

Florida Medicaid

Nursing Facility Services Coverage and Limitations Handbook

Agency for Health Care Administration





JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

February 2, 2006

Dear Nursing Facility Provider:

Enclosed please find an erratum to the Florida Medicaid Nursing Facility Services Coverage and Limitations Handbook, which was updated effective July 2004. The erratum allows physicians to delegate all nursing facility patient visits to a physician assistant, nurse practitioner, or clinical nurse specialist. Prior policy required the physician to personally make every other visit.

Please replace the following pages in the handbook with the attached revised pages.

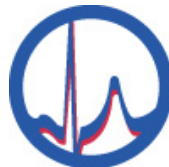
Updated Pages
Update Log
Chapter 1, pages 1-6

Please call your area Medicaid office if you have any questions. The area offices' telephone numbers are in Appendix C of the Florida Medicaid Provider General Handbook.

We appreciate the services that you provide to Florida's Medicaid recipients.

Sincerely,

Thomas W. Arnold
Deputy Secretary for Medicaid



UPDATE LOG

NURSING FACILITY SERVICES

COVERAGE AND LIMITATIONS HANDBOOK

How to Use the Update Log

Introduction

Changes to the handbook will be sent out as handbook updates. An update can be a change, addition, or correction to policy. It may be either a pen and ink change to the existing handbook pages or replacement pages.

It is very important that the provider read the updated material and file it in the handbook as it is the provider's responsibility to follow correct policy to obtain Medicaid reimbursement.

Explanation of the Update Log

The provider can use the update log to determine if all the updates to the handbook have been received.

Update No. is the month and year that the update was issued.
Effective Date is the date that the update is effective.

Instructions

1. Make the pen and ink changes and file new or replacement pages.
2. File the cover page and pen and ink instructions from the update in numerical order after the log.

If an update is missed, write or call the Medicaid fiscal agent at the address given in Appendix C of the Florida Medicaid Provider General Handbook.

UPDATE NO.	EFFECTIVE DATE
Aug2000 – Revised Handbook	August 2000
Oct2001 – Update Pages	April 2001
Oct2003 – Revised Handbook	October 2003
Jul2004 – Update Pages	July 2004
July2004 – Erratum	July 2004

NURSING FACILITY SERVICES COVERAGE AND LIMITATIONS HANDBOOK

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INTRODUCTION TO THE HANDBOOK

Overview

Introduction

This chapter introduces the format used for the Florida Medicaid handbooks and tells the reader how to use the handbooks.

Background

There are three types of Florida Medicaid handbooks:

- Provider General Handbook describes the Florida Medicaid Program.
- Coverage and Limitations Handbooks explain covered services, their limits, who is eligible to receive them, and the fee schedules.
- Reimbursement Handbooks describe how to complete and file claims for reimbursement from Medicaid.

Exceptions: For Prescribed Drugs and Transportation Services, the coverage and limitations handbook and the reimbursement handbook are combined into one.

Legal Authority

The following federal and state laws govern Florida Medicaid:

- Title XIX of the Social Security Act,
- Title 42 of the Code of Federal Regulations,
- Chapter 409, Florida Statutes, and
- Chapter 59G, Florida Administrative Code.

The specific Federal Regulations, Florida Statutes, and the Florida Administrative Code, for each Medicaid service are cited for reference in each specific coverage and limitations handbook.

In This Chapter

This chapter contains:

TOPIC	PAGE
Handbook Use and Format	ii
Characteristics of the Handbook	iii
Handbook Updates	iii

Handbook Use and Format

Purpose	<p>The purpose of the Medicaid handbooks is to furnish the Medicaid provider with the policies and procedures needed to receive reimbursement for covered services provided to eligible Florida Medicaid recipients.</p> <p>The handbooks provide descriptions and instructions on how and when to complete forms, letters or other documentation.</p>
Provider	<p>The term “provider” is used to describe any entity, facility, person or group who is enrolled in the Medicaid program and renders services to Medicaid recipients and bills Medicaid for services.</p>
Recipient	<p>The term “recipient” is used to describe an individual who is eligible for Medicaid.</p>
General Handbook	<p>General information for providers regarding the Florida Medicaid Program, recipient eligibility, provider enrollment, fraud and abuse policy, and important resources is included in the Florida Medicaid Provider General Handbook. This general handbook is distributed to all enrolled Medicaid providers and is updated as needed.</p>
Coverage and Limitations Handbook	<p>Each coverage and limitations handbook is named for the service it describes. A provider who furnishes more than one type of service will have more than one coverage and limitations handbook.</p>
Reimbursement Handbook	<p>Each reimbursement handbook is named for the claim form that it describes.</p>
Chapter Numbers	<p>The chapter number appears as the first digit before the page number at the bottom of each page.</p>
Page Numbers	<p>Pages are numbered consecutively throughout the handbook. Page numbers follow the chapter number at the bottom of each page.</p>
White Space	<p>The "white space" found throughout a handbook enhances readability and allows space for writing notes.</p>

Characteristics of the Handbook

Format

The format styles used in the handbooks represent a concise and consistent way of displaying complex, technical material.

Information Block

Information blocks replace the traditional paragraph and may consist of one or more paragraphs about a portion of the subject. Horizontal lines separate blocks.

Each block is identified or named with a label.

Label

Labels or names are located in the left margin of each information block. They identify the content of the block in order to facilitate scanning and locating information quickly.

Note

Note is used most frequently to refer the user to pertinent material located elsewhere in the handbook.

Note also refers the user to other documents or policies contained in other handbooks.

Topic Roster

Each chapter contains a topic roster on the first page which serves as a table of contents for the chapter, listing the subjects and the page number where the subject can be found

Handbook Updates

Update Log

The first page of each handbook will contain the update log.

Every update will contain a new updated log page with the most recent update information added to the log. The provider can use the update log to determine if all updates to the current handbook have been received.

An "Update No." and the "Effective Date" will designate each update.

Handbook Updates, continued

How Changes Are Updated

The Medicaid handbooks will be updated as needed. Changes may consist of any one of the following:

1. Pen and ink updates—Brief changes will be sent as pen and ink updates. The changes will be incorporated on replacement pages the next time replacement pages are produced.
2. Replacement pages—Lengthy changes or multiple changes that occur at the same time will be sent on replacement pages. Replacement pages will contain an effective date that corresponds to the effective date of the update.
3. Revised handbook—Major changes will result in the entire handbook being replaced with a new effective date throughout.

Numbering Update Pages

Replacement pages will have the same number as the page they are replacing. If additional pages are required, the new pages will carry the same number as the preceding replacement page with a numeric character in ascending order. (For example: page 1-3 may be followed by page 1-3.1 to avoid reprinting the entire chapter.)

Effective Date of New Material

The month and year that the new material is effective will appear in the inner corner of each page. The provider can check this date to ensure that the material being used is the most current and up to date.

If an information block has an effective date that is different from the effective date on the bottom of the page, the effective date will be included in the label.

Identifying New Information

Vertical lines will indicate new material. The following information blocks give examples of how new labels, new information blocks, and new or changed material within an information block will be indicated.

New Label

A vertical line to the left and right of the label only will indicate a new label for an existing information block.

New Label and New Information Block

A new label and a new information block will be identified by a vertical line to the left of the label and to the right of the information block.

New Material in an Existing Information Block

A vertical line to the left and right of the information block will indicate new or changed material within an existing information block.

New or Changed Paragraph

A vertical line to the left and right of the paragraph will indicate a paragraph within an information block that has new or changed material.

Paragraph with new material.

CHAPTER 1

NURSING FACILITY SERVICES

PROVIDER QUALIFICATIONS AND ENROLLMENT

Overview

Introduction

This chapter describes the Florida Medicaid Nursing Facility Services Program, the specific authority regulating nursing facility services, the program’s purpose, provider qualifications and responsibilities, and facility staffing requirements.

Legal Authority

Nursing facility services are governed by Title 42, Code of Federal Regulations (C.F.R.) Parts 405, 442, 456 and 483.

State Authority for participation in the Title XIX Medicaid Program is Chapter 409.919 and 409.908, Florida Statutes (F.S.). The state authority for the licensing of nursing facilities is Chapter 400, Part II, and Chapter 395, Part I, F.S. Reimbursement requirements are contained in Chapter 409.908, F.S. and Chapter 59G, Florida Administrative Code (F.A.C.).

In This Chapter

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Purpose and Definition

Purpose

The purpose of the nursing facility services program is to provide 24 hour-a-day nursing, rehabilitative and residential services to Florida residents who meet the Medicaid Institutional Care Program (ICP) eligibility requirements. The Department of Children and Families determines ICP recipient eligibility. The Medicaid per diem rate cannot be billed until the Department of Children and Families has approved ICP Medicaid eligibility for a nursing facility resident.

Definition

Nursing facility services are medical and health-related services provided by or under the direction of professional or technical personnel, in an institution that is licensed and certified as a Medicaid nursing facility. Services provided must be medically necessary.

Purpose of this Handbook

This handbook is intended for use by nursing facility providers, rural swing bed hospitals, and general hospitals with skilled nursing units that furnish nursing facility services to eligible Medicaid recipients. It must be used in conjunction with the Florida Medicaid Provider Reimbursement Handbook, Institutional 021, which contains specific procedures for submitting claims for payment, and the Florida Medicaid Provider General Handbook, which contains general information about the Medicaid program.

Provider Qualifications and Responsibilities

**Nursing Facility
Provider
Qualifications**

A Medicaid nursing facility must:

- Have a Certificate of Need prior to licensure;
- Be licensed as a nursing facility under Chapter 400, Part II, F.S., or be licensed as a rural hospital swing bed or hospital based skilled nursing facility under Chapter 395, Part I, F.S.;
- Comply with the provisions of Title 42, C.F.R., Part 483; Title XIX of the Social Security Act; Chapters 400 and 409, F. S.; and Chapters 59A-4 and 59G-4 and 59G-6, F.A.C. as determined through the standard survey conducted by the Agency for Health Care Administration (AHCA), Health Quality Assurance (HQA);
- Provide services in Florida;
- Execute an institutional Medicaid provider agreement with AHCA;
- Have a Medicaid reimbursement rate established by submitting a projected budget or a Medicaid cost report; and
- Be certified or eligible for certification in the Medicare program.

**Enrollment
Effective Date**

The enrollment effective date of nursing facilities is determined by successful completion of the HQA survey process that determines the Medicare effective date. The Medicaid effective date will correspond to the Medicare effective date.

