



NURSING HOME MANUAL

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Introduction

The MO HealthNet Division (MHD) Nursing Home Program provides reimbursement to nursing facilities (NFs) for the care of MO HealthNet participants. Providers are reimbursed for MO HealthNet participants based on the participants' days of care multiplied by the NF's Title XIX per diem rate less any patient surplus (i.e., funds contributed by the participant). A per diem rate is established for each NF by MHD's Institutional Reimbursement Unit utilizing a prospective reimbursement system. A prospective rate is established on a particular cost report year and may be adjusted in subsequent years for various items, such as acuity adjustments, quality measures, or global per diem adjustments granted to the industry as a whole.

Section 1: Reimbursement Methodology

1.1 Prospective Rate

The reimbursement methodology for long term care facilities is found in [13 CSR 70-10.015](#) Prospective Reimbursement Plan for Nursing Facility Services and [13 CSR 70-10.016](#) Global Per Diem Adjustments to Nursing Facility and HIV Nursing Facility Reimbursement Rates. The reimbursement methodology for Intermediate Care Facilities/Developmental Disability's (ICF/DD's) is found in [13 CSR 70-10.030](#) Prospective Reimbursement Plan for Nonstate-Operated Facilities for ICF/MR Services and [13 CSR 70-10.060](#) Retrospective Reimbursement Plan for State Operated Facilities for ICF/MR Services.

Section 2: Benefits and Limitations

2.1 General Information

Funding Sources

Missouri has two (2) programs for eligible participants needing financial assistance in nursing facilities (NFs). They are the Supplemental Nursing Care (SNC) Program and the Vendor Nursing Care Program.

Under the SNC program, if a person meets eligibility requirements as determined by the Department of Social Services (DSS) Family Support Division (FSD) and resides in an NF that is licensed but not Title XIX (Medicaid) certified, that person may receive a cash grant. The maximum cash grant is established by Missouri statute. Assistance payments to persons in this cash grant program are made entirely from state funds. These persons are also eligible for most MO HealthNet benefits.

For more information regarding the SNC Program, contact FSD. For FSD contact information refer to the [Regional Nursing Home Offices map](#). The information in this manual does not apply to the SNC Program.

Under the Vendor Nursing Care Program, the MO HealthNet Division (MHD) provides reimbursement to the provider of nursing services. Federal matching funds are available to the state for this program. MHD may reimburse an NF for an individual's care if:

- The NF is an enrolled MO HealthNet provider
- The participant is determined by the FSD to be MO HealthNet eligible
- The participant has been screened under the Missouri Care Options process
- The participant has been screened for a mental impairment and found appropriate for NF services under Preadmission Screening and Resident Review (PASRR)
- The participant meets the medical eligibility (level of care) as determined by the Department of Health and Senior Services (DHSS), Division of Regulation and Licensure (DRL), Section for Long Term Care Regulation, Central Office Medical Review Unit (COMRU)
- The participant resides in a Title XIX certified bed

This manual applies only to the Vendor Nursing Care Program.

Supplemental Security Income

Supplemental Security Income (SSI) is entirely federally funded and administered by the Social Security Administration (SSA). The program provides cash assistance for disabled and elderly individuals. Individuals may be eligible to receive both a SNC cash grant and an SSI payment if they are in a NF that does not participate in the Title XIX Vendor Nursing Care Program. For participants who reside in a Title XIX bed and whose nursing care is paid for by MHD, SSI payments are reduced to zero (\$0.00) if they have other income, or to the personal needs allowance amount established by the SSA if they have no other income.

NFs are reminded that the local SSA Office must be notified when a participant who receives SSI is admitted to the NF. The Social Security Office must update the residents address and benefit eligibility information to avoid the potential of overpayments or a delay in the receipt of benefits.

Licensed Facilities/Certified Facilities

All NFs, unless exempt by [**Revised Statutes of Missouri \(RSMo\) 198.006**](#), are required to be licensed by Department of Health and Senior Services (DHSS) if there are three (3) or more residents living in the home. There are four (4) types of long term care licenses issued: Skilled Nursing, Intermediate Care, Assisted Living and Residential Care.

In order to participate in the MHD Vendor Nursing Care Program (Title XIX), an NF must be licensed as a skilled nursing or intermediate care facility and must also be certified as meeting federal requirements for providers of NF services or intermediate care services for individuals with intellectual disabilities (ICF/ID). Provider participation in the Vendor Nursing Care Program is voluntary.

State licensing inspections and MHD certification surveys are performed by personnel within the DHSS, DRL. Although they are two (2) separate procedures, they are frequently performed concurrently. Certification surveys for hospital-based nursing facilities are also performed by personnel within the DHSS, DRL.

State licensing regulations may be found in [19 CSR 30-81.010](#) through [19 CSR 30-88.020](#). Federal requirements for Title XIX NF participation may be found in Title 42 Code of Federal Regulations (CFR) Part 483, Subpart B; for intermediate care for the intellectually disabled, [Title 42 CFR Part 483, Subpart I](#).

Medicare Nursing Facilities

An NF that has been certified as a skilled NF may choose to execute a provider agreement with the Centers for Medicare & Medicaid Services (CMS) to provide services under Title XVIII (Medicare). The Medicare Program is administered by the SSA. Medicare NFs are not required to participate in Title XIX (Medicaid), nor are Title XIX NFs required to participate in Title XVIII (Medicare). However, many facilities do have provider agreements with both programs. If an NF has valid participation agreements with both Medicare and MO HealthNet, MHD reimburses the NF for the Medicare coinsurance for participants eligible under both programs if they reside in a Medicare/MO HealthNet certified bed. Refer to the [MHD General Sections Manual](#) for information on MO HealthNet billing of deductible/coinsurance.

For MO HealthNet participants who are also Medicare beneficiaries and are either a Qualified Medicare Beneficiary (QMB) Only or QMB Plus and receive services covered by a Medicare Advantage/Part C plan, MHD pays the deductible, coinsurance and copayment if they reside in a Medicare/MO HealthNet certified bed.

Refer to the [MHD General Sections Manual](#) for a detailed explanation of these claims.

2.2 Procedures for Provider Participation

Application to Participate

The DHSS, DRL is responsible for the certification surveys of NFs and the long term care wings located within a hospital. Each NF that chooses to participate in the Title XIX Program must complete and submit application materials to the DHSS, DRL.

Facility Certification

Upon receipt of the completed application materials by the DHSS, DRL, Section for Long Term Care Regulation, Licensure and Certification Unit, the appropriate Section of the Long Term Care Regional Office is notified to schedule a survey at the NF. The survey is normally conducted by at least a Registered Nurse (RN) and a Senior Regulatory Auditor.

The amount of time required to conduct a survey depends upon the size, condition and type of NF surveyed. Normally, an inspection to determine compliance with state licensing regulations is conducted concurrently with the Title XIX certification survey. The survey packet is submitted to COMRU for review. The certification decision is sent to the Missouri Medicaid Audit & Compliance (MMAC) Division. Subsequent surveys are performed no more than 15 months from the previous survey.

Distinct Part

A NF may choose not to have all of its licensed areas certified for participation in the MO HealthNet Program or there may be some licensed areas that do not meet MHD certification requirements. Federal regulations allow an NF to establish a “distinct part” provided the distinct part meets requirements for certification. The distinct part must be an identifiable unit such as an entire ward, floor or wing. When an NF designates a distinct part, a Bed Listing for Licensure and Certification must be completed showing which rooms are in the distinct part. A copy of this form is sent to MHD. Vendor payments cannot be made for a participant residing in an area that has not been certified. It is the provider’s responsibility to ensure that a participant for whom MHD payment is made is placed in a Title XIX certified bed. Any payments made for a participant not in a Title XIX certified bed are recouped. A request to add or change a distinct part is processed upon written notification from the NF. The request should be sent to the DHSS Section for Long Term Care Regulation, Licensure and Certification Unit for approval. The NF may make two (2) increases or one (1) increase and one (1) decrease in Medicaid beds each NF fiscal year. The effective dates may only be at the beginning of an accounting quarter or at the beginning of the fiscal year. Facilities are required to submit their request in writing to LTCCertification@health.mo.gov no later than 45 days before the effective date. Facilities may change the location of their distinct part by submitting a request in writing to LTCCertification@health.mo.gov no later than 30 days before the effective date.

Provider Agreements

The MMAC Division sends a Title XIX Nursing Home Provider Agreement/Questionnaire to the NF upon request for participation and completion of the survey process. The completed material should be returned to the MMAC Provider Enrollment Unit within ten (10) days of receipt. It is a federal requirement that a NF must have a signed Participation Agreement with MHD prior to payment of MHD funds.

