PART II

POLICIES AND PROCEDURES
for
NURSING FACILITY SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION of MEDICAL ASSISTANCE PLANS

Version Date: October 1, 2026

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Policy Revision Record
from 2025 to Current[1]

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added **D**=Deleted **M**=Modified	(Revision required by Regulation, Legislation, etc.)
10/01/2026	1009.1	From: Effective August 13, 2021, the Division will provide supplemental quality incentive payments to eligible skilled nursing facilities that demonstrate improvement in the quality of care rendered to members. Utilizing calendar year 2020 data as the baseline, nursing facilities that demonstrate improvement in the four categories identified below will be eligible for a supplemental payment. Nursing facilities must demonstrate improvement in at least one or more of the areas noted below to receive the supplemental payment. The supplemental payment will be based on the percentage of improvement ranked by decile for each of the four categories listed below. 1009.1.1. High-Risk Long Stay Residents with pressure ulcers 1009.1.2. Long-stay residents who received an antianxiety or hypnotic medication 1009.1.3. Long-stay residents who received an antipsychotic medication 1009.1.4. Long-stay residents with a urinary tract infection To: Effective August 13, 2021, the Division will provide supplemental quality incentive payments to eligible skilled nursing facilities that demonstrate improvement in the quality of care rendered to members. Utilizing calendar year 2020 data as the baseline, nursing facilities that demonstrate improvement in the **CMS Long Stay Quality Measure identified by the Department no later than September 30th preceding**	M	Clarification

[1] The revisions outlined in this Table are from 2025 to current. For revisions prior to 2025, please see prior versions of the policy.

		the start of the upcoming evaluated calendar year. Nursing facilities must demonstrate improvement in at least one or more of the **CMS Long Stay Quality Measures and have a minimum of 50% Medicaid utilization to receive the supplemental payment.** **The supplemental payment will be based on each nursing facility's overall ranking in each CMS Long Stay Quality Measure resulting in the nursing facility receiving a payment proportional to their improvement (e.g., a facility with the highest improvement will receive the highest supplemental payment for that measure).**		
10/01/2026	1009.2	From: Supplemental payments will be distributed to eligible nursing facilities once per year. For each subsequent year after calendar year 2020, the base year will be adjusted annually to reflect improvement against the prior year. For example, CY2021 would be paid out against improvement against CY2020, CY2022 would be paid out against CY2021, and CY2023 against improvement in CY2022. Only those facilities who demonstrate improvement will be eligible for the add on payment. To: Supplemental payments will be distributed to eligible nursing facilities once per year. For each subsequent year after calendar year 2020, the base year will be adjusted annually to reflect improvement against the prior year. For example, CY2021 would be paid out against improvement against CY2020, CY2022 would be paid out against CY2021, and CY2023 against improvement in CY2022. Only those facilities who demonstrate improvement **in at least one or more of the CMS Long Stay Quality Measures and have a minimum of 50% Medicaid utilization to receive the supplemental payment.**	M	Clarification
07/01/2026	1002.1.9 Definitions	From: Gross Square Footage is the outside measurement of everything under a roof, which is heated and enclosed. When the Division issues the provider a rate under the Fair Rental Value System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage	M	Clarification

		and age of a facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc. To: Gross Square Footage is the outside measurement of everything under a roof, which meets the following criteria: 1. **Fully enclosed;** 2. Heated and/or cooled; **and** **3. Construction of similar material as the nursing facility and permanently affixed to a concrete slab.** **Gross square footage includes common areas, building core, and other areas of the building used for maintenance and operations. All buildings included in gross square footage must be within a reasonable distance (i.e. ¼ mile) to the nursing facility as determined by the Division or its agents. The nursing facility's square footage must be properly documented.** When the Division issues the provider a rate under the Fair Rental Value System, it is a tentative rate based upon the data previously submitted to the Division for verification. The data received on gross square footage and age of the facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.		
07/01/2026	1002.3A	From: Facilities purchased from a party not related to the new owner between January 1, 2012 and June 30, 2014 will have their per diem rates effective July 1, 2015 through June 30, 2021 determined based on the cost of the new owner. Related parties shall be defined to include the following: To: Facilities purchased from a party not related to the new owner between January 1, 2012 and June 30, 2014 will have their per diem rates effective July 1, 2015 through June 30, 2021 determined based on the cost of the new owner. ~~Related parties shall be defined to include the~~	M	Clarification

		~~following:~~		
07/01/2026	1002.5	From: Facilities purchased from a party not related to the new owner between January 1, 2012 and June 30, 2014 will have their per diem rates effective July 1, 2015 through June 30, 2021 determined based on the cost of the new owner. Related parties shall be defined to include the following: 1) Immediate family members including the previous owner's spouse, child, sibling, parent, grandparent, or grandchild. Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and 2) A business corporation, general partnership, limited partnership, limited liability company, joint venture, nonprofit corporation, or any other or profit or not-for-profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner. The new owner's rate effective July 1, 2015 through June 30, 2021 will be determined as follows: To: Facilities purchased from a party not related to the new owner between January 1, 2012 and June 30, 2014 will have their per diem rates effective July 1, 2015 through June 30, 2021 determined based on the cost of the new owner. Related parties shall be defined to include the following: 1002.5.1 Immediate family members including the previous owner's spouse, ex-spouse, child, sibling, parent, grandparent, or grandchild. Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and 1002.5.2 A business corporation, general partnership, limited partnership, limited liability company, joint venture, nonprofit corporation, or any other or profit or not-for-profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner. **1002.5.3 A definition of related party ownership is contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1004) states the existence of an immediate**		

		family relationship will create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests of sections 1002.2 and 1002.3 above are met. Even through a purchase which converts the entity from a proprietary to a nonprofit status, the initial owners maintain the related party status.		
07/01/2026	1002.8.3.2	From: A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. All partial replacements will be treated as renovations and will have their base year adjusted based on the methodology proscribed for a renovation. To: A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation. **A Gut and rebuild must include taking all walls down to the studs (exposing the structural skeleton of the existing building), removing and replacing flooring, existing interior doors and trim, cabinets, sinks, wiring, etc.** All partial replacements **will be treated as renovations which includes cosmetic or structural improvements to a wing or section of the facility (i.e. painting walls, adding nursing stations, new flooring, changing layout of existing floorplan, replacing bathroom fixtures, windows, exterior doors, the roof, and most or all plumbing, and electrical) and** will have their base year adjusted based on the methodology **prescribed** for a renovation. **Parking lots and landscaping costs are not included as allowable construction renovation costs for fair rental value.**	M	Clarification
07/01/2026	1002.8.4	From: A Renovation Construction Project shall mean a capital expenditure (as defined in Section 1002.8.4.1 that exceeds $500 per existing licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8: To: A Renovation Construction Project shall mean a capital expenditure (as defined in Section 1002.8.4.1 that exceeds $500 per existing licensed bed. Applications	M	Clarification

		must be filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8 **for renovation projects for that are requesting complete facility replacement and/or gut rebuild "deemed new" consideration.**		
07/01/2026	Appendix D.G	From: A request for a fair rental value rate increase that is the result of a Renovation Construction Project, bed addition or replacement subsequent to July 1, 2009, must be submitted to the Department after completion of the project. Effective July 1, 2013, the Department will have sixty (60) days to approve or deny any such request. Any corresponding Fair Rental Value rate increase shall take effect at the beginning of the quarter following the quarter in which the request for a Fair Rental Value rate increase is approved by the Department. The request must be completed on the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form. The request must be submitted to: Georgia Department of Community Health, Office of Reimbursement 2 Martin Luther King Jr Dr SE East Tower-17th Floor Atlanta, GA 30334 An electronic version of the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form should also be emailed to FRVS@dch.dch.ga.gov. To: A request for a fair rental value rate **review as a result** of a Renovation Construction Project, bed addition or replacement subsequent to July 1, 2009, must be submitted to the Department after completion of the project **or after each phase of a multi-phase project that will extend beyond a 12-month period (i.e. gut and rebuild).** Effective July 1, 2013, the Department will have sixty (60) days to approve or deny any such request. Any corresponding Fair Rental Value rate increase shall take effect at the beginning of the quarter following the quarter in which the request for a Fair Rental Value rate increase is approved by the Department. The request must be completed on the Initial Start Up And Fair Rental Value System Reimbursement	M	Clarification