**Provider
Responsibilities**

Florida Medicaid has implemented all of the requirements contained in the federal legislation known as the Health Insurance Portability and Accountability Act (HIPAA). As trading partners with Florida Medicaid, all Medicaid providers, including their staff, contracted staff and volunteers, must comply with HIPAA privacy requirements effective April 14, 2003. Providers who meet the definition of a covered entity according to HIPAA must comply with the HIPAA Electronic Data Interchange (EDI) requirements effective October 16, 2003. The Coverage and Limitations Handbooks contains information regarding changes in procedure codes mandated by HIPAA. The Florida Medicaid Provider Reimbursement Handbooks contain the claims processing requirements for Florida Medicaid, including the changes necessary to comply with HIPAA.

Note: For more information regarding HIPAA privacy in Florida Medicaid, see Chapter 2 in the Florida Medicaid Provider General Handbook.

Note: For more information regarding changes to claims processing procedures in Florida Medicaid due to HIPAA, see the Florida Medicaid Provider Reimbursement Handbook, Institutional 021.

Note: For more information regarding changes in the EDI requirements for Florida Medicaid because of HIPAA, contact the Medicaid fiscal agent EDI help desk at 800-829-0218.

Provider Qualifications and Responsibilities, continued

Billing Agents

If a nursing facility contracts with an agent for the billing of Florida Medicaid, the billing agent must enroll as a Medicaid billing agent and have a separate Florida Medicaid provider number.

Note: See Chapter 2 in the Florida Medicaid Provider General Handbook for additional information on Billing Agents.

**Rural Hospital
Swing Bed
Provider
Qualifications**

Rural hospital swing beds must be licensed under Chapter 395, Part I, F.S., and must meet the following Centers for Medicare and Medicaid Services (CMS) requirements:

- Have a Medicare provider agreement;
 - Have 100 or less licensed beds, excluding newborn and intensive care beds;
 - Be located in a rural area;
 - Not have had a swing-bed approval terminated within two years prior to application; and
 - Be in compliance with the skilled nursing facility requirements in 42 C.F.R., Part 483, Subpart B.
-

**Hospital-Based
Skilled Nursing
Facility Provider
Qualifications**

Hospital-based skilled nursing facilities must be licensed under Chapter 395, Part I, F.S., and must meet the following CMS requirements:

- Have received a certificate of need for skilled nursing beds prior to licensure as a hospital-based skilled nursing facility;
 - Have skilled nursing beds located in a distinct part of the hospital;
 - Have skilled nursing beds used only for skilled nursing care; and
 - Be enrolled as a Medicaid hospital-based skilled nursing facility.
-

Provider Qualifications and Responsibilities, continued

**Medicaid
Decertification**

If AHCA determines that Medicaid participation requirements are not met, AHCA has the option to cancel the facility from the Medicaid program.

A 30-day cancellation notice will be given before termination of the Medicaid Program agreement without cause.

Medicaid can continue to pay the facility for up to 30 days after the termination date or until Medicaid recipients can be relocated, whichever comes first.

**Federal
Certification
Sanctions**

The agency can impose the following sanctions for federal certification violations:

- Directed plans of correction;
- Appointment of a State Monitor;
- Directed in-service training;
- Denial of payment for new admissions;
- Denial of payment for all individuals;
- Appointment of a temporary manager; and
- Termination of licensure.

It is critical that facilities comply with all sanctions. Failure to do so may result in additional sanctions including revocation of license.

**Out-of-State
Nursing Facility
Care**

Florida Medicaid does not will reimburse for out-of-state nursing facility care except in the following circumstances:

- During a disaster when residents are relocated to an out-of-state nursing facility on a temporary basis; or
 - A Florida Medicaid recipient visiting another state becomes ill and requires nursing facility care following hospitalization in an acute care facility. In these circumstances, Florida Medicaid will reimburse the out-of-state facility based upon the average per diem in the recipient's county of residence. Furthermore, Florida will only reimburse the facility until it is determined that the recipient's condition is stable enough for him to safely return to Florida.
-

Staffing Requirements

Introduction

Only qualified staff are allowed to provide services in a nursing facility. If a nursing facility purchases services from a vendor, the vendor and its staff must meet all mandatory educational, licensing and certification requirements for the specific area of service furnished.

For information specific to staffing requirements, please contact the Health Facility Regulation, Long Term Care Unit, in the area Medicaid office.

Physician Services

Nursing facilities must have a physician available (on call) at all times. A physician must approve in writing all nursing facility admissions. A physician must examine residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. A physician may delegate the visits to a physician assistant (PA), nurse practitioner (NP), or clinical nurse specialist (CNP).

The non-physician practitioners (PA, NP, CNP) who perform the visits must have a direct relationship with the physician and not be employed by the facility.

Nursing Services

Nursing facilities must have the appropriate number of staff to provide 24-hour nursing and related services to residents in order to maintain the highest levels of physical, mental and psychosocial well being of each resident, as determined by resident assessments and documented in individual plans of care.

Rehabilitative Services

Nursing facilities must have available specialized rehabilitative services including physical therapy, occupational therapy, respiratory therapy and speech therapy.

Medically necessary services may be provided directly by the nursing facility or they may be obtained by the nursing facility from an outside source. Therapies must be provided by licensed personnel under a physician's written order and included in the plan of care.

Nursing facilities providing Medicaid-reimbursable therapy services to non-residents must have a separate Medicaid therapy provider number and bill Medicaid using that provider number.

Dietary Services

Nursing facilities are required to retain a qualified dietician who is registered with the American Dietetic Association on a full time, part time, or consulting basis. Sufficient support staff must be available to carry out the functions of the dietary service.

Staffing Requirements, continued

Pharmacy Services

Nursing facilities are required to have available the services of a licensed pharmacist on a full time or contractual basis to dispense routine and emergency prescription drugs.

Please refer to Chapter 400.022, F.S. for information regarding a resident's right to choose a pharmacy and Chapter 400.141, F.S. for information about repackaging of prescription medications.

Nursing Assistants

Federal regulations prohibit nursing facilities from employing any individual as a nursing assistant for more than four months unless that individual is certified. Individuals enrolled in or graduated from a state approved training program who have not completed the competency evaluation may work as nursing assistants for up to four months.

Facilities may also employ the following groups as nursing assistants for up to four months:

- Individuals certified in another state and awaiting Florida certification;
 - Individuals able to show a notice of preliminary "pass" given by the exam site immediately after completion of the test; and
 - Individuals who have recently graduated from nursing school (either nursing or practical nursing) and are not yet licensed or registered.
-

Certified Nursing Assistants (CNAs)

The Department of Health (DOH) maintains a registry of all certified nursing assistants. Prior to hiring, facilities must receive verification of certification from the CNA Registry at DOH.

Nursing Facility Screening and Reimbursement Requirements

Federal Requirements for CNA Reimbursement for Training and Testing

Federal regulations require that certified nursing assistants (CNAs) be reimbursed for the training and testing required for certification. Nursing facilities must reimburse individuals for training and testing costs incurred by any nursing assistant who is hired or receives an offer of employment within 12 months of completing the state-approved nurse aide training and competency evaluation program. Reimbursement must be made in full and is not to be made in installments. Reimbursement may be withheld until the nursing assistant completes the facility's probationary period consistent with the facility's personnel policies and procedures. The nursing facility cannot refuse to reimburse this cost if the facility is enrolled as a Medicaid provider.

Reimbursable costs include: (1) tuition, required textbooks, and other required course materials; and (2) the competency evaluation, including the written or oral examination and the skills demonstration. The cost of tuition is the amount charged by an approved training site. Reimbursable costs do not include personal items. Examples of personal items are uniforms, shoes, notepads, pencils, dictionaries and insurance.

In order to be reimbursed for training, the CNA must present documentation of the reimbursable costs associated with the training. Acceptable documentation includes dated receipts from the training site, cancelled checks, or letter from the training site stipulating dates of attendance and successful completion of coursework with documentation of payment by the individual. CNAs are eligible for reimbursement only if the costs were personally incurred. If training was provided through a scholarship or a job-training program, the employee is not eligible for reimbursement.

Medicaid Reimbursement for CNA Training and Testing

Medicaid reimburses nursing facilities a percentage of the total costs of CNA training and testing based on the percentage of Medicaid occupancy for the month prior to billing. The nursing facility's costs for training and competency evaluation of nurse aides must be allocated among Medicaid, Medicare, and private pay residents. Medicaid will reimburse the nursing facility only for the properly allocated Medicaid portion of these costs. Costs are to be allocated based on the percentage of Medicaid occupancy determined by the daily census log for the month preceding the date of billing; i.e., if billing in January, the facility would use the December census log and divide Medicaid days by the total days.

Nursing facilities cannot include costs incurred for nurse aide certification in their cost reports. Medicaid does not reimburse costs incurred for certification after three unsuccessful attempts at passing the examinations.

To obtain Medicaid reimbursement, nursing facilities must submit the completed "Nurse Aide Training and Competency Evaluation Program Invoice" form to their area Medicaid office along with appropriate documentation that the course work was completed satisfactorily and resulted in certification.

Nursing-Facility Screening and Reimbursement Requirements, continued

Medicaid Reimbursement for CNA Training and Testing, continued

Note: See Appendix A for a copy of the Nurse Aide Training and Competency Evaluation Program Invoice, AHCA Form 5210-001, and instructions to obtain reimbursement for CNA training and testing costs. This form may also be obtained from the area Medicaid offices. See Appendix C in the Florida Medicaid Provider General Handbook for a listing of the area offices' telephone numbers and addresses.

Staff Screening

Section 400.215, F.S., requires background screenings be conducted for certain nursing facility employees. The law requires screening of nursing facility employees or prospective employees who are expected to fulfill the following responsibilities:

- Those who provide personal care or services to residents;
- Have access to resident living areas; or
- Those who have access to resident funds or other personal property.

Facilities must have in their possession evidence that screening has been completed before allowing an employee to begin working with patients.

The Background Screening Unit of AHCA's Bureau of Health Facility Regulation coordinates background checks. For additional information, call (850) 410-3400.

CHAPTER 2

NURSING FACILITY SERVICES

COVERED SERVICES, LIMITATIONS AND EXCLUSIONS

Overview

Introduction

This chapter describes the services covered under the Florida Medicaid Nursing Facility Services Program. It also describes the requirements to receive services, service limitations and exclusions, and the utilization review process.

In This Chapter

This chapter contains:

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Requirements to Receive Services

Introduction

Nursing facilities may obtain reimbursement for services provided to recipients privately or through long term care insurance. There are also specific situations when Medicare will be the payer. Medicaid is always the payer of last resort.

Recipients Covered by Medicare Part A

If Medicare Part A covers the recipient, Medicare will reimburse the facility for the entire cost of the care provided for the first twenty (20) days the resident is in the facility following an acute care hospitalization. During the period of time between the twenty-first and one-hundredth days, the resident will incur a charge for coinsurance.

