with Nursing Rehab / ADL 4-5 | BA2 | 0.750 | 0.750 |
| 30 | Physical | Reduced Physical Function / ADL 6-8 | PB1 | 0.749 | 0.749 |
| 31 | Impaired Cognition | Cognitive Impairment / ADL 4-5 | IA1 | 0.703 | 0.703 |
| 32 | Physical | Physical Function with Nursing Rehab / ADL 4-5 | PA2 | 0.637 | 0.637 |
| 33 | Behavioral Problems | Behavior Problem / ADL 4-5 | BA1 | 0.612 | 0.612 |
| 34 | Physical | Reduced Physical Function / ADL 4-5 | PA1 | 0.575 | 0.575 |

APPENDIX E

INSTRUCTIONS FOR COMPLETING FORM

DMA-6 and DMA-59

Form DMA-6 Instructions

This section provides detailed instructions for completion of the Form DMA-6. Before payment can be made, a Form DMA-6 must be completed by the facility and signed by the admitting physician.

Completion of Form DMA-6 (Revised 2/91) "Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded"

Complete Sections A, B, and C. The original form should be kept at the facility.

Rev. 04/03

The Form DMA-6 is considered valid only if it is signed by the admitting physician and dated no more than thirty (30) days before the date of admission.

Section A - Identifying Information

It is the responsibility of the facility to see that Section A of the form is completed.

Item 1: Facility's Name and Address
Enter the complete name and address of the facility including the zip code and county.

Item 2: Medicaid Case Number
Enter the Medicaid case number exactly as it appears on the Medical Assistance Eligibility Certification (this number may change so it is imperative that you review the Certification during each month of service.) A valid Medicaid case number will be formatted in one of two ways as follows:

- a. If the client is an SSI recipient, the client ID number will be the 9-digit social security number plus an "S", e.g., 123456789S.
- b. If the client is a recipient of Medical Assistance Only, the ID number will be the 9-digit PARIS number plus a "P", e.g., 123456789P.

The entire number, including all zeros, must be placed on the form correctly or it will be rejected. In exceptional instances, the case number may be obtained from the county Department of Family and Children Services office.

- Item 3: Social Security Number
Enter the recipient's nine-digit social security number.
- Item 4 & 4A: Enter the recipient's sex whether male or female and age and date of birth.
- Item 5: Type of Facility
Enter a check in the box corresponding to the type of facility.
- Item 6: Type of Recommendation
Enter a check in the box corresponding to the type of recommendation being made. If the recommendation is for a recipient's initial admission or readmission to the facility, the box corresponding to initial should be checked. If the recommendation is for continued placement, the box corresponding to continued placement should be checked on the subsequent recommendation form.
- Item 7: Patient's Name
Enter the recipient's full last name, first name, and middle initial in that order.
- Item 8: Date of Nursing Facility Admission
Enter the date of the recipient's admission to the nursing facility.
- Item 9: Patient Transferred From
Enter a check in the box corresponding to either hospital, private pay, home, another nursing facility, or Medicare, according to the recipient's status immediately preceding admission to the facility.
- Enter the recipient's home address, mother's maiden name, and the date of Medicaid application.
- Item 9A: State Authority (MH and MR Screening)
Enter the restricted authorization code and date assigned by the Contractor. This field is for new admissions only.
- Item 9B: State Authority (MH and MR Screening)
Enter the restricted authorization code and date assigned by the Contractor originally (new admission 9A). This field should be used for a readmission or transfer to another nursing facility.
- Item 10 & 11: Authorization for Facility or Attending Physician to Provide Necessary Information Including Medical Data to the Georgia Division of Medical Assistance and the Division of Family and Children Services of the Department of Human Resources

Have the patient, his/her spouse, parents, or other relative or legal representative sign and date (Item 11) the authorization.

Section B - Physician's Examination Report and Recommendation

- Item 12: Diagnosis on Admission to Facility (Hospital Transfer Record may be Attached)
Describe the primary, secondary, and any third diagnoses relevant to the recipient's condition in the appropriate blocks. Leave the blocks labeled ICD blank.
- Item 13: Treatment Plan (Attach a Copy of the Order Sheet if More Convenient)
The hospital admitting diagnoses (primary, secondary, and other) and dates of admission and discharge must be recorded. The treatment plan also should include all medications the recipient is to receive. Names of drugs with dosages, routes, and frequencies of administration are to be included. Any diagnostic or treatment procedures and frequencies should be indicated.
- Item 14: Recommendation Regarding Level of Care Considered Necessary
Enter a check in the correct box for Skilled or Intermediate Care for the Mentally Retarded. The Skilled box is appropriated as the nursing facility level of care.
- Item 15: Length of Time Care is Needed
Enter the length of time as permanent.
- Item 16: Is Patient Free of Communicable Diseases?
Enter a check in the appropriate box (Yes or No).
- Item 17: Alternatives to Nursing Home Placement
The admitting or attending physician must indicate whether the patient's condition could be managed by provision of Community Care or Home Health Services. Enter a check in the box corresponding to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.
- Item 18: Certification by Physician Regarding Patient's Level of Care
The admitting or attending physician must certify that the patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded. The physician must sign the form. Signature stamps are not acceptable.
- Item 19: Physician's Name and Address (Print)
Enter the admitting or attending physician's name and address in the spaces provided.
- Item 20: Date Signed by Physician
Enter the date that the attending or admitting physician signs the form.

Item 21: Physician's Licensure Number and Physician's Phone Number
Enter the Georgia license number for the attending or admitting physician and phone number.

Section C - Evaluation of Nursing Care Needed

All items in Section C of this form must be completed by licensed personnel involved in the care of this patient.

Item 22: Diet
Enter the appropriate diet for the recipient. If "other" is checked, please specify type of diet.

Item 23: Bowel
Check the appropriate box to indicate bowel habits of recipient.

Item 24: Overall Condition
Check the appropriate box to indicate the recipient's overall condition.

Item 25: Restorative Potential
Check the appropriate box to indicate the recipient's restorative potential.

Item 26: Mental and Behavioral Status
Check all appropriate boxes to indicate the recipient's mental and behavioral status.

Item 27: Decubiti
Check the appropriate box to indicate if recipient has decubiti. If "yes" is checked and "surgery" is also checked, the date of surgery should be included in the space provided.

Item 28: Bladder
Check the appropriate box to indicate bladder habits of the recipient.

Item 29: Miscellaneous
Indicate the number of hours the recipient is to be out of bed per day in the space provided. Check other treatment procedures the recipient requires.

Item 30: Indicate Frequency Per Week
If applicable, indicate the number of treatment or therapy sessions per week the recipient receives or needs.

Item 31: Record Appropriate Legend
Enter appropriate number indicating the level of impairment or the level of assistance needed in the boxes provided.

Item 32: Remarks
Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form.

Item 33: Pre-admission Certification Number
This space is not to be used. Effective April 1, 2003, Nursing Facilities are no longer required to make contact with the Contractor for precertification of the DMA-6.

Item 34: Signed
The person completing Section C should sign in this space.

Item 35: Date Signed
Enter the date this form is signed.

Form DMA-59 Instructions

Form DMA-59 will allow a patient to be admitted, changed, and terminated on one form. A vendor payment cannot be authorized for an applicant until he/she is found eligible and certified for Medicaid coverage.

Rev. 04/03

Rev. 07/01

1. The Form DMA-59 is used by nursing facilities and intermediate care facilities for the mentally retarded to request skilled (a nursing facility level of care) and ICF/MR vendor payments. Also, the Form is used by facilities to report changes, such as transfers, discharge to home or Hospice, or death.

