Utah Department of
Health & Human Services
Integrated Healthcare

Utah Medicaid Provider Manual

Long Term Care Services in Nursing Facilities

Division of Integrated Healthcare

Updated April 2018

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1 Long term care program for Medicaid clients residing in a nursing facility

This manual provides information on coverage of Long Term Care (LTC) for Medicaid clients in Nursing Facilities (NFs) and Intermediate Care Facilities for Persons with Intellectual Disabilities (ICFs/ID). For information regarding other Medicaid requirements and policies, refer to SECTION 1 of this Medicaid provider manual.

Nursing facility services are mandated under the Medicaid program. ICF/ID services are optional services.

Institutions primarily for the care and treatment of mental disease (IMDs) are not reimbursable for persons over age 21 and under age 65.

1-1 List of contacts

For more information on a specific policy or procedure, please contact the responsible agency as indicated below:

Customer Service and Provider Manual Distribution
Office of Medicaid Operations
(801) 538-6155 Toll-free: 1-800-662-9651

Medicaid Financial Eligibility
Office of Eligibility Policy
(801) 538-6494

Resident Assessment
Office of Long Term Services and Supports
(801) 538-6155 Toll-free: 1-800-662-9651

Preadmission Screening and Resident Review (PASRR)
Department of Health and Human Services
Division of Integrated Healthcare
(801) 538-3918

Facility Licensing

Office of Health Facility Licensing and Certification
(801) 273-2994

Nurse Aide Training and Competency Evaluation Program
Office of Managed Health Care
(801) 538-6636

Reimbursement
Office of Reimbursement and Audit
(801) 538-6096

1-2 Hospice and home-based long term care

Other long term care programs in the Utah Medicaid program are the Home and Community-Based Services Waiver Programs, Hospice Care, Personal Care Services, and Home Health Services.

Contact Medicaid information to obtain information regarding these programs, or view the provider manuals at: https://medicaid.utah.gov.

1-3 Appropriate placement

The cost of care in a nursing facility must be less than the cost of care for alternative, non-institutional services for the Department to approve nursing facility coverage for an applicant. The Department may not consider the availability of Medicaid reimbursement for alternative services as a factor in determining the relative costs of alternative services. Unless the cost of care through alternative, non-institutional services is higher than the cost of care in a nursing facility, the Department will deny nursing facility coverage for an applicant whose health, rehabilitative, and social needs may reasonably be met through alternative non-institutional services.

Reference: R414-502-3 of the Utah Administrative Code (UAC).

2 Definitions

ACT

The Federal Social Security Act.

Ancillary charges
Any charges made by a medical provider, not included as part of nursing facility coverage.

Applicant
Any person who requests assistance under the medical programs available through the Division.

Certified program
A nursing facility program with Medicaid certification.

Code of Federal Regulations (CFR)
The publication by the Office of the Federal Register, specifically Title 42, used to govern the administration of the Medicaid program.

Crossover payments
When a client is eligible for both Medicare and Medicaid, claims are first sent to Medicare. After the Medicare payment is made, Medicaid is then sent the remaining bill. Payment depends on services covered and the amount paid by Medicare.

Department
The Department of Health and Human Services.

Director
The director of the Division of Integrated Healthcare within the Department of Health and Human Services.

Division
The Division of Integrated Healthcare within the Department of Health and Human Services.

Executive Director
The executive director of the Department of Health and Human Services.

Family
The monthly amount a Medicaid recipient must pay from his own funds toward the cost of nursing facility care.

Medicaid certification
The right to Medicaid reimbursement as a provider of a nursing facility program shown by a valid federal Centers for Medicare and Medicaid Services (CMS) Form 1539 (7-84).

Medicaid rate
The patient reimbursement rate paid to a nursing facility for an individual eligible for the Utah Medicaid program.

Medical assistance program or Medicaid program
The state program for medical assistance for persons who are eligible under the State Plan adopted pursuant to Title XIX of the Federal Social Security Act, as implemented by Title 26, Chapter 18, UCA.

Medical or hospital assistance
Services furnished or payments made to or on behalf of recipients eligible for the Utah Medicaid Program.

Nursing facility
Any Medicaid participating NF, SNF, ICF, ICF/ID, or a combination thereof, as defined in 42 USC 1396r (a) (1988), 42 CFR 440.150 and 442.12 (1993), and UCA 26-21-2(15).

Nursing facility program
The personnel, licenses, services, contracts, and all other requirements that must be present for a nursing facility to be eligible for Medicaid certification as detailed in 42 CFR 442.1 through .119, 483.1 through .480, and 488.1 through .64 (1993), which are adopted and incorporated by reference.

Physical facility

The building(s) or other physical structure(s) where a nursing facility "program" is operated.

Private pay rate
The rate an individual not eligible for Medicaid would pay for long term care in the facility.

Resident
An individual eligible for the Utah Medicaid Program who resides in a nursing facility.

Service area
The boundaries of the distinct geographical area served by a type of certified program, the Department to determine the exact area, based on fostering price competition and maintaining economy and efficiency in the Medicaid program.

Utah Administrative Code (UAC)
The compilation of rules promulgated by state agencies under delegation of authority from the Utah Legislature.

Utah Code Annotate (UCA)
The compilation of legal statutes enacted by the Utah Legislature.

3 Provider enrollment

3-1 Medicare skilled nursing facility certification

All skilled nursing facilities must be certified for Medicare participation as a condition of Medicaid certification. Authority: R414-27 of the Utah Administrative Code (UAC).

3-2 Certification of new nursing facilities

Medicaid limits reimbursement of nursing facility programs to programs certified as of January 13, 1989. In addition:

1. The Department shall not process initial applications for Medicaid certification or execute initial provider agreements with nursing facility programs, except as authorized by Chapters 3 - 21 or 3 - 22.