Medicaid Payment for Medicare Part A Coinsurance

Medicaid will cover the amount of the coinsurance if the recipient is eligible for Medicaid either as a Qualified Medicare Beneficiary (QMB) or through the Institutional Care Program (ICP). The Medicaid payment for the recipient's Part A coinsurance is the lesser of:

- The Medicare Part A coinsurance rate established by CMS; or
- The nursing facility's Medicaid per diem rate.

For QMB recipients only, there is no patient responsibility during the Medicare coinsurance days. Questions regarding the recipient's patient responsibility obligations or QMB eligibility should be directed to the local Department of Children and Families, Office of Economic Self-Sufficiency.

Medicaid will not pay the coinsurance if the resident is enrolled in a Medicare replacement HMO.

Medicaid Institutional Care Program (ICP)

Medicaid reimburses nursing facilities for services provided to residents who have been determined to meet Medicaid ICP eligibility. In all cases, in order to receive reimbursement from Medicaid for nursing facility care, the facility must have received written notification from the Department of Children and Families approving the individuals for institutional care benefits.

Written Physician Orders

In order to qualify for ICP services, a resident must have a written order for nursing facility care from a Florida licensed doctor of medicine or osteopathy, pursuant to Chapters 458 and 459, Florida Statutes.

Requirements to Receive Services, continued

Eligibility Determination

Department of Children and Families (DCF) district staff determines eligibility for ICP. ICP eligibility must be approved for all individuals whose care will be paid for by Medicaid, including SSI recipients and individuals who were eligible for Medicaid in the community before entering a nursing facility. The possession of a Medicaid card is not proof that the individual is eligible for institutional care benefits. Eligibility determination is still required and must be done prior to billing Medicaid for services. DCF must determine and notify the facility in writing regarding the correct amount of the patient responsibility prior to the first billing. (See below for patient responsibility deductions.)

A nursing facility must not bill Medicaid until it has written confirmation from DCF that all eligibility determination requirements are met including the patient responsibility determination. All notices of eligibility must be kept on file and must be readily accessible by facility staff. Medicaid reimbursement made to nursing facilities for residents not approved for ICP is subject to recoupment.

Exception: Level of Care "X" for individuals eligible as Qualified Medicare Beneficiary (QMB) may be billed to Medicaid during the coinsurance period without an ICP approval notice. However, if the resident's stay in the facility exceeds the coinsurance period, an ICP application must be submitted and approved before billing for Medicaid ICP services.

Eligibility for ICP is determined using program-specific technical, financial and medical eligibility criteria. Applicants age 21 and older must also meet level of care (LOC) evaluation criteria determined by the Department of Elder Affairs, Comprehensive Assessment and Review for Long Term Care Services (CARES). Applicants under 21 must have a level of care determined by the Department of Health, Children's Medical Services, Children's Multidisciplinary Assessment Team (CMAT). The level of care evaluations are coordinated by DCF during the eligibility determination process.

Patient Responsibility Deductions

Effective January 1, 2004, DCF can deduct the cost to pay for necessary medical expenses not covered by Medicaid from the patient responsibility.

The following types and amounts of medical expenses are deductible:

- The actual amount incurred for health insurance payments (other than Medicare); and
- The actual amount incurred for medical services or items. The medical services or items must:
 - ⇒ Be recognized under state law,
 - ⇒ Be medically necessary,
 - ⇒ Not be a Medicaid-compensable expense,
 - ⇒ Not be subject to payment by a third party, and
 - ⇒ Not be covered by the Medicaid nursing facility or other facility per diem.

Requirements to Receive Services, continued

Patient Responsibility Deductions,
continued

Medical expenses may not be deducted when:

- An individual's income is protected for living expenses outside a nursing facility in the month(s) of admission or discharge.
- Medical expenses are paid by someone other than the recipient or other than someone acting on behalf of the recipient using the recipient's funds.
- Payments are made to someone other than the provider.
- The medical expense is for nursing facility services, including those incurred during a penalty.

DCF must inform the nursing facility in writing of all changes in the patient responsibility. The facility may not make changes to the patient responsibility until it has been notified by DCF in writing.

Note: Please refer questions regarding patient responsibility to DCF.

Client Referral Notice

For residents who have not yet applied for Medicaid, the nursing facility sends a referral to DCF by completing a CF-ES 2506A Form, Client Referral Notice. A supply of these forms may be obtained from the DCF district office. The CF-ES 2506A Form and instructions for completion are included as Appendix B.

To apply for ICP benefits, the individual or individual's representative must file for benefits at the local DCF service center.

Retroactive Eligibility

Medicaid eligibility can be established retroactively for any of the three months before the date of application if the resident meets all ICP eligibility criteria, including level of care.

Income Trust

Medicaid's income trust policy allows institutionalized individuals with income over the Medicaid program standards to qualify for Medicaid. If an individual establishes a qualified income trust within federal requirements and meets all other financial eligibility criteria, the individual qualifies for the Medicaid institutional care program coverage.

Transfer of Resources or Income

When an individual transfers or gives away income or resources (assets) without fair compensation to become Medicaid eligible and the transfer is completed within 36 months of application (longer if trusts are involved), the individual will be ineligible for Medicaid ICP coverage for a period of time based on the amount of transferred income or resources. This policy applies to all Medicaid recipients residing in a nursing facility.

Pre-Admission Screening and Resident Review Requirements

Introduction

The federal government requires states to conduct Pre-Admission Screening and Resident Reviews (PASRR) for all residents in Medicaid certified nursing facilities. The purpose of PASRR is to ensure that nursing facility applicants and residents with mental illness or mental retardation are identified and admitted or allowed to remain in a nursing facility only if there is a verified need for nursing facility services. Additionally, if a need for specialized services is determined, federal guidelines require that such services be provided.

All new admissions are subject to pre-admission screening requirements regardless of payer.

Pre-Admission Screenings

Pre-admission screening consists of a Level I screening to determine the possibility that mental illness or mental retardation is present. If either condition is suspected, a referral must be made to the Department of Children and Families for a Level II evaluation.

The Level I pre-admission screening is most frequently completed at the time the level of care is determined by CARES or CMAT. However, if the resident is admitted as a private paying individual or as a beneficiary of long term care or other insurance, the pre-admission screening requirements must be fulfilled by qualified professional nursing facility staff.

An individual is subject to pre-admission screening only once. All subsequent reviews will be categorized as "resident reviews" and will be based upon data entered into the Minimum Data Set. It is important that if a transfer to another nursing facility occurs, the pre-admission screening documentation be sent by the discharging facility along with all other records.

Note: See Utilization Review in this chapter for information on the Minimum Data Set.

Level I Pre-Admission Screening for Residents Age 21 and Older

The Department of Elder Affairs, CARES staff performs Level I pre-admission screenings for Medicaid-eligible adults age 21 and older, using the PASRR Checklist for documentation. The CARES level-of-care determination includes a needs assessment that is done in conjunction with DCF's ICP financial eligibility determination.

For private pay and Medicare admissions, completion of Level I pre-admission screening is the responsibility of nursing facility staff.

Results of the Level I screening are to be sent to the resident or his responsible party as well as the nursing facility. A copy of the screening must be kept in the resident's medical file. Claims for facility reimbursement must not be submitted prior to completion of the pre-admission screening for mental illness or mental retardation. To determine the possible presence of mental illness or mental retardation, facility staff may use the PASRR Checklist.

Note: See Appendix C for a copy of the PASRR Checklist.

Pre-Admission Screening and Resident Review Requirements, continued

**Level I
Pre-Admission
Screening for
Residents Under
Age 21**

Children's Multidisciplinary Assessment Team (CMAT) conducts Level I pre-admission screenings for Medicaid-eligible residents under the age of 21. The screenings are conducted preferably before or immediately after the resident's admission to the nursing facility.

For Medicaid reimbursement purposes, residents under the age of 21 entering a nursing facility must be staffed by CMAT for level-of-care determination.

The CMAT's documentation package for the nursing facility includes the Physician Referral form, the PASRR Checklist, the CMAT nursing and psychosocial assessments, and the CMAT staffing summary that includes the resident's level of care.

For private pay and other admissions, completion of Level I pre-admission screening is the responsibility of nursing facility professional staff. To determine the possible presence of mental illness or mental retardation, facility staff may use the PASRR Checklist.

Results of the PASRR screening are to be sent to the parent or other designated responsible party as well as the nursing facility. A copy of the screening must be kept in the resident's medical file. Claims for reimbursement must not be submitted prior to completion of the pre-admission screening for mental illness or mental retardation.

Note: See Appendix C for a copy of the PASRR Checklist.

**Level II Pre-
Admission
Evaluations all Ages**

Based upon the results of the initial screening, a determination is made regarding the need for further evaluation. If mental illness or mental retardation is suspected, a written referral is then made to DCF for a Level II evaluation. The resident or his responsible party must be informed in writing of the referral for the more comprehensive Level II evaluation.

The DCF Office of Mental Health conducts a Level II evaluation for residents with suspected mental illness. The DCF Developmental Services Program conducts Level II evaluation for residents with suspected mental retardation.

A comprehensive Level II evaluation makes three determinations:

- Confirms or rules out the presence of mental illness or mental retardation;
 - Confirms the need for nursing facility services and the appropriateness of placement; and
 - Determines the need for specialized services.
-

Pre-Admission Screening and Resident Review Requirements, continued

Specialized Services

Specialized services are directed toward diagnosing and reducing a resident's behavioral symptoms. Such services seek to improve the resident's level of independence so that a reduction in intensity of services to below the level of "specialized" services can occur as soon as possible.

These services must be incorporated into the individual's plan of care and:

- Be provided by Department of Children and Families;
- Be supervised by an interdisciplinary team including the attending physician, qualified mental health professionals and other professionals as appropriate; and
- Prescribe specific therapies for treatment of an acute episode of serious mental illness.

Resident Reviews

Whenever there is a significant change in the mental or physical condition of a resident previously identified through the pre-admission screening as being mentally ill, mentally retarded or developmentally disabled, a review must be conducted to determine whether the resident continues to require nursing facility care. If specialized services are being provided, a review is required by the appropriate DCF staff to determine the effectiveness of these services and whether continuation is needed. Resident reviews of developmentally disabled residents are conducted by the district DCF Developmental Services staff. DCF Office of Mental Health staff will conduct reviews of those residents identified as having a mental illness.

Nursing facility staff must complete a Minimum Data Set (MDS) within fourteen days of a significant change in a resident's mental or physical condition. The appropriate DCF Developmental Services or Mental Health staff must also be notified about any change in mental condition.

Note: See Utilization Review in this chapter for information on the MDS.