The provider is issued a nine (9)-digit MO HealthNet identification provider number upon approval of the provider’s Participation Agreement. That provider number is used for billing purposes. For questions regarding enrolling with MMAC, email MMAC.ProviderEnrollment@dss.mo.gov.

2.3 Termination, Suspension or Withdrawal

Termination

If a survey by the DHSS, DRL finds an NF out of compliance with federal standards of participation, a letter is sent to the NF notifying them of the areas that are out of compliance. The NF must submit to the DHSS, DRL a plan of correction with timetables for correcting those deficiencies.

If the NF has not corrected its deficiencies within three (3) months of the date of the survey, an alternative remedy, denial of payment for new MO HealthNet admissions, may be imposed. The DHSS, DRL makes public the fact that the denial of payment for new MO HealthNet admissions has been imposed. The NF must post a notice to this effect in a conspicuous location in the NF.

The NF must agree to repay to MHD the federal portion of payments received for services after the three (3)-month period if corrective action is not taken in accordance with the approved corrective action plan and its timetables. If the NF does not agree to those terms, its participation agreement in the MO HealthNet Program is terminated at the end of the three (3) month period.

If compliance is not achieved within six (6) months of the survey initially noting deficiencies, the NF's MO HealthNet participation is terminated. Payment for services provided after the effective date of termination may be made for up to an additional 30 days if a reasonable and timely effort is being made to transfer MO HealthNet patients.

Suspension of Payments

Payments to an NF by MHD may be suspended for one of the following:

- Failure of the NF to comply with MHD requirements to submit requested reports and/or other necessary information
- Failure to repay or make arrangements for the repayment of identified overpayments within a specified time frame ([13 CSR 70-3.030](#))

Payments held in abeyance due to the suspension may be subject to release when the NF is reinstated. MHD reserves the right to cancel payments for such periods of time during which the NF was not in compliance with the terms of the Participation Agreement.

Withdrawal

In the event a NF finds it no longer desires to participate in Title XIX, a 30day written notice must be given to MMAC and DHSS, DRL stating the reason withdrawal is desired.

Public Disclosure

Federal regulations at [42 CFR 431.115](#) require that a vendor's deficiencies and plan of correction be made readily available to the public upon request. Survey information is sent to the DSS) FSD and to the District SSA Office.

When inquiries are made by the public regarding a particular health care NF, the FSD county office opens the NF file to such persons making the inquiry and also recommends they contact the DHSS, DRL, Section for Long Term Care Regulation.

2.4 Per Diem Rate

In accordance with [13 CSR 70-10.015](#) and [13 CSR 70-10.016](#) a per diem rate must be established by MHD in order to reimburse a NF. A per diem is also established for an ICF/ID in accordance with [13 CSR 70-10.030](#) and [13 CSR 70-10.060](#). Reimbursement is based on the number of covered days multiplied by the per diem rate.

2.5 Nursing Facility Admission Requirements

There are two (2) admission requirements that must be performed before payment for NF benefits will be approved. These requirements are described below.

Preadmission Screening and Resident Review

An online application process is required for any individual seeking admission into a Medicaid certified bed in an NF on or after October 31, 2021. Information regarding the new process can be found on the [DHSS Preadmission Screening and Resident Review \(PASRR\)](#) website.

A Level I screening must be performed for all potential residents of a MO HealthNet certified bed. If there is any indication of serious mental illness (MI), intellectual disability (ID), developmental disability (DD), or related condition (RC), a Level II screening must be performed prior to admission unless a special admission category applies. A physician must complete and submit the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition](#) online prior to or on the date of admission. Payment is no earlier than the date a physician submits the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition](#) online form or the date of a Level II determination, if needed.

Level of Care Determination

If MO HealthNet benefits for NF services are requested, the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition](#) and the [Level II Nursing Facility Level of Care Assessment](#) must be submitted online to the DHSS, DRL, Section for Long Term Care Regulation, COMRU. After reviewing these forms for level of care, COMRU sends information to the FSD office.

FSD sends a MO HealthNet Vendor Notice (FA-465) to the NF after MO HealthNet eligibility has been established. The FA-465 is the NFs authorization to bill MHD. Please refer to [Section 2.10](#) or [Section 3.4](#) of this manual for more information on the FA-465. It has information concerning the earliest date of service that MHD reimburses for and the amount of surplus, if any, that is deducted from reimbursement.

Each of these two (2) requirements are discussed separately. Facilities certified as ICF/IDs are only required to meet the level of care admission requirement.

2.6 Preadmission Screening and Annual Resident Review

The Omnibus Budget Reconciliation Act of 1987 (OBRA '87, 90) requires states to have in effect a PASRR program for persons with MI, ID, DD or a RC and who are applying to, or residing in, a Title XIX Medicaid certified NF. The requirements of CFR [483.100 through 483.138](#) governing the states responsibility for PASRR of individuals with MI and ID/DD are based on section 1919(e) (7) of the Act. PASRR protects individuals with MI, ID, DD and RC from inappropriate placement in NFs and ensures that individuals receive all services necessary to meet the individuals needs related to their condition.

The law states that an NF must not place in a Medicaid certified bed any new resident who is known or suspected MI, ID, DD or RC unless the State Mental Health or Division of Developmental Disabilities Authority has determined that the NF is appropriate for the individual.

The law applies to every applicant to a Title XIX certified bed whether or not the applicant is or will be Title XIX eligible. MHD payments are not made for services provided to an individual for whom a determination is required but has not been performed.

Preadmission Screening Procedures

The process for preadmission screening is divided in two (2) parts: The identification function is termed Level I. The purpose of Level I is to identify any applicant to an NF who is known or suspected of being MI, ID, DD or RC as defined in [CFR 483.102](#) applicability and definitions. Level II is the function of evaluation and determination. The purpose of Level II is to evaluate and determine if the individual with MI, ID, DD or RC needs NF level of service and, if so, whether or not the individual needs specialized services.

Level I: Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition

Identification of suspected MI, ID or DD individuals is made on the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition](#) online application and must be completed and submitted prior to a NF admitting any new resident to a MO HealthNet certified bed.

Not Known or Not Suspected to be MI, ID or DD

If the below sections of the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition](#) online application indicates no further mental health evaluation is required as defined in [CFR 483.102](#), the person is considered not suspected to be MI, ID, DD or RC and the individual may be admitted to the NF.

- Section D: Level One Screening Criteria for Serious Mental Illness
- Section E: Level One Screening Criteria for ID or RC
- Section F: Special Admission Categories

The [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition](#) online application must be filed in the patient's medical record and be available for review by state or federal auditors.

If the individual is applying for MHD NF services, the individual's level of care must be determined. For MHD eligibility purposes, the [Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition](#) and the [Nursing Facility Level of Care Assessment](#) must be submitted online together.

Known or Suspected to be Mental Illness, Intellectual Disability, Developmental Disability or Related Condition

If Section D or E of the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition** form indicates a serious MI, ID, DD and/or RC, the person is considered a suspected MI, ID or DD, and a **Level II Nursing Facility Level of Care Assessment** must be submitted prior to the person's admission to the NF unless a special admission category (Section F) applies.

The following are terms used on the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition**:

- **Dementia** - An individual with a primary diagnosis of Major Neurocognitive Disorder (MNCD) (including Dementia, Alzheimer's disease or a related disorder) is not considered seriously mentally ill for the purpose of PASRR and does not require a Level II evaluation. This person may be admitted to a NF without further screening. However, if a person with a diagnosis of dementia also has a diagnosis of ID, DD or RC, a Level II is required prior to admission.
- **Special Admission Categories** - Special Admission Categories only apply for persons who are suspected of being MI, ID, DD or RC. There are five (5) such categories.

With two (2) of the categories, Terminal Illness and Serious Physical Illness, the Level II evaluation is not performed prior to admission. The Level II is evaluated immediately following admission.

Each of the other three (3) categories has a strict time period and are described below.

- **Respite Care**: An individual may be admitted and remain in an NF for 30 consecutive days or less in order to provide respite for the caregiver. A Level II is not required. The DSS/FSD controls the NF authorized payment dates by means of a form they send to state office. No payment can be made to the NF beyond the 30 days. If a situation arises in which the respite care is longer than 30 days, the NF must contact the DHSS, DRL via email at **COMRU@health.mo.gov**. If continued stay is authorized, a Level II is performed. FSD is notified if vendor payments may continue and they will change the NF dates to allow payment.
- **Emergency Provisional Admission**: This category is for the situation in which an individual needs placement to protect the individual from serious physical harm to self or others. The NF must contact DHSS, DRL, **Abuse, Neglect and Exploitation of the Elderly and Disabled**. This type of stay must be prior authorized by the DHSS Division of Regulation and Licensure as an emergency. No more than seven (7) days is allowed for an emergency admission. Again, the DSS/FSD manages those dates based on information from the DHSS, DRL. If the resident stays in the NF longer than seven (7) days, the NF must immediately notify DHSS, DRL to determine continued stay. A Level II may be performed after the initial

seven (7) day period, depending on the circumstances.