Rev. 04/03

2. When making the initial request for an authorization of vendor payments for a new admission or readmission, the entire Section I of the Form DMA-59 is completed. When reporting a status change, Section I should be completed.
 - a. Enter the name and location of the provider.
 - b. Enter the nine-character Medicaid provider number.
 - c. Enter recipient's social security number.
 - d. Enter the name of the recipient (last name, space, first name, space middle initial, space, any title like Jr., Sr., etc.).
 - e. Enter the recipient's identification number (Medicaid identification number) exactly as it appears on the Medical Assistance Eligibility Certification. (This number may change so it is imperative that you review the certification during each month of service.) A valid Medicaid recipient ID number will be formatted in one of two ways as follows:
 - 1) If the client is an SSI recipient, the client ID number will be the 9 digit social security number plus an "S", e.g., 123456789S.
 - 2) If the client is a recipient Medical Assistance Only, the ID number will be the 9 digit PARIS number plus a "P", e.g., 123456789P.
 - 3) If the client is a Qualified Medicare Beneficiary (QMB), the ID number will be the 9 digit Medicaid number plus a "Q", e.g., 123456789Q.
 - f. Enter the primary ICD-9-CM diagnosis code.
 - g. Enter the secondary ICD-9-CM diagnosis code.
 - h. Enter recipient's date of birth.

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3. Section II of the Form DMA-59 is to be completed for initial admissions or readmissions. Complete all necessary fields to explain the status of the recipient.

a. Enter the physician's recommended level of care based on the Form DMA-6. Skilled for a nursing facility level of care or IC/MR for the intermediate care for the mentally retarded.

1 - Skilled 2 - IC 3 - IC/MR

b. Enter admission date to the facility.

c. Enter the location of the patient prior to admission.

A - Hospital D - Own Home
B - Nursing Facility (NF) E - Other (please specify)
C - State Institution F - SNF Medicare

Rev. 07/01

d. Leave the fields for VA Aid and Attendance, attachment of the DMA-6 and QMB eligibility blank.

e. Leave the payment effective date and patient income fields blank.

4. When requesting authorization for a status change, Section III of the Form DMA-59 (in addition to Section I) must be completed. The facility must initiate the status change request when it is the responsibility of the facility to make such change. The Form DMA-59 is designed so that a recipient may be admitted and changed on the same form.

a. The new level of care and level of care effective date are required fields and both must be completed. Skilled for the nursing facility level of care, IC/MR for facility of the mentally retarded.

1) Enter the new level of care offered to the recipient.

1 - Skilled 2 - IC 3 - IC/MR

2) Enter the new level of care effective date in MMDDYY format.

5. Section IV (along with Section I) of the Form DMA-59 is completed whenever services rendered to a recipient are terminated due to the recipient's departure from the facility.

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- a. Enter the reason why the recipient's services were terminated.

E – Ineligible (Leave this field blank).

F – Discharged

G - Died

- b. Enter the date in MMDDYY format on which the recipient's services were terminated due to death or discharge.
- c. Enter the destination of the recipient following termination.

A - Home with a Health Plan

D - Other (please specify)

B - Hospital

E - Own Home

C - Nursing Facility (NF)

F - SNF Medicare

L - Limited Stay Expired

6. Section V of the Form DMA-59 must be completed every time the form is used for any reason by the facility.
 - a. Enter the signature of the facility administrator.
 - b. Enter the date the facility administrator signed the Form-59 in MMDDYY format.

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7. Leave Section VI blank.

APPENDIX F

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

**PASRR LEVEL I APPLICATION
RESIDENT IDENTIFICATION SCREENING INSTRUMENT**

In accordance with Section 1919(b)(3)(f) of the Social Security Act, a nursing facility cannot admit any new resident without this preadmission identification screen. This screen is part of the Preadmission Screening/Resident Review (PASRR), and determines whether each applicant to a nursing facility has indicators for a related condition of mental illness, mental retardation or developmental disability.

| | |
|--|-----------------------------|
| Name of applicant/resident _____ | Name of facility/city _____ |
| Current location of applicant: Home Residential Nursing facility Psychiatric inpatient Acute hospital Other | |
| Check all that apply to the applicant/resident: New admission Readmission to NF from psychiatric hospital Readmission to NF from acute hospital Transfer from residential to NF Transfer between NF's Out-of-state resident Other: _____ | |
| Sex: M F Date of birth _____ - _____ - _____ Social Security Number _____ - _____ - _____ | |
| | |
| 1. Does the individual have a mental illness, mental retardation, developmental disability or related condition? | Yes No |
| a. Does the individual have a primary (Axis I) diagnosis of dementia based on DSM IV criteria? If yes, check the type of dementia, due to: | Yes No |
| <input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Head Trauma <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Vascular changes <input type="checkbox"/> Huntington's Disease <input type="checkbox"/> Pick's Disease <input type="checkbox"/> HIV <input type="checkbox"/> Creutzfeldt-Jakob (ABE) <input type="checkbox"/> Other _____ | |
| b. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness? If yes, specify the physical illness: | Yes No |
| <input type="checkbox"/> Coma <input type="checkbox"/> Functioning at a brain stem level <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Chronic Obstructive Pulmonary Disease <input type="checkbox"/> Ventilator dependence <input type="checkbox"/> Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease) <input type="checkbox"/> Delirium <input type="checkbox"/> Other _____ | |
| b.1 If yes, is the level of impairment so severe that the individual could NOT be expected to benefit from specialized services? | Yes No |
| c. Does the individual have a terminal illness as defined for hospice purposes under 42 CFR §483.130 which includes medical prognosis that his/her life expectancy is 6 months or less? | Yes No |
| d. Does the individual require nursing facility services after hospital discharge and whose attending physician has certified that the nursing facility stay is likely to require less than 30 days? | Yes No |
| If YES was answered for numbers 1a, 1b, 1c OR 1d above, do not proceed. Submit the signed form to GHP. | |
| ***** CHECK ALL THAT ARE TRUE ***** | |
| 2. The individual has a primary (Axis I) diagnosis of mental illness based on DSM IV criteria. If yes, check all that apply. | Yes No |
| <input type="checkbox"/> Schizophrenia, Paranoid Type <input type="checkbox"/> Other Psychotic Disorder _____ <input type="checkbox"/> Schizophrenia, Disorganized Type <input type="checkbox"/> Depressive Disorder _____ <input type="checkbox"/> Schizophrenia, Catatonic Type <input type="checkbox"/> Bipolar Disorder _____ <input type="checkbox"/> Schizophrenia, Undifferentiated Type <input type="checkbox"/> Anxiety Disorder _____ <input type="checkbox"/> Schizophrenia, Residual Type <input type="checkbox"/> Somatoform Disorder _____ | |
| Comments: _____ | |
| a. Does the treatment history indicate the individual has experienced at least ONE of the following? | |

(1) In-patient psychiatric treatment more than once in the past 2 years. **Yes No**

(2) Within the last 2 years experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. **Yes No**

b. **Within the past 3 to 6 months** the disorder results in functional limitations of major life activities that would normally be appropriate for the individual's developmental stage. The individual typically has AT LEAST ONE of the following characteristics on a continuing or intermittent basis:

(1) **Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other persons, has a possible history of altercations, evictions, firing, fear of strangers, avoidance of interpersonal relationships and social isolation. **Yes No**

(2) **Concentration, persistence and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings, manifests difficulties in concentration, inability to complete simple tasks within an established time period, makes frequent errors, or requires assistance in the completion of these tasks. **Yes No**

(3) **Adaptation to change.** This individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system. **Yes No**

3. The individual has an Axis II diagnosis of mental retardation based on DSM IV criteria (diagnosed prior to age 18) or developmental disability (manifested before the person reaches age 22). **Yes No**

a. Diagnoses of any of the following disabilities MAY indicate a RELATED CONDITION: Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida, Muscular Dystrophy, Orthopedic Impairment, Speech Impairment, Spinal Cord Injury, Deafness/Blindness.