2. The Department shall not reinstate Medicaid certification for a previously certified provider whose Medicaid certification expires, or is terminated by action of the federal or state government, except as authorized by Chapters 3 - 21 or 3 - 22
3. The Department shall not execute a Medicaid provider agreement with a certified program that moves its nursing facility program to a new physical facility, except as authorized by Chapters 3 - 21 or 3 - 22.

Authority for this subsection is found in Sections 26-18-2.3, 26-1-5, 26-1-30(2)(a), (b), and (w) and 26-18-3 of the Utah Code Annotated (UCA) , and R414-7A of the Utah Administrative Code (UAC).

The purpose of this subsection is to control the supply of Medicaid nursing facility programs. The oversupply of nursing facility programs in the state has adversely affected the Utah Medicaid program and the health of the people within the state. This subsection continues the prohibition against certification of new nursing facility programs that has been in place since January 13, 1989. This subsection clarifies that prohibition and sets up policy to deal with the possible future need for additional Medicaid nursing facility programs in a service area. The July 1990 Report of the Governor's Task Force on Long Term Care recommended continuation of this prohibition. The task force concluded that "Market entry into the nursing facility industry should be regulated to allow supply to come more in line with demand". This subsection also supports the policy of the Department to direct new resources into community based alternatives.

3-3 Authorization to renew, assign, or transfer Medicaid certification

1. The Department may renew Medicaid certification of a certified program without any lapse in service to Medicaid recipients, if its nursing facility program was certified by the Department at the same physical facility.

2. The Department may certify a new nursing facility program if a certified program transfers all of its rights to Medicaid certification to the new nursing facility program and the new program meets all of the following conditions:

a) The new nursing facility program operates at the same physical facility as the previous certified program.
b) The new nursing facility program complies with 42 CFR 442.14 (1993).
c) The new nursing facility program receives Medicaid certification within one year of the date the previously certified program ceased to provide medical assistance to a Medicaid recipient.

3. The Department may certify a previously certified program that moves to a new physical facility and meets all of the following conditions:

a) On the last day that the certified program provided medical assistance to a Medicaid recipient in the original physical facility, it meets all applicable requirements to be a certified program.
b) The new physical facility is in the same service area.
c) The time between which the certified program ceases to operate in the original physical facility and begins to operate in the new physical facility does not exceed three years.
d) The provider operating the certified program gives written assurances satisfactory to the executive director or his designee that:
    i. no third party has a legitimate claim to operate a certified program at the previous physical facility;
    ii. the certified program agrees to defend and indemnify the Department against any claims made by third parties who may assert a right to operate a certified program at the previous physical facility; and
    iii. if a third party is found, by a final agency action of the Department after exhaustion of all administrative and judicial appeal rights, to be entitled to operate a certified program at the original physical facility, the certified program shall voluntarily comply with item D of this subsection (3 21).
4. Upon a finding being made as set forth in item C. 4. C. of this subsection (3 - 21), the certified program shall immediately surrender its Medicaid certification, cease billing Medicaid for all services to Medicaid recipients, and arrange for the orderly discharge of Medicaid recipients to a facility

satisfactory to the Department. If the third party found to be entitled to operate a certified program at the original physical facility requests Medicaid certification, and the previously certified program has surrendered its Medicaid certification, the Department shall treat the request as a transfer of all its rights under item B of this subsection (3 - 21).

3-4 Certification of additional nursing facility programs

The Department may certify additional nursing facility programs if the executive director or his designee determines that there is insufficient capacity at certified programs in a service area to meet the public need.

1. The Department may certify an additional nursing facility program only when the following conditions are met:

   a) After 30-day notice to the Department of Human Services of the Department's finding that there is insufficient capacity at certified programs in a service area to meet the public need, the Department of Human Services cannot demonstrate that community-based services can meet the public need; and

   b) After the close of the 30-day notice to the Department of Human Services and a separate 30-day notice to all certified programs operating in the service area, the certified programs operating in the service area cannot demonstrate that they have tangible plans to add additional capacity to their nursing facility programs to meet the public need.

2. If community-based services and existing certified programs operating in the service area cannot demonstrate that they can meet the public need, the Department may select an additional nursing facility program through a request-for-proposal process.

   a) Each proposal must include sufficient information to allow the Department to evaluate and rank it among all proposals according to the criteria in item 2 below, as well as other information that the Department solicits in its request-for-proposals. The Department shall reject all proposals that

offer to operate for a reimbursement rate higher than that paid to similar certified programs.

b) The Department shall evaluate and select from among the proposals based on maintaining price competition, economy, and efficiency in the Medicaid program; the ability of the proposed nursing facility program to deliver quality care; and how quickly the proposed nursing facility program can begin to operate.

3. If a nursing facility program that the Department selected under the request-for-proposal process fails to undertake the necessary steps to become Medicaid certified or fails to begin to provide medical assistance to Medicaid recipients as represented in its proposal, the Department may reject that nursing facility program, and either select the next ranked nursing facility program or solicit new proposals without again complying with the requirements of item A in this subsection (3 - 22).

4. If, after certifying an additional nursing facility program, the executive director or his designee determines that there is sufficient capacity at certified programs in a service area to meet the public need, the limitations set out in items A, B and C in this subsection (3 - 22) control the certification of nursing facility programs.

3-5 Provider contract

1. With respect to agreements between the Medicaid agency and each provider furnishing services under the plan:
   a) For all providers, the requirements of 42 CFR 431.107 and 42 CFR Part 442, Subparts A and B (if applicable) are met.
   b) For providers of NF services, the requirements of 42 CFR Part 483, Subpart B, and section 1919 of the Act are also met.
   c) For providers of ICF/ID services, the requirements of participation in 42 CFR Part 483, subpart I are also met.