Pre-Admission Screening and Resident Review Requirements, continued

Categorical Determinations

Federal PASRR guidelines permit advance determinations by category, recognizing that certain diagnoses, levels of severity of illness, or need for a particular service clearly indicate that admission to or residence in a nursing facility services are normally needed. One of the following advance determinations that nursing facility services are needed may be applied to individuals following the Level I only when existing data on the person are current, accurate, and sufficient to easily determine that the person fits into the category:

1. The individual is not a danger to self or others and is certified by a physician to be terminally ill (the prognosis of life expectancy is six months or less), requires continuous nursing care or medical supervision and treatment,
2. The individual is not a danger to self or others and is comatose or ventilator dependent, functions at the brain stem level, has a diagnosis of chronic obstructive pulmonary disease, Huntington's disease, severe Parkinson's disease, amyotrophic lateral sclerosis, congestive heart failure, or any other diagnosis that results in a level of impairment so severe that the individual can no longer be expected to benefit from specialized services, or
3. The individual is not a danger to self or others and is admitted from home within five days following a hospitalization resulting from an acute illness for which continued convalescent care is required. The attending physician must certify, prior to the nursing facility admission, that the impending stay is likely to be less than 30 days.

If indicated by the Level I screening, an individualized Level II for specialized services is required for all the above categories. If indicated, a Level II evaluation is also required after the expiration of the specified time limits in the following instances:

1. The individual is not a danger to self or others, and needs a provisional admission of up to seven days pending further assessment in the case of delirium where an accurate diagnosis cannot be made until the delirium clears,
2. The individual is not a danger to self or others, and needs a provisional admission of up to seven days pending further assessment in an emergency situation requiring protective services, with placement in a nursing facility not to exceed seven days, or
3. The individual is not a danger to self or others and needs a very brief and finite stay up to 14 days twice a year to provide respite care to in-home caregivers to whom the individual with mental illness or mental retardation is expected to return.

Important: If the resident exceeds the specific time limits in the seven or fourteen day periods specified above and the need was identified based on the Level I assessment, a Level II evaluation must be completed.

Items and Services Included in the Per Diem

Introduction

Medicaid pays a per diem (daily) rate for care in a nursing facility. The per diem includes all services and items described below. The provider cannot charge a resident, a resident's family, or any other third party for items included in the per diem rate.

Charging for Items Not Included in the Per Diem

Facility staff must inform Medicaid residents or their representatives in writing about the items and services that are included in the per diem at the time of admission or when residents become Medicaid eligible. Nursing facilities cannot require a resident to request items not provided in the per diem rate. Facilities must discuss with residents or their representatives the cost of any items or services not included in the per diem before a nursing facility supplies such items or services.

Payment for Items Not Included in the Per Diem

Nursing facilities may charge residents, residents' families or other authorized representatives (hereafter referred to as representatives) for items not stocked by the facility. The facility may charge the resident the difference in cost between the stocked and the requested item. However, a facility must inform residents or their representatives of the cost of unstocked items or services before supplying the items or services.

Third Party Guarantee of Non-Covered Services

Nursing facilities may require a third-party payment guarantee for services not covered in the per diem. However, facilities cannot require a resident to purchase services not covered under the per diem rate as a condition of admission.

Room

The per diem rate covers the resident's room and basic room furnishings including a bed of proper size and height, a clean comfortable mattress, pillows, clean linens and bedding appropriate to the weather and climate, towels and washcloths, functional furniture appropriate to the resident's needs, and individual closet space with clothes racks and shelves.

Items and Services Included in the Per Diem, continued

Laundry Services

The per diem rate covers laundry services that include basic personal laundry. The per diem does not include dry cleaning, mending, hand washing, or other specialty services.

Nutritional Services

The per diem rate covers all nutritional services, including meals, snacks, food supplements, tube feedings, supplies and equipment required for tube feedings, and food substitutes needed for special diets.

Total Parenteral Nutrition (TPN) is payable as a prescription item and is not included in the nursing facility per diem rate.

Personal Care Services

The per diem rate covers personal care services rendered by nursing staff or nutritional services staff and assistance with activities of daily living rendered by any staff, including hair and nail hygiene, bathing, and routine foot care. Haircuts are not included in the per diem.

Personal Care Supplies

The per diem rate covers personal care supplies including gowns, water pitchers, drinking glasses, straws, wash pans, emesis basins, bedpans, urinals, oral and rectal thermometers, soap, shampoo, deodorant, razors, shaving supplies, toothpaste, toothpowder, denture cups, denture powder, denture adhesive, comb and brush, toothbrush, dental floss, powder, nail care supplies, cotton balls and swabs, tissues, body oils, and ointments or lotions.

Incontinence Supplies

Incontinence supplies covered under the per diem include catheters, catheter irrigation trays, supplies needed to insert catheters, linen savers, waterproof pads, diapers, rubber pants, absorbent bladder control garments, colostomy and ileostomy bags, and any other incontinence supply items prescribed by a physician.

Rehabilitative and Restorative Care Services

The per diem rate covers rehabilitative and restorative care including physical, speech, occupational, and respiratory therapy ordered by a resident's physician and included in the plan of care. The per diem rate also covers a facility's interventions or programs designed to assist the resident in attaining or maintaining the highest possible level of functioning.

Items and Services Included in the Per Diem, continued

Durable Medical Equipment

Durable medical equipment covered in the per diem rate includes the equipment that the nursing facility is required to have available for residents' use. Examples of medical equipment that the nursing facility is required to have available are hospital beds, standard wheelchairs, walkers, Geri-chairs, crutches, canes, bedside commodes, traction equipment, blood pressure equipment, protective restraints, ventilators and respiratory equipment including routine oxygen, lifts, nebulizers, air mattress, weight scales, and gait belts.

In addition, the per diem covers other types of equipment that are included in the resident's plan of care, are prescribed by the resident's physician, and are covered under the Medicaid Durable Medical Equipment and Medical Supplies Program. Any piece of durable medical equipment prescribed by the attending physician while the recipient is in a nursing facility is included in the per diem and is not reimbursable through Medicaid.

Medical equipment items included in the per diem rate belong to the facility and cannot be taken home when the resident leaves.

Stock Medical Supplies

The following pharmacy items must be provided by the facility as floor stock:

- All over-the-counter medications;
- Syringes;
- Vitamins, minerals and iron;
- Sterile saline for wound irrigation and other wound care dressings;
- Durable and non-durable supplies, including non-prescribed oxygen;
- Dietary supplements, salt and sugar substitutes, and tube feedings; and
- Over-the-counter laxatives and anti-diarrhea medications.

These items cannot be reimbursed under the Medicaid prescribed drug services program, because they are included in the facility's cost report.

Analgesics

Over-the-counter analgesics covered under the per diem include aspirin, acetaminophen, ibuprofen, and any other analgesics that the physician prescribes.

Antacids

Non-legend antacids covered under the per diem rate include at least one product in each of the following categories:

- Magnesium hydroxide and aluminum hydroxide with or without simethicone;
- Aluminum hydroxide; and
- Calcium carbonate.

Items and Services Included in the Per Diem, continued

Laxatives

Laxatives covered under the per diem include at least one product from each of the following categories: bulk, fecal softener, irritant, saline, emollient, or enema and any other laxatives that the physician prescribes.

Vitamins

Over-the-counter vitamins covered under the per diem include at least one product in each of the following categories:

- B-complex with vitamin C stress formula;
 - Therapeutic multi-vitamin, multi-mineral combination;
 - Ferrous sulfate;
 - Ferrous gluconate, ferrous fumarate products;
 - Oil and water soluble multiple vitamins with minerals; or
 - Oil and water soluble multiple vitamins without minerals.
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Wound Care Supplies

Over-the-counter wound care supplies covered under the per diem include sterile saline for irrigation, hydrogen peroxide, astringent, tincture of benzoin, povidone-iodine ointment and solution, topical anti-bacterial preparation, zinc, specialty decubitus treatments and dressings, bandages, adhesive strips, dressings, sterile gauze, and any other wound care supplies prescribed by a physician.

Other Available Medicaid Services

Introduction

Medicaid services that are medically necessary and not included in the per diem rate are available to Medicaid-eligible, nursing facility residents. The rendering provider bills Medicaid directly. The resident's physician must order all other Medicaid services and record the order in the resident's clinical chart. The Medicaid services described in this section have limitations when the services are rendered to nursing facility residents.

Note: For information about other Medicaid services, contact your local area Medicaid office. See Appendix C in the Florida Medicaid Provider General Handbook for area Medicaid offices' telephone numbers and addresses. Medicaid handbooks for other Medicaid services can be obtained from the Medicaid fiscal agent by calling 800-289-7799 or from its website at <http://floridamedicaid.acs-inc.com>.

Physician Services

Medicaid reimburses physician evaluation and management services provided to residents at the nursing facility. Physician visits are limited to one visit per month for chronic care management. Medicaid reimburses physicians for any necessary visits to manage acute events.

Other Available Medicaid Services, continued

Dialysis Services

Dialysis services are available to nursing home residents who require dialysis treatment. Medicaid reimbursable services may be obtained from freestanding centers or through inpatient or outpatient hospital settings.

If a resident receives end stage dialysis services in the nursing facility as covered by Medicare, the resident must be informed that neither Medicare nor Medicaid will cover the cost of the technician.

Community Mental Health Services

Medicaid may reimburse mental health service providers for treatment planning, testing, and therapy services for nursing facility residents under the following conditions:

- An assessment of the resident by the nursing facility determines the resident to be in need of mental health services;
- The resident has a mental health diagnosis that is covered under the community mental health services program;
- The need for mental health services and the resident's diagnosis is documented on the Minimum Data Set (MDS); and
- The resident's physician orders mental health services.

A written referral and a copy of the MDS must be provided to the community mental health services provider.

Dental Services

Emergency oral examinations may be reimbursed for a Medicaid eligible resident in a nursing facility if the resident exhibits the need for dental care. The attending physician and the nursing facility's Director of Nursing must request the oral examination. Dental care for Medicaid recipients age 21 and older includes only medically-necessary emergency services to alleviate pain or infection. Dental services are limited to an emergency examination, necessary x-rays, extractions and the incision and drainage of an abscess.

Effective January 1, 2005 through June 30, 2005, Medicaid will reimburse adult denture services.

The following information must be included in the resident's facility medical record as well as the recipient's dental record in the dentist's office:

- A statement identifying the rationale for the referral to the dentist;
- A statement regarding the resident's or the representative's knowledge, understanding, and concurrence with the referral; and
- The duration of the problem, and the anticipated impact on the resident's health if the problem is unresolved.

Nursing facilities must assist residents in obtaining dental care by assisting in arrangements for transportation to dental services.

Other Available Medicaid Services, continued

Podiatry Services

Podiatry services may be provided in a nursing facility. Routine nail care provided by a podiatrist is not a covered service. Visits are limited to one visit per month, per resident, per provider or provider group. All podiatry visits to nursing facilities must be referred by the resident's attending physician and must be medically necessary.