		(FRVS) Update Request Form directed to: Georgia Department of Community Health, Office of Reimbursement 2 Martin Luther King Jr Dr SE East Tower-17th Floor Atlanta, GA 30334 An electronic version of the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form should also be emailed to FRVS@dch.ga.gov **along with supporting documentation for the renovation project or bed addition (Nursing Home License, Certificate of Occupancy, Approved County/City Records, Fixed Asset Schedule, Invoices, General Ledger Listing of Invoices/Listing of Invoices, Appraisal, Construction Contract, Blueprints, and Certificate of Need (CON) approval).**		
07/01/2026	1002.2.1.	Add: **For dates of service beginning July 1, 2026, the June 30, 2024, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.**	A	Legislative Update
07/01/2026	1002.2.1.	Changed: For dates of service beginning July 1, 2025, the June 30, 2023, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related. **Moved to 1002.2.2 and changed To:** For dates of service beginning July 1, 2025 **through June 30, 2026** the June 30, 2023, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.	M	Clarification
07/01/2026	1002.2.9	Changed: Effective July 1, 2025, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2023 GL-PL Insurance Supplemental Report. **Moved to 1002.2.10 and changed To:** Effective July 1, 2025 **through June 30, 2026**, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the	M	Clarification

		June 30, 2023 GL-PL Insurance Supplemental Report.		
07/01/2026	1002.2.9	**Add:** **Effective July 1, 2026, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2024 GL-PL Insurance Supplemental Report.**	A	Legislative Update
04/01/2026	1002.8.4	Updated language - A Renovation Construction Project shall mean a capital expenditure (as defined in Section 1002.5 that exceeds $500 per existing licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8: To: A Renovation Construction Project shall mean a capital expenditure (as defined in Section **1002.8.4.1** that exceeds $500 per existing licensed bed and has been filed with the Office of Health Planning as a New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8:	M	Clarification
01/01/2026	Appendix Q, C.2.ii	Updated language - The written request must address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration can must be submitted electronically to nh.appeals@dch.ga.gov. May also be directed to: To: "The written request must be submitted on letterhead and address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration must be submitted electronically to nh.appeals@dch.ga.gov. May also be directed to:	M	Clarification
10/01/2025	1002.9	Corrected reference from "In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 or Section 1002.3, Nursing Facility Manual, …" To "In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 ,Section 1002.3, Section 1002.4, or Section 1002.5 Nursing Facility Manual, ..."	M	Clarification

10/01/2025	1002.1.7.9.2	Added "..used for reimbursement, in accordance with 1002.6.1 and Appendix D, section C(ix)." to clarify when the hospital-based status will be recognized for rate setting.	M	Clarification
07/01/2025	1002	Corrected reference from Appendix I to Appendix Q.	M	Clarification
07/01/2025	1002.1.4	Removed reference to cost center cost report lines because they are referenced in the Uniform Chart of Accounts.	M	Clarification
07/01/2025	1002.1.10	Corrected reference from 1002.6 to 1002.8	M	Clarification
07/01/2025	1002.2.1-1002.2.5	Added "for all cost centers EXCEPT Property and Related" to clarify what cost centers the cost report update applies.	M	Clarification
07/01/2025	1002.2.1	Added effective date July 1, 2025 the 2023 Cost Report will be used for rate setting.	A	Legislation
07/01/2025	1002.2.2	Removed "and thereafter" and added end date "through June 30, 2025. Revised the sentence "The Department will update the Medicaid Cost Report as the basis for the nursing facility reimbursement rate a minimum of every two years "provided budget appropriations."	M	Clarification
07/01/2025	1002.2.3	Removed "and thereafter" and added end date "through June 30, 2024.	M	Clarification
07/01/2025	1002.2.1	Added 2023 Cost Report effective date July 1, 2025	A	Legislation
07/01/2025	1002.3-1002.5	Added "for all cost centers EXCEPT Property and Related" to clarify what cost centers the cost report update applies.	M	Clarification
07/01/2025	1002.2.8.	Added effective date July 1, 2025 the 2023 GL/PL Insurance Supplemental Report will be used for rate setting.	A	Legislation
07/01/2025	1002.2.9	Removed "and thereafter" and added end date "through June 30, 2025.	M	Clarification
07/01/2025	1002.2.13	After this section, deleted "For these facilities the following formulas apply:"	M	Clarification
07/01/2025	1002.3.2.1-1002.3.2.3	Added "a growth allowance" summation …..	M	Clarification
07/01/2025	1002.3.3	Added reference 1002.4.12 for additional Efficiency details.	M	Clarification
07/01/2025	1002.4	Revised sentence "Further explanation of the reimbursement formula terms is included below"	M	Clarification
07/01/2025	1002.4.2	Corrected reference from Appendix I to Appendix Q. Corrected reference from 1002.5 to 1002.8	M	Clarification
07/01/2025	1004.4.1	Added "the audited" historical…. Deleted "The example below shows the treatment of	M	Clarification

		these costs”		
07/01/2025	1004.4.2 – 1004.4.5	Added “the audited” historical…. Deleted Cost Report Line references.	M	Clarification
07/01/2025	1002.4.4.7	Added “Taxes and Insurance Net Per Diem is the audited historical Taxes and Insurance Costs.	M	Clarification
07/01/2025	1002.4.5	Deleted “Property and Related” and replaced with “Taxes and Insurance”	M	Clarification
07/01/2025	1002.5	Change last sentence to reflect “Related parties shall be defined “as including the following:”.	M	Clarification
07/01/2025	1002.5.5 and 1002.5.6	Change “as a result of” to “because of”.	M	Clarification
07/01/2025	1002.6.3	Change reference from “Section 1002.5(a) through (g) to 1002.8.	M	Clarification
07/01/2025	1002.6.4.	Change reference from Appendix I to Appendix Q.	M	Clarification
07/01/2025	1002.7.1	Added sentence “The Department will use the most current data available to determine the ad-on percentage.”	M	Clarification
07/01/2025	1002.7.1.2	Delete “For the most recent quarter for which MDS information is available.”	M	Clarification
07/01/2025	1002.7.2	Change sentence to reflect: “A quality add-on adjustment may be added….”	M	Clarification
07/01/2025	1002.7.2.2	Vendor name change – change MyInnerView to NCR.	M	Clarification
07/01/2025	1002.7.2.2	Vendor updated quality measures they extract from CMS: Change “Chronic Care Pain – Residents “with” unplanned weight loss/gain” Remove “PAC Pain – Residents without antipsychotic medication use” Change “High Risk Pressure Ulcer – Residents “with” acquired pressure ulcers.” Change Physical Restraints – Residents “with” acquired restraints” Remove “Low Risk Pressure Ulcer – Residents without acquired catheters”	M	Clarification
07/01/2025	1002.8.2.1.1	Updated to July 1, 2025 value per square foot for 2023 RSMeans is $244.83.	A	Legislation
07/01/2025	1002.8.2.4	Update reference from 1003.4 to 1002.8.5.	M	Clarification
07/01/2025	1002.8.2.7	Update refence from 2001 to 2003. Add reference Appendix D-Exhibit 3.	M	Clarification