- **Direct Transfer from a Hospital:** Under the final PASRR rule a transfer from a hospital for a stay of 30 days or less is exempt from the PASRR process. If a physician attests that the individual is likely to need 30 days or less NF care for the condition for which the individual has been hospitalized, no Level II is necessary. NF payment is made for no more than 30 days. If it becomes apparent that the individual needs longer than 30 days, the NF must immediately notify DHSS, DRL. If continued stay is approved, a Level II is performed.

Level II: Nursing Facility Level of Care Assessment

In order to begin the process for a Level II review, both forms, the **Nursing Facility Level of Care Assessment** and the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition** should be submitted together.

The DHSS, DRL reviews the level of care assessment and sends the information to the Department of Mental Health (DMH) who is responsible for completing the Level II review.

For individuals suspected of ID, DD or RC, the DMH Division of Developmental Disabilities contracts with an independent agent who conducts the Level II screenings.

For individuals suspected of MI, the DMH Division of Behavioral Health contracts with an independent agent who conducts Level II screenings.

If an individual is suspected of having MI, ID, DD or RC, the Level II review is completed by the contract agent of the State Mental Health (DMH) authority. DMH reviews the Level II screening completed by the contract agent.

Possible Outcomes of Level II Review

- An MI, ID or DD individual who does not need the level of service provided by an NF is not appropriate for placement in an NF.
- An MI, ID or DD individual who needs the level of service provided by an NF and needs less intensive specialized services that can be provided by the NF is appropriate for placement in a Title XIX certified nursing bed.
- An MI, ID or DD individual who needs the level of service provided by an NF but needs specialized services that cannot be provided in the NF is inappropriate for placement in Title XIX certified bed.
- Individuals of advanced years who are not a danger to themselves or others and who are in need of specialized services may choose not to receive them. These individuals may be admitted to NFs.

Policy Issues Regarding Preadmission Screening

- Preadmission screening is required for any individual seeking placement in a MO

HealthNet certified bed without respect to payment source. This includes private pay and Medicare beneficiaries as well as MO HealthNet participants.

- NFs or hospitals are responsible for the PASRR Level I (**Level One Nursing Facility Pre- Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition**) screening process, which must be completed and submitted online prior to an individual's admission to a Medicaid certified bed.
- If an individual transfers from a noncertified Medicaid bed to a Medicaid certified bed, whether or not the transfer is made within the same NF or a different one, the NF must complete the Level I screening process. If a Level II evaluation is needed, this must be performed prior to the individual's transfer.
- There is no need to complete a second **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition** online application when:
 - A participant transfers from a Medicaid certified bed in one NF to a certified bed in another NF.
 - A participant is discharged from a Medicaid certified bed to a hospital and returns to a certified bed, whether the same or a different NF in less than 60 days. If the length of stay is more than 60 days, another Level I (**Level One Nursing Facility Pre- Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition**) and **Nursing Facility Level of Care Assessment** must be submitted online.
 - A participant is discharged from a Medicaid certified bed to home but returns to a certified bed in the same or a different NF in less than 60 days. If the length of stay is more than 60 days, another Level I (**Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition**) and a **Nursing Facility Level of Care Assessment** must be submitted online.

NOTE: There must be a **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition** online application in an individual's medical file. NFs and providers should obtain a copy when a person transfers. If a copy is not obtained (e.g., cannot be obtained from DHSS after sunshine request), complete and submit a new **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition** and **Nursing Facility Level of Care Assessment** to the DHSS, DRL

- If there is a significant change in the mental health status of an individual, the provider completes another **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related**

Condition and **Nursing Facility Level of Care Assessment** and submits online to DHSS, DRL COMRU.

- The **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability or Related Condition** has been designed so that upon its completion, the provider should know if the individual can be admitted to the NF or if a Level II evaluation must be performed before admittance.
- An individual transferred from an out-of-state NF to an NF in Missouri must be screened under the Missouri state plan if Missouri is going to pay for services. Therefore, a Level I and Level II, where applicable, must be performed before payment is authorized.
- The physician authorization and signature are required in Section G of the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition**. The date is very significant for an individual applying for MHD NF benefits because eligibility for NF benefits can be no earlier than the date shown in Section G.
- For those individuals who are MI, ID, DD or RC and require a Level II evaluation, MHD NF benefits can be no earlier than the date a Level II determination is made.
- If MHD benefits for NF services are requested by the individual, the **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition** and the **Nursing Facility Level of Care Assessment** must be completed and submitted online to the Department of Health and Senior Services, DRL, COMRU at **COMRU@health.mo.gov**.

Resident Review

Public Law 104-315, Title XIX of the Social Security Act requires an NF to notify the State Mental Health authority promptly after a significant change in the physical or mental condition of a resident who is MI, ID, DD or RC.

A review and determination must be done promptly after an NF has notified the State Mental Health authority that there has been a significant change in the resident's physical or mental condition. A resident review (RR) is triggered whenever an individual undergoes a significant change in status and that change has a material impact on their functioning as it is related to their MI, ID, DD or RC status. The significant change is defined by responses to the Minimum Data Set (MDS). Information and guidance can be found on the **DMH PASRR Level II Evaluations** webpage.

The DMH Division of Developmental Disabilities through its Regional Centers or contracted provider Emeritus Corporation, d.b.a Bock Associates, is responsible for completing Level II change in status reviews for individuals with ID, DD and RC as indicated. The DMH Behavioral Health Division, through

its contract agent, is responsible for completing Level II change in status reviews of MI residents as indicated.

For seriously mentally ill residents, DMH also contracts with Emeritus Corporation, d.b.a. Bock Associates, to perform Level II screenings and resident reviews.

NFs must make information in resident's charts available to the evaluator who will send the NF a copy of the full evaluation for each resident reviewed upon completion. The evaluation informs the NF of mental health services that the NF is required to include in the plan of care related to the individual's MI, ID, DD or RC status and provide to the individual.

A completed copy of Level II screenings and resident reviews are sent to the NF. The evaluation informs the NF of mental health services that the NF is required to include in the plan of care and to provide to the individual.

Possible Outcomes of Change of Condition (Status) Resident Review

The following are possible outcomes after a Change of Condition (Status) Resident Review is performed:

- The individual needs the level of services provided by an NF but does not require specialized services. The resident may remain in the NF; no further action is required.
- The individual needs the level of services provided by an NF and needs specialized services for their MI or ID. Whether the resident may remain in the NF depends on whether the NF can provide or arrange for the active treatment the resident needs. The resident may have a choice as to whether or not to participate in active treatment depending on the resident's age and mental capacity.
- The individual does not need the level of services provided by an NF and does not require specialized services. Arrangements must be made for the resident's discharge.
- The individual does not need the level of services provided by an NF but does require specialized services that cannot be provided by the NF. Whether the resident may remain in the NF depends on the length of time that the individual has continuously resided in an NF.
- If the individual has continuously resided in an NF for at least 30 months before the date of review, the resident is given the choice of remaining in the NF or of receiving services in an alternative setting. Regardless of the participant's choice, specialized services must be provided or arranged to meet the individual's needs.
- Individuals who have resided in an NF for fewer than 30 months do not have an option; they must be discharged, but arrangements to meet their specialized services needs in an alternative setting are made by DMH.

NOTE: The 30-month rule is based on continuous residence in an NF. The stay need not be in one NF as long as the residency in an NF is continuous. A hospitalization is not considered a break in a continuous stay if the person is admitted to an acute care NF from an NF and upon discharge returns to an NF. It is not considered a break in a continuous stay if a person leaves an NF for no more than 12 days per six (6) calendar months.

Definitions of Mental Illness and Developmental Disability

Mental Illness (MI): Individuals are considered to have MI if they have a current primary or secondary diagnosis of a serious mental disorder, as defined by the Secretary of Health and Human Services, such as schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder, or other psychotic disorder; or another mental disorder that may lead to a chronic disability but is not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder and meets the criteria as outlined in [CFR 483.102](#) related to level of impairment and recent treatment.

Developmental Disability (DD) (including Intellectual Disability (ID) and Related Conditions (RC): Individuals are considered to have a DD if they have a level of disability defined under [RSMo 630.005 \(9\)](#).

ID is a disability characterized by significant limitations both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behavior, which covers a range of everyday social and practical skills. This disability originates before the age of 18.