2. The Provider contract is appendix A.

4 Requirements for nursing facilities

4-1 Nurse aide training and competency evaluation program

Any individual working in a nursing facility as a nurse aide for more than four months on a full-time basis must have successfully completed a nurse aide training and competency evaluation program or competency evaluation program approved by the state. The Omnibus Budget Reconciliation Acts of 1987, 1989, and 1990 prohibits facilities from employing a nurse aide for more than four months on a full-time basis who has not successfully completed a nurse aide training and/or competency evaluation program approved by the state. The text of the Nursing aide training and competency evaluation program provider manual is Appendix B.

4-2 Free choice of providers

1. Except as provided in paragraph B, the Medicaid agency assures that a recipient eligible for Medicaid may obtain Medicaid services from any institution, agency, pharmacy, person, or organization that is qualified to perform the services, including an organization that provides these services or arranges for their availability on a prepayment basis.

2. Paragraph A does not apply to services furnished to a recipient:

    a) Under an exception allowed under 42 CFR 431.54, subject to the limitations in paragraph 3, or

    b) Under a waiver approved under 42 CFR 431.55, subject to the limitations in paragraph 3, or

    c) Enrollment of an individual eligible for medical assistance in a primary care case management system described in Section 1915(b)(1) of the Social Security Act, a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the recipient may receive emergency services or services under Section 1905(a)(4)(c).

4-3 Leave of absence

Definition: Any day during which the resident is absent from a facility for therapeutic or rehabilitative purposes and does not return by midnight of the same day.

1. Reimbursement for a nursing facility resident temporarily admitted to hospital

   A nursing facility certified under Title XIX will not receive payment for any day or days for which a bed is held while a resident is temporarily in a hospital. The facility will receive payment for the day of admission to the facility, but not for the day of discharge to the hospital.

2. Reimbursement for temporary leave of absence for reasons other than admission to hospital

   a) Nursing facility
      i. Payment for therapeutic or rehabilitative leave of absence shall be limited to 12 days per calendar year for each resident of a nursing facility.
      ii. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Integrated Healthcare. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by the resident's attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.
   b) Intermediate care facility for people with intellectual disabilities
      i. Payment for therapeutic or rehabilitative leave of absence shall be limited to 25 days per calendar quarter for each resident of an intermediate care facility for people with intellectual disabilities.
      ii. Payment for additional leave of absence days may be authorized only with prior approval from the Division of Integrated Healthcare. The facility's request for prior approval must be accompanied by appropriate and adequate documentation and must include approval of the additional leave days by client's

attending physician and/or the interdisciplinary team as appropriate to meet and support the resident's plan of care.

c) Any therapeutic or rehabilitative leave of absence must be pursuant to a written order by the resident's attending physician, appropriately and adequately documented in the progress notes of the resident's chart and identified as rehabilitative leave by the physician and/or the interdisciplinary team as meeting and supporting the resident's plan of care.

d) All leave of absence days must be reported on the monthly billing form.

4-4 Notice of financial rights and covered services

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid of the following:

1. The items and services that are included in nursing facility services under the Medicaid State Plan and for which the resident may not be charged;

2. Other items and services the facility offers for which the resident may be charged and the amount of charges for those services.

The facility must inform each resident when changes are made to the items and services specified above.

The Medicaid flat rate reimbursement shall cover the services specified in Appendix G, Utah State Plan, Attachment 4.19D, Section 400.

4-5 Resident personal funds

Medicaid clients are permitted to retain a fixed monthly amount for personal needs. For most individuals the amount is $45 a month. For individuals receiving a VA Aid and attendance payment, the amount is $90. This monthly allowance is reserved strictly for a resident to use as wished for personal reasons and is protected as a resident right in accordance with Section 1919(F)(7) of the Social Security Act and 42 CFR 483.10.

4-6 Protection of resident personal funds

1. The resident has the right to manage his or her financial affairs, and the facility may not require residents to deposit their personal funds with the facility.

2. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as follows:

   a) The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and that credits all interest earned on resident's funds to that account. In pooled accounts there must be a separate accounting for each resident's share.

   b) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest bearing account, or petty cash fund.

3. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

   a) The accounting system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

   b) The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

4. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less that the SSI resource limit for one person and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

5. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final

accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.

6. If the facility sells or leases the business, it must:

   a) Provide the buyer or lessee with a written statement of all of the residents' monies and properties being transferred;

   b) Obtain a signed receipt from the new owner or lessee before the sale or lease is final; and

   c) Provide each resident's legal guardian, representative payee, or other person the resident authorized to manage his personal funds; a written accounting of all funds held by the facility before any transfer of ownership. The new owner or lessee shall assume full liability for all residents' personal needs accounts.

7. The facility must notify the Social Security Administration office to have a representative payee appointed for residents who do not have a legal guardian, representative payee, or other authorized individual to manage their personal needs funds.

8. The facility must serve as a temporary representative payee for the resident until the representative payee is appointed.

9. The facility must give any benefits to the resident either personally or through the resident's personal need fund unless there is a written authorization from the resident or legal guardian to do otherwise. This includes resident entitlements from Social Security Supplemental Income, government and private pensions, Veterans Administration, and other similar entitlement programs.

10. The facility must allow the resident to access his funds for at least one hour during business hours.

11. Upon request, the facility must return funds to the resident from an outside interest-bearing account within one business day.

12. The facility may deposit the resident's Social Security check into the facility's bank account if the resident's personal needs allowance portion of the resident's check is transferred to the resident's account on the same day.

4-7 Limitations on charges to resident personal funds

The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid and not requested by the resident. The facility may not require a resident to request any item or service as a condition of admission or continued stay.