07/01/2025	1002.8.4	Update reference from 1002.5(4a) to 1002.8	M	Clarification
07/01/2025	1002.8.4.1	Change reference from 1003.3 to 1002.8.4	M	Clarification
07/01/2025	1002.8.5.1	Change 2023 to 2025.	M	Clarification
07/01/2025	1002.8.5.2	Change 2023 to 2025. Update reference from 1002.5(3a) to 1002.8	M	Clarification
07/01/2025	1002.8.5.3	Update reference from 1002,5(3a) to 1002.8.3	M	Clarification
07/01/2025	1002.8.5.4	Add reference Appendix D-Exhibit 4.	M	Clarification
07/01/2025	1002.8.6	Update reference from 1002.5(4a) to 1002.8.3.2	M	Clarification
07/01/2025	1002.8.6.1	Change "complete date" to "completion date"	M	Clarification
07/01/2025	1002.8.6.4	Add reference Appendix D-Exhibit 5.	M	Clarification
07/01/2025	1009.1	Change delete "in order" in the last sentence.	M	Clarification
07/01/2025	1003	Update reference from 1002.4 to 1002.7	M	Clarification
07/01/2025	Appendix D.B(i)	Update reference in 2nd paragraph from Section 2.b and 2.g to Section C(2) and C(6).	M	Clarification
07/01/2025	Appendix D.C(i)	Update reference from 2(d) below to Appendix D.C.(iv).	M	Clarification
07/01/2025	Appendix D.C(vii)	Update reference from Appendix I to Appendix Q.	M	Clarification
07/01/2025	Appendix D.C(xi)	Update reference from "i above" to "x above".	M	Clarification
07/01/2025	Appendix D.E.(ii)	Change RUG to Patient Driven Payment Model (PDPM). Change RUG to PDPM. Delete "Version 5.12, with 34-grouper and index maximizer".	M	Clarification
07/01/2025	Appendix D.E(iii)	Update reference from D.4(a) to Appendix D.E(i)	M	Clarification
07/01/2025	Appendix D.E.(iv)	Update reference from Exhibit D-1 to Appendix D – Exhibit 1. Change RUG to PDPM.	M	Clarification
07/01/2025	Appendix D.E.(v)	Update reference from Exhibit D-1 to Appendix D – Exhibit 1. Change RUG to PDPM.	M	Clarification
07/01/2025	Appendix D.7	Delete section referencing Temporary COVID-19 Disaster Relief Interim Payments to Nursing Facilities as directed by CMS because the Public Health Emergency (PHE) was temporary.	M	Clarification
07/01/2025	Appendix D.G	Update the 2nd paragraph last sentence to say "The request must be submitted electronically FRVS@dch.ga.gov. The documentation may also be submitted to:"	M	Clarification
07/01/2025	Exhibit D-1	Updated to Appendix D – Exhibit 1	M	Clarification

07/01/2025	Exhibit D-2	Updated to Appendix D – Exhibit 2	M	Clarification
07/01/2025	Exhibit D-3	Delete section referencing Letter of Agreement related advance payments as directed by CMS because the Public Health Emergency (PHE) was temporary.	M	Clarification
07/01/2025	Appendix D – Exhibit 3	Add table reflecting Example Calculation of Initial Fair Rental Value Per Diem	M	Clarification
07/01/2025	Appendix D – Exhibit 4	Add table reflecting Example Calculation of the Impact of Added Beds on a Nursing Facility's Base Year	M	Clarification
07/01/2025	Appendix D – Exhibit 5	Add table reflecting Example Calculation of the Impact of Renovation on a Nursing Facility's Base Year	M	Clarification
07/01/2025	Appendix Q.B	Updated Department of Community Health for the Policy Specialist to 2 Marttin Luther King Jr. Drive, SE, East Tower – 19th Floor, Atlanta, Ga. 30334	M	Clarification
07/01/2025	Appendix Q.C	In 2nd paragraph, update the reference from (a) – (c) below to below.	M	Clarification
07/01/2025	Appendix Q.C(ii)	Revise sentence to say "Requests for reconciliation "must be submitted electronically" to nh.appeals@dch.ga.gov. "May also be" directed to…	M	Clarification
07/01/2025	Appendix Q.D(i)2	Update reference from 106.8 to 107.	M	Clarification
04/01/2025	Appendix J, K & M	Deleted Georgia Families, Georgia Families 360 and Non-Emergency Medical Transportation (NEMT) Appendices.	D	N/A
04/01/2025	Appendix U	Added comprehensive appendix which includes links to the websites providing information on Georgia Families, Georgia Families 360 and NEMT.	A	N/A
04/01/2026	1002.8.4	Update reference from 1002.5 to 1002.8.4.1	M	Clarification

Nursing Facility Service
Chapter 600: Special Conditions of Participation

601. Certification from the Department of Community Health

In order for a facility to participate in the Medicaid program, the following information must be provided:

601.1. Certification that the facility is in compliance with the requirements for participation, the period of time covered by the certification, and any specific conditions pertaining to the certification. Certification requirements are found in the Code of Federal Regulations (CFR) at 42 CFR, Section 483.

601.2. License number and effective date of license to operate a nursing facility or an intermediate care facility for the intellectually disabled. Licensure requirements are found in Georgia Administrative Code, specifically Chapter 111-8, which covers Healthcare Facility Regulation.

601.3. Verification that the entire facility is certified to participate in the Medicaid program.

601.3.1. Facility Classification

Facilities participating in the Program may be certified as Nursing Facilities (NFs) or ICFs/ID. All NFs and ICFs/ID must meet the conditions as set forth in the Code of Federal Regulations (CFR), Title 42, Part 483.

601.3.2. Nursing Facilities must:

601.3.2.1. Have a governing body which is responsible for the overall conduct of the facility and for compliance with pertinent laws and regulations;

601.3.2.2. Be under the supervision of an appropriately licensed administrator;

601.3.2.3. Fully disclose ownership and make known to the State corporate officers and others owning ten percent or more of the ownership

601.3.2.4. Satisfy fire, safety, sanitation and health requirements;

601.3.2.5. Have a written transfer agreement in effect with one or more hospitals or nursing homes, as appropriate, to assure prompt transfer of care when needed;

601.3.2.6. Be operated according to policies established by DCH;

601.3.2.7. Maintain separate personnel folder for each employee containing all personal information; application and qualifications for employment; physical examination and job title assigned;

601.3.2.8. Provide social services by on-staff caseworkers or through arrangements with an appropriate outside agency;

601.3.2.9. Comply with State and Federal laws and regulations in providing pharmacy services and in handling patient medication;

601.3.2.10. Provide care to each patient/resident according to need and the individual plan of care;

601.3.2.11. Have an effective microbial and infection control program;

601.3.2.12. Use restraint and/or forcible seclusion only on a signed physician order except in emergency and then only until a physician can be consulted;

601.3.2.13. Maintain medical and health records for each patient/resident according to accepted professional standards and practices;

601.3.2.14. Provide patient activities according to the needs and interests of patients/residents;

601.3.2.15. Be constructed, equipped and maintained to protect the health and safety of patients, personnel and the public and be accessible to and functional for the physically handicapped;

601.3.2.16. Have a written, acceptable disaster plan.

602. Enrollment

602.1. Medicare Certification is required for nursing facilities in the State of Georgia. Facilities must be enrolled as a Medicare provider, as a condition of enrollment in the Georgia Medicaid Program.

Note: In emergency situations, the Department of Community Health may make exceptions to the out-of-state provider enrollment policy as noted in Part I, Chapter 100, Section 105.1 c). An example would be if it is determined a Georgia Medicaid member requires immediate/urgent/sustained care and transport back to Georgia is not medically advised.

An exception is predicated on sufficient documentation to justify care when supported by a timely request. Please know timeliness is critical given authorization and claims processing protocols.