Flu and Pneumonia Injections

Medicaid nursing facility residents are eligible and encouraged to receive flu vaccine once a year and a pneumococcal vaccine once in a lifetime through the Medicaid Prescribed Drug Program.

Visual Services

Medicaid limits visual services for recipients age 21 and above to prosthetic eyes and medically-necessary contact lenses. Residents under the age of 21 are allowed up to two pairs of medically-necessary eyeglasses annually. Medicaid will reimburse procedures related to providing eyeglasses that are performed in a nursing facility only when transportation to the visual service provider would pose a health risk to the resident, and the medical need is documented by a physician and included in the resident's medical record

Transportation Services

Medicaid pays for transportation for nursing facility residents to obtain Medicaid-covered services. Emergency transportation services are covered when the resident is in a life-threatening situation. Medicaid authorizes non-emergency transportation only when residents have no other means, such as family or nursing facility vehicle, available to them to obtain medical services.

Excluded Services

Introduction

Residents who desire items or services that are not included in the per diem must purchase them directly or through their representative.

Personal Items

The following personal items are not included in the per diem: telephones, television, radio, tobacco, cosmetics, personal clothing, personal reading materials, gifts, flowers, plants, and alternative food requests.

Private Duty Nursing Services

Privately hired nurses or aides also are not included in the nursing facility per diem.

Durable Medical Equipment

Durable medical equipment not required to be available for facility residents or not covered by the Medicaid Durable Medical Equipment-Medical Supplies Program is not reimbursable.

Note: For information about the Medicaid Durable Medical Equipment and Medical Supplies Program, contact your local area Medicaid office. See Appendix C in the Florida Medicaid Provider General Handbook, for area Medicaid offices' telephone numbers and addresses. The Florida Medicaid Durable Medical Equipment and Medical Supply Services Coverage and Limitations handbook can be obtained from the Medicaid fiscal agent by calling 800-289-7799 or through its website at <http://floridamedicaid.acs-inc.com>.

Community Mental Health Exclusions

The following community mental health services are not reimbursable for Medicaid residents residing in nursing facilities:

- Mental health day treatment,
 - Rehabilitation day treatment,
 - Basic living skills training,
 - Social rehabilitation and counseling,
 - Office and outpatient visits, and
 - Clinic visits.
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Psychiatric Services

Medicaid does not reimburse psychiatric services rendered at nursing facilities.

Resident Rights

Introduction

Residents in nursing facilities have full rights as citizens. In addition, residents entering a nursing facility gain special “resident’s rights” under federal regulations and state laws. Nursing facilities must post a copy of these rights in an area easily accessible to all residents, and must provide a copy to each resident upon admission. Alternative languages and formats must be provided, as necessary.

The federal requirements for resident rights are in Title 42, Code of Federal Regulation (C.F.R.), Parts 483.10, 483.12, 483.13, 483.15, and 483.20. The state requirements are in Chapter 400.022, F.S. For hospital-based skilled nursing units, the requirements are in Chapter 381 F.S.

Summary of Resident Rights

Resident rights include but are not limited to the following:

- The right to civil and religious liberties, including knowledge of available choices and the right to independent personal decision.
- The right to private and uncensored written and verbal communication including the right to visit with any person of the resident’s choice during visiting hours.
- Any entity or individual providing health, social, legal or other services to a resident has the right to reasonable access to the resident. The resident has the right to deny or withdraw consent to access at any time by any entity or individual.
- The right to present grievances on behalf of himself or others to the staff or administrator of the facility to government officials, or to any other person. This right includes access to ombudsmen and advocates. This right further includes the right to prompt efforts by the facility to resolve resident grievances, including those with respect to the behavior of other residents.
- The right to participate in social, religious, and community activities that do not interfere with the rights of other residents.
- The right to examine the results of the most recent inspection of the facility conducted by a federal or state agency and any resulting plan of correction in effect.
- The right to be fully informed, in writing and orally, prior to or upon admission and during his stay, of services available in the facility and of related charges for such services.
- The right to be adequately informed of his medical condition and proposed treatment unless the resident is determined to be unable to provide informed consent under Florida law.
- The right to refuse medication or treatment and to be informed of the consequences of such decisions unless the resident is determined to be unable to provide informed consent under Florida law.

Resident Rights, continued

Summary of Resident Rights, continued

- The right to receive adequate and appropriate health care and protective and support services, including social services; mental health services; planned recreational activities; and therapeutic and rehabilitative services consistent with the resident care plan.
- The right to have privacy in treatment and in caring for personal needs; to close room doors and to have facility personnel knock before entering the room, except in the case of an emergency or unless medically contraindicated.
- The right to security in storing and using personal possessions.
- The right to be treated courteously, fairly, and with the fullest measure of dignity.
- The right to be transferred or discharged only for medical reasons or for the welfare of other residents, and the right to be given reasonable advance notice of no less than 30 days of any involuntary transfer or discharge, except in the case of an emergency as determined by a licensed professional on the staff of the nursing home, or in the case of conflicting rules and regulations which govern Title XVIII or Title XIX of the Social Security Act.

Personal Needs Allowance

If a Medicaid resident has an income, he is allowed to keep \$35.00 out of their monthly income as a personal needs allowance. Veterans residing in a nursing facility, either single veterans or veteran's surviving spouses may be allowed to keep more of their income. At the time of Medicaid eligibility determination, the Department of Children and Families determines the amount of the personal needs allowance and notifies the facility of the amount.

The resident's personal need allowance funds must be given to the resident; or if the resident makes a written request, the facility must maintain these funds in an account separate from the operating funds of the facility. Residents or their representatives may access the allowance.

Nursing facilities must place patient accounts of \$50.00 or more of the resident's unspent personal needs allowance in an interest bearing account. Nursing facilities may use one account for all personal needs accounts of \$50.00 or greater.

At the end of each quarter of its fiscal year, the nursing facility must give residents or their representatives a report of all activity in the resident's account.

Resident Rights, continued

Treatment of Resident Funds

A nursing facility may not use resident funds to pay for items and services included in the per diem.

When a resident who has personal funds deposited with the facility dies, the facility must convey within 30 days the resident's funds and the final accounting of the funds to the individual or probate jurisdiction administering the resident's estate.

All funds belonging to the resident may be released to the resident's personal representative if one has been appointed. If there is no designated representative, funds may be returned to the resident's spouse or adult next of kin named in the beneficiary form provided by the nursing facility. If there is no designated representative, no adult next of kin or such person cannot be located, or the estate has not been probated, the funds shall be held in trust and placed in an interest-bearing account separate from the active resident trust account.

In the event the deceased resident's trust has not been probated within two years, the nursing facility must send the funds to AHCA, Health Facility Regulation Office, 2727 Mahan Drive, Tallahassee, Florida 32308, for deposit in the Resident Protection Trust Fund. The funds must be submitted to AHCA by check, payable to the State of Florida.

Private Room

A nursing facility must provide a Medicaid resident with a private room at no additional charge if the resident's physician determines it medically necessary.

If a private room is requested and the room is not medically necessary, the facility may charge a Medicaid resident's family, friend, or trustee an additional amount for a Medicaid certified private room with the following restrictions:

- The amount charged to the family or friend is the difference between the facility's semi-private room rate and the facility's private room rate;
 - The additional payment can not be a requirement of admission or continued stay in the facility; and
 - The facility cannot charge an additional amount if the private room is medically necessary.
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Admissions

Introduction

A nursing facility may charge an applicant or his designated representative private pay rates during the Medicaid eligibility determination period. Once eligibility has been approved, if the individual was determined eligible for any of the months in which he resided in the nursing facility as a private pay resident, the nursing facility must bill Medicaid for the nursing facility care provided during those months. This policy applies even if the resident was not in a "Medicaid bed." After Medicaid reimbursement has been made, the nursing facility must refund the entire private payment made for the period covered by Medicaid.

The nursing facility cannot charge any administrative fees concerning refunding private payments.

Admission Contract

An admission contract (per Chapter 400.151, F.S.) is required for each resident entering a nursing facility.

The admission contract must, at a minimum, contain the following:

- All of the conditions that the nursing facility provider and the resident must meet;
- Medicaid policy regarding resident absences from the facility;
- Medicaid policy regarding resident transfer and discharge;
- A list of the services that are included in the per diem rate;
- The rates or charges for any services or supplies not covered in the per diem; and
- The facility's refund policies.

Note: Please contact AHCA, Health Facility Regulation, Long Term Care Unit for additional information regarding admission requirements.

Reporting Requirements for Supplemental Security Income (SSI) Residents

Nursing facilities must report the admission of a Supplemental Security Income (SSI) resident to the Social Security Administration within two weeks of admission. This is to prevent SSI overpayments caused by a resident's inability or failure to make a timely report of changes. The facility must also refer the resident to the Department of Children and Families for completion of ICP eligibility requirements. This will include an assessment by the Department of Elder Affairs' CARES unit or Department of Health CMAT to determine whether the individual meets medical level of care criteria.

Transfers and Discharges

Notice of Discharge or Transfer

At least thirty days prior to any proposed transfer or discharge, the facility must provide advance written notice of the proposed transfer or discharge to the resident and if known, to a family member, or the resident's legal guardian or representative. The notice must be in a language and manner that is easily understandable by the nursing facility resident or the resident's family.

In the following circumstances, the facility is required to provide the notice as soon as possible before the discharge or transfer:

- The transfer or discharge is necessary for the resident's welfare or resident's needs can no longer be met in the facility as documented in the resident's medical record by the attending physician or the facility's medical director;
- The health of the resident has improved sufficiently and the resident no longer needs the services provided by the facility, documented in the resident's medical record by the attending physician or the facility's medical director;
- The health or safety of the other residents or facility employees would be endangered as documented in the resident's medical record by the attending physician or the facility's medical director;
- The resident has failed, after reasonable and appropriate notice, to pay his bill for the facility services;
- The resident has not resided in the facility for 30 days; or
- The facility is closing.

When a discharge or transfer is initiated by the nursing facility, the administrator of that facility must sign the notice of discharge or transfer. If the notice indicates a medical reason for transfer or discharge, it must be signed by the resident's attending physician or the medical director of the facility or include an attached written order for the discharge or transfer.

Appeal for Fair Hearing

If a resident or representative receives a discharge notice and requests a hearing within ten days of receiving the notice, the facility may not transfer or discharge the resident. Medicaid continues to pay for the resident's care until the hearing decision has been rendered. The resident may also request a review of the notice of transfer or discharge by the local ombudsman.

The Department of Children and Families, Office of Appeals Hearings conducts all hearings. A decision must be rendered within 90 days of the request for a hearing. If the hearing decision is favorable to the resident, and the resident has already been discharged, the facility must re-admit the resident to the first available Medicaid bed.