When the resident requests a non-covered item or service for which a charge will be made, the facility must inform the resident that there will be a charge and the amount of the charge. There must be an agreement in writing between the facility and the resident regarding the service and the amount to be paid by the resident prior to the resident receiving the non-covered service. Without written agreement, the facility may not bill the resident. Refer also to SECTION 1, General Information, Chapter 6 - 8, Billing patients, and 6 - 9, Exceptions to billing patients.

1. During the course of a covered Medicaid stay, the facility may not charge a resident for routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to the following:

   a) Hair hygiene supplies;

   b) Comb and brush;

   c) Bath soap;

   d) Disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection;

   e) Razor;

   f) Shaving cream;

   g) Toothbrush;

   h) Toothpaste;

   i) Denture adhesive;

   j) Denture cleanser;

   k) Dental floss;

l) Moisturizing lotion;

m) Tissues;

n) Cotton balls;

o) Cotton swabs;

p) Deodorant;

q) Incontinence care and supplies

r) Sanitary napkins and related supplies;

s) Towels and washcloths;

t) Hospital gowns;

u) Over the counter drugs;

v) Hair and nail hygiene services;

w) Bathing;

x) Basic personal laundry.

2. With written agreement, categories of items and services that the facility may charge to residents' funds if they are requested and if payment is not made by Medicaid, include:

a) Telephone;

b) Television/radio for personal use;

c) Personal comfort items, including smoking materials, notions and novelties, and confections;

d) Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid;

e) Personal clothing;

f) Personal reading matter;

g) Gifts purchased on behalf of a resident;

h) Flowers and plants;

i) Social events and entertainment offered outside the scope of the activities program required by 42 CFR 483.15;

j) Non-covered special care services such as privately hired nurses or aides;

k) Private room, except when therapeutically required (for example, isolation for infection control);

l) Specially prepared or alternative food requested instead of the food generally prepared by the facility, as required by 42 CFR 483.35.

4-8 Privacy act notification statement

Each facility is required to provide a Privacy Act Notification Statement to each new resident at the time of admission. The statement explains the release of certain data about each resident to the Office of Medicare/Medicaid Program Certification and Resident Assessment for data collection and analysis. The required statement follows this chapter of the manual.

Privacy Act Notification Statement

The Centers for Medicare and Medicaid Services (CMS) is authorized to collect these data by Sections 1819(f), 1919(f), 1819(b)(3)(A), and 1864 of the Social Security Act. The purpose of this data collection is to aid in the administration of the survey and certification of Medicare/Medicaid long term care facilities and to study the effectiveness and quality of care given in those facilities. This system will also support regulatory, reimbursement, policy, and research functions. This system will collect the minimum amount of personal data needed to accomplish its stated purpose.

The information collected will be entered into the Long Term Care Minimum Data Set (LTC MDS) system of records, System No. 09-70-1516. Information from this system may be disclosed, under specific circumstances, to: (1) a congressional office from the record of an individual in response to an inquiry from the congressional made at the request of that individual; (2) the Bureau of Census; (3) the Department of Justice; (4) an individual or organization for a research, evaluation, or epidemiological project relating to the prevention of disease of disability, or the restoration of health; (5) contractors working for CMS to carry out Medicare/Medicaid functions, collating or analyzing data, or to detect fraud or abuse; (6) an agency of a State government for purposes of determining, evaluating and/or assessing overall or aggregate cost, effectiveness, and/or quality of health care services provided in the State; (7) another Federal agency to fulfill a requirement of a Federal statute that implements a health benefits program funded in whole or in part with Federal funds or to detect fraud or abuse; (8) Peer Review Organizations to perform Title XI or Title XVIII functions, (9) another entity that makes payment for or oversees administration of health care services for preventing fraud or abuse under specific conditions.

You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

Collection of the Social Security Number is voluntary; however, failure to provide this information may result in the loss of Medicare benefits provided by the nursing

home. The Social Security Number will be used to verify the association of information to the appropriate individual.

4-9 Family income

This chapter provides instructions regarding the amount of family income to be collected by nursing facilities and the submission of family income to the appropriate state agency. There are six subsections in this chapter.

1. Determination of family income
2. Collection of family income
3. Reporting changes in family income
4. Special situations
5. Remitting income to the Office of Recovery Services
6. Definitions

4-9.1 Determination of family income

The Medicaid eligibility worker determines the amount of income the Medicaid client must pay to the facility in order to be eligible for Medicaid. This amount is called family income. When there are questions or information concerning Medicaid patients that may affect the amount of family income, Medicaid eligibility, or the collection of family income, please contact the local Medicaid worker.

It is important to be aware that Medicaid policy states that the eligibility worker must calculate family income based on the gross entitlement amount of the client's income. Sometimes the entitlement amount differs from the amount actually received by the client. In determining family income, the eligibility worker cannot allow a deduction from the entitlement amount for any amounts withheld because of a previous overpayment or court-ordered support payment.

The deduction allowed from the gross entitlement amount varies according to the client's marital status and the length of time the client is expected to stay in the facility.

1. For married clients and long term stay (more than six months) clients, the following deductions apply:
   a) A personal needs allowance of $45.
   b) The $90 VA payment.
   c) Medical insurance premium and income to be sent to the spouse at home.

2. An unmarried client is not expected to contribute as much countable income to the facility if a medical doctor expects the client to stay in the facility for six months or less. The following deductions apply:
   a) Basic maintenance needs allowance. (As of March 1999, the allowance is $382.)
   b) The cost of medical insurance.

4-9.2 Collection of family income

The facility is responsible for collecting the family income amount from the client. This amount is the portion of the cost of care the client must pay to the facility. Since this amount is owed to the facility by the client, a state agency cannot be involved in the collection process.

4-9.3 Reporting changes in family income

The facility, the client, or the client's representative is responsible to report to the Medicaid eligibility worker all changes that may affect the client's contribution to the cost of care within 10 days of the date of the change. This includes, but is not limited to, the amount of income received, medical premiums paid, length of stay, and marital status.