602.2. For billing, please refer to section 1000, which provides that Medicare must be billed first for all Medicare-eligible members.

602.3. Facilities must maintain a valid provider Medicaid application on file with the Department of Community Health to be reimbursed under this program. The type of facility certified by the DHS must be noted on the nursing facility permit.

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

602.4.1. Enrollment for facilities is subject to the following conditions:

602.4.1.1. The maximum time limitations for agreements with facilities certified under Medicare (Title XVIII) shall be in accordance with the period of time prescribed by the Secretary of Health and Human Services (HHS).

602.4.1.2. The maximum time limitations for the agreements with nursing facilities and intermediate care facilities for the intellectually disabled shall be in accordance with the period of time prescribed by the DHSR.

602.4.1.3. Any enrolled provider that undergoes a change (including, but not limited to, lease, dissolution, incorporation, reincorporation, reorganization, change in

ownership of assets, merger or joint venture), so that as a result, the provider either becomes a different legal entity or is replaced in the program by another provider, must give the Division at least ten days prior written notice. The successor provider simultaneously must submit a new enrollment application that includes an executed Statement of Participation to become effective at the time of the above-described change. Failure of the successor to submit a new application package will prevent the Division from reimbursing services as of the date of change (see Part I Section 104 of the Policies and Procedures for Medicaid/PeachCare Manual {the Manual}). A provider that undergoes a change of ownership but does not become a different legal entity must execute a new enrollment application and must notify the Division in writing of the change in ownership in accordance with all pertinent requirements.

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

602.4.1.5. Only when there is a Change of Ownership (CHOW) can a new owner of a Nursing Facility have the Loss of Nurse Aide Training Program (NATP) status removed.

602.4.1.6. The Official Code of Georgia Annotated (OCGA), Section 31-6-45.2 provides for a monetary penalty when a proposed or existing facility that obtained a certificate of need (CON), based in part on assurances that it will participate as a provider of medical assistance, terminates it participation in the Medicaid program. The monetary penalty amount is the difference between the Medicaid covered services the facility agreed to provide in its CON application and the amount actually provided. The monetary penalty shall begin upon notification that a facility has terminated participation in the Medicaid program. The penalty shall be levied and collected on an annual basis for each year that the facility fails to participate.

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

602.4.1.8. The proposed or existing facility's CON application was approved by the planning agency prior to April 6, 1992,

or the planning agency's approval of such application was under appeal on or after April 6, 1992, and ultimately affirmed; the facility's participation as a provider of medical assistance is terminated by the state or federal governments; the facility establishes good cause for terminating its participation as a provider of medical assistance and gives 30 days written notice.

602.4.1.9. When a facility voluntarily terminates participation in the Medicaid program, OCGA Section 49-4-146.2 provides that the facility develops a resident transfer plan and assist in relocation efforts. A nursing facility may voluntarily terminate participation in the program by giving 60 days written notice to the Division and complying with the following requirements:

Note: Provide the residents or their representatives with a contact name and information regarding appropriate facilities for replacement. Contact identified facilities on behalf of the residents. Develop a transfer plan for each resident addressing the resident's individual needs. Make arrangements for the safe and orderly transfer of residents. Provide counseling to residents or their representatives regarding available community resources and appropriate state or social service organizations.

Enter into a limited provider agreement and continue to serve Medicaid eligible residents during the period of time from notice of termination through Decertification. Decertification occurs at such time when no Medicaid eligible residents reside in the facility. A facility may voluntarily terminate upon 60 days written notice to the Division. The notice should include the reason for termination; the names and Medicaid numbers of all eligible residents; the names of residents with pending Medicaid applications along with names of authorized representatives; copies of notices the facility intends to provide to residents and any other information deemed necessary to process the termination.

603. Conditions of Participation

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

603.1. Medicaid Payment

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

603.1.2. The facility will not contact Medicaid recipients for the purpose of soliciting requests for the facility's services. Providers of nursing care, who meet conditions of participation in the Georgia Medicaid Program, are not prohibited from displaying Medicaid Approval in directories and brochures outlining services of the facility. However, all such facility advertisements shall contain the following statement: "By its approval, the Georgia Medicaid program does not guarantee either:

603.1.2.1. that the quality of service offered in this facility is superior to that offered by other facilities, or (2) that all of the costs of care in this facility will be paid by Medicaid. Federal law provides that Medicaid recipients shall have freedom of choice among nursing facilities.

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

603.2. Certification and Re-certification for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID)

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

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

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

603.3. Bed Registry

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

603.4. Admission Preferences

603.4.1. As enrolled providers in the Medicaid program, facilities are expressly prohibited by federal law from discriminating on the basis of handicap, history or condition of mental or physical disease or disability (including patients infected with the HIV Virus), race, color, or national origin. Giving preference in admissions to prospective private-pay residents over Medicaid recipients for any of the above reasons constitutes a violation of these prohibitions and subjects' facilities to civil fines as well as programmatic sanctions such as termination from the Medicaid program. Providers may not designate a certain number of beds as Medicaid only beds.

603.4.2. If a facility is certified for enrollment in Medicaid, then all of its bed is certified for us by Medicaid recipients including dually eligible Medicare/Medicaid recipients; there is no such thing as "limited certification." As long as any bed designated for a prospective Medicaid recipient is unoccupied, a Medicaid enrolled facility may not refuse that bed to a recipient on the grounds that it is not certified as a Medicaid bed. Making the bed unavailable on such grounds will subject the facility to the same programmatic sanctions that apply in cases of discrimination on the basis of handicap or other conditions as stated above. A Medicaid nursing facility can however, designate a portion of their beds as MEDICARE only beds when following the Healthcare Facility Regulation Division licensure process.

603.5. Private-Pay Duration-of-Stay Agreements

603.5.1. Providers may not engage in the practice of having prospective residents sign documents in which the prospective resident agrees to reside as a private-pay resident at the facility for a specified minimum period of time prior to becoming a Medicaid-pay resident. In some cases, the prospective resident is already Medicaid-eligible; in others, an application for eligibility is either pending or is to be held in abeyance until a later date. Here a prospective resident is already Medicaid-eligible, all such agreements are illegal and unenforceable under federal law and subject the facility to criminal prosecution and fines of up to $25,000 plus imprisonment for up to five years. The law states that: Whoever knowingly and willfully

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

603.5.1.2. As a precondition of admitting a patient to a hospital, nursing facility or intermediate care facility for the intellectually disabled, or as a requirement for a patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a

felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both. [42 U.S.C. Section 1320a-7b(d)] In the cases in which a prospective resident is not already Medicaid eligible, such an agreement is unenforceable as soon as the resident becomes Medicaid eligible. At that time, the facility must convert the resident's status from private pay to Medicaid immediately and return the balance of any and all fees paid by or for the recipient. The facility may not in any way solicit, encourage, or coerce any prospective recipient in delaying or abstaining from applying for Medicaid. This means that facilities are also prohibited from arranging private-pay agreements without fully disclosing to prospective residents their right to apply for and obtain Medicaid coverage at their earliest convenience. [See also OCGA 10-1-421; DHS Rule 290-5-39-03.] [Part I, 106.17.]

603.6. Responsible Party Agreements

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

Facilities must accept Medicaid's payment as payment in full for covered services, even if that payment is zero for a specific service.

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

604. Program Requirements for Participation

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

604.1. ICF/IID Onsite Review

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

604.1.2. Following an on-site visit, the contractor will forward a report of its

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

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

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

604.2. Intermediate Sanctions

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

604.2.1.1. DCH is the State agency overseeing survey responsibilities, which includes certification, enforcement for compliancy, and remedy recommendations to CMS. CMS may impose Remedies subsequent to DCH recommendations such as a Civil Monetary Penalty (CMP) and may initiate other adverse actions or enforcement remedies to the facility.