DD is an umbrella term that includes ID but also includes other disabilities that are apparent during childhood. DDs are severe, chronic disabilities that can be cognitive, physical or both. The disabilities appear before the age of 22 and are likely to be lifelong. Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example down syndrome or fetal alcohol syndrome.

PASRR is also intended to identify and evaluate individuals with RCs, which are conditions that are not a form of ID, but which often produce similar functional impairments and require similar treatment or services (hence the term "related").

The provisions of this section also apply to persons with RCs, as defined by 42 [CFR 435.1009](#) that states: Persons with related conditions means an individual who has a severe, chronic disability that meets any of the following conditions:

- It is attributable to:
 - Cerebral palsy or epilepsy

- Any other condition, including autism, down syndrome, fetal alcohol syndrome, muscular dystrophy, seizure disorder and traumatic brain injury, other than MI, found to be closely related to a DD. This condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with a DD, and requires treatment or services similar to those required for a DD.
- It is manifested before the person reaches age 22
- It is likely to continue indefinitely
- It results in substantial functional limitations in three (3) or more of the following areas of major life activity:
 - Self-care
 - Understanding and use of the language
 - Learning
 - Mobility
 - Self-direction
 - Capacity for independent living

Definition of Specialized Services

Specialized Services for Individuals with MI: A continuous and aggressive implementation of an individualized plan of care developed by a physician and an interdisciplinary team of qualified mental health professionals. The plan prescribes therapies and activities for the treatment of persons experiencing an acute episode of severe MI that requires supervision by trained mental health personnel. It is directed toward reducing the resident's psychotic symptoms and improving their level of independent functioning.

Specialized Services for Individuals with DD: A continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, health and related services that is directed toward the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

In order to benefit from specialized services, an individual must have potential for learning. Specialized services do not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous treatment program. Individuals requiring specialized services are generally only able to benefit from training programs that are under the direction of trained ID/DD personnel, available 24 hours per day.

Specialized services must include an Individualized Support Plan (ISP) developed and implemented by appropriate disciplines. The ISP must be reviewed and revised as necessary but at least annually

by a qualified ID professional or qualified mental health professional.

2.7 Procedures for Determining Participant's Level of Care

Medical Eligibility—Nursing Facility Level of Care Assessment

MHD requires NFs to have prior authorization or certification of need for NF level of care before an MHD NF payment can be made on behalf of a participant. There are established guidelines for determining level of care. These can be found in [19 CSR 30-81.030](#). DHSS, DRL makes a certification of level of care based on the guidelines established in regulation and the information given on the [Nursing Facility Level of Care Assessment](#). If the [Nursing Facility Level of Care Assessment](#) report is completed at the NF, it is important that every effort is made to have the report reflect the patient's condition and plan of care. There is an explanation of the [Nursing Facility Level of Care Assessment](#) in [Section 3](#) of this manual.

Levels of Care

Nursing Facility (NF): NF services are physician-directed services provided by an NF certified as an NF to individuals whose physical or mental condition requires health-related services on an inpatient basis.

- To qualify for NF care, an individual must have an assessed point level of at least 18 using the assessment procedure as described in [19 CSR 30-81.030](#).

Intellectual Disability (ID) or Related Conditions (RC): Intermediate care facility for the intellectually disabled or RCs (ICF/ID) are services provided in a certified facility whose primary purpose is to provide health or habilitative services for individuals with ID or with RC.

- To qualify for ICF/ID services an individual must have mild, moderate, severe or a profound ID or RC and be receiving active treatment.

2.8 Determining Patient Surplus (Liability)

It is a federal requirement that MHD payment to an NF be reduced by a participant's income less certain deductions; i.e., personal allowance, medical insurance and any allotments to a spouse and/or eligible dependents. This income is called patient liability or patient surplus and is computed by FSD.

The surplus amount is automatically deducted from the provider's reimbursable amount by [eMOMED](#). With electronic billing, the provider is not required to enter a surplus amount on the electronic claim.

Surplus and Month of Admission

Patient surplus is not collected by the NF the first month a participant is admitted if admission is after the first day of the month. If admission is the first day of the month, then patient surplus is charged to the participant for the first month.

Medicare and MO HealthNet Days in the Same Month

When there are Medicare days and MO HealthNet days in the same month, surplus is applied to the MO HealthNet days. Surplus is not applied to the MO HealthNet days when the individual was not a resident of the NF on the first day of the month. Medicare days refers to Medicare covering up to 100 days of care in a Skilled Nursing Facility, in a single benefit period, as long as the resident is eligible.

If the participant is in the hospital on the first day of the month, and Medicare covers the cost of the remainder of the month, then no surplus is due. For any month following the month of readmission in which there are Medicare and MO HealthNet days, the surplus is applied to any MO HealthNet days in the month regardless of the date of readmission.

Surplus and Readmission

If a participant enters a hospital during one month and is not readmitted to the NF until after the first day of the following month, surplus is to be billed to the participant or the participant's representative (responsible party) for the month of readmission. If a participant is out of an NF for more than 30 days, FSD informs the NF and the participant or the participant's representative if surplus should be collected for the month of readmission.

Surplus When Stay Is For a Partial Month

Patient surplus is not prorated. If a participant is in the NF for only part of a month, it is possible that the patient surplus is greater than the covered days times the per diem amount. MHD payment in this case is \$0.00 (zero). If the surplus amount is greater than the charge for the number of days in the NF, the difference must be refunded to the participant's account. The provider should bill MHD for a participant even though the reimbursement is zero in order to receive credit for those patient days.

2.9 MO HealthNet Vendor Notice - A Facility's Authorization to Bill MO HealthNet Division

The FSD caseworker completes a MO HealthNet Vendor Notice (FA-465) for each eligible resident after financial and medical eligibility has been determined. This notice is sent to the NF. The FA-465 is important to the provider as it establishes three (3) items:

- The earliest date of service for which MHD vendor payment is made
- The participant's level of care, which must be shown on the claim
- The patient liability (surplus) amount to be collected from the participant or their representative and the effective date that the surplus amount is first due

The FA-465 is an NF's authorization to submit claims for MHD payment on behalf of the participant named on the notice.

A claim for MHD payment must not be submitted until the provider has a copy of an FA-465 for the resident. If an FA-465 is not received within a reasonable time, contact the participant's caseworker. Refer to [Section 3](#) of this manual for more information.

When a participant transfers from one NF to another, the receiving NF must have a new FA-465 from FSD before billing MHD.

When to Bill the Participant for Surplus

It is recommended that providers collect surplus at the beginning of the month for that month's services. This avoids the situation in which a SSA payment, which would have been used to pay surplus, must be returned to SSA because the participant died the previous month. Below is an example:

Participant enters NF on January 15 and dies on April 20	
Jan 15–31	No surplus collected (admitted after the first day of the month)
Feb 1–29	Surplus collected at beginning of February for February services from the individual's February 3 rd SSA payment
March 1–31	Surplus collected at the beginning of March for March services from the March 3 rd SSA payment
April 1–19	Surplus collected at beginning of April for April services from the April 3 rd SSA payment
April 20	Participant Expired
May 3	SSA payment received must be returned to SSA as individual is deceased

Effect on Surplus When Social Security Increases

If Congress approves a SSA increase, the participant surplus is adjusted. FSD supplies a listing to the NF showing all MO HealthNet participants, their old surplus, and their new surplus and effective date. FSD issues an FA-465 notice reflecting the correct surplus amount for participants who have more than one source of income, i.e., Railroad Retirement, Veterans Benefits or private retirement plans. A new FA-465 is not generated for any participant who appears with the correct amount on the listing.

SSA benefit increases are normally effective January 1 and listings are distributed to NFs in the latter part of December. The adjusted surplus amount is effective for January dates of service.

2.10 Spousal Impoverishment

The purpose of the Medicare Catastrophic Coverage Act of 1988, commonly known as spousal impoverishment, is to prevent forcing a married couple to deplete their savings in order for one spouse receiving nursing care to qualify for MO HealthNet coverage thereby leaving the spouse who remained in the community impoverished.

The law seeks to reduce that threat by protecting a portion of the income and/or resources of a couple for maintenance of the spouse still in the community. The following instructions explain the treatment of resources for MO HealthNet eligibility and the actions an NF must take.

When one (1) member of a married couple enters a MO HealthNet certified bed in an NF and the other remains in the community, all countable assets held by either or both spouses are considered available equally to both spouses in determining MO HealthNet eligibility. Their home and most personal goods are excluded from such countable assets.

The spousal impoverishment provisions allow the spouse in the community to set aside some or all of the income from the institutionalized spouse. To determine specific allowable amounts, individuals should review [**Appendix J**](#) of the [**MO HealthNet for the Aged, Blind and Disabled \(MHABD\) Manual**](#).