4-9.3.1 Income changes

If a change in income results in an increase in the client's contribution to the cost of care, do not collect the increase. Notify Medicaid eligibility immediately and they will determine what the increased contribution to the cost of care will be and when you should begin to collect it. The change will usually be effective for the next month.

If the client receives a one-time lump sum payment, do not collect it and do not send it to the Office of Recovery Services (ORS). Collect only the

usual amount of family income and contact the Medicaid eligibility worker.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker.

4-9.4 Special situations concerning family income

This subsection addresses collection of family income in the following circumstances:

1. Income between the private pay and Medicaid rates
2. Income above the private pay rate
3. Medicare and Medicaid crossover payments
4. Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization
5. Recipient is discharged, and the family income changes for the month of discharge
6. Short term hospitalization
7. Long term hospitalization

The policy references the form **Sending Family Income to ORS** (Office of Recovery Services). This form is included with this manual and follows this chapter.

If you have questions concerning the collection of family income as explained in this subsection, please contact the Medicaid eligibility worker, or you may call Medicaid Information and ask for the supervisor for Nursing Home Medicaid eligibility workers.

4-9.4.1 Income between the private pay and Medicaid rates

When the family income is more than the Medicaid rate but less than the facility's monthly private pay rate, please take three actions:

1. Collect the family income.
2. Keep enough of the family income to cover the Medicaid rate.

3. Submit the remaining income to Recovery Services with the form **Sending Family Income to ORS**. Mark 1 on the form to indicate the income is between the private pay and Medicaid rate.

4-9.4.2 Income above the private pay rate

If the family income is more than the facility's monthly private pay rate, take two actions:

1. Collect from the resident enough income to cover the family income.

2. Contact the Medicaid eligibility worker. He or she will confer with you to determine if it is in the resident's best interest to seek Medicaid coverage for ancillary services. Please assist the worker in establishing the anticipated cost of ancillary charges and the resident's cost for long term care at the Medicaid rate.

   a) Resident eligible for coverage of ancillary charges.
      i. The Medicaid worker determines the amount of family income owed to the State. (The resident is allowed to keep more than the standard personal needs allowance.)
      ii. The resident must remit the correct amount of income to the Medicaid office before he or she is actually eligible for Medicaid for that month.
      iii. The Medicaid worker will notify you when the resident is eligible for Medicaid to cover ancillary charges only. Once the resident pays the monthly amount owed to the State, Medicaid will cover medical costs other than the nursing facility rate.

   b) Resident NOT eligible for coverage of ancillary charges.
      i. If the resident is no longer eligible for Medicaid, the Medicaid case is closed.
      ii. If the resident does not pay the monthly amount owed to the State, the Medicaid case is closed.
      iii. When the resident is not eligible for Medicaid, the facility may charge the private pay

4-9.4.3 Medicare and Medicaid crossover payments

When Medicare and Medicaid crossover payments cover part of the Medicaid rate and family income covers the remainder of the rate, take two actions:

1. Collect the entire amount of family income amount.
2. Keep enough of the family income amount to cover the remainder of the Medicaid rate.

Submit all remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark line 2 of the form to identify the refund as one which results from Medicare/Medicaid coverage.

When Medicare and Medicaid crossover payments cover all of the Medicaid rate, take these actions:

1. Collect the entire amount of family income.
2. Submit all family income to Recovery Services with the form **Sending Family Income to ORS**.
3. Mark 2 on the form to identify the refund as one which results from Medicare/Medicaid coverage.

4-9.4.4 Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization

When the recipient dies, and the family income amount is greater than the per diem rate for the total days billed, follow these instructions:

1. Collect the entire amount of family income. Please explain to the responsible party that:
   a) There may be bills for medical care other than the nursing facility charge, and all family income must be applied toward payment of these medical costs.
   b) The responsible party may request a refund by contacting the Medicaid eligibility worker. The refund amount will be the family income minus

the costs of all medical care, including the nursing facility charge. Refer to subsection F of this chapter, Refunds of Income Sent to ORS.

c) Of the family income collected, the facility is entitled to keep the product of the per diem rate multiplied by total days billed.

d) Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from death or discharge of the recipient.

2. If the responsible party refuses to pay the entire amount owed, contact the Medicaid worker and report the amount you have collected. If you have collected more than the Medicaid rate, follow the directions in item A above.

4-9.4.5 Recipient is discharged and the family income changes for the month of discharge

If the client is single or has a spouse who is also a resident of a medical institution, the client may be entitled to keep a larger portion of family income for the month of discharge. The Medicaid agency requests that the facility assist in refunding to the client as soon as possible the difference between the original family income collected and the correct amount. The client needs this money to live on during the month of discharge.

1. The facility can help in two ways:

a) Notify Medicaid. You can help by expeditiously notifying the Medicaid worker that the client has left the facility. The Medicaid worker will compute a new family income amount, which may be less than the original amount collected.

b) Make refund.

After the worker tells you the correct family amount, please refund the difference between the original amount collected and the correct amount to the client. Make this refund as soon as possible.

There are two exceptions to the refund process:

i. If refunding income to the client creates a hardship for your facility for any reason, let the Medicaid worker know. The worker can request the refund from the Division of Integrated Healthcare. The Division will correct your nursing facility payroll as necessary.

ii. Any refunds computed for the month of discharge after the month following the month of discharge will be handled through the Division's internal procedures.

2. Family income collected exceeds nursing facility bill

In some cases, after all adjustments are made, the amount collected by the facility will still exceed the amount owed to the facility. If so, take two actions:

a) Of the family income collected, keep the product of the per diem rate multiplied by total days billed.

b) Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 3 on the form to identify the payment as one resulting from the discharge of the client.