604.2.2. DCH may impose the following Remedies:

604.2.2.1. A facility's loss of Nurse Aide Training Program

604.2.2.2. CMP

604.2.2.3. Mandatory Denial of Payment for New Admissions (DPNA)

604.2.2.4. Appointment of Temporary Management

604.2.2.5. State Monitoring

604.2.2.6. Mandatory or in Emergency Cases Termination/Closure of the facility and/or transfer of residents

604.2.2.7. The State provides notification to the facility when taking an enforcement action in accordance with 42CFR488.402

604.2.3. Advanced Directives

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

604.3. Resident Assessment Instrument

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

604.4. Nurse Aide Training and Competency Evaluation Program

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

604.4.2. The Contractor will maintain a registry of certified nurse aids. The registry is sufficiently accessible to the public and health care providers. You may access the registry by calling 678-527-3010 or 1-800-414-4358. The registry is also WEB accessible at www.mmis.georgia.gov. For adverse findings and certification status, go to the "Nurse Aide/Medication Aide Tab". This tab will allow the public/providers to view links related to nurse/medication aides and to search for a nurse aide by entering certain search criteria.

Note: The website does not provide a printed list of all nurse aides on the

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

604.5. Dining Assistants Program

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

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

604.5.3. Dining assistants shall have certification of successful completion of all work under the direct supervision of a registered nurse or a licensed practical nurse. Direct supervision means that the registered nurse or licensed practical nurse is present in the same room and available to respond to the need for assistance. a. The registered nurse directing the training program must certify successful completion by a dining assistant of the required training program. At a minimum, the certification must include the dining assistant's name and address, the nursing home's name and address, the name and signature of the registered nurse, and the date.

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

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

604.5.4.2. A copy of the nursing home's Dining Assistant Training Program

604.5.4.3. Documentation of successful completion of the training program for each dining assistant.

Note: Dining assistants are intended to supplement, not replace, existing nursing staff requirements and as such are not considered nursing staff and are not to be included in computing the required minimum hours of direct nursing care. See DHS Rules and Regulations for Nursing Homes (Chapter 111-8-56-.25) for complete Regulations.

605. Pre-Payments or Deposits

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

605.1.1. Eligible Recipient

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

605.1.2. Individuals with Eligibility Pending

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

606. Free Will Contributions

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

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

606.1.1. The name of the person making the contribution;

606.1.2. The amount of the contribution;

606.1.3. Whether the contribution was “restricted” or “unrestricted”. “Restricted” contributions are funds, cash or otherwise, which must be used only for a specific purpose designated by the donor. “Unrestricted” contributions are funds, cash or otherwise, which are given to a provider without restrictions by the donor;

606.1.4. The list of all contributions received in the prior calendar month must be approved by the administrator of the facility and submitted to the Division. 606.2 Audit and completion of payment of the claims will be delayed if the listing of contributors is not attached to, or there is no

certification for, contributions included with faxed information or indicated on the certification sheet if the provider bills electronically.

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

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

607. Reporting Interest on Recipient Funds

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

608. Freedom of Choice, see 42 CFR 431.51

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

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

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

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

609. Required Nursing Hours

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

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

610. Program for Licensing Nursing Home Administrators

The Georgia Board of Nursing Home Administrators manages the licensing of nursing home administrators and to ensure quality administration and sound management of nursing homes. The Board also administers an administrator-in-training program.

611. Records

611.1. It is the responsibility of all Georgia Department of Community Health (DCH) enrolled providers to ensure the health records of Medicaid members are documented accurately and maintained in compliance with both state, federal and national laws. Providers are responsible for being aware of record keeping requirements as outlined by the Centers for Medicare & Medicaid Services (CMS), Georgia DCH, other program affiliated associations and Health Insurance Portability and Accountability Act (HIPAA) guidelines. The Georgia DCH recommends the following record keeping guidelines. These recommendations should be considered basic - a minimum standard for each provider's practice. It is not inclusive of all record keeping requirements and providers will be responsible for any additional documentation requested in the event of audits. Records should include:

611.2. DCH's current regulations require a Comprehensive Care Plan. This Comprehensive Care Plan must be completed for all residents and must include any requirements for behavioral health or all other specialized services. There is a requirement that the facility not only include the provision of the recommended services in the Comprehensive Care Plan, in addition, the facility must also address the need for services, if applicable, in the baseline care plan on admission to the facility.

611.3. Within the plan of care each recommendation will identify the resident's needs and wishes and the disciplines within the team and outside agencies that will be responsible for overseeing that the plan is implemented. Also, it is to provide guidance to all staff members on how to consistently deliver the recommendations within the Comprehensive Care Plan. A complete medical file on each patient containing sufficient information to validate the diagnosis and to establish the basis upon which treatment is given. A care plan that includes clear and specific coordination with all providers involved in the treatment of the individual. It should include (but not be limited to) individualized expectations, prescribed services, service frequency, scope and duration and goals to be achieved.

611.4. Procedures for Medicaid/PeachCare for Kids, Section106, General Conditions of Participation.

611.4.1. Progress notes that are legible, detailed, complete, signed and dated.

611.4.2. All documentation requiring signatures must be legible, original and belong to the person

611.4.3. If corrections are needed, they should be made by striking one line through the error, writing the correction, and including the initials of the

person making the correction along with the date the correction is made. White-out cannot be used for corrections.

611.4.4. Records should be documented in 'real time' and should not be backdated.

611.4.4.1. At a minimum, member records should include but not be limited to the following:

611.4.4.1.1. Individual's name and/or other information related to their identification (SS#, Medicaid ID, etc…)

611.4.4.1.2. Date and time of admission

611.4.4.1.3. Admitting Diagnosis

611.4.4.1.4. Verified Diagnosis

611.4.4.1.5. The name, address and telephone number of the responsible party to contact in an Emergency

611.4.4.1.6. Appropriate authorizations and consents for medical procedures

611.4.4.1.7. Medical necessity of the service being provided

611.4.4.1.8. Results of testing and/or assessments

611.4.4.1.9. Records or reports from previous or other current providers, including previous assessments

611.4.4.1.10. Documented correlation between assessed need and care plan

611.4.4.1.11. Documentation of treatment that supports billing

611.4.4.1.12. Financial and insurance information

611.4.4.1.13. Pertinent medical information;

611.4.4.1.14. Physicians' progress notes

611.4.4.1.15. Nurses' notes

611.4.4.1.16. Practitioner and case management notes

611.4.4.1.17. Clear evidence that the services billed

are the services provided

611.4.4.1.18. Treatment and medication orders

611.4.4.1.19. Date and time of discharge or death

611.4.4.1.20. Condition on discharge

Chapter 700: Eligibility Conditions

701. Eligibility Criteria

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

701.2. Should a recipient leave a nursing facility to return home, the higher income limit would no longer apply, and only the basic eligibility criteria would be used to determine continued eligibility for Medical Assistance. In addition, nursing facility applicants must complete the prior approval/admissions procedures and community care assessment described in Section 800 of the manual.

702. Spousal Impoverishment

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

703. Transfer of Resources

703.1. The Department complies with the provisions of State and Federal law with respect to transfer of resources. Disposal of resources for less than fair market value will affect eligibility for certain services, except in those instances where the Department determines that the transfer rules would work an undue hardship. Such transfers may result in denial of certain Medicaid services and/or a period of ineligibility for payment of nursing home and home and community-based services.