In determining the spousal share (what the spouse in the community can keep), the assets held at the beginning of the first continuous 30 day period of institutionalization are assessed. The institutionalized spouse can qualify for MO HealthNet when the remaining portion of countable resources is at or below the eligibility limit, found on [**Appendix J**](#).

FSD completes an assessment and documentation of a married couple's joint assets at the first continuous period of institutionalization whenever requested by either spouse or their representative. An assessment should be requested even when there are no immediate plans for the institutionalized spouse to apply for MO HealthNet benefits.

Section 1919(c)(1)(B)(1) of the Act requires NFs to advise new admissions to certified beds of MO HealthNet eligibility and, also, that resource assessments are available from FSD upon request. DSS monitors NFs to ensure that they advise individuals of the opportunity for assessments.

New admissions can be directed to the [**MO HealthNet Nursing Home Coverage flyer**](#) for information on Missouri Medicaid NF coverage and the prevention of spousal impoverishment.

2.11 Program Policies

Reimbursement

MHD reimburses an enrolled NF based on the eligible participant's days of care multiplied by the NF's Title XIX per diem rate less any patient surplus amount.

MHD pays for the day of admission but does not pay for the day of hospice election, transfer, discharge or death. The day of hospice election, transfer, discharge or death may not be billed to the participant or their representative.

If a participant dies on the day of admission, contact MHD Provider Communications by calling the Interactive Voice Response (IVR) system at (573) 751-2896, option 6 for special handling.

MHD does not pay for any day a participant is not in the NF except for therapeutic home reserve and, under certain circumstances, hospital leave days. To determine a "day," a bed count performed at 11:59 PM is the most acceptable.

If a participant is receiving outpatient hospital services that span midnight but is not admitted to the hospital, the NF may bill for that day.

If the participant has both Medicare Part A and MHD coverage, the Medicare Part A benefit must be utilized until it has been exhausted. During a Medicare Part A coverage period, only claims reflecting Medicare days, revenue code 0189, are to be submitted. NFs are not to submit claims for room and board charges, revenue codes 0110, 0119, 0120, 0129, 0190, 0191, 0192, 0193, 0194 and 0199, during Part A coverage periods.

Therapeutic Home Reserve Days

MHD reimburses the NF for therapeutic home reserve days provided the attending physician has documented approval in the patient's plan of care. The coverage of a temporary leave of absence includes those periods when a participant is away from the NF visiting a friend or relative. It does not apply to any days during which the participant is hospitalized except for the provision under hospital reserve days.

The number of days allowed for home leave is 12 days for the first six (6) calendar months and 12 days for the second six (6) calendar months of the year.

Hospital Reserve Days

Payment to an NF for hospital reserve days is made under the following specific conditions only:

- The NF is licensed by DHSS
- DHSS has not taken any legal action to terminate the NF's participation in MHD or deny payments for new admissions as a result of noncompliance with federal standards
- The NF has 97% occupancy of the MHD certified area in the prior calendar quarter in which the first hospital reserve day occurs. Determination of occupancy is based on the quarterly survey report submitted by every NF to DHSS.
- The inpatient hospital stay is three (3) days or less
- The resident has enough unused therapeutic home reserve days to use two (2) home reserve days when one (1) hospital reserve day is requested
- The resident or the resident's responsible party notifies the NF that the resident intends to return to the NF following the hospital stay

A resident is not required to use therapeutic home reserve days when hospital reserve days are applicable. The resident has two choices, described below.

- The resident may choose not to reserve a room at all. Under OBRA 1987 the NF is obligated to place the resident in the first available semi-private room with a Medicaid certified bed upon the participant's discharge from the hospital.

- The resident may pay the NF to reserve the bed during the hospitalization period instead of using the participant's therapeutic home reserve days. The NF should have a statement on record signed by the resident or resident's guardian that the resident chooses not to use therapeutic home reserve days to cover the hospital leave day's charge and understands that in order to hold a specific bed the resident is financially responsible.

Bed-Hold Policy

Neither a resident nor the responsible party is required to pay an NF to hold a bed. If the resident or responsible party chooses to, they may pay an NF to reserve the same bed the participant is leaving. An NF has an obligation to inform a resident or the responsible party that paying to hold a bed is voluntary.

When a resident is transferred to a hospital, the NF is required, both by federal statute and federal regulation, to readmit the resident immediately upon the first availability of a bed in a semi-private room.

Private Room

The MHD per diem includes reimbursement for a semi-private room and board. The MHD per diem covers a private room when necessary to isolate a participant due to a medical or social condition. A MO HealthNet participant or responsible party may elect a private room subject to availability and pay the difference between an NF's private pay semi-private rate and the private pay private rate.

A MO HealthNet participant may not be placed in a private room and charged any additional amount above the NF's MHD per diem rate unless the participant or responsible party specifically requests a private room in writing prior to placement in a private room and acknowledges that an additional amount not payable by MHD will be charged.

Deposits

Upon acceptance of a participant's MHD benefits, and under the terms of the provider agreement and federal and state regulations, an NF may not require MO HealthNet residents to pay a deposit as a condition of admission.

It is a felony and grounds for termination from the Title XIX Program to charge money as a precondition of admission or as a requirement for continued stay. The following is a section from 1128B(d) of the Social Security Act:

(d) Whoever knowingly and willfully—

- (2) Charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State Plan approved under this title (42 USCS section 1396 et seq.), any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)—

- (A) As a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or
- (B) As a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State Plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than \$25,000, or imprisoned for not more than five (5) years, or both.

If a resident is admitted as private pay and a deposit has been collected, this deposit must be returned to the resident or to the resident's representative if the individual later becomes MO HealthNet eligible.

Participant Nonliability

Covered Services

MHD covered services rendered to an eligible participant are not billable to the participant if MHD would have paid had the provider followed the proper policies and procedures for obtaining payment through MHD as set forth in [**13 CSR 70-4.030**](#).

Retroactive Coverage

The Social Security Act at 1919(c)(5) specifies admission practices MO HealthNet NF must follow regarding a participant's right to MO HealthNet benefits. A resident cannot be required to waive their rights to benefits under MHD. Therefore, if a resident is not eligible for MO HealthNet benefits at the time of admission but is eligible retroactively to the time of admission, the resident is not responsible for payment of those days.

Those days can be billed to MHD. If the resident or their family paid for those days until eligibility was established, the money must be returned after MO HealthNet eligibility is established. Failure to return the money after MO HealthNet eligibility has been established is a MHD violation under [**13 CSR 70-3.030**](#).

Remaining Personal Funds for a Deceased Participant

NFs are required to submit a written account of the remaining personal funds for any deceased resident who has received aid, care, assistance or services paid by the DSS ([Section 198.088\(7\), RSMo](#) [Cum. Supp. 1993]). For the purpose of this policy, personal funds of the deceased resident include all of the resident's remaining funds held by the NF, in whatever title the account or accounts may be known. The resident's personal funds account balance must be submitted on the [**Personal Funds Account Balance Report**](#) within 60 days from the date of the resident's death. Providers must send the completed report to [**MHD.CostRecovery@dss.mo.gov**](mailto:MHD.CostRecovery@dss.mo.gov).

The NF must include the name and address of the resident's estate or the individual designated to receive the resident's quarterly accounting of all financial transactions on the report.

Cost Recovery/Third Party Liability Unit

Providers may contact the Third Party Liability Unit at MHD.CostRecovery@dss.mo.gov or by calling (573) 751-2005 during regular business hours to ask questions regarding this matter, including verifying if a resident has received aid or assistance.

Funeral Expenses

Funeral expenses may be paid from a resident's personal funds held by an NF if no other funds are available to cover the cost. If personal funds are used for this purpose, complete the **Personal Funds Account Balance Report** indicating in Remarks that funds were used to pay funeral expenses, the payee and the amount applied toward the funeral expenses.

Aid and Assistance Paid by the Department of Social Services

Upon receipt of the report, MHD determines the amount of aid, care, assistance and services paid on behalf of the deceased resident by DSS. Within 60 days of receipt of the **Personal Funds Account Balance Report**, MHD notifies the NF of the amount determined to have been paid by DSS on behalf of the deceased participant. The NF must pay to DSS any remaining personal funds, up to the amount of aid and assistance that was paid by DSS. The NF must send a check payable to DSS within 60 days of the NF's receipt of the notification for payment. Instructions for payment are on the DSS notification letter.

If a balance remains in the residents personal fund account after payment has been issued to DSS, then the deceased resident's remaining personal funds should be treated in the same manner as the NF does for residents who do not receive aid and assistance.

Providers are in violation of MHD regulation **13 CSR 70-3.030** if, within 60 days of the death of the resident, they fail to submit a complete accounting of the remaining personal funds of a deceased resident who has received aid, care, assistance or services paid by DSS.