Transfers and Discharges, continued

Disasters

When a nursing facility evacuates a resident to another Medicaid-participating facility due to a disaster without discharging the resident, Medicaid pays the sending facility its per diem payment for care of that resident. The sending facility is responsible for the resident and for paying the receiving facility for the resident's days in that facility during the nursing facility stay.

If a facility discharges a Medicaid resident, and the resident is admitted to another Medicaid-participating facility, the receiving facility would bill its per diem rate using standard billing from the date of admission.

Any discharges resulting from an emergency situation or disaster must be consistent with the federal regulations in 42 CFR Part 483.12, the state law in Section 400.0255, F.S., and this handbook.

Note: For additional information, please contact AHCA, Division of Health Quality Assurance.

Discharge to the Community

Within ten working days of discharge to a community setting, the facility must prepare and submit a discharge claim and notify the Department of Children and Families' Office of Economic Self Sufficiency so that appropriate changes can be made to the recipient's eligibility status. This is critical because failure to do so may prevent the recipient from receiving Medicaid benefits in the community for which he may be eligible.

Bed-Hold Reservations and Absences from a Nursing Facility

Reserving a Nursing Facility Bed

Medicaid can pay to reserve a bed in the nursing facility for up to eight (8) days when a Medicaid-only resident is approved for the Institutional Care Program (ICP) and goes into the hospital or on therapeutic leave during their per diem days.

Effective July 1, 2004, the facility must have at least 95 percent of its Medicaid certified beds filled in order to bill Medicaid. If 5 percent or more of the facility's Medicaid certified beds are available, Medicaid does not pay for a bed-hold. The percentage of Medicaid occupancy is based upon the nursing facility's occupancy for the prior quarter of the year.

There are three options for calculating a prior quarter's occupancy rate for the purpose of bed-hold eligibility. A facility can use the average occupancy of the last calendar quarter, the average of the last fiscal year quarter, or the average of the last "rolling" quarter (average last three months.) A facility must decide which option it is going to use. This option must be documented in the facility's policies and procedures. All residents, families and staff must be made aware of the calculation method.

Bed-Hold Reservations and Absences from a Nursing Facility, continued

Reserving a Nursing Facility Bed,
continued

Facilities must develop a policy and be consistent in its implementation. Facilities found to be alternating between quarter calculation options are subject to Medicaid sanctions.

The hospitalization may be in an acute care hospital or an inpatient psychiatric unit of an acute care hospital. A physician must determine the hospitalization to be medically necessary.

Settings for therapeutic leave include a private home, a boarding home or an assisted living facility.

In addition to informing residents and their representatives in writing of the Medicaid bed-hold policy at the time of admission, nursing facilities must also inform residents and their representatives in writing of the Medicaid bed-hold policy at the time a resident leaves the facility for a hospitalization or therapeutic leave.

Notice Requirements

Nursing facilities are required to establish and follow a written bed-hold policy, which must include the duration of the bed-hold days and the facility's policy permitting the resident to return.

A resident and the resident's designated representative must be informed in writing about the facility's bed-hold policy before the facility transfers a resident to the hospital or allows the resident to go on therapeutic leave. This information must also be included in the admission contract.

A nursing facility's policy cannot conflict with licensure policy or Medicaid policy.

Paid Bed-Hold Reservation

A nursing facility cannot require or accept payment from any other source for a bed reserved under the paid bed-hold reservation policy.

Federal regulation allows a resident or the resident's responsible party to pay privately to hold a bed after the paid bed-hold days expire. If a resident is unwilling or unable to make private payment to continue to hold the bed, the facility may discharge the resident when the bed-hold days run out. However, a facility must readmit the resident to the first available Medicaid bed in a semi-private room, as specified in 42 CFR 483.12(b)(3).

In addition, a resident cannot be discharged from a nursing facility if the sole reason for transfer or discharge is because of the source of payment.

Please refer to Title 42, C.F.R., Part 483.12 and Chapter 400.0255, F.S. for valid reasons for discharge.

Bed-Hold Reservations and Absences from a Nursing Facility, continued

Days Reserved for Hospital Stays

Medicaid pays to reserve a bed for a maximum of eight days for each hospital stay. One day is defined as an overnight stay away from the nursing facility. Medicaid will pay up to eight days for all medically necessary hospitalizations. Each admission to the hospital, even on the same day, begins a new hospital stay.

Medicaid will not pay when a resident does not plan to return to the nursing facility. The nursing facility must direct the hospital or resident to send notification when the resident decides not to return. If the decision not to return to the nursing facility is made while the resident is in the hospital but prior to the end of the eight-day allowable period, Medicaid will pay to reserve the bed until the nursing facility is advised by the hospital or resident that the resident will not return to the nursing facility.

Nursing facilities must reserve the bed for eight days unless there is written notification that the resident will not return to the facility.

Days Reserved for Therapeutic Leave

Medicaid pays the nursing facility to reserve a resident's bed in order for a resident to go to a family-type setting for a maximum of 16 days per each state fiscal year (July 1 through June 30). Therapeutic leave means the resident leaves the facility to go to a family-type setting and not to another nursing facility. One day is defined as an overnight stay away from the nursing facility.

Nursing Facility Absences and Exclusions

Medicaid will not pay for nursing facility absences when it is determined that the resident no longer requires nursing facility care or will not be returning to the nursing facility.

Effective July 1, 2004, the facility must have at least 95 percent of its Medicaid certified beds filled in order to bill Medicaid for the bed-hold of a resident. If 5 percent or more of the facility's Medicaid certified beds are available, Medicaid does not pay for a bed-hold. The percentage of Medicaid occupancy is based upon the nursing facility's occupancy for the prior quarter of the year as defined on the previous page under Prior Quarter Definition.

Medicaid will not pay for nursing facility absences for:

- Residents who have applied for but have not yet been found eligible for ICP (the resident's ICP eligibility determination is pending approval);
- Residents residing in rural swing beds or hospital-based skilled nursing units;
- Retroactive ICP approvals; or
- Dually-eligible residents that are in the Medicare Part A only covered period or a Medicare Part A and coinsurance period. Medicare does not make payment for nursing facility absences.

Bed-Hold Reservations and Absences from a Nursing Facility, continued

**Admissions
Moratorium**

Nursing facilities under a moratorium on admissions must obtain approval from the Division of Health Quality Assurance prior to readmitting residents who are in a bed-hold period for either hospitalization or therapeutic leave.

Note: See Per Diem Payment, Denial of Payment for New Admissions, in Chapter 3 for additional information.

Exclusions

No bed-hold days are allowed for the following residents:

- Medicaid residents in swing beds or hospital-based skilled nursing units;
 - Medicare Part A residents during the Medicaid coinsurance period; or
 - Residents whose ICP applications are pending.
-

Swing-Bed Provisions

Introduction

A licensed rural hospital with 100 or fewer beds may designate acute care hospital beds as swing beds. Swing beds may be used as hospital beds, skilled nursing facility beds, or intermediate care facility beds.

**Availability
Agreements**

Licensed rural hospitals must have an availability agreement with each skilled nursing facility in its geographic area. The agreement must require the skilled nursing facility to notify the hospital when a Medicaid certified bed is available and the date the bed will be available.

**Restrictions on Use
of Swing Beds**

Medicaid residents are not required to have a hospital stay before admission to a swing bed. The stay in the swing bed must be determined medically necessary by CARES or the CMAT. The maximum length of stay in swing beds is 60 days unless CARES or CMAT has given an extension for a longer length of stay.

Swing-Bed Provisions, continued

Extensions	<p>An extension of a resident's stay in a swing bed can be requested from CARES or the CMAT. There is no limit to the number of extensions that can be approved. Extensions are approved when:</p> <ul style="list-style-type: none"> • The resident is determined by CARES or the CMAT to be too medically complex for a nursing facility, or • The resident chooses to remain in the swing bed.
Documentation Requirements for Medically-Complex Residents	<p>Medical documentation is required for residents who are too medically complex for a nursing facility. If no nursing facility beds are available, the hospital must provide CARES or the CMAT with names of nursing facilities contacted, the date contacted, and names of the persons contacted.</p>
Availability of a Nursing Facility Bed	<p>Availability of a nursing facility bed in the resident's county of residence or within 30 minutes travel time and the resident's preference are taken into account when an extension is under consideration.</p>
Extension Approvals	<p>Extension requests must be submitted in writing by the hospital for approval by CARES or the CMAT. The written request must be received 15 days before the current approval expires.</p> <p>An initial extension is for 60 days; thereafter, CARES or the CMAT approves extensions in 30 and 60-day increments. There is no limit to the number of extensions.</p>

Hospital-Based Skilled Nursing Facilities

Introduction	<p>If a hospital has obtained a certificate of need for skilled nursing beds and enrolled as a Medicaid Hospital-Based Skilled Nursing Facility, it may designate acute care beds that are located in a distinct part of the hospital as a skilled nursing unit. These beds may be used only for skilled nursing care.</p>
Length of Stay	<p>The maximum length of stay for hospital-based skilled nursing care is 30 days per episode.</p>
Length of Stay Extension	<p>CARES or CMAT may grant one extension of 15 days if the resident's physician verifies in writing that the resident requires additional short term rehabilitative or recuperative services. Requests for extensions must be submitted in writing to the local CARES or CMAT office at least five days before the expiration of the original 30 days.</p>

Hospice Recipients Residing in Nursing Facilities

Service Requirements

Hospice care may be provided to a Medicaid or dually-eligible Medicare and Medicaid hospice recipient in a Medicaid participating nursing facility. The hospice is required to notify the nursing facility in writing of the recipient's election of hospice and the anticipated start date. Such notification must be given to the nursing facility within two working days of the recipient's election using AHCA Form 5000-24, Notice of Hospice Election. This form specifies a start date for hospice services. Beginning on that date, room and board payment to the nursing facility and collection of patient responsibility becomes the responsibility of the hospice provider.

If a resident has been transferred from the nursing facility to an inpatient hospital and elects hospice during the facility's bed-hold period, the hospice must notify the nursing facility on the day of the recipient's election of hospice. Such notification may be made by telephone and is in addition to the required written two-day notification. Medicaid payment to the nursing facility for bed-hold will terminate on the start date noted on the Notice of Election.

The hospice must enter into a written contract with the nursing facility for the provision of room and board and other services. This written contract must, at a minimum, include provisions as follows:

- Concurrence with the recipient's care plan by the nursing facility's professional staff;
- The amount to be paid to the nursing facility by the hospice; and
- A determination of whether the hospice or the nursing facility will do the actual collection of the patient responsibility.

Medicaid hospice recipients must occupy a Medicaid certified bed.

Reimbursement to the Hospice

Once a resident elects hospice, hospice is responsible for all services provided for the terminal illness and related conditions. The hospice is also responsible for all related billings and collection of the patient responsibility amount now paid to the hospice. If agreeable to both parties and detailed in the contract, the nursing facility may continue to collect the patient responsibility from the resident or the resident's designated representative as before, but this amount must be turned over to the hospice.