4-9.4.6 Short term hospitalization

Short term hospitalization is any month during which the recipient is a resident of a LTC facility, is discharged to a hospital, and then returns or is expected to return to the facility by the end of the next month. The facility should take three actions:

1. Collect the family income.

2. Of the family income collected, the facility is entitled to keep the product of the per diem rate multiplied by the total days billed.

3. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 4 on the form to identify the payment as one resulting from short term hospitalization.

4-9.4.7 Long term hospitalization

Any hospitalization which does not meet the short term definition is long term. In long term hospitalizations, take four actions:

1. Notify the Medicaid worker that the client is in the hospital for a long term stay.
2. Collect the family income amount for the month the client is discharged to the hospital.
3. Calculate and keep the cost of care, which is the product of the per diem rate multiplied by the total days billed.
4. Send the remaining family income to Recovery Services with the form **Sending Family Income to ORS**. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

Family income for subsequent months of hospitalization

Generally, the Medicaid office will collect family income for months after the initial month the client is in the hospital. However, collection can be negotiated between the Medicaid office and the facility. For example, when the facility is the payee for the client, and it is expected that the client will return to the facility, it may be simpler for the facility to continue collecting the family income. During these months, send any family income collected to the local Medicaid office with the form Sending Family Income to ORS. Mark 5 on the form to identify the payment as one resulting from long term hospitalization.

4-9.5 Remitting income to the Office of Recovery Services

When sending family income to Recovery Services, **make checks payable to 'Office of Recovery Services'**. Send the check to the following:

ATTN: Team 85
Department of Health and Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach a copy of the form **Sending Family Income to ORS** to the check. This form appears on the next page. Place an X on the appropriate line to inform ORS of the reason for the refund.

4-9.6 Refunds of income sent to ORS

If the client or family asks for a refund of any family income that has been or should be sent to ORS, instruct them to contact the local Medicaid worker. The only exception to this is found in subsection D - 4 of this chapter (Death of recipient, and family income is greater than the product of the daily Medicaid rate multiplied by the countable days of institutionalization).

UTAH MEDICAID PROGRAM

NURSING HOME PROGRAM

SENDING FAMILY INCOME TO OFFICE OF RECOVERY SERVICES (ORS)

When it is appropriate to submit income to ORS, make checks payable to ORS and send to:

Attention: Team 85
Department of Human Services
Office of Recovery Services, Medicaid Section
P.O. Box 45025
Salt Lake City, Utah 84145-5025

Attach this form to the refund check and identify the reason for the refund by placing an X in the appropriate space.

1. **Income Between the Private Pay and Medicaid Rate**
2. **Medicare and Medicaid Cross-Over Payments**
3. **Recipient Dies or is Discharged and the Family Income is Greater than the Product of the Daily Medicaid Rate Multiplied by the Countable Days of Institutionalization.**
4. **Short Term Hospitalization**
5. **Long Term Hospitalization**

4-10 Nursing facility refunds to Medicaid clients who paid the private pay rate

When a nursing facility resident is or becomes eligible for Medicaid, the resident's financial liability is limited to the monthly client contribution to cost of care required by Medicaid. The client contribution, also called the family income amount, is determined by the Medicaid eligibility worker. The family income amount is stated in the Medicaid notice of eligibility. See also Chapter 4 - 7, Family income.

If the resident has paid or been billed at the private pay rate for the month and then becomes eligible for Medicaid for the same month, the facility may owe the client a refund. The facility must refund to the client the difference between the amount paid and the family income amount. The facility may bill Medicaid for any cost of care not covered by the family income amount.

The facility must refund any excess income paid because it is required to accept the Medicaid reimbursement amount as payment in full. The Medicaid reimbursement is the client's contribution to cost of care *plus* the remainder of the Medicaid per diem payment. Residents eligible for Medicaid must not be billed in excess of the required contribution to cost of care.

5 Preadmission screening and continued stay review

R414-501 of the Utah Administrative Code (UAC) defines the preadmission and continued stay review process.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-501.htm for the most current information relating to this rule.

5-1 Preadmission/continued stay inpatient care transmittal (form 10A)

The Preadmission/Continued Stay Inpatient Care Transmittal (commonly known as Form 10A) is the document used in the nursing preadmission and continued stay approval process. Form 10A contains data elements that will be entered into the computer system and generate the approved level of care. Errors in the completion of Form 10A will result in delay and/or nonpayment of services approved for

payment. Form 10A and instructions are included with this manual as Appendix E.

5-2 Patient/resident release of information

The Patient/Resident Release of Information form is for authorization from the resident, or the responsible party and/or next of kin. The release permits the Resident Assessment Section to review the medical and psycho-social information necessary and to assess care and service needs relating to the proposed placement in the nursing facility or ICF/ID specified in the Form 10A. A copy of this form is on the next page of this manual.

Department of Health and Human Services

Division of Integrated Healthcare

Office of Facility Review

Patient Release of Information

Patient Name _____

I D # _____

Facility Name _____

NPI #_____

PATIENT / RESIDENT Release of Information:

I hereby authorize the release to PATIENT ASSESSMENT SECTION, information relative to my medical and social status for the purpose of assessing my care/service needs in relationship to the proposed placement in the nursing care facility specified in this document.

If placement in a nursing care facility is not recommended at this time, I also authorize the release by PATIENT ASSESSMENT SECTION to other State agencies of pertinent information from my file for the purpose of developing implementing and appropriate alternative placement to meet my medical/social care and service needs.

SIGNATURE_____

Patient/Resident Date

SIGNATURE_____

Next of Kin and/or responsible party (if applicable) Date

5-3 Nursing facility levels of care

R414-502 of the Utah Administrative Code (UAC) defines the levels of care provided in nursing facilities.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-502.htm for the most current information relating to this rule.