2.12 Included Services, Items and Supplies

All supplies, items and services included in the calculated per diem rate must be provided to the resident, per **13 CSR 70-10.015**. Supplies and services otherwise covered in a per diem rate that are also billable to the Title XVIII Medicare Program must be billed to that program for facilities participating in the Title XVIII Medicare Program. Included supplies, items and services may not be billed to the resident or responsible party. Covered services in the per diem rate include, but are not limited, to the following:

- Services, items and supplies required by federal or state law or regulation that must be provided by long term care NFs participating in the Title XIX Program
- Semi-private room and board
- Private room and board when it is necessary to isolate a participant due to a medical or social condition (examples are contagious infection, loud irrational speech)

- Therapeutic home leave days for MO HealthNet participants, not to exceed 12 days for the first six (6) calendar months and not to exceed 12 days for the second six (6) calendar months
- Hospital leave days when all criteria are met
- Provision of nursing services
- Provision of routine personal hygiene and routine care services
- Basic hair care, including haircuts, shampoo, and sets as necessary. Only services that are performed by other than NF personnel at the election of the participant may be billed to the participant. Included in basic hair care is any over-the-counter shampoo.
- All general personal care services that are furnished routinely and relatively uniformly to all residents for their personal use for purposes of cleanliness and appearance; e.g., necessary clipping and cleaning of fingernails and toenails, and shaves to the extent necessary for reasonable personal hygiene. The provider shall not bill the participant or their representative for this type of personal service or supplies
- All laundry services, including personal laundry
- All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items.
- All consultative services required by federal or state law or regulation
- All therapy services required by federal or state law or regulation
- All routine care items, including disposables and including but not limited to those items specified below
 - All nursing care services and supplies, including disposables and including but not limited to those items specified below
 - Any and all non-legend antacids, non-legend laxatives, non-legend stool softeners and non- legend vitamins and minerals. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in an NF's per diem rate.

Personal Care

Baby powder	Hair care, basic including washing, sets, brushes, combs, non-legend shampoo
Bedside tissues	Lotion, soap and oil

Bibs, all types	Oral hygiene including denture care, cups, cleaner, mouthwashes, tooth brushes and paste
Deodorants	Shaves, shaving cream and blades
Disposable underpads of all types	Nail clipping and cleaning-routine
Gowns, hospital	
Equipment	
Arm Slings	Hot pack machines
Basins	Hypothermia blanket
Bathing equipment	Mattresses, except those authorized by MHD Exception
Bed frame equipment including trapeze bars and bedrails	Patient lifts, all types
Bed pans, all types	Respiratory equipment, compressors, vaporizers, humidifiers, Intermittent Positive Pressure Breathing machines, nebulizers, suction equipment and related supplies, etc.
Beds, manual, electric	Restraints
Canes, all types	Sand bags
Crutches, all types	Specimen container, cup or bottle
Foot cradles, all types	Urinals, male and female
Glucometers	Walkers, all types
Heat cradles	Water pitchers
Heating pads	Wheelchairs, standard, geriatric and roll-about

Nursing Care/Patient Care Supplies

Catheter, indwelling and non-legend supplies	Medicine droppers
Decubitus ulcer care: pads, dressings, air mattresses, aquamatic K pads (water heated pads), alternating pressure pads, flotation pads and/or turning frames, heel protectors, donuts and sheepskins	Medicine cups

Diabetes blood and urine testing supplies	Needles including but not limited to hypodermic, scalp, vein
Douche bags	Nursing services: regardless of level, administration of oxygen, restorative nursing care, nursing supplies, assistance with eating and massages provided by facility personnel
Drainage sets, bags, tubes, etc.	Nursing supplies: lubricating jelly, betadine, benzoin, peroxide, A & D Ointment, tapes, alcohol, alcohol sponges, applicators, dressings, and bandages of all types, cotton balls, and aerosol merthiolate, tongue depressors
Dressing trays and dressings of all types	Ostomy supplies: adhesive, appliance, belts, face plates, flanges, gaskets, irrigation sets, night drains, protective dressings, skin barriers, tail closures, and bags
Enema supplies	Suture care including trays and removal kits
Gloves, non-sterile and sterile	Syringes, all sizes and types including ascepto
Ice bags	Tape for laboratory tests
Incontinence care including pads, diapers and pants	Urinary drainage tube and bottle
Irrigation trays and non-legend supplies	
Therapeutic Agents and Supplies	
Drugs, stock (excluding insulin)	Nutritional supplements
Enteral feedings (including by tube) and all related supplies	Oxygen, (portable and stationary), oxygen delivery systems, concentrators and supplies
I.V. therapy supplies: arm boards, needles, tubing and other related supplies	Special diets
Any and all non-legend antacids, non-legend laxatives, non-legend stool softeners and non-legend vitamins and minerals. Providers may not elect which non-legend drugs in any of the four (4) categories to supply; and all must be provided to residents as needed and are included in the facilities per diem rate.	

2.13 Facilities for the Mentally Ill

Facilities that care primarily for residents with mental disease are considered “institutions for the mentally ill.” By federal rule, **42 CFR 440**, MHD cannot reimburse an institution for the mentally ill for participants who are between the ages of 21 and 65. In general, an institution for mental diseases means a hospital, NF or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services.

Whether an institution is an institution for mental diseases is determined by its overall character as that of an NF established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the intellectually disabled is not an institution for mental diseases.

2.14 MO HealthNet Programs That Have Specific Benefits and Limitations for Nursing Facility Residents

Ambulance Services

Ambulance services are covered if they are emergency in nature and if the participant is transported to the nearest hospital with appropriate facilities.

Ambulance service to a physician's office, a dentist's office, a patient's home or to an NF is not an MHD ambulance covered service. Refer to the [**Non-Emergency Medical Transportation \(NEMT\) Provider Manual**](#) for more information.

Clinic Services

MHD covers clinic services. However, MHD is prohibited from covering such services when the clinic is located on the premises of an NF, regardless of any office space leasing arrangement a practitioner may have with an NF. Whether the services are provided in the long term care NF itself or in the clinic physically situated on the long term care NF premises, those services are not covered by MHD. Clinic services provided off the NF premises are covered by MHD.

Dental Services

Routine dental services performed in an NF do not require prior authorization. For further information on dental services, refer to the [**Dental Provider Manual**](#).

Exceptions

Group two (2) or three (3) pressure support surfaces are the only NF items that may be considered by the Exception Process for payment outside the per diem.

Requests for group two (2) and three (3) pressure support surfaces may be submitted by fax to (573) 522-3061. In addition to the [**MO HealthNet Exception Request**](#), prescribers must also complete the [**Air Fluidized/Low Air Loss Therapy Request**](#).

Refer to the [**MHD General Sections Manual**](#) for more information on the Exception Process. For further assistance, contact the Pharmacy and Medical Pre-Certification Help Desk at [**MHD.PharmacyAdmin@dss.mo.gov**](mailto:MHD.PharmacyAdmin@dss.mo.gov) or call (800) 392-8030.

Hearing Aid Services

Requests for audiometric testing and hearing aids must originate with the participant and must proceed with the participant's full knowledge and consent.

Prior authorization is required for all hearing aid services provided in an NF except for post-fitting adjustments, post-fitting evaluations and repairs to hearing aids no longer under warranty. A [Report of Hearing Aid Evaluation \(RHAЕ\)](#) completed to the extent possible must be attached to all prior authorization requests for hearing aid services to be provided in an NF. The hearing aid provider is responsible for completing the RHAЕ and obtaining the required signatures. The participant or legal guardian must sign Section D of the RHAЕ certifying that they initiated the request for the service. The NF administrator must also sign Section D of the RHAЕ to certify that the participant initiated the request for a hearing aid.

Separate prior authorization requests are required for the testing and the hearing aid if the testing or dispensing is to be provided in the NF.

For further information on hearing aid services, refer to the [Hearing Aid Provider Manual](#).

Hospice Services

MHD covers hospice services. The hospice benefit is designed to meet the needs of patients with a life-limiting illness and to help families cope with the problems and feelings related to this difficult time. Hospice care is an approach to treatment that recognizes that the impending death of an individual warrants a change in focus from curative to palliative care.

When providers verify participant eligibility, the hospice participant is identified by the lock-in provider's name and phone number. Eligibility may be verified by calling the IVR system at (573) 751-2896 or using [eMOMED](#). Refer to the [MHD General Sections Manual](#) for more information.

MO HealthNet eligible individuals residing in MO HealthNet certified NFs who meet the hospice eligibility criteria may elect MO HealthNet hospice care. When a participant in an NF elects hospice services, the hospice provider provides or arranges for all care, supplies, equipment and medicines related to the terminal illness. MHD reimburses the hospice provider who then reimburses the NF for room and board services. The NF must agree to accept the hospice provider's negotiated per diem rate as payment in full since it cannot bill MHD for NF services on behalf of the hospice patient.