703.2. Institutionalized individuals, and the spouses of such individuals, who transfer nonexempt assets or dispose of assets for less than fair market value will be subject to a "penalty period" of ineligibility. In order to determine if a transfer of assets occurred, the Department will look-back over a period of time, as specified under federal law, to find non-exempt transfers of assets. If a non-exempt transfer of assets occurred during the look-back period, a penalty period of ineligibility will be assessed. Each transfer is assigned its own penalty period. In instances wherein multiple transfers occurred, consecutive penalty periods of ineligibility will occur. Nursing Facilities should not attempt to submit claims for residents during a Transfer of Resources period (between the TOR begin and end date as indicated on the member's file).

703.2.1. The Department will deny payment to institutionalized individuals for the following services:

703.2.1.1. Nursing facility services;

703.2.1.2. Nursing facility level of care provided in a medical institution;

703.2.1.3. Home and community-based services under a 1915(c) or (d) waiver.

703.3. The beginning date of each penalty period imposed for an uncompensated transfer of assets is the first day of the month in which the asset was transferred. The number of months of ineligibility shall be equal to the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date, divided by the average monthly cost to a private patient of nursing facility services in the State at the time of application.

703.4. The agency does not impose a penalty period for transferring assets for less than fair market value in those instances in which the agency determines that such an imposition would work an undue hardship. An undue hardship occurs if imposing a penalty period would deprive the individual of the following:

703.4.1. Medical care such that the individual's health or life would be endangered; or

703.4.2. Food, clothing, shelter, or other necessities of life.

703.4.2.1. The procedures for a hardship waiver include the following:

703.4.2.2. Notice to the recipient subject to the penalty, that an undue hardship exception exists;

703.4.2.3. A timely process for determining whether an undue hardship waiver will be granted; and

703.4.2.4. A process, which is described in the notice, under which an adverse determination may be appealed. (See 42

U.S.C. § 1396p(c); Georgia State Plan under Title XIX of the Social Security Act)

Note: See 42 U.S.C. § 1396p(c); Georgia State Plan under Title XIX of the Social Security Act

Chapter 800: Prior Approval/Admission Procedures and Community Care Assessment

801. General

All individuals seeking nursing facility admission must have pre-admission screening for mental illness and intellectual disabilities. A physician will sign a DMA-6 or a *Pediatric DMA-6A [Pediatric form for individuals 18 years of age or under] for those who seek Medicaid payment for nursing facility services. The DMA-6 will serve as authorization by the physician that the resident meets the "nursing facility level of care". See minimal requirements page VIII-3 for applicants 19 years of age and older and VIII-4 for the minimal requirements for individuals age of 18 years of age and under. The DMA-6 must be kept in the resident's file in the nursing facility. Nursing facility staff will complete the Minimum Data Set (MDS) within fourteen (14) days of admission. Nursing facility staff will also continue to complete MDS documentation as required by the federal mandate.

All nursing facility admissions are prefaced on the completion of the DMA-6 Level of Care signed by a physician and a Pre-Admission Screening and Resident Review DMA-613 (described below). The only exception to this rule is in instances of emergency placement by the State Adult Protective Services office. In these instances, the DMA-6 requirement may be waived for 72 hours.

If at the initial MDS assessment or any time during the admission, the resident no longer meets a nursing facility level of care, the nursing facility must initiate the discharge process. All admissions will be considered permanent until the resident no longer meets a nursing facility level of care. Each nursing facility is responsible for making that decision. Additionally, all individuals seeking nursing facility admission must be given information on options for Home and Community-Based services (see Section 802). Individuals seeking Medicaid payments for services in an Intermediate Care Facility for the Intellectually Disabled (ICF/IID) must receive prior approval for the services from the Long-Term Care Contactor. These individuals must have an evaluation of continued need of care once per year.

802. Pre-Admission/Prior Approval Procedures for Nursing Facilities

Pre-admission screening (PAS), DMA-613, Level I assessment is mandatory for all individuals seeking admission to a nursing facility, regardless of payment source. Preadmission screening procedures must be completed at the time a facility enrolls with the Division as a Medicaid provider

for all individuals residing in the facility on the enrollment date. The pre-screening may proceed to further assessment (Level II) to determine if the resident may be appropriately admitted into a nursing facility.

802.1. a Pre-Admission Screening and Resident Review (PASRR) for all residents including hospice and private pay applicants must be performed to determine if there are indicators of mental illness and/or intellectual disabilities. All nursing facilities must ensure that a person does not require Level II screening before any applicant is admitted to a nursing facility. The completion of the Level I/Level II screening process is mandatory to receive the issued Prior Authorization (PA) number which can be entered on claim for Medicaid reimbursement. Authorization must be received and remain in member's file. The DMA-6 or P6A and the DMA-613 are the forms that are required for nursing facility admission.

802.2. The form DMA-6 (Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Intellectually Disabled) (see Appendix E) or the P6A (see Appendix F) must be completed and signed by the physician). The dated signature of a physician on the DMA6 or P6A must not exceed thirty (30) days prior to the DMA-613 pre-authorization (see 801.1) of a resident. It is the responsibility of the nursing facility to secure the signed DMA-6 or P6A and the DMA-613 prior to admission. The forms are kept on file in resident's permanent chart in the facility. If the resident is transferred to another facility, the original DMA-613 should go with the resident and a copy kept on file. (Rev. 01/2014)

802.3. A new DMA-6 or P6A is not necessary if the resident is transferred from the facility's Medicaid Program into the Hospice Program. (This is considered a status change; however, only the DMA-59 is to be completed. (A DMA-59 is required to report status change to DFCS/LTC Unit. See 801.3). See 801.3). A new DMA-613 is not necessary. If the resident is discharged with anticipated return (returns after hospital, annual leave, or private bed hold without a DMA-59 discharge), the resident is considered a readmission; the admission process does not need to be repeated. A new DMA-6 or P6A or DMA-613 is not required. (A DMA-59 is required to report status change to DFCS/LTC Unit. See 8013.3).

802.4. If a resident is discharged from the nursing facility without anticipated return, but there is no "break in service" because the resident does not return "home", a new DMA-613 is not necessary if there has been no new mental health diagnosis or hospitalization for behavior management. For example: The family does not hold the bed after seven days of the resident's admission to the hospital or the resident is transferred to another nursing facility but later returns to the same nursing facility placement after the resident was previously discharged by a DMA-59 sent to DFCS/LTC Unit, the admission process s tarts over with a new DMA-6 and a new DMA-59. The initial DMA-613 pre-authorization continues to be valid. If the resident has returned home, a "break in service", a new DMA-613 is required.

802.5. The minimal requirements to qualify for a nursing facility level of care are on the following six (6) pages and you may also use this Web shortcut for the pediatric minimal requirements: http://dch.georgia.gov/vgn/images/portal/cit_121.21.38.31946825Katie_LOC.pdf The minimal requirements for an applicant to qualify for a nursing facility level of care:

803. Level of Care Criteria

803.1. Intermediate care services may be provided to an individual with a stable medical condition requiring intermittent skilled nursing services under the direction of a licensed physician (Column A Medical Status) AND a mental or functional impairment that would prevent self-execution of the required nursing care (Column B and C Mental Status, Functional Status).

803.2. Special attention should be given to cases where psychiatric treatment is involved. A patient is not considered appropriate for intermediate care services when the primary diagnosis or the primary needs of the patient are psychiatric rather than medical. This individual must also have medical care needs that meet the criteria for intermediate care facility placement. In some cases, a patient suffering from mental illness may need the type of services which constitute intermediate care because the mental condition is secondary to another more acute medical disorder.

803.3. Requirements: Number one (1) and one other condition from 2-8, must exist from Column A (medical status), one from Column B (mental status) or C (functional status) with the exception of #5, Column C.