5-4 Preadmission screening and annual resident review

R414-503 of the Utah Administrative Code (UAC) implements requirements for the preadmission screening and annual review of nursing facility residents with serious mental illness or for people with intellectual disabilities.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-503.htm for the most current information relating to this rule.

5-5 Preadmission screening and annual resident review identification screen

The Preadmission Screening and Annual Resident Review Identification Screen which follows is the document to be used in the Level I screening process.

STATE OF UTAH

Preadmission Screening and Resident Review

Identification Screening

(Level I – ID Screen)

Utah Department of Health & Human Services

INSTRUCTIONS FOR FILLING OUT ID SCREEN

1. ID SCREEN MUST BE COMPLETED PRIOR TO ADMISSION TO MEDICARE/MEDICAID CERTIFIED NURSING HOME, REGARDLESS OF THE PAYMENT SOURCE.
2. PAGES 4 AND 5 MUST BE READ, AND QUESTIONS ANSWERED *BEFORE* **SECTIONS A** AND **B** ON *PAGE 3* ARE COMPLETED.
3. FILL OUT PAGE 3 THROUGH 5 COMPLETELY, KEEP THIS FORM WITH THE PATIENT'S MEDICAL RECORDS.

IF A PREADMISSION/CONTINUED STAY INPATIENT CARE TRANSMITTAL (10A) FORM IS SENT TO THE RESIDENT ASSESSMENT SECTION FOR MEDICAID REIMBURSEMENT, PLEASE COPY PAGES 3, 4, AND 5, SEND WITH TRANSMITTAL TO:

UTAH DEPARTMENT OF HEALTH RESIDENT ASSESSMENT SECTION 288 NORTH 1460 WEST P.O. BOX 142905 SALT LAKE CITY, UT 84114-2905

IF YOU HAVE QUESTIONS, PLEASE CALL RESIDENT ASSESSMENT DEPT at (801) 538-6158, OR TOLL FREE 1-800-662-4157.

THE LOCAL PASRR OFFICES FOR SMI ASSESSMENTS ARE:

1. Salt Lake, Summit, and Tooele counties: 801-567-3663
2. Box Elder, Cache, Rich, Morgan, and Weber counties: 801-625-3840
3. Wasatch and Utah counties: 801-373-7394
4. Davis County: 801-773-7060
5. Washington County: 435-634-5600
6. Iron County: 435-586-8226
7. Kane, Garfield and Beaver counties: 435-676-8176
8. Carbon, Daggett, Duchesne, Emery, Grand, Juab, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties: 435-6546465.

STATE DIVISION OF MENTAL HEALTH/PASRR SECTION 801-538-9857

STATE DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES/PASRR SECTION FOR PEOPLE WITH INTELLECTUAL DISABILITIES OR DEVELOPMENTAL DISABILITY ASSESSMENTS 801-538-4209

THE LEVEL-1 ID SCREEN WILL BE BASED ON FEDERAL MINIMUM CRITERIA REQUIRED UNDER SECTION 1929(b)(3)(f) OF THE SOCIAL SECURITY ACT AND MUST, AT A MINIMUM, INCLUDE AN EVALUATION OF THE FOLLOWING CRITERIA TO DETERMINE IF THE APPLICANT/RESIDENT HAS A POSSIBLE SERIOUS MENTAL ILLNESS AND/OR INTELLECTUAL DISABILITY/DEVELOPMENTAL DISABILITY.

Revised 10/12

NOTICE OF REFERRAL FOR
PREADMISSION SCREENING RESIDENT REVIEW (PASRR)
LEVEL – II EVALUATION

NAME: _____

SOCIAL SECURITY NUMBER: _____: _____ : _____

This is to inform you and your legal representative that you have received a positive PASRR Level-I identification screen (ID Screen) for the licensed health care professional signing this notice.

A positive Level-I ID Screen indicates you have a diagnosis of mental illness or intellectual disability/developmental disability. This requires a referral for a Level-II evaluation.

When the PASRR Level-I Screen is positive, a PASRR Level-II evaluation must be done prior to admission to a Medicaid certified nursing facility, regardless of the source of payment.

You will be contacted by a representative from either the Division of Mental Health or the Division of Services for People with Disabilities, to arrange for the PASRR Level-II evaluation.

If you have questions regarding this notice, please contact the Level-I ID Screen evaluator.

_____

Signature: Level-I ID Screen Evaluator & Phone Number

_____

Date

cc: Legal Representative

PREADMISSION SCREENING RESIDENT REVIEW
IDENTIFICATION (ID) SCREENING
DOCUMENT NUMBER
- - - - - - - - - - - - - -

Screening Date: _______ / _________ / _________
MM DD YY

Name: _______________________________ Soc. Sec. No.: _____ - ___ - ____

DOB: : _____ / _____ / _____Medicaid #:_________ Medicare #:___________
MM DD YY

Facility: ______________________________ Admission Date: ____ - ___ - ___
MM DD YY

Residence: ____
Address City State Zip

Placement prior to Request for Nursing Facility: ___________________________

Nursing Facility Payment Source: __________________________________

- -

THIS SECCTION TO BE FILLED OUT BY A LICENSED HEALTH PROFESSIONAL: I certify that the above information is true and correct to the best of my knowledge and is adequately documented in the applicant/resident case record.