The individual is a "PERSON WITH RELATED CONDITIONS" having a severe, chronic disability that meet ALL of the following conditions:

(1) It is attributable to cerebral palsy, epilepsy or any other condition other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required by these persons.

(2) It is manifested before the person reaches age 22.

(3) Is likely to continue indefinitely.

(4) It results in substantial functional limitations in THREE or more of the following areas of major life activities:

- Self-care;
- Understanding and use of language;
- Learning;
- Mobility;
- Self direction; and
- Capacity for independent living.

I understand that this report may be relied upon in the payment of claims that will be from Federal and State funds, and that any willful falsification or concealment of a material fact may be prosecuted under Federal and State Laws. I certify that to the best of my knowledge the foregoing information is true, accurate and complete.

Physician's Signature

Date

Print Physician's Name

Office or Hospital or Agency Address

City

State

County

Zip

If questions #2 and #3 were answered "yes", do not admit the patient to the nursing facility until GHP and PASRR Determination Unit approves the admission and gives an authorization number.

If all questions were answered "no" and there is no further evidence to indicate the possibility of mental illness, mental retardation or related condition, the nursing facility may admit the patient if approved.

Admission to the facility does not constitute approval for Title XIX patient status.

A copy of this form, as well as a copy of the DMA-6, must be placed in each resident's file in the facility.

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY

CITY

MEDICAID PROVIDER NO

SOCIAL SECURITY NO

| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|
| | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|

RECIPIENT'S NAME

RECIPIENT'S MEDICAID NO

PRIMARY ICD-9-CM

SECONDARY ICD-9-CM

DATE OF BIRTH

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

SECTION II - ADMISSION

LEVEL OF CARE

1-Skilled
 2-IC
 3-IC/MR

PATIENT ADMITTED FROM:

A-Hospital
 B-Nursing Facility (NF)

ADMISSION DATE

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

C-State Instit.
 D-Own Home
 E-Other _____
 F-SNF Medicare

VA AID & ATTENDANCE INCLUDED:
() Yes \$ _____ () No

DMA-6 ATTACHED () Yes () No

OMB ELIGIBLE: () Yes () No

PAYMENT EFFECTIVE DATES

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

PATIENT INCOME

| |
|--|
| |
|--|

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE:

1-Skilled
 2-IC
 3-IC/MR

LOC EFFECTIVE DATE:

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

VA AID & ATTENDANCE INCLUDED:
() Yes \$ _____ () No

DMA-6 ATTACHED () Yes () No

OMB ELIGIBLE: () Yes () No

PAYMENT EFFECTIVE DATES:

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

PATIENT INCOME

| |
|--|
| |
|--|

SECTION IV - TERMINATIONS

REASON:

E-INELIGIBLE
 F-DISCHARGED
 G-DIED

EFFECTIVE DATE:

| | | | | | |
|---|---|---|---|---|---|
| M | M | D | D | Y | Y |
|---|---|---|---|---|---|

DISCHARGE DESTINATION

A-Home with a Health Plan
 B-Hospital
 C-Nursing Facility (NF)
 D-Other _____

E-Own Home
 F-SNF Medicare
 L-Limited Stay
 Expired

SECTION V - FACILITY CERTIFICATION

I do hereby certify that the above statements are true and correct I agree to submit to the County Department a status change request for any change in the monthly contributions by the recipient