Hospice reimburses the nursing facility for the recipient's daily room and board according to the amount agreed upon in the contract. Hospice then bills Medicaid, minus the patient responsibility, for its services.

In the event the resident elected hospice after the date the nursing facility collected the patient responsibility for that month, the nursing facility must pay the hospice a prorated amount of the patient responsibility. This amount will be based on the number of nursing home days and the number of days to be covered by hospice.

Utilization Review

Introduction

Each nursing facility must safeguard against unnecessary or inappropriate utilization of institutional care services.

Certification of Need

A physician who has knowledge of the resident's condition must certify in writing the resident's need for a specific level of institutional care or service under the Medicaid program. This certification must be signed and dated on the day of admission or no more than 45 days before the day of admission, and signed and dated on or before the date of approval of the Institutional Care Program (ICP) payments.

When a resident is transferred from one level of care to another within the facility, or from one type of facility to another, a new certification is required.

Resident Assessment and the Minimum Data Set

Within fourteen days of a resident's admission to a nursing facility and at least every twelve months thereafter, the facility must complete the Minimum Data Set (MDS) for every resident regardless of payer. The MDS is a complete, comprehensive, and accurate assessment of the resident's functional capacity. The MDS must be:

- Reviewed no less than once every three months;
- Reviewed and revised promptly after a significant change in the resident's physical or mental condition; and
- Revised as appropriate to assure the continued accuracy of the assessment.

The MDS must be completely reviewed and updated annually.

Plan of Care

The facility is responsible for developing a comprehensive plan of care for each resident. The plan of care must include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychological needs as identified during the resident's assessment and recorded in the Minimum Data Set (MDS).

The plan of care must be completed within seven days after the completion of the initial MDS and must include:

- Admitting diagnoses, physician's admission orders, medical history, physical exam and determination of rehabilitative or restorative potential;
- A preliminary nursing evaluation with physician's orders for immediate care, completed on admission;
- A copy of the MDS;

Utilization Review, continued

Plan of Care,
continued

- Symptoms, complaints and complications indicating the need for admission;
- Measurable objectives;
- Physician's orders for medications, treatments, restorative and rehabilitative services, therapies, social services, diet, etc.;
- Special procedures recommended for the health and safety of the resident;
- Plans for continuing care, including review and modification of the plan of care; and
- Plans for discharge.

The attending or staff physician and other personnel involved in the resident's care must review the plan of care at least every 60 days.

**Continued
Residency Reviews**

CARES or the CMAT will evaluate residents' need for continued placement and the specific level of services required at least annually. If the facility determines that a resident no longer meets nursing facility level of care, the facility must contact CARES or the CMAT within two days of this determination and request a review of the level of care or the need for continued placement in the facility.

A facility may not retain a resident who requires a level of care for services that the facility is not certified or equipped to provide. Medicaid ICP benefits are not available for individuals who do not meet level of care requirements.

CHAPTER 3
NURSING FACILITY SERVICES
PER DIEM AND SUPPLEMENTAL PAYMENTS

Overview

Introduction

This chapter describes the nursing facility per diem, payment of Medicare coinsurance and supplemental payments for nursing facility services.

In this Chapter

This chapter contains:

TOPIC	PAGE
Per Diem Payment	3-1
Payment of Medicare Coinsurance	3-2
Supplemental Payments	3-3
Contributions To Facilities	3-4

Per Diem Payment

Introduction

Medicaid pays a daily rate for care in a Florida nursing facility. This per diem rate is calculated based on the nursing facility's annual cost report. By federal regulations, Medicaid is the payer of last resort; as such, Medicaid pays after reimbursement by all other responsible parties.

Per Diem

The per diem rate includes all services and items necessary to ensure appropriate care. The amount paid by Medicaid is the difference between the nursing facility's Medicaid rate and the recipient's patient responsibility. The patient responsibility is prorated on a daily basis by the Medicaid fiscal agent payment system.

The nursing facility billing representative must enter the full monthly patient responsibility amount on the claim to be submitted for payment. The Department of Children and Families, Office of Economic Self Sufficiency determines the amount of the patient responsibility and sends a notice to the facility. DCF notices must be maintained at the facility and be readily available for audit purposes.

Medicaid pays for the first day of service. Medicaid does not pay for the day of discharge from a nursing facility.

A listing of the items and services included in the per diem rate is included in Chapter 2 of this handbook.

Per Diem Payment, continued

**Denial of Payment
for New Admissions**

When the Center for Medicare and Medicaid Services (CMS) imposes the sanction of denying payment for new admissions to a nursing facility, the facility may accept Medicare and Medicaid recipients. However, the facility is not permitted to seek reimbursement from the resident or Medicaid or Medicare for new residents admitted during the sanction period. Failure to comply will result in recoupment of funds paid during this period. Additionally, the facility may be subject to further sanction for its failure to comply with this federally imposed restriction.

Payment of Medicare Coinsurance

Dual Eligibility

When a recipient is Medicare and Medicaid eligible and is in the Medicare coinsurance period (21 through 100 days of Medicare coverage), Medicaid pays the Medicare coinsurance amount for the recipient.

The amount paid by Medicaid is the lesser of the Medicare rate or the Medicaid per diem rate minus the patient responsibility.

Medicaid does not pay for a Medicare HMO recipient during the coinsurance period.

**Qualified Medicare
Beneficiary**

Medicaid pays the coinsurance premiums and deductibles for Qualified Medicare Beneficiaries (QMBs) during the Medicare coinsurance period. There is no patient responsibility for QMB nursing facility recipients during the Medicare coinsurance period (days 21 through 100 days of nursing facility stay). Contact the local Department of Children and Family Services office to confirm QMB eligibility.

Supplemental Payments

Children Under Age 21

In addition to the per diem payment, Medicaid pays a supplemental payment for medically-fragile recipients under 21 and recipients with AIDS. Children under age 21 must be reviewed by the Children's Multidisciplinary Assessment Team (CMAT) for determination of all levels of care for appropriate placements, as referenced in 59G-4.290, F.A.C.

Nursing facilities will be entitled to supplemental payments for certain recipients under age 21 who are determined by CMAT to be medically fragile.

Medically-Fragile Recipients Under Age 21 Supplemental Payment

Medicaid pays a supplemental payment to nursing facilities for the care of medically-fragile recipients under age 21 who:

- Have a medical condition that causes the recipient to be technologically dependent on medical apparatus or procedures to sustain life; and
- Could expire without warning unless continually under observation.

Prior to billing Medicaid, the provider must obtain prior authorization from the CMAT to receive a supplemental payment for a medically-fragile recipient. The service authorization nurse from the Medicaid area office must approve the CMAT's level of care decision.

Note: See Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, Institutional 021 for prior authorization procedures.

Note: See Appendix D of the Florida Medicaid Provider General Handbook for the definition of medically fragile.

AIDS Supplemental Payment

Medicaid pays a supplemental payment to nursing facilities for the care of recipients with Acquired Immune Deficiency Syndrome (AIDS). Nursing facilities must obtain prior authorization from AHCA to receive the additional funds for the care of AIDS patients.

Dually eligible, Medicare-Medicaid recipients are eligible for the AIDS supplement during the coinsurance period.

Note: See Chapter 2 of the Florida Medicaid Provider Reimbursement Handbook, Institutional 021 for prior authorization procedures.

Exclusions

Medicaid does not make supplemental payments for recipients:

- In swing beds or hospital-based skilled nursing units;
 - In Medicaid hospice who reside in nursing facilities; or
 - During the bed-hold period if the resident is hospitalized or on therapeutic leave.
-

Contributions To Facilities

Recipient Specific Contributions

Contributions to a nursing facility on behalf of a specific resident are considered third party payments and must be reported to Medicaid Third Party Recovery as such contributions are considered "income" for the recipient.

Non-Specific Contributions

General contributions to a facility not designated for a specific resident are not considered third party payments if AHCA Form 5000-3300 is completed.

Note: See Appendix D for the Medicaid Nursing Facility/ICF-DD Contribution Notice, AHCA Form 5000-3300. The form is available from the area Medicaid office.

Contributions Cannot Be Required

A nursing facility cannot require that contributions be made by or on behalf of a recipient in order for the recipient to be admitted to or remain in the nursing facility.

APPENDIX A

CERTIFIED NURSING ASSISTANT REIMBURSEMENT INSTRUCTIONS

**NURSE AIDE TRAINING
AND COMPETENCY EVALUATION PROGRAM INVOICE**

FOR THE MONTH OF _____

1. Provider No.				2. Invoice No.	
3. Facility Name				4. FEID No.	
5. Mailing Address					
TUITION					
6.	Name of Examinee(s)			Social Security No.	
	Last	First	MI		7. Date
Total amount Tuition				8. \$	
WRITTEN EXAMINATION					
9.	Name of Examinee(s)			Social Security No.	
	Last	First	MI		10. Date
Total Amount Written Exam (\$ x no. of persons)				11. \$	
SKILLS DEMONSTRATION					
12.	Name of Examinee(s)			Social Security No.	
	Last	First	MI		13. Date
Total Amount Skills Demo (\$ x no. of persons)				14. \$	
Total Amount (tuition + written exam. + skills demo)				15. \$	
Total Payment Requested (\$ total amount x Medicaid Percentage)				16. \$	
17. This is to certify that the above information is true, accurate and complete. Facility Representative's Signature/Title/Telephone No.:				18. Date Signed	
DO NOT WRITE BELOW THIS LINE					
19. Date Invoice Received		20. Date of Approval		21. Total Amt. Approved for Payment \$	
22. Org. Code		23. EO			
24 Signature of Individual Approving Payment				25. Date Signed	

NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAM INVOICE

This form is to be completed by Medicare and Medicaid participating nursing facilities that employ nurse aides. Federal Medicaid regulations require that certified nurse aides (CNAs) employed by nursing facilities be reimbursed for costs associated with training and testing within one year of certification. Medicaid reimburses the Medicaid share of costs based on the facility's percentage of Medicaid occupancy for the month preceding the date of billing.

This form is to be submitted to the Area Medicaid Office for reimbursement of costs associated with nurse aide certification.