- -

____

PLEASE PRINT NAME AND TITLE OF PROFESSINOAL

_____ _____ ____/____/____

Signature Title MM DD YY

SECTION A: Current Medical Diagnosis (with ICD-10-CM coding)

1. (-) _____ 4. (-) _____

2. (-) _____ 5. (-) _____

3. (-) _____ 6. (-) _____

SECTION B: Psychiatric Diagnosis (with ICD-10-CM Coding)

1. (-) _____ 2. (-) _____

***THE APPLICANT HAS BOTH A SMI AND MR/DD DIAGNOSIS: YES ( ) NO ( )**

Instructions on page 5 indicate Intellectual Disability/Developmental Disability YES ( ) NO ( )

REFFERED BY PASRR LEVEL-II DATE: ____/____/____

MM DD YY

NAME OF PERSON AND AGENCY CONTACTED: _____

PASRR EXEMTPION/HOSPITAL TRANSFER ONLY: DISCHARGE M.D. HAS CERTIFIED IN WRITING; THE NURSING FACILITY STAY IS ANTICIPATED TO BE LESS THAN 30 DAYS. YES ( ) NO ( )

LEVEL I REVISION DUE TO: _____ DATE: ____/____/____

MM DD YY

SIGNATURE: _____

*Call both Mental Health & MR/DD PASRR Programs

SERIOUS MENTAL ILLNESS
CATEGORIES AND CRITERIA

Schizophrenia and Other Psychotic Disorders
Depression or Bipolar Disorders
Delusional Disorder
Panic or Other Server Anxiety Disorders
Somatization Disorders
Borderline Personality Disorder

THE APPLICANT/RESIDIENT REQUIRES A REFERRAL FOR A PASRR LEVEL-II ASSESSMENT WHEN:

1. THERE IS A CURRENT SMI DIAGNOSIS OR WITHIN THE PAST YEAR, THERE HAVE BEEN SYMPTOMS OF A SERIOUS MENTAL ILLNESS THAT FALL INTO THE ABOVE CATEGORIES, **AND IF ANY** OF THE QUESTIONS BELOW ARE MARKED YES.

2. THIS SMI DIAGNOSIS PREDATES THE ONSET OF ANY ORGANIC MENTAL DISORDER (I.E., CVA, DEMENTIA, MENTAL DISORDER DUE TO A GENERAL MEDICAL CONDITION, ETC.)

   YES_____ NO_____

3. THIS PERSON IS CURRENTLY RECEIVING, OR IN THE PAST YEAR HAS BEEN PRESCRIBED AN ANTIPSYCHOTIC, ANTIDEPRESSANT OR ANTIANXIETY MEDICATION FOR A SMI.

   YES_____ NO_____

COMMENTS: _____

_____

_____

_____

_____

_____

PERSON WITH INTELLECTUAL DISABILITES
DEVELOPMENTAL DISABILITY
CRITERIA

REFER FOR A PASRR LEVEL-II ASSESSMENT IF ANY OF THE FOLLOWING ARE MARKED YES.

THE RESIDENT APPLICANT HAS A DIAGNOSIS OF PERSON WITH INTELLECTUAL DISABILITIES

YES ( ) NO ( )

IF YES, LIST DIAGNOSIS: _____

_____ **OR**

THE RESIDENT/APPLICANT HAS A DIAGNOSIS OF A RELATED CONDITION; I.E., CEREBRAL PALSY, TRAUMATIC BRAIN INJURY, EPILEPSY/SEIZURES, OR AUTISM, (THIS IS NOT AN ALL- INCLUSIVE LIST), OR DEVELOPMENTAL DELAYS, WHICH INCLUDES A HISTORY OF FUNCTIONAL LIMITATIONS RELATED TO THAT CONDITION WHICH:

C. OCCURRED PRIOR TO HIS/HER 22ND BIRTHDAY YES ( ) No ( )
D. IS LIKELY TO CONTINUE THROUGHOUT HIS/HER LIFE YES ( ) No ( )
E. HAS RESULTED IN SIGNIFICANT FUNCTIONAL DEFICITS YES ( ) No ( )

COMMENTS: _____

_____

_____

_____

_____

_____

_____

_____

6 Program certification and resident assessment

6-1 Program survey and certification

Requirements related to program survey and certification are contained in state operations manual transmittals 273, 274 and 277. Copies of these transmittals can be obtained from the Office of Medicare/Medicaid Program Certification and Resident Assessment.

6-2 Alternative remedies for nursing facilities

R414-7C of the Utah Administrative Code (UAC) provides for the imposition of alternative remedies as the result of on-site inspection findings.

Please refer to http://www.rules.utah.gov/publicat/code/r414/r414-07c.htm for the most current information relating to this rule.

6-3 Minimum Data Set (MDS)

All certified Medicare or Medicaid nursing facilities must complete, record, encode and transmit the Minimum Data Set (MDS) for all residents in the facility, regardless of age, diagnosis, length of stay or payment category. MDS requirements do not apply in the following situations:

1. Unless otherwise required by the state, licensed-only nursing facilities that do not participate in either Medicare or Medicaid.

2. Unless otherwise mandated by the state, individuals residing in non-certified units of nursing facilities.

7 Billing and reimbursement

7-1 LTC turnaround document (TAD) replaced by 837 I

Utah Medicaid has replaced the proprietary TAD with the HIPAA compliant 837 Institutional (837I) electronic transmission.

The Utah Medicaid LTC Companion Guide for the 837I can be found here. (For more details about electronic billing see the “EDI with UHIN and Utah Medicaid” article in the January 2006 Medicaid Information Bulletin).

Ancillary services include any services rendered by a medical provider that are not included as part of the nursing facility daily rate. These services must be provided by and billed by the ancillary service provider. The ancillary service provider must be an enrolled Medicaid provider for the services rendered in order to seek reimbursement. Medicaid coverage and criteria are applicable to all ancillary services. See also: Utah State Plan, Attachment 4.19-D; Section 430, Non-Routine Services.

8 Payment rates and cost profiling

8-1 Nursing facility reimbursement

The Utah State Plan, Attachment 4.19-D, provides details concerning nursing facility reimbursement. For details visit the website at http://health.utah.gov/medicaid/stplan/longtermcare.htm.