Signature of Facility Administrator X _____

DATE

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____ County Code

DATE

| | | | | | |
|--|--|--|--|--|--|
| | | | | | |
|--|--|--|--|--|--|

**PHYSICIAN'S RECOMMENDATION CONCERNING NURSING FACILITY CARE
OR INTERMEDIATE CARE FOR THE MENTALLY RETARDED**

| Section A - Identifying Information | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|---|------------------|---------------------------|--------------------|---------------------|----------------|---------------------------|--------------------|----------|--|--|--|--|--|--|--------|--|--|--|--|--|--|
| 1. Facility Name and Address Country: _____ | | 2. Medicaid Case Number 3 Digits 2 digits | | | | | | | | | | | | | | | | | | | | | | |
| 5. Type of Facility (Check One) 1. <input type="checkbox"/> Nursing Facility 2. <input type="checkbox"/> ICF/MR | | 3. Social Security Number 4. Sex Age 4A. Birthdate | | | | | | | | | | | | | | | | | | | | | | |
| 6. Type of Recommendation 1. <input type="checkbox"/> Initial 2. <input type="checkbox"/> Level Change 3. <input type="checkbox"/> Continued Placement | | 7. Patient's Name (Last, First, Middle Initial) | | | | | | | | | | | | | | | | | | | | | | |
| 8. Date of Nursing Facility Admission | | 9. Patient Transferred from: (check one) <input type="checkbox"/> Hospital <input type="checkbox"/> Home <input type="checkbox"/> Another Nurs. Home <input type="checkbox"/> Private Pay <input type="checkbox"/> Medicare | | | | | | | | | | | | | | | | | | | | | | |
| 10. Signed: _____ (Patient, Spouse, Parent, or other Relative or Legal Representative) 11. Date _____ | | 9A. State Authority (MH S 12-1 Screening) Level I/II Restricted Auth. Code Date | | | | | | | | | | | | | | | | | | | | | | |
| 12. Diagnosis on Admission to Facility (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____ | | 9B. This is not a re-admission for OBRA purposes Restricted Auth. Code Date | | | | | | | | | | | | | | | | | | | | | | |
| Section B - Physician's Examination Report and Recommendation | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. Treatment Plan (Attach copy of order sheet if more convenient) Hospital Dates: _____ to _____ | | 1. ICD 2. ICD 3. ICD | | | | | | | | | | | | | | | | | | | | | | |
| 14. Recommendation Regarding Level of Care Considered Necessary 1. <input type="checkbox"/> Skilled 2. <input type="checkbox"/> Intermediate 3. <input type="checkbox"/> Intermediate care for the Mentally Retarded | | 15. Length of Time Care Needed 1. <input type="checkbox"/> Permanent 2. <input type="checkbox"/> Temporary _____ months estimated | | | | | | | | | | | | | | | | | | | | | | |
| 16. Is Patient free of communicable diseases? 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No | | 17. This patient's condition <input type="checkbox"/> could <input type="checkbox"/> could not be managed by provision of <input type="checkbox"/> Community Care or <input type="checkbox"/> Home Health Services. | | | | | | | | | | | | | | | | | | | | | | |
| 18. I certify that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded. | | 19. Physician's Name (Print) _____ Physician's Address (Print) _____ | | | | | | | | | | | | | | | | | | | | | | |
| 20. Date Signed By Physician _____ | | 21. Physician's License No. _____ Physician's Phone No. _____ | | | | | | | | | | | | | | | | | | | | | | |
| Section C - Evaluation of Nursing Care Needed (check appropriate box only) | | | | | | | | | | | | | | | | | | | | | | | | |
| 22. Diet <input type="checkbox"/> Regular <input type="checkbox"/> Diabetic <input type="checkbox"/> Formula <input type="checkbox"/> Low Sodium <input type="checkbox"/> Tube Feeding <input type="checkbox"/> Other | 23. Bowel <input type="checkbox"/> Continence <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Colostomy | 24. Overall Cond. <input type="checkbox"/> Improving <input type="checkbox"/> Stable <input type="checkbox"/> Fluctuating <input type="checkbox"/> Deteriorating <input type="checkbox"/> Critical <input type="checkbox"/> Terminal | 25. Restorative Pot. <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Questionable <input type="checkbox"/> None | | | | | | | | | | | | | | | | | | | | | |
| 26. Mental & Behavioral Status <input type="checkbox"/> Agitated <input type="checkbox"/> Confused <input type="checkbox"/> Cooperative <input type="checkbox"/> Depressed <input type="checkbox"/> Forgetful <input type="checkbox"/> Alert | <input type="checkbox"/> Noisy <input type="checkbox"/> Nonresponsive <input type="checkbox"/> Vacillating <input type="checkbox"/> Violent <input type="checkbox"/> Wanders <input type="checkbox"/> Withdrawn | <input type="checkbox"/> Dependent <input type="checkbox"/> Independent <input type="checkbox"/> Anxious <input type="checkbox"/> Well Adjusted <input type="checkbox"/> Discouraged <input type="checkbox"/> Inappropriate Reaction | | | | | | | | | | | | | | | | | | | | | | |
| 27. Decubiti <input type="checkbox"/> Yes <input type="checkbox"/> Surgery <input type="checkbox"/> No Date _____ <input type="checkbox"/> Infected <input type="checkbox"/> On Admission | 28. Bladder <input type="checkbox"/> Continence <input type="checkbox"/> Occas. Incontinent <input type="checkbox"/> Incontinent <input type="checkbox"/> Catheter | 30. Incontinence Frequency Per Week <table border="1" style="width:100%; text-align: center;"> <tr> <th>Physical Therapy</th> <th>Occupational Therapy</th> <th>Remotive Therapy</th> <th>Reality Orientation</th> <th>Speech Therapy</th> <th>Bowel and Bladder Retrain</th> <th>Activities Program</th> </tr> <tr> <td>Received</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Needed</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> | | Physical Therapy | Occupational Therapy | Remotive Therapy | Reality Orientation | Speech Therapy | Bowel and Bladder Retrain | Activities Program | Received | | | | | | | Needed | | | | | | |
| Physical Therapy | Occupational Therapy | Remotive Therapy | Reality Orientation | Speech Therapy | Bowel and Bladder Retrain | Activities Program | | | | | | | | | | | | | | | | | | |
| Received | | | | | | | | | | | | | | | | | | | | | | | | |
| Needed | | | | | | | | | | | | | | | | | | | | | | | | |
| 28. Hours Out of Bed Per Day _____ <input type="checkbox"/> Inlets <input type="checkbox"/> IV <input type="checkbox"/> Bedfast | | 29. Catheter Care <input type="checkbox"/> Catheter Care <input type="checkbox"/> Colostomy Care <input type="checkbox"/> Sterile Dressings <input type="checkbox"/> Suctioning | | | | | | | | | | | | | | | | | | | | | | |
| 31. Record Appropriate Legend IMPAIRMENTS 1. Severe 2. Moderate 3. Mild 4. None Sight Hear Speech Ltd. Motion Para-lysis <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTIVITIES OF DAILY LIVING 1. Dependent 2. Needs Asst. 3. Independent 4. Not App. Eats Wheel chair Transfers Bath Ambulation Dressing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | |
| 32. Remarks | | 33. Pre-Admission Certification Number _____ | | | | | | | | | | | | | | | | | | | | | | |
| 34. Signed _____ | | 35. Date Signed _____ | | | | | | | | | | | | | | | | | | | | | | |
| Do Not Write Below This Line | | | | | | | | | | | | | | | | | | | | | | | | |
| Continued Stay Review Date: _____ | | Payment Date _____ Approved For _____ Days Only | | | | | | | | | | | | | | | | | | | | | | |
| 36. Level of Care Recommended by G.M.C.F.: _____ | | 37. Signature (G.M.C.F.) _____ | | | | | | | | | | | | | | | | | | | | | | |
| 38. Attachments (G.M.C.F.) 1. <input type="checkbox"/> Yes 2. <input type="checkbox"/> No | | Date _____ | | | | | | | | | | | | | | | | | | | | | | |

NURSING FACILITY LEAVE OF ABSENCE FORM

| Patient's Name | Level of Care | Patient's Medicaid Number | OUT Date Time | Staff Signature | In Date Time | Staff Signature | Number of Days Exceeded |
|-----------------------|----------------------|----------------------------------|----------------------|------------------------|---------------------|------------------------|--------------------------------|
| | | | | | | | |

ACKNOWLEDGEMENT OF RECEIPT OF HOME AND COMMUNITY-BASED SERVICES INFORMATION

It is the policy of the State of Georgia that services be delivered in the least restrictive manner that addresses the service needs of the individual while enhancing the promotion of social and community integration. Based on this policy, all potential residents (hereafter referred to as "applicant/consumer") and/or their authorized representative will be afforded an opportunity to make an informed choice concerning services.

Once an applicant/consumer is determined to be likely to require the level of care provided in a Nursing Facility the applicant/consumer or his/her authorized representative will be informed of alternatives available under home and community-based service options as described in the DCH Home and Community-Based Services booklet.

Verification

I have verified that the applicant/consumer or his/her authorized representative has been given information about home and community-based services in the manner outlined above.

Signature of Informant

Date

Acknowledgement

I have been informed of home and community-based service options as an alternative to nursing home placement. I have received the information contained in the DCH Home and Community-based Service Manual, which advises me of these options and provides information about how to apply for services.

Signature of Applicant/Consumer

Date

or

Signature of Authorized Representative

Date

(DMA-385; 04/03)

**18 NURSING HOME CO-INSURANCE
MEDICAID - MEDICARE
CROSS-OVER INVOICE**

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

MAIL CLAIMS FOR PAYMENT TO:
EDS
P.O. BOX 105036
TUCKER, GA 30085-5036

FOR FISCAL AGENT USE ONLY

| |
|--|
| |
|--|

PROVIDER MEDICARE NUMBER
(1)

PROVIDER MEDICAID NUMBER
(2)

BILLING DATE
(3) MO DA YR

DATES OF SERVICE
FROM TO
(4) MO DA YR MO DA YR

RECIPIENT MEDICARE CASE NUMBER
(5)

RECIPIENT MEDICAID CASE NUMBER
(6)

NO. CO. INS. DAYS
(7)

MEDICAL RECORD NUMBER
(8)

RECIPIENT NAME
LAST FIRST INIT.
(9)

IMPORTANT
A REMITTANCE ADVICE FROM MEDICARE OR AN APPROVED MEDICARE CLAIM MUST BE ATTACHED FOR THIS CLAIM TO BE PROCESSED BY THE DEPARTMENT OF MEDICAL ASSISTANCE.

| FOR DEPARTMENT USE ONLY | | | | |
|-------------------------|--|--|--|-------|
| | | | | DATES |
| N.H. PATIENT INCOME | | | | |
| N.H. PATIENT INCOME | | | | |
| N.H. PATIENT INCOME | | | | |
| N.H. PATIENT INCOME | | | | |
| CO-INSURANCE AMT. | | | | |
| | | | | |

PHYSICIAN'S SUPPLIER'S AND OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.
(10)

This is to certify that the foregoing information is true, accurate, and complete. I understand that payment and satisfaction of this claim will be from Federal and State Funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

(11)
PROVIDER'S SIGNATURE
WHITE: FISCAL AGENT COPY; YELLOW: PROVIDER COPY

DMA-296 (11/89)

Adjustment Request Form

| | |
|---|---|
| 1. Transaction Control Number (TCN) / Internal Control Number (ICN) of the paid claim to be adjusted as shown on the Remittance Advice | 3. Provider Name/Address |
| Member Medicaid Information 2. Medicaid Number Member Name (Last, First, Initial) | Provider Number Phone Number () |
| 4. Reason for adjustment (check one box) A. <input type="checkbox"/> Apply COB (indicate amount in Block #5D) B. <input type="checkbox"/> Change information as indicated in Block 5 below C. <input type="checkbox"/> Void claim D. <input type="checkbox"/> Medicare adjustment (attach all EOMB's that apply to this adjustment) | |

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter zero in the line number field. COB applied should always be line #0.

| 5A | 5B | 5C | 5D |
|----------------------|---------------------------|----------------------------|----------------------------|
| Line to be Corrected | Information to be Changed | From (Current) Information | To (Corrected) Information |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| |
|-------------------------------|
| 6. Explanation for Adjustment |
|-------------------------------|

| |
|--|
| 7. FOR DCH USE ONLY CCN _____ FS Line Amount \$ _____ |
|--|

Provider Signature _____ Date _____



Request for Forms

Completion Instructions:

- ◆ **Quantity** – Indicate quantity requested in the **Quantity Ordered** column.