A. INSTRUCTIONS FOR COMPLETION OF THE TOP PORTION OF THE INVOICE

1. Provider No.: Enter the facility's Medicaid provider number
2. Invoice No.: Enter a unique number assigned by the facility to identify each invoice
3. Facility Name : Enter the complete name of the facility
4. FEID No.: Enter the facility's federal employer identification number
5. Address: Enter the complete mailing address of the facility
6. Tuition: Enter the name and social security number of each nurse aide
7. Date: Enter the date that each nurse aide took the course
8. Total Tuition: Enter the total amount of training costs (textbooks, fees, and other course materials)
9. Written Exam: Enter the name and social security number of each nurse aide
10. Date: Enter the date that each nurse aide completed the written examination
11. Total Amount Exam: Enter \$35 per student (allowed by Medicaid) for cost of the written examination
12. Skill Demonstration: Enter the name and social security number of each nurse aide
13. Date: Enter the date that each nurse aide completed the skills demonstration
14. Total Amount Skills: Enter the amount requested for the skills demonstration
15. Total Amount: Enter the sum of the amounts for tuition, written exam, and skills demonstration
16. Total Payment: Multiply the total amount from line # 15 by the Medicaid percentage derived from Medicaid days divided by total days for the month preceding the date of billing
17. Rep's Signature: Enter the name, title and telephone number of the facility representative responsible for completing the invoice
18. Date: Enter the date the invoice was signed by the facility representative

B. INSTRUCTIONS FOR COMPLETION OF THE BOTTOM PORTION OF THE INVOICE

Area Medicaid Office staff is responsible for completing this portion of the invoice.

C. REQUIRED DOCUMENTATION

Please attach a copy of the cancelled check or paid receipt from a college or other teaching institution to ensure payment.

Please Contact the Area Medicaid Office with any Questions

APPENDIX B

CF-ES 2506 and 2506A FORMS



Client Discharge/Change Notice

TO: Dept. of Children & Families

FROM: _____
(facility name)

ESS _____
(location)

Contact Name: _____

Date: _____

Telephone #: _____

Patient: _____

SS#: _____

Date of Birth: _____

Medicaid ID #: _____

THIS IS TO ADVISE YOU OF THE STATUS OF THE ABOVE PATIENT:

LEFT THE FACILITY ON _____ DUE TO:
(date)

Discharged to: ALF Home Other (specify): _____

Where? _____
(address)

Hospitalization at: _____
(facility name)

Holding bed or Not holding bed

Therapeutic home visit. Returned: _____
(date)

Death on: _____
(date)

STATUS CHANGE:

Medicare coverage began on _____; Ended on _____
(date) (date)

Change in income: Type _____ Amount \$ _____

TO: _____ FROM DCF: _____

ESS Name

ATTENTION: _____ PHONE #: _____

DATE: _____

COMMENTS: _____



Client Referral/Notice

TO: Dept. of Children & Families

ESS _____

(location)

Date: _____

FROM: _____
(facility name)

Contact Name: _____

Telephone #: _____

Patient: _____

SS#: _____

Date of Birth: _____

Medicaid ID #: _____

Patient's Rep.: _____

Address: _____

Telephone #: _____

Relationship: _____

This is to notify you that the above patient was admitted on: _____

From: Hospital Home ALF Another nursing facility
 Other: (specify) _____

As: Medicare Medicaid Private

A Medicaid determination for institutional services is requested. Please mail the Request for Assistance to the patient's representative at the above address.

TO: _____
(facility name)

ATTENTION: _____

FROM DCF: _____
ESS Signature (Please Print)

PHONE #: _____

DATE: _____

The above patient:

- Is NOT currently eligible for Institutional Care Services or any other Medicaid coverage.
- Is NOT currently eligible for Institutional Care Services but is eligible for other Medicaid services.
- Is eligible as a **QMB** individual with no patient responsibility during the Medicare period.
MID # _____. You need no further authorization to bill for Medicare co-payment.
- Has a **PENDING** application for Institutional Care Services, with _____
The phone # is: _____.

If requested above, we have forwarded a form to the representative indicated to apply for institutional care. It is the applicant's/designated representative's responsibility to follow through with the Dept. of Children and Families in the application process. We will notify you of the decision.

APPENDIX C

PASRR CHECKLIST

PASRR CHECKLIST

This checklist is to be completed prior to admission to a nursing facility. Failure to complete this form timely or accurately will result in disallowment of Medicaid payment.

Name: _____ DOB: _____ SS#: _____

Is this a first time admission to any nursing facility? _____

Indicate the date of the admission: _____

Identify the admitting diagnosis:

Primary: _____

Secondary: _____

Others: _____

SECTION I: DANGER

Is the individual a danger to self and/or others? _____ Yes _____ No

If the answer is **Yes**, this individual **cannot** be admitted or retained in a nursing facility (NF) pursuant to federal regulations. Appropriate treatment and placement must be sought. Upon stabilization, the case can be reviewed. However, documentation must be secured from the attending physician or psychiatrist that indicates the individual is no longer a danger to self and/or others.

If the answer is **No**, proceed to Section II.

SECTION II: EXEMPTED HOSPITAL DISCHARGE

Is the individual being admitted from a hospital after receiving acute inpatient care and requires NF services for the condition for which he or she received care in the hospital and whose attending physician has certified before admission that the individual is likely to require less than 30 days NF services? _____ Yes _____ No

If the answer is **Yes**, this individual can be admitted or retained in a NF pursuant to federal regulations. A Level II Evaluation is not needed. Reviewer can sign and date checklist. **If the individual is later found to require more than 30 days of NF care, a resident review must be conducted within 40 calendar days of admission.**

If the answer is **No**, proceed to Section III.

SECTION III: DEMENTIA/RELATED DISORDER

Does the individual have a primary diagnosis of dementia (including Alzheimer's Disease or a related condition); or a non-primary diagnosis of dementia with a primary diagnosis that is not a major mental illness? _____ Yes _____ No

If the answer is **Yes**, this individual can be admitted or retained in a nursing facility pursuant to federal regulations. A Level II Evaluation is not needed. Reviewer can sign and date Checklist.

If the answer is **No**, proceed to next question.

Does the individual have a dementia that exists in combination with MR or a related condition?

_____ Yes _____ No

If the answer is **Yes**, this individual can be admitted or retained in a NF pursuant to federal regulations. Level II Evaluation is not needed. Reviewer can sign and date Checklist.

If the answer is **No**, proceed to Section IV.

SECTION IV: ADVANCE GROUP DETERMINATIONS

A provisional admission to a nursing facility can be made under the following time limited categories.

1. Pending further assessment of delirium where an accurate diagnosis cannot be made until the delirium clears, **not to exceed seven days.** _____ Yes _____ No

2. Pending further assessment in emergency situations requiring protective services, with placement in a nursing facility **not to exceed seven days.** _____ Yes _____ No

3. Brief respite care for in-home caregivers, with placement in a nursing facility twice a year **not to exceed 14 days total.** _____ Yes _____ No

If any answer is **Yes**, this individual can be admitted or retained in a NF pursuant to federal regulations. A Level II Evaluation is not needed. Reviewer can sign and date Checklist. **If the individual is later**

determined to need a longer stay, a resident review must be conducted before continuation of the stay may be permitted and payment made for days of NF care beyond the State's time limit.

If all answers are **No**, proceed to Section V.

SECTION V: MI/MR

Part A - Mental Illness

Does the individual have a diagnosis of a major mental disorder as defined in the DSM-IV, limited to schizophrenic, mood, paranoid, or other severe anxiety disorder, or a mental illness disorder that may lead to a chronic disability? _____ **Yes** _____ **No**

Part B - Mental Retardation

Does the individual have a diagnosis of mental retardation as defined in the AAMD Manual on Classification in Mental Retardation or other related conditions such as cerebral palsy, epilepsy, or any other conditions, including autistic disorders, that are closely related to mental retardation because it results in impairment of general intellectual functioning or adaptive behavior (42 CFR 435.1009) which manifested prior to the age of 22? _____ **Yes** _____ **No**

If both answers are **No**, this individual can be admitted or retained in a NF pursuant to federal regulations. A Level II Evaluation is not needed. Reviewer can sign and date Checklist.

If either answer is **Yes**, proceed to Section VI.

SECTION VI: INDIVIDUALIZED EVALUATIONS

A Level II Evaluation is required for individuals with MI or MR who meet the following advanced group determination of the need for NF services. The Level II Evaluation must be received prior to NF admission.

1. Does the individual require convalescent care from an acute physical illness that required hospitalization and does not meet all the criteria for an exempt hospital discharge? _____ **Yes** _____ **No**

2. Does the individual have a terminal illness as defined for hospice purposes (**life expectancy six months or less**)? _____ **Yes** _____ **No**

3. Does the individual have a severe physical illness such as coma, ventilator dependence, functioning at a brain stem level, or diagnoses such as Chronic Obstructive Pulmonary Disease, Parkinson's Disease, Huntington's Disease, Amyotrophic Lateral Sclerosis and Congestive Heart Failure, which result in a level of impairment so severe that the individual could not be expected to benefit from Specialized Services? _____ **Yes** _____ **No**

SECTION VII: REVIEWER(S)

Part A: Level I Reviewer

Signature: _____

Title: _____

Agency: _____

Date Completed: _____

Date of Psychiatric Evaluation, if applicable: _____

Date referred for Level II, if applicable: _____

Level II Agency: _____

Part B: Level II Reviewer

Signature: _____

Title: _____

Date of Level II: _____

Disposition:

1. Are Specialized Services needed? _____ **Yes** _____ **No**

2. If yes, can these Specialized Services be provided in a nursing facility? _____ **Yes** _____ **No**

3. If Specialized Services are needed, attach the care plan of services that are required.

4. If Specialized Services are not needed, attach other service recommendations required to meet identified needs.

APPENDIX D

MEDICAID NURSING FACILITY/ICF-DD CONTRIBUTION NOTICE

Medicaid Nursing Facility/ICF-DD Contribution Notice

Provider Name		Medicaid Provider ID Number		
Provider Street Address	City	State	Zip	
Resident's Name:	First	Middle	Last	Medicaid ID Number
Contributor's Name:	First	Middle	Last	Relationship to Resident
Contributor's Street Address	City	State	Zip	
\$	Amount of Contribution		Frequency of Contribution (one time, monthly, etc.)	

Contributor Agreement:

I, _____, understand and agree to each condition listed below. I certify that this contribution is made freely and voluntarily and may be terminated at any time. The contribution is not made as a condition of admission, retention, maintenance or treatment of _____, or any other Medicaid resident in this facility.
Medicaid Resident

I affirm that the information provided above is accurate to the best of my knowledge.

Signature of the Contributor

Provider Agreement:

Facility Administrator

Name of Facility

As representative for the above named facility, I certify that the contribution is not being made as a condition of admission, retention, maintenance or treatment of: _____,
Medicaid Resident

or any other Medicaid resident in this facility. The contribution is not being used to supplement the Medicaid per diem rate.

Signature of Facility Administrator

Distribution of AHCA Form 5000-3300:
Original - Resident's facility record
Second Copy - Third Party Liability Program
2002 Old St. Augustine Road
Suite B-16
Tallahassee, FL 32301



Jeb Bush
Governor

Alan Levine
Secretary

2727 Mahan Drive
Tallahassee, FL 32308

<http://ahca.myflorida.com>