The room and board services provided by the NF include the performance of personal care services that a caregiver would provide if the individual were at home.

These services include assistance in the activities of daily living: washing and grooming, toileting, dressing, meal services, socializing (companionship, hobbies, etc.), administration of medication, maintaining the cleanliness of the resident's bed and room and supervising and assisting in the use of durable medical equipment and prescribed therapies (such as range of motion exercises, speech and language exercises).

There must be a written agreement between the hospice provider and the NF under which the hospice provider takes full responsibility for the professional management of the individual's hospice care, and the NF agrees to provide room and board to the individual.

Payment for hospice NF room and board is determined in accordance with rates established under 1902(a)(13) of the Social Security Act.

Payment of Surplus

It is a federal requirement that hospice patients in a MO HealthNet certified bed must use any income they receive, less certain deductions such as medical insurance, for their room and board (hospice care). The procedure to determine the amount of surplus for hospice patients is performed by FSD.

When the NF and the hospice provider have agreed to the placement (admission) of a hospice patient in the NF, the NF must notify FSD of the placement, and request that the hospice patient or the responsible party apply for vendor services. The **Nursing Facility Level of Care Assessment** and **Level One Nursing Facility Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition form** must be completed and submitted to the DRL. When FSD receives these forms from the DRL, FSD enters the participant's income and expenses in **eMOMED** to calculate the surplus amount. The MO HealthNet Vendor Notice (FA-465) is sent to the NF. The participant (and their authorized representative, if applicable) receive a MO HealthNet Action Notice (FA-460) with the surplus amount. The NF should provide a copy of the FA-465 to the hospice provider.

It is between the hospice provider and the NF to determine who bills for and collects the surplus amount, if any, from the patient. MHD payment for NF services is made to the hospice provider. This payment is reduced by any surplus amount shown in the file for that individual. The NF must not bill MHD for these days. The hospice provider is responsible for reimbursing the NF.

When a participant elects or revokes hospice care in the middle of the month, surplus is applied to the appropriate provider's claim for the first of the month. The remaining surplus balance, if any is carried forward and applied to the subsequent provider's claim until it is satisfied in full. Below is an example:

Participant, Jane Doe, is a resident of an NF and elects hospice on June 15 then later revokes hospice on August 3. She has a monthly surplus of \$800.

June 1-14	NF submits a claim for room and board. Payment is deducted by Jane's \$800 surplus.
June 15-30	Hospice provider submits a claim for the NF room and board. Payment is made in full to the hospice provider at 95% of the NF's per diem.
July 1-31	Hospice provider submits a claim for the NF room and board. Payment is deducted by the \$800 surplus and the remaining is paid to the hospice provider at 95% of the NF's per diem.
August 1-3	Hospice provider submits a claim for the NF room and board. The allowed amount of 95% of the nursing home's per diem for the three (3) days is only \$300. The hospice provider receives a \$0.00 payment from MHD.
August 4-31	NF submits claim for the room and board. Payment is reduced by the remaining \$500 surplus and the rest is paid at 100% of the NF's per diem.

It is important for both NF and hospice providers to submit claims for each day the participant is under their care, even if no money is received from MHD for that claim. Surplus can only be correctly applied if all days have been submitted.

Providers should note that Missouri Care Options and the PASRR process apply to hospice admissions.

Optical Services

Optical services performed in an NF are subject to precertification requirements as described in the Optical Provider Manual. Routine optical services performed in an NF do not require prior authorization. The participant, participant's family, personal representative or legal guardian must have full knowledge of and consent to requests for all optical services.

For further information on optical services, refer to the [**Optical Provider Manual**](#).

Pharmacy Services

See the Pharmacy Manual for details.

Physician Services in Nursing Facilities

The following is a summary of physician services that are required for MO HealthNet residents in a Title XIX NF and usually performed in an NF. It includes both federal and state licensing requirements.

- The physician must see the resident at least once every 30 days for the first 90 days and at least once every 60 days thereafter. The physician must examine the resident as often as necessary to ensure proper medical care.
- For each medical examination, the physician must review the resident's care, including medications and treatments, write, sign and date progress notes and sign and date all orders.
- All physician telephone orders must be signed and dated within seven (7) days of the original telephone order.

Durable Medical Equipment

Some services or equipment are not included in the NF per diem and may be covered through the Durable Medical Equipment (DME) Program.

Wheelchairs

Standard, geriatric and roll-about wheel chairs must be supplied by the NF without charge to the participant. Customized wheelchairs, however, may be available through the MHD DME Program. The term "customized wheelchair" is defined as those chairs that are tailor-made for one (1) participant and cannot be used by anyone else.

Wheelchairs that are categorized as “custom” should be requested through an MHD participating DME provider. The DME provider must request prior authorization as instructed in the [**MHD General Sections Manual**](#).

Customized wheelchairs that are purchased by MHD become the property of the participant. If the participant transfers from one NF to another, the custom wheelchair must accompany the participant.

Home Parenteral Nutrition

Home parenteral nutrition (HPN) is covered through the DME Program. HPN requires pre-certification through MHDs Web tool CyberAccessSM. Additional information regarding CyberAccessSM and the medical criteria documents established by MHD may be found on the [**Pharmacy and Clinical Services webpage**](#).

Volume Ventilator Rental

Ventilators are covered through the DME Program. Back-up ventilators are not approved for participants in an NF.

Behavioral Health Services in a Nursing Facility

MHD allows Psychiatric Diagnostic Evaluations (procedure codes 90791 and 90792) for participants in a Skilled NF when performed by a Psychiatrist, Psychiatric Clinical Nurse Specialist (PCNS) or Psychiatric Mental Health Nurse Practitioner (PMNHP).

The Psychiatric Diagnostic Evaluation includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies.

2.15 Catastrophes/Disasters

NFs needing to temporarily relocate residents to another NF due to a catastrophe or a disaster-related situation may bill MHD for those residents as usual, but the NF relocating residents is responsible for entering into a reimbursement agreement with the NF accepting the residents.

2.16 Invasive Ventilator Program

(MHD, in collaboration with DHSS, has implemented the Invasive Ventilator Program (IVP). This program will provide additional reimbursement to NFs in the State of Missouri for care of ventilator dependent participants. To assist with the increased financial obligations that accompany the proper care of a ventilator dependent participant, the IVP will provide an increased payment amount in addition to the per diem rate of the authorized NFs. This additional payment will be made for each ventilator dependent participant for prior authorized dates of service. The IVP is limited to adults, age 21 and over, who are dependent on an invasive ventilator as a means of life support. Facilities receive an additional per diem amount of \$150.00 for each participant approved by MHD for providers who participate in the IVP.

Provider Participation in the Invasive Ventilator Program

NFs that participate in the IVP must submit a **Nursing Facility Invasive Ventilator Program Addendum to the Nursing Home Provider Agreement** to MMAC, Provider Enrollment Unit. The MMAC Provider Enrollment Unit will update the provider's file to allow the increased per diem payment, when prior authorized.

Prior Authorization of Invasive Ventilator Program Participant Placement

Prior Authorization (PA) must be obtained through MHD prior to the placement of a ventilator dependent participant in a skilled NF. The PA must be initiated by an authorized medical provider who has evaluated the medical needs of the individual. Authorized providers include physicians, advanced practice nurses, respiratory therapist, hospitals or skilled nursing facilities. The PA documents that the participant meets criteria for the IVP and will allow the NF to receive their additional payment for the participant. If the PA is not obtained, the additional payment will not be added to the NF's per-diem rate. The PA is approved for the duration of the physician's prescription for invasive ventilation. If the invasive ventilator is used for weaning purposes, a PA must be completed every 90 days to ensure individuals continue to meet the requirements for participation in the IVP. To request a PA for a participant, complete the **Invasive Ventilator Program Prior Authorization Request** and fax to (573) 522-8514.

Section 3: Special Documentation Requirements

3.1 Missouri Care Options

New referrals for home care services are made by contacting the Division of Senior and Disability Services (DSDS), at (866) 835-3505.

3.2 Level Of Care Determination

Nursing Facility Level of Care Assessment

Eligibility for MO HealthNet Division (MHD) nursing facility (NF) benefits is based on MHD categorical eligibility, determined by the Family Support Division (FSD), and medical eligibility, determined by the Division of Regulation and Licensure (DRL). These determinations of eligibility must be made before an MHD NF payment can be made on behalf of a participant. The DRL determines if the applicant meets NF Level of Care (LOC). The determination is based on the established guidelines found in **19 CSR 30-81.030** and the information provided on the **Nursing Facility Level of Care Assessment and Level One Nursing Pre-Admissions Screening for Mental Illness, Intellectual Disability, or Related Condition forms**.