COLUMN A MEDICAL STATUS	COLUMN B MENTAL STATUS	COLUMN C FUNCTIONAL STATUS
Requires monitoring and overall management of a medical condition(s) under the direction of a licensed physician. In addition to the criteria listed immediately above, the patient's specific medical condition must require any of the following (2-8) plus, one item from Column B or C Nutritional management, which may include therapeutic diets or maintenance of hydration status. Maintenance and preventive skin care and treatment of skin conditions, such as cuts, abrasions, or healing decubiti. Catheter care such as catheter change and irrigation. Therapy services such as oxygen therapy, physical therapy, speech therapy, occupational therapy (less than five (5) times weekly).	Mental Status The mental status must be such that the cognitive loss is more than occasional forgetfulness. Documented short or long-term memory deficits with etiologic diagnosis. Cognitive loss addressed on MDS/care plan for continued placement. Documented moderately or severely impaired cognitive skills with etiologic diagnosis for daily decision making. Cognitive loss addressed on MDS/care plan for continued Placement. Problem behavior, i.e., wandering, verbal abuse, physically and/or socially disruptive or inappropriate behavior requiring appropriate supervision or intervention. Undetermined cognitive patterns which cannot be	Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. Transfer and locomotion performance of resident requires limited/extensive assistance by staff through help or one-person physical assist. Assistance with feeding. Continuous stand-by supervision, encouragement or cueing required and setup help of meals. Requires direct assistance of another person to maintain continence. Documented communication deficits in making self- understood or understanding others. Deficits must be addressed in medical record with etiologic diagnosis address on MDS/care plan for continued placement.

Restorative nursing services such as range of motion exercises and bowel and bladder training. Monitoring of vital signs and laboratory studies or weights. Management and administration of medications including injections.	assessed by a mental status exam, for example, due to aphasia.	Direct stand-by supervision or cueing with one-person physical assistance from staff to complete dressing and personal hygiene. (If this is the only evaluation of care identified, another deficit in functional status is required).

Note: Level of care criteria are based on definitions and guidelines derived from the Federal regulations and are used to assist assessors in evaluating clinical information submitted.

804. Nursing Facility Level of Care

Summary:

804.1. Nursing facility level of care is appropriate for individuals who do not require hospital care, but who, on a regular basis, require licensed nursing services, rehabilitation services, or other health- related services ordinarily provided in an institution. With respect to an individual who has a mental illness or intellectual disabilities, nursing facility level of care services are usually inappropriate unless that individual's mental health needs are secondary to needs associated with a more acute physical disorder.

804.2. The criteria set forth herein encompass both "skilled" and "intermediate" levels of care services.

804.3. A nursing facility level of care is indicated if the conditions of Column A is satisfied in addition to the conditions of Column B being satisfied. Conditions are derived from 42 C.F.R.409.31 – 409.34.

COLUMN A		COLUMN B
The individual requires service which is so inherently complex that it can be safely and effectively performed only by, or under the supervision of technical or professional personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, and speech pathologists or audiologist, AND In addition to the condition listed above, one of the following subparts of #2 must be met: I.	OR II. The service is one of the following or similar and is required five days per week: Ongoing assessment of rehabilitation needs and potential: services concurrent with the management of a patient care plan Therapeutic exercises and activities performed by PT or OT	The service needed has been ordered by a physician. The service will be furnished either directly by, or under the supervisor of appropriately licensed personnel. The service is required and is ordinarily furnished, as a practical matter, on an inpatient basis.

The service is one of the following or similar and is required seven days per week: Overall management and evaluation of a care plan for an individual who is totally dependent in all activities of daily living. Observation and assessment of an individual's changing condition because the documented instability of his or her medical condition is likely to result in complications, or because the documented instability of his or her mental condition is likely to result in suicidal or hostile behavior Intravenous or intramuscular injections or intravenous feeding Enterable feeding that comprises at least 26 percent of daily calorie requirements and provides at least 501 milliliters of fluid per day Nasopharyngeal or tracheostomy aspiration Insertion and sterile irrigation or replacement of suprapubic catheters Application of dressings involving prescription medications and aseptic techniques Treatment of extensive decubitus ulcers or other widespread skin disorder Heat treatments as part of active treatment which requires observation by nurses Initial phases of a regimen involving administration of medical gases Rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, that are part	Gait evaluation and training to restore function to a patient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality Range of motion exercises which are part of active treatment of a specific condition which has resulted in a loss of, or restriction of mobility Maintenance therapy when specialized knowledge and judgement is needed to design a program based on initial evaluation Ultrasound, short-wave, and microwave therapy treatment Hot pack, hydrocollator, infrared treatments, paraffin baths, and whirlpool treatment when the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, etc. and specialized knowledge and judgement is required Services of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing OR III. service is one of the following if an additional special complication requires it be performed or supervised technical or professional sonnel: Administration of routine medications, eye drops, and	

of active treatment	ointments. General maintenance care of colostomy or ileostomy. Routine services to maintain satisfactory functioning of indwelling bladder catheters. Changes of dressings for noninfected postoperative or chronic conditions. Prophylactic and palliative skin care, including bathing and application of creams, or treatment of minor skin problems. Routine care of incontinent individuals, including use of diapers and protective sheets. General maintenance care (e.g. in connections with a plaster cast). Use of heat as a palliative and comfort measure (e.g. whirlpool and hydrocollator). Routine administration of medical gases after a regimen of therapy has been established. Assistance in dressing, eating, and toileting. Periodic turning and positioning of patients. General supervision of exercises that were taught to the individual and can be safely performed by the individual including the actual carrying out of maintenance programs	

805. Intermediate Care Facility (ICF/IID) Level of Care

805.1. ICF/IID level of care is appropriate for individuals who require the type of active treatment typically provided by a facility whose primary purpose is to furnish health and rehabilitative services to persons with intellectual disabilities or related conditions.

805.2. An ICF/IID level of care is generally indicated if one condition of Column A is satisfied in addition to the conditions of Column B and Column C being satisfied. Conditions derived from 42 C.F.R. 440.150, 435.1009, and 483.440(a).

COLUMN A	COLUMN B	COLUMN C
The individual has an intellectual disability. The individual has a severe chronic disability attributable to cerebral palsy or epilepsy. The individual has a condition, other than mental illness, which is found to be closely related to an intellectual disability because it is likely to last indefinitely, requires similar treatment and services, constitutes an impairment of general intellectual functioning, and results in substantial limitations in three or more of the following: selfcare, understanding and use of language learning, mobility, self-direction, and capacity for independent living	On a continuous basis, the individual requires aggressive consistent implementation of a program of specialized and generic training, treatment, health services, and related services which is directed towards— The acquisition of the skills necessary for the individual to function with as much self determination and independence as possible; and The prevention of further decline of the current functional status or loss of current optimal functional status.	The service needed has been ordered by a physician. The service will be furnished either directly by, or under the supervisor of, appropriately licensed personnel. The service is required and is ordinarily furnished, as a practical matter, on an inpatient basis. The service is above room and board, maintenance of a generally independent individual who is able to function with little supervision, and interventions or activities to address age-appropriate limitations.

805.3. The form DMA-613 (Level I PASRR Request, Appendix F) must be completed and a copy kept in the resident's file. The DMA-6 will serve as authorization by the physician that the resident meets the "nursing facility level of care". The physician does not need to sign the DMA-613, but the person completing the form should attest to the accurateness of the "foregoing" information submitted. The document must be submitted to the Contractor via the web for pre-admission screening and Prior Authorization. The electronic version of the DMA-613 may be accessed at www.ghp.georgia.gov. To start prior authorization, select the Provider Information tab;

scroll down to PASRR Request and proceed to enter physician-completed information for the applicant in the online DMA-613 (PASRR) Form.

805.4. The Contractor's screening/determination may result in prior authorization for a resident to be admitted into a nursing facility or may "pend" for further review and/or trigger a Level II pre-admission screening. Level II assessments are performed by the Department of Behavioral Health and Developmental Disabilities (DBHDD).