- ◆ **Shipping Address** – Type or print your GHP provider number, provider name, , and address in the **FROM** box.
*NOTE: We must have a **STREET ADDRESS**; UPS will not ship to a post office box.*

- ◆ **Mail this form to:** – GHP, P. O. Box 5000, McRae, GA 31055

| Item | Form Type | Qty. Ordered |
|---------|--|--------------|
| DMA-6 | Physician’s Recommendation Concerning Nursing Facility Care or Intermediate Care for the Mentally Retarded | |
| DMA-44 | Home Health Patient Profile | |
| DMA-59 | Authorization for Nursing Facility Reimbursement | |
| DMA-69 | Informed Consent for Voluntary Sterilization | |
| DMA-80 | Prior Authorization Request | |
| DMA-81 | Prior Approval for Medical Service | |
| DMA-276 | Statement of Medical Necessity | |
| DMS-311 | Certification of Necessity for Abortion | |
| DMS-323 | Unknown Eligibility Affidavit | |
| DMA-375 | Newborn Eligibility | |
| DMA-380 | Optical Device Prescription | |
| DMA410 | Third Party Liability (TPL) Confirmation Statement | |
| DMA-501 | Adjustment | |
| DMA-520 | Provider Inquiry Form | |
| DMA-521 | Hospice Referral Form for Non-Hospice Related Services | |
| DMA-550 | Newborn Medicaid Certification | |
| DMA-610 | Prior Authorization Request | |
| DMA-613 | Level I Applicant/Resident I.D. Screening Instrument | |
| DMA-615 | ESRD Enrollment Application | |
| DMA-632 | Presumptive Eligibility Determination for Pregnancy-Related Care | |
| DMA-633 | Change Form /Temporary Medicaid Card | |
| DMA-634 | Notice of Action | |
| DMA-635 | Post Partum Home Visit Mother Assessment | |
| DMA-637 | Post Partum Teaching Guide | |
| DMA-638 | Letter of Understanding | |

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|---------|---|--|
| DMA-639 | Model Waiver Assessment | |
| DMA-641 | Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7 month visit) | |
| DMA-642 | Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11-12 month visit) | |

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|----------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|
| F R O M | Provider Medicaid ID Number (10-digits) | | | | | | | | | | | | |
| | Provider Name | | | | | | | | | | | | |
| | Street Address | | | | | | | | | | | | |
| | City, State, Zip Code | | | | | | | | | | | | |

APPENDIX G

ROLE OF THE CONTRACTOR

General

The Division of Medical Assistance contracts for the performance of preadmission Level 1 screening. (PASRR, DMA-613).

The Contractor reviews the DMA-613, initiating the Level 1 screening and determines:

- a. If the DMA-613 does not reveal indicators for serious mental illness or mental retardation, no further screening is necessary.
- b. If the DMA-613 does reveal indicators for serious mental illness or mental retardation, proceeds with request of further screening by PASRR. The Contractor will notify PASRR. The process is completed when PASRR informs the Contractor of findings and the Contractor informs the originator of the preadmission request.

Initial Admission

A recipient may be admitted to a nursing facility or an intermediate care facility for the mentally retarded, only upon the recommendation of a physician (Doctor of Medicine or Osteopathy). Nursing facility applicants must also have the Level 1, DMA-613 screening. (See Section 801))

Re-evaluations

When the applicant receives authorization from PASRR but requires a re-evaluation within a stated period of time, it is the facility's responsibility to request this re-evaluation.

It is necessary for the facility to forward information to the Contractor, five (5) days prior to date of required re-evaluation by PASRR. Following a review by PASRR the facility will be notified of the approval or denial of continued stay by the Contractor.

Utilization Review

Effective October 1, 1990, federal regulations eliminated the requirement for utilization review and inspection of care in nursing facilities.

The contractor handles all phases of Utilization Review in intermediate care facilities for the mentally retarded. As a result, intermediate care facilities for the mentally retarded are not permitted to include in their cost report any costs related to utilization review.

Utilization Review will consist of the following:

Pre-Admission Approval for ICF/MR Facilities

The contractor must receive a comprehensive medical and social evaluation; a plan of care and a psychological evaluation of need for care. The psychological evaluation must be made before admission or authorization of payment, but not more than three months before admission. Mental Health/Mental Retardation applicants admitted in a nursing facility may be called into the contractor so that the local community Mental Health Center may be notified if a Level II determination would be necessary. Telephone pre-admission approval cannot be utilized for individuals with a Mental Health/Mental Retardation diagnosis admission into ICF/MR.

Periodic Medical Review - Independent Professional Review (On-Site) for ICF-MR

The contractor will inspect the care and services provided to each recipient in the facility at least annually. The current requirements for an Independent Professional Review are carried out by teams composed of a Physician, a Registered Nurse, and a Social Worker, none of whom is directly responsible for the care of any recipient reviewed. One member of the team must know the problems and needs of mentally retarded individuals. A team member shall not have a financial interest in any institution where they are conducting reviews, nor be employed by an institution where such reviews are conducted. The team will determine 1) if the services available in the facility adequately meet the health needs of each recipient; 2) if the rehabilitative and social needs of each recipient are adequately met, and 3) if the facility promotes his maximum physical, mental and psychosocial functioning.

Certification and Re-certifications for ICF-MR

A physician must certify for each applicant or recipient that ICF/MR services are or were needed. The certification must be made at the time of admission or, if an individual applies for assistance while in an ICF/MR, before the Division authorizes payment. The initial certification must be signed and dated by the physician in his/her handwriting.

A physician, or physician assistant or nurse practitioner acting within the scope of practice as defined by State law and under the supervision of a physician, must re-certify for each applicant or recipient that ICF/MR services are needed. Re-certification must be made at least every 12 months after the initial certification.

Failure to comply with this requirement shall result in the loss of reimbursement to the facility for each day an ICF/MR recipient is not certified. The amount shall be determined by multiplying the facility's applicable billing rate by the number of days of non-compliance for each recipient not certified on that date.

Plan of Care

In order to comply with federal regulations regarding the updating of plans of care, it is necessary that the attending or staff physician involved in the recipient's care must establish a written plan of care, and must also update and date the plan of care. The plan of care must

include diagnosis, symptoms, complaints; complications indicating the need for admission; a description of the functional level of the individual; objectives; any orders for medications and treatments; restorative and rehabilitative services; activities, therapies; social services; diet, and special procedures designed to meet the objectives of the plan of care; plans for continuing care and plans for discharge. A plan of care for a recipient residing in an ICF/MR must be reviewed, dated and updated every ninety days.