The signing physician is responsible for providing complete information on the forms. The forms should be completed in their entirety to allow DRL to make a valid determination.

If providers have questions concerning how to complete the forms, they may contact the Central Office Medical Review Unit (COMRU), DRL, at (573) 526-3092. Incomplete forms may be returned to the submitter, delaying the review and approval process.

3.3 Exception Requests

There are three (3) items/services for which NFs providers may request an exception. These are: total parenteral nutrition, rental of non-invasive ventilators and specialty mattresses.

MO HealthNet Exception Requests

Emergency requests may be called in by a physician to (800) 392-8030 option 4.

Non-emergency requests may be made by completing the [MO HealthNet Exception Request](#). The request should be faxed to (573) 522-3061 or mailed:

Attn: Exceptions Unit MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

Air Fluidized/Low Air Loss Therapy Form

Requests for specialty mattresses and bed rentals related to low-air loss flotation mattresses and air-fluidized beds must be made in writing. In addition to completing the [MO HealthNet Exception Request](#), providers must complete the [Air Fluidized/Low Air Loss Therapy](#) form. Providers can fax or mail both forms to the number or address provided above.

Exception requests are explained in the [MHD General Sections Manual](#). All [MO HealthNet Exception Request](#) must be initiated by the physician. An NF cannot initiate the request.

3.4 Reporting Requirement for Accidental Injuries

Missouri statute 208.215 requires MO HealthNet participants to report injuries to MHD within 30 days of occurrence. For MO HealthNet participants residing in NFs, the [Accident Report \(TPL-2P\)](#) should be completed by authorized NF personnel to report injuries sustained by the participant while under the care of the NF.

Exception—Minor injuries should not be reported. As a guideline, a report is requested for any injury in which a medical professional, doctor or nurse is consulted, either staff or outside, or x-ray services are required AND the injury requires specialized care for a period of time.

Example: A fall out of bed results in bruises, which are evaluated by a staff nurse. In this case, specialized care is not expected. If the fall involves a broken bone, dislocation, concussion or similar injury, it is expected that specialized care is necessary.

NF personnel must complete the [Accident Report \(TPL-2P\)](#) with details concerning the accident and submit to MHD.CostRecovery@dss.mo.gov or mail to the following address:

Third Party Liability Unit
MO HealthNet Division
P.O. Box 6500
Jefferson City, MO 65102-6500

A copy of the [Accident Report \(TPL-2P\)](#) should be filed in the patient's case record.

If a claim is processed in which the NF has indicated a trauma diagnosis code, and no [**Accident Report \(TPL-2P\)**](#) has been received by the Third Party Liability Unit, the system generates an [**Accident Report \(TPL-2P\)**](#) to the participant requesting further information.

Reference the [**MHD General Sections Manual**](#) for more information on the [**Accident Report \(TPL-2P\)**](#).

Section 4: Billing Instructions

4.1 Electronic Data Interchange

Providers exchanging electronic transactions with MHD should access the [**ASC X12 Implementation Guides**](#), adopted under the Health Insurance Portability and Accountability Act (HIPAA). For Missouri specific information, including connection methods, the biller's responsibilities, forms to be completed prior to submitting electronic information, as well as supplemental information, reference the [**X12 Version v5010**](#) and [**NCPDP Telecommunication D.0 & Batch Transaction Standard V.1.1 Companion Guides**](#).

4.2 Internet Electronic Claim Submission

Providers may submit claims via [**eMOMED**](#). Providers are required to complete the on-line [**Application for MO HealthNet Internet Access Account**](#). Providers are unable to access [**eMOMED**](#) without proper authorization. An authorization is required for each individual user. Refer to the [**MHD General Sections Manual**](#) for more information.

The following claim types can be used in [**eMOMED**](#) applications: Medical (NSF), Inpatient and Outpatient ([**UB-04**](#)), Dental ([**2019 American Dental Association**](#)), Nursing Home and Pharmacy. For convenience, some of the input fields are set as indicators or accepted values in drop-down boxes. Providers have the option to input and submit claims individually or in a batch submission. A confirmation file is returned for each transmission.

4.3 Provider Relations Communication Unit

It is the responsibility of the Provider Communications Unit to assist providers in filing claims. For questions, providers may send an inquiry via [**eMOMED**](#) or call the Interactive Voice Response (IVR) system at (573) 751-2896. Refer to the [**MHD General Sections Manual**](#) for more information. If assistance is needed regarding establishing required electronic claim formats for claims submissions, accessibility to electronic claim submission via [**eMOMED**](#), network communications, or ongoing operations, the provider should contact the [**eMOMED**](#) Help Desk at (573) 635-3559.

4.4 Resubmission Of Claims

Any claim that resulted in a zero payment can be resubmitted if it denied due to a correctable error. The error that caused the claim to deny must be corrected before resubmitting the claim. An example of a correctable error is an invalid participant number.

The [**MHD General Sections Manual**](#) explains the adjustment request process.

4.5 Paper Claim Submissions

Under certain circumstances, such as residents who have retroactive level of care, claims may be filed manually.

When using the direct data entry option via [eMOMED](#), select Submit Manually at the bottom of the Manage Participant screen. This should be done after all editing is finished for the resident. When choosing this option, a claim is not submitted. Once Submit Manually is selected, a pop-up window with a print option is displayed; a separate paper claim is generated for each detail line billed.

This is the format that should be used to print claims requiring special handling. The system should be able to determine whether or not a claim was originally submitted timely, however, there are instances in which the system cannot make this determination. In these cases it is necessary to submit the claim manually and attach a copy of a previously submitted Remittance Advice (RA) showing proof of timely filing. The paper claim and the attachment must be mailed to Wipro Infocrossing for processing.

The following address must be used when mail delivery is by U.S. Post Office:

Missouri Medicaid
P.O. Box 5600
Jefferson City, MO 65102

Please note that multiple details (which result in multiple claims) require an attachment with each printed claim.

4.6 Nursing Facility Claims Subject To Third Party Liability Edits

All nursing facility claims are subject to Third Party Liability (TPL) edits in [eMOMED](#).

If [eMOMED](#) indicates there is applicable insurance coverage and no third party payment amount is indicated on the claim, or documentation is not attached to indicate a denial of payment by the insurance company, the claim is denied. Refer to the [MHD General Sections Manual](#) for TPL information and instructions. The [MHD General Sections Manual](#) answers questions regarding, among other TPL issues, what constitutes a third party resource and how to interpret TPL information. Contact the TPL Unit at MHD.CostRecovery@dss.mo.gov or at (573) 751-2005 regarding TPL.

MHD is not responsible for payment of claims denied by the third party insurance if all required forms were not submitted to the insurance company to process the claim or if the claim provided incomplete information. It is the responsibility of the provider and the patient to comply with all requirements, including any timely filing requirements and appropriate assignment of benefits, in order to receive payment from the third party insurance resource.

4.7 Insurance Coverage

Participant eligibility and TPL information may be verified by calling the IVR system at (573) 751-2896 or via [eMOMED](#). Reference the [MHD General Sections Manual](#) for more information.

Participants must always be asked if they have third party insurance regardless of the TPL information given by the IVR or **eMOMED**. It is the provider's responsibility to obtain from the patient the name and address of the insurance company, the policy number and the type of coverage. For additional TPL information, refer to the **MHD General Sections Manual**.

Section 5: Procedure Codes

Procedure codes are used by the MO HealthNet Division (MHD) to identify services performed by a provider. MHD does not require nursing facilities (NFs) to use procedure codes. Revenue codes are used to report reserve days and skill indicator information.

5.1 Reserve Type Period Revenue Codes

Code	Description
0180	leave of absence (non-covered leave of absence)
0182	patient convenience (home leave)
0183	therapeutic leave (home leave)
0184	ICF/MR – any reason (inpatient hospital leave)
0185	nursing facility; for hospitalization (inpatient hospital leave)
0189	other leave of absence (Medicare qualifying stay days)

5.2 Skilled Nursing Services Revenue Codes

Code	Description
0190	subacute care general classification
0191	subacute care – level I
0192	subacute care– level II
0193	subacute care– level III
0194	subacute care– level IV
0199	subacute care other

Indicating any of the above revenue codes will not alter the amount of the per diem payment. These ancillary revenue codes should not be used to report NF accommodation services.

5.3 Non-Skilled Nursing Services Revenue Codes

Code	Description
0110	room-board/private
0119	other/private
0120	room-board/semi
0129	other/2 bed

Indicating any of these will not alter the amount of the per diem payment.