The Division is not mandating any particular form; however, each facility must ensure that each plan of care is dated, updated and signed by the physician in his/her handwriting. Computerized forms may be used if the format complies with these regulations.

Nursing Facility Bed Registry

Nursing facilities and intermediate care facilities for the mentally retarded are required to participate in the Bed Registry Program. The Bed Registry Program, administered by the Contractor, will provide for a more effective transfer of patients to the appropriate facility.

A participating facility is required to furnish, by telephone, the following data to the Contractor:

- a. Any vacancy or potential vacancy on a predetermined day of each week.
- b. Follow-up information on any potential vacancy previously reported.
- c. Additional information as required regarding bed availability.

APPENDIX H

DIVISION OF MEDICAL ASSISTANCE MENTAL HEALTH AND MENTAL RETARDATION REHABILITATION SERVICES

The Omnibus Budget Reconciliation Act (OBRA) of 1987, as amended in 1989 and 1990, mandates that nursing facility applicants and residents comply with the Preadmission Screening and Annual Resident Review (PASRR) program. The PASRR program requires applicants to Medicaid-certified nursing facilities who have indicators of serious mental illness (MI) or mental retardation (MR) and related conditions to undergo a preadmission screening (PAS). All residents of Medicaid-certified nursing facilities who are diagnosed with MI/MR or a related condition must be reevaluated at least annually. PASRR assessments must be completed on applicants and residents of Medicaid-certified nursing facilities, *regardless of the individual's source of payment*. The PASRR process is currently administered by the Department of Human Resources' OBRA Determination Unit (ODU) in the Division of Mental Health, Mental Retardation and Substance Abuse.

The PASRR final regulations, published in the Federal Register, Volume 57, Number 230, on November 30, 1992, became effective January 29, 1993. As a result of the final regulations, nursing facility residents must be provided mental health or mental retardation (MR/MR) rehabilitation services (i.e., services of a lesser intensity than Specialized Services) determined to be required as a result of a PASRR Level II assessment.

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There are approximately 1,400 nursing facility residents in Georgia needing MH/MR rehabilitation services as a result of PASRR. The services are necessary for the residents to attain and maintain their highest practicable level of functioning. Residents in the OBRA population reside in approximately 320 nursing facilities throughout the state. The number of residents requiring MH\MR rehabilitation services in a given facility range from one (1) to thirty-seven (37), with the rehabilitation service needs ranging from minimal to extensive.

PREADMISSION SCREENING (PAS)

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The PAS process begins with a Level I Assessment (DMA-613). The Division's Contractor, evaluates the DMA-613 and Level I and refers applicants requiring a Level II assessment (i.e., those who are suspected of or diagnosed with MI, MR or a related condition) to PASRR. The Level II assessment is a comprehensive medical, psychosocial and functional assessment. There are two Level II instruments used by PASRR; one for MI, and another for MI/MR.

- A PAS is required only during the initial entry into the nursing facility system.
- Individuals discharged from a hospital directly to a nursing facility for a stay of less than 30 days for treatment of a condition for which they were

hospitalized, will not require a PAS, provided the attending physician certified **before the admission** that the admission is for an anticipated stay of not more than thirty (30) days.

- No PAS will be required for readmission to a nursing facility within one (1) year of a previous Level II for an individual who, after being admitted to a nursing facility, was transferred to a hospital for treatment, regardless of the type of care received in the hospital or the reason for hospitalization.
- The PAS provides information that the nursing facility staff can use in performing the Resident Assessment and in patient care planning. A PAS may serve as a starting point for the first resident assessment after admission to a nursing facility.

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LEVEL II ASSESSMENT

- In order to complete the Level II assessment, the assessor will need access to the individual's medical record and will need copies of pertinent medical data. The assessor is responsible for conducting a face-to-face interview with the individual. The assessor should meet with the facility staff who is knowledgeable of the individual as well as available family members (if permission is obtained from the resident).
- Federal law requires each Level II assessment should include a physical examination signed by a physician. If a physician does not conduct the physical examination, a physician must review and concur with the findings. In order to fulfill this requirement, the assessor will need a copy of the resident's most recent physical examination performed and/or signed by a physician.
- The Level II assessment will determine and report:
 - 1) the individual's diagnoses;
 - 2) whether the individual meets criteria for a nursing facility level of care;
 - 3) whether the individual requires specialized services or requires MH/MR rehabilitative services of a lesser intensity than specialized services. If the individual needs MH/MR rehabilitative services, treatment recommendations will be included. Proposed treatment recommendations will be discussed with appropriate staff at the time of the assessment or subsequently.
- First Mental Health will send a Summary of Findings, including the determinations made, to the nursing facility. This copy should be used in care planning and must be available for review by surveyors from the Office of Regulatory Services to review. **The nursing facility must request a copy of an individual's Summary of Findings from First Mental Health once an individual has been admitted to the facility.**

- First Mental Health is required to notify applicants and residents both orally and in writing, of the outcome of the assessment, excluding denials, and interpret the assessment findings. Oral notification is made by phone to applicants and residents or their legal representatives. A written notice is mailed to applicants and residents or their legal representatives, as well as to the individual's primary care physician and hospital (if applicable).

PASRR ASSESSORS

- Assessors are to complete Level II assessments on individual referred to the Contractor.
- Assessors are to contact the individual listed on the intake referral form (PAS assessments) or a nursing facility staff member (ARR assessments) to schedule a convenient time to conduct the assessment. Assessments should be completed during regular/customary working hours (excluding official State holidays and weekends). Assessments may be conducted outside normal business hours only for the convenience of the facility, applicant or resident, or the resident's family.
- The assessor should arrive at the hospital or nursing facility with appropriate identification which includes a letter of introduction from PASRR and information identifying the assessor as an agent of First Mental Health.
- Copies of the most recent physical examination performed or signed by a physician, the most recent care plan and any other pertinent information should be made available to the assessor.

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OUT-OF-STATE APPLICANT/RESIDENT

PASRR will coordinate all out-of-state assessments. For any individual residing in another state who desires nursing facility placement in Georgia, the Contractor will evaluate the Level I and refer an individual requiring a Level II to PASRR office. PASRR will arrange for the PASRR office in the applicant's state of residence to complete a Level II assessment. The Level II will be forwarded to PASRR for determination. The Contractor will be notified of the Level II determinations in order to issue a pre-certification number.

DENIALS, ALTERNATIVE PLACEMENTS AND APPEALS

Letters of denial will be issued by PASRR to individuals who do not meet criteria for a nursing facility level of care. Residents will not be discharged based on a PASRR denial until a discharge notice is issued by the Division of Medical Assistance. Residents or their family members will be advised of their appeal rights in the denial letter. Alternative placements for residents requiring discharge will be coordinated by the Division of Mental Health, Mental Retardation and Substance Abuse in accordance with federal regulations.

NURSING FACILITY REHABILITATION SERVICES

Effective July 1, 2004, Medicaid Certified Nursing Facilities must provide rehabilitative services to nursing home residents who are in the PASRR population and have a diagnosis of Mental Retardation or related condition. This change ***does not*** affect residents in the PASRR program who have a diagnosis of Mental Illness or dually diagnosed with Mental Illness and Mental Retardation (MHM will continue to provide services to these residents).

The following procedures have been developed by the Department for providing Mental Retardation Services to nursing facility residents in the PASRR population:

It will be the responsibility of the nursing facility to review the resident's current treatment plan, determine the resident's MR level (mild, moderate, severe, or profound), modify the treatment plan, and if necessary provide required treatment.

The amount of frequency of treatment is dependent upon the resident's level of Mental Retardation. *Example: A resident with mild MR may require skills training with dressing, grooming, general hygiene, etc., on a monthly basis as opposed to a resident with moderate MR, whose needs would be more frequent, maybe two times a month with more repetitions.*

Two (2) types of reports will need to be completed and submitted to the Department:

• **Demographics Report- (Contents)**

- Name and address of facility;
- Name of resident;
- Resident's Medicaid ID;
- Date of service;
- Diagnosis;
- Type of Service provided (counseling, skills, training, etc.);
- Resident's level of service (mild, moderate, extensive); and
- Clinical staff/service provider's title (psychiatrist, social worker, counselor, nursing, etc.);

• **Status Report-**

- Summary of findings received;
- Active residents in program; Residents discontinued from PASRR program
 - Transfer (where to)
 - Deceased
 - Discharged (where to)

Reports must be per month and submitted by the 15th day of the month following the end of the previous quarter to **Attn:**

**PASRR Program Specialist 37TH FLOOR
DEPARTMENT OF COMMUNITY HEALTH
AGING AND COMMUNITY SERVICES
2 PEACHTREE STREET, N.W.
ATLANTA, GEORGIA 30303-3159**

(See the PASRR REHABILITATION SERVICES DEMOGRAPHICS REPORT on the following page)

QUARTER ENDING _____
Month of _____

PASRR REHABILITATION SERVICES
DEMOGRAPHICS REPORT

| Name of Facility | | | | | Address of Facility | | |
|------------------|---------------|-----------------|-----------|-----------------|---------------------|----------------------------------|--|
| Name of Resident | Medicaid ID # | Date of Service | Diagnosis | Type of Service | Level of Service | Name and Title of Clinical Staff | |
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Monthly Report _____
Month Ending _____

**PASRR REHABILITATION SERVICES
STATUS REPORT**

Summary of Findings Received:

Active Residents:

Current Residents
(# at end of the previous month)
New Residents (PASRR)
(# added during current month)

Residents Discontinued from PASRR:

Transferred
Deceased
Discharged

TOTAL:

Nursing facilities must also provide services of a lesser intensity than specialized services (MH/MR rehabilitative services) to all residents who require these services as documented on the resident's treatment recommendation plan.

These services may include:

a. Crisis Services Immediate, brief response to an abrupt and substantial behavior change which has resulted in severe functional impairment, extreme personal distress, or potential danger to self or others. Steps may include:

- rapid assessment of the nature and severity of the problem;
- diagnostic assessment, including risk analysis;
- crisis service planning with nursing facility staff;
- any combination of psychiatric assessment and care, individual or group activity/ counseling, and behavior change interventions necessary to resolve the crisis; and
- appropriate referral if indicated.

b. Behavior Change Interventions

Systematic analysis of problems behaviors and their antecedents and consequences, leading to the development and implementation of a specific plan of intervention.

Steps include:

- identification and clear definition of problem behaviors;
- identification of antecedents and consequences of problem behaviors;
- identification of additional available and effective re-inforcers;
- identification of acceptable alternative behaviors;
- development of specific plans for withholding re-inforcers of problem behaviors and shaping and reinforcing desirable alternative behaviors;
- training of staff in implementation of behavior change plan; and
- monitoring of plan and its effectiveness.

c. Individual or Group Activity/Counseling

Systematic interaction in a group setting directed toward restoration, enhancement, or maintenance of the resident's level of functioning to include:

- assessment of the resident's daily living, social and independent living skills;
- development and practice of interpersonal and communication skills;
- disability and medication education;
- assistance in resolution, prevention, or controlling of symptoms or disabilities, including involvement of staff for support as appropriate;
- assistance in understanding and managing relationships with family, friends, other residents and staff; and
- psychotherapy.

d. Skills Training

Teaching, restoration, and maintenance of skills where indicated and appropriate including the following by explanation, demonstration, physical assistance and supervised practice:

- community living skills required for independent or semi-independent living outside a nursing facility, such as paying bills, planning and cooking meals, shopping, using public transportation.

e. Psychiatric Assessment and Care Services

Services of a Psychiatrist including:

- evaluation and assessment of physiological and psychological symptoms and signs;
- diagnostic evaluation;
- review and evaluation of medication;
- adjust and prescription of psychotropic medication;
- medical or psychiatric therapy; and
- assessment of the appropriateness of initiating or continuing services for mental illness.

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MH/MR REHABILITATION SERVICES

The Division has contracted with a Mental Health/Mental Retardation Rehabilitation Service to provide MH/MR rehabilitation services to residents in the OBRA population which are beyond those services typically provided in a nursing home. This contract is contingent upon approval of the Freedom of Choice Waivered by HCFA.

Nursing facilities are required to provide the MH/MR rehabilitation services contractor with the most recent copies of the Level II assessment and the OBRA/ PASRR Nursing Facility Treatment Recommendation (NFTR) plan for all residents in the OBRA population residing in the facility. Thereafter, the nursing facility must provide the service contractor with copies of all future Level II assessments and treatment plans received for new and current residents.

The Division's contractor will be responsible for providing MH/MR rehabilitation services to Medicaid recipients that are above and beyond those services typically provided in a nursing facility. The facility is responsible for obtaining or providing services of a lesser intensity than specialized services, (i.e., MH/MR rehabilitation services) to non-Medicaid residents.

The contractor will arrange to provide the services in the nursing facility, whenever possible, on Monday through Friday between 8:00 a.m. to 6:00 p.m., unless otherwise requested by the facility.

The contractor must document the services provided to individual residents in the nursing facility medical record. The resident's progress, as a result of the MH/MR rehabilitation services provided, must also be documented. The contractor must consult with appropriate nursing facility staff regarding the resident's needs, progress and outcomes to provide the continuity of care.

The following procedure is to be used when a resident does not want to be seen by a particular MH/MR professional:

1. Upon written or verbal notification from a resident or the resident's responsible party that the resident does not want to be seen by a particular MH/MR professional in the provider group, the nursing facility staff or the MH/MR professional must document the request on the Resident Request To Change MH/MR Professional form.
2. The original form must be placed in the resident's medical record and be retained until the resident withdraws the request.
3. The nursing home must notify the contractor by phone of the resident's request within 24 hours.
4. A copy of the form must be submitted to the contractor's Project Director by mail or by fax within ten (10) business days.
5. The contractor must comply with all such requests from residents. A tracking system utilized by the contractor and approved by the Division will be established to ensure that all requests from residents to change a MH/MR professional are honored.
6. MHM must send copies of all requests for change to the Department on a monthly basis.

The Division will monitor the work of the MH/MR rehabilitation services contractor. All concerns or complaints regarding MH/MR rehabilitation services should be brought to the attention of the Office of Institutional Policy.

SPECIALIZED SERVICES FOR NURSING FACILITY RESIDENTS

Specialized services will be provided by the state to all residents with mental illness or those with a dual diagnosis of both Mental Illness and Mental Retardation whose needs are such that continuous supervision, treatment and training by qualified mental health or

mental retardation personnel is necessary as determined by PASRR. Specialized services are defined as follows:

1. For Mental Illness

Psychiatric treatment for an acute episode of mental illness, to be provided in a state or private hospital psychiatric unit. The treatment is directed toward stabilization and restoration of the level of functioning that preceded the acute episode.

2. Mental Illness And Dually Diagnosed with Mental Retardation and/ or Related Condition

Aggressive, consistent implementation of an intensive program of training and related services, designed by qualified mental retardation professionals or specialists in related conditions, and directed toward the acquisition of behaviors necessary for the resident to function with habilitation of services of lesser intensity, or to prevent regression or loss of current functional status.

This document is intended to serve as a guide for nursing facilities regarding the PASRR process. Questions regarding PASRR should be referred to the PASRR Program Specialist 404.657.7211, Division of Medical Assistance, Department of Community Health.

APPENDIX I

NURSING FACILITY ADMINISTRATIVE REVIEWS

Application

This section describes appeals procedures for certain nursing facility (including ICF/MR) situations.

* **Please see Part I Policy and Procedures/ Billing Manual for specifics on appeal and review.**

Pre-Admission Approval

- a. Upon application for pre-admission approval, the nursing facility and the applicant/recipient or an authorized representative shall be given written notification of the Division's determination. Upon denial of pre-admission approval, the applicant/recipient or an authorized representative may obtain a reconsideration by the Division by so requesting in writing.

All requests for reconsideration must be received by the Department of Community Health Program Specialist no later than ten (10) days following receipt of the initial denial and must be accompanied by additional medical documentation to justify a reconsideration. All such requests are to be addressed to:

Attn: Pamela Madden, Program Specialist
Department of Community Health
Aging and Community Services Floor 37
2 Peachtree Street, NW
Atlanta, Georgia 30303-3159

- a. A decision on the request for reconsideration will be accomplished within fifteen (15) working days of its receipt by the Specialist. The applicant/recipient and the nursing facility will be notified in writing of the reconsideration decision by the Division .
- b. If an applicant/recipient disagrees with the Division's decision, that person, or an authorized representative, may file a request for a hearing. All such requests must be received by the local county Department of Family and Children Services Office or the Fair Hearings Unit of the Department of Human Resources no later than thirty (30) days after the date of the notice of decision.
- c. An initial decision on any matter with respect to which a hearing is requested shall be rendered in writing by a Hearing Officer of the Fair Hearings Unit. Should such a decision be adverse to the medical assistance applicant/recipient, that person or representative may appeal the decision by filing an appeal with the

Hearing Officer for Final Appeals in accordance with directions from the Fair Hearings Unit.

- d. If an aggrieved applicant/recipient of medical assistance exhausts all the administrative remedies provided, judicial review of the decision may be obtained in the same manner and under the same standards which are applicable to those contested cases which are reviewable pursuant to O.C.G.A., Section 50-13-19.

Billing Rate and Disallowance of Cost from the Cost Report

Reimbursement rates (billing rates) for nursing facilities (including ICFs/MR) are established pursuant to the provisions discussed in Chapter 1000 of this manual. A billing rate calculation notice will be sent to a provider each time a rate is initially calculated for a given cost report period or is subsequently adjusted as a result of audit or review by the Division or its agent. Nursing facilities rates and percentiles will be based on costs reported by the providers which are reviewed by the Division or its agent. Cost reports and adjustments determined appropriate by the Division will be used to establish rates. Those cost reports and adjustments determined appropriate prior to initial establishment of the annual percentile ceilings (as described in Chapter 1000 of this manual) shall be used in calculation of the percentiles. Those cost reports and adjustments determined appropriate subsequent to initial establishment of the annual percentile ceilings shall be used to adjust rates only; percentile ceilings will not be adjusted.

Any provider wishing to appeal its rate as initially established, its subsequent rate change as a result of audit or review, or its disallowance(s) of cost from the cost report must follow the process set out in subsections (a) - (c) below:

- a. Should a provider wish to appeal a decision of the Division regarding a billing rate calculation, including related disallowances from the cost report, the provider must file a written request for reconsideration with the Division. All such requests must be received by the Division within thirty (30) days of the date of the billing rate calculation notice. Requests received after this deadline shall not be considered. If no request for reconsideration is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report.

The written request must address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration must be directed to:

Director
Nursing Home Reimbursement
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, GA 30303-3159

The Director of the Nursing Home Reimbursement Division will have one hundred twenty days (120) from the date of receipt of the reconsideration request to render a decision unless the Director determines there are extenuating circumstances (e.g., multiple facilities are involved or the rate change is a result of a federal disallowance) or additional information is required. If the Director (or any authorized staff of the Nursing Home Unit) requests additional information, the nursing facility must submit and the Division must receive the response within thirty (30) days of the date of such request. The Director will have ninety (90) days from the date of receipt of the additional information to render a decision concerning the written requests or inquiries submitted by a nursing facility. Failure of a nursing facility to provide information within the specified time frame requested by the Division will result in the denial of the nursing facility's appeal by the Director. Failure of the Director to respond within the time frames described herein will result in approval of the nursing facility's request.

- b. The provider must file a request for a reconciliation conference if it wishes to appeal the Division's reconsideration decision. All such requests must be in writing and must be received within thirty (30) days from the date of the notice of the reconsideration decision. Requests received after this deadline shall not be considered. If no request for a reconciliation conference is received by the Division by the deadline, the provider shall be deemed to have waived its right to a hearing concerning the calculation of the billing rate and related disallowances from the cost report. All such requests must be directed to the address noted in subsection a) above.

Conferences will be scheduled at the Division's office. The Division Director will have sixty (60) days from the date of the reconciliation conference to render a decision unless both parties to the conference agree to extend the time limitation.

If the provider appeals a rate adjustment which is the result of a cost report adjustment(s) determined appropriate subsequent to the establishment of percentile ceilings, the change will not be effected until the date of the Division's reconciliation conference decision. To the extent that such a rate change decreases a rate granted prior to review, it shall be effected by retroactive rate adjustment rather than through a request for refund or by recoupment.

If the provider disagrees with the reconciliation conference decision, the provider may obtain a hearing on the matter by filing a written request there for with the Office of Legal Services of the Division in accordance with Section 508 of this chapter.

Sanctions

In addition to the termination and suspension actions provided for in Section 402, Part I of the Policies and Procedures manual, the Division may impose the sanctions described below.

Nursing Facilities

- a. The Division may sanction a nursing facility for failure to submit the required cost report as outlined in Appendix D.
- b. The Division may deny reimbursement for services to ICF/MR recipients admitted to a facility on or after the effective date specified on written notice to that facility that it is not in compliance with Subsection 106.8.

If the Division or its agent has determined that conditions in the facility have neither damaged nor immediately endanger the health, safety, or welfare of a recipient, the effective date of the notice shall be no earlier than five days after the date of receipt by the facility, during which time the facility will have the opportunity to correct the cited conditions.

The Division's action shall be predicated on a report from the agent, under its contract with the Division to perform on-site reviews of nursing facilities, which takes into account the medical, safety, environmental, and physical needs of the facility's residents. The denial of reimbursement shall remain in effect until such time as the Division determines, after subsequent on-site review, that the facility is meeting the aforementioned needs of its residents and is no longer damaging or endangering the health, safety, or welfare of any recipient. This denial shall not apply to temporarily hospitalized recipients, previously residing in a facility placed on such notice, who return to the facility after the date of notice: Neither shall it apply to persons who resided in the facility prior to the date of notice, and subsequently become Medicaid eligible.

A facility which has received notice of the Division's denial of reimbursement for newly admitted patients may appeal such action in the manner described in Section 508, Part I of the Policies and Procedure Manual. However, nothing in this provision shall impede the authority of the Division to deny payment for new admissions or suspend or terminate a facility's participation under Section 402, Part I of the Policies and Procedure Manual.

- c. The Division may deny reimbursement for services to recipients in nursing facilities, who are admitted after the facility's receipt of notice that its participation in the program will be terminated by the Department of Community Health, under its own volition or as a result of an action taken by the Office of Regulatory Services of the Department of Human Resources, or by the Health Care Financing Administration of the U.S. Department of Health and Human Services.

The Division may impose any or all of the remedies specified in Appendix G of this manual, when a nursing facility fails to meet a Program Requirement as defined therein.