805.5. When the Level I pre-admission screen is approved, a Prior Authorization number is issued by the Contractor in approved status and submitted to the MMIS. The Prior authorization number and status may be tracked through the secure login of the Provider Workspace function under the Prior Authorization tab in the web portal. If the Contractor's review determines that a Level II is necessary, the Level II assessment must be completed by DBHDD. DBHDD or its agent will perform the Level II screening to determine whether the applicant may be admitted into a nursing facility. The results of a Level II screen may be one of the following:

805.5.1. Applicant cannot be appropriately served in a nursing facility and Level II is denied.

805.5.2. Applicant can be appropriately served in a nursing facility and Level II is approved.

805.5.3. Applicant can be appropriately served in a nursing facility with specialized services and Level II is approved. A determination of result #2 or #3 must be made and a prior authorization number obtained before the applicant may be admitted into a facility.

805.5.3.1. Level II prior authorization numbers are issued by DBHDD's agent, Beacon Health Options. To obtain the Level II Prior Authorization number, contact Beacon Health: Phone: 1-855-606-2725 Website: www.GeorgiaCollaborative.com

805.5.3.2. Once approved and the applicant is placed in a facility according to PASRR guidelines/timelines, the prior authorization number may be utilized for the duration of a resident's Nursing Facility stay as long as there is no break in service or change in condition.

805.5.3.3. A prior authorization does not relieve the nursing facility from its requirement to provide an annual Physician Attestation Statement certifying the member meets the nursing facility level of care.

805.6. Prior Authorization Claims Requirement

Beginning July 1, 2012, the prior authorization number (either the number assigned when Level I/DMA-613 is approved or the approved Level II number when DBHDD or its agent has made a determination regarding the support needs of the applicant) will be required to be entered on Nursing Facility claims. Claims submitted without the prior

authorization number will be denied. Claims submitted with an incorrect prior authorization number are subject to recoupment if not denied by the MMIS. Other claims processes and requirements related to the prior authorization include:

805.6.1. A Level II prior authorization can be submitted to MMIS in denied status. A denied Level II does not authorize placement in or claims for service provided by a nursing facility. Claims submitted with a Level II authorization in denied status will be denied.

805.6.2. Claim dates of service must be covered by the effective and end dates of the prior authorization.

805.6.3. Claims must reference the most current approved prior authorization for the dates of services being billed. If a member has a Level I prior authorization in history, but subsequently a Level II was approved, the provider must use the Level II authorization.

805.6.4. If a new Level I or Level II is generated based on a change in condition or readmission after a break in stay, the new prior authorization number will automatically end date the prior authorization number that is already in the system to the day before the new one starts. Claims for DOS must match to the correct prior authorization.

805.6.4.1. The DMA-613 is not necessary when a resident is admitted directly from a hospital after receiving acute inpatient care, requires NF services for the condition for which care was provided in the hospital and whose attending physician has certified before admission to the facility that the resident is anticipated to require less than thirty (30) days nursing facility services.

805.6.4.2. The DMA-613 is not necessary if the physician certifies before the admission that admission is for an anticipated stay of not more than 30 days following hospitalization for treatment of the same condition for which the individual was hospitalized.

805.6.4.3. If a resident is admitted and the expected stay is less than 30 days AND there is other health insurance coverage in place for those 30 days, a PASRR DMA613 is not required. However, IF the provider will expect to be able to bill Medicaid for any of those 30 days, a PASRR DMA-613 should be submitted since that submission will trigger the creation of the required L1 or L2 Prior Authorization for nursing facility stay.

805.6.4.4. If the resident stays more than 30 days, a resident review must be conducted by the State mental health and intellectual disability authority within 40 days of the admission. Contact the contractor with a completed DMA-613 to initiate process for an authorized facility

stay. IF the contractor is not notified by day 40 that patient will be staying longer than 30 days, a new PASRR will need to be submitted.

805.6.4.5. The DMA-613 may be postponed for provisional admissions in emergency situations requiring Protective Services, with placement not to exceed seven (7) days. Contact the Contractor with a completed DMA-613 to initiate process for an authorized facility stay.

805.6.4.6. The DMA-613 may be postponed for very brief and finite anticipated stays of not more than 30 days in a nursing facility, to provide respite relief to in-home caregivers to whom the individual with MI or ID is expected to return. Contact the Contractor with a completed DMA-613 to initiate process for an authorized facility stay.

805.6.4.7. The Contractor will determine whether the individual may be admitted to a nursing facility utilizing the following procedures described in section 800. If the DMA-613 as determined by the Contractor's assessment does not reveal indicators for serious mental illness or intellectual disability, the individual may be admitted by a valid Physician's Recommendation Concerning Nursing Facility Care DMA-6 form and DMA-613 form (See Section 801).

805.6.4.8. If the DMA-613 reveals indicators for serious mental illness or intellectual disability, the Contractor will initiate a Level II Assessment before a person can be admitted into a nursing facility or upon the specified times indicated in 801.1c, e, and f.

805.6.4.9. The procedure for the DMA-613 is also a requirement for physical or mental status change for any Nursing Facility resident. A status change occurs if a resident is newly diagnosed with a serious mental illness or discovered to be diagnosed with intellectual disabilities before the age of eighteen (18) or hospitalized, e.g. mental health care, emotional care, etc., for an extended period or if physical illness impairs resident so severely that resident could not be expected to benefit from specialized services. The status change will pend for a Level II. Hospice and private pay residents are subject to this residential review (RR).

805.6.4.10. The Level II Assessment determines if there is serious mental illness or intellectual disabilities and whether the individual require the level of care provided by a nursing

facility. If the individual meets both determinations, DBHDD will also determine whether the individual requires specialized services for the mental illness and/or intellectual disability or developmental disability during the nursing facility stay. Any final decisions about the specific treatment, duration, and method of service delivery for specialized services are made collaboratively by the nursing home medical director, nursing home staff, the resident or his/her representative, and the mental health service provider continues as current and previous processes.

805.6.4.11. DBHDD will inform the Contractor that the individual may be admitted, and the Contractor will assign a Restricted Authorization Code (See 801.2). DBHDD will also inform the Contractor if a time limit is imposed and specify the time limit when the individual may be reassessed. A new DMA-6 will need to be signed by the physician for continued stay within thirty (30) days of the time limit expiration date.

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

NOTE: Effective July 1, 2009, Medicaid Certified Nursing Facilities are responsible to arrange Specialized Services to PASRR population nursing home residents. SEE Appendix H, PASRR and SPECIALIZED SERVICES, for complete overview of policy and documentation requirements for PASRR and Specialized Services for the PASRR Resident.

805.7. Restricted Authorization Code

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

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

NOTE: The dated Authorization of the DMA-613 must not exceed sixty (60) days prior

to the facility's admission of a resident.

805.8. Payment/DMA-59

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

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

805.8.3. For the resident's status change into Hospice, advise DFCS/LTC Unit that the NF member is transferring into Institutional Hospice (IH) as indicated in Section IV Terminations, Discharge Destination-D, Other and enter IH on the line.

805.8.4. For those residents who discharge into Money Follows the Person (MFP)/Community Care Services Program (CCSP)/Independent Care Waiver Program (ICWP)/New Options Waiver (NOW) or Comprehensive Supports Waiver Program (COMP), complete Section IV-Terminations, Discharge Destination-D, Other and enter "home with a health plan" on the line. A copy of the DMA-59 should be provided within a maximum of 3 calendar days to the transition coordinator and DFCS and/or LTC Unit for continuity of care of the member.

805.9. Medicaid payment can only be made for services during an approved length of stay. Medicaid payment cannot be made for services prior to the admission date. Additionally, Medicaid payment cannot be made until DFCS/LTC Unit determines that the individual is eligible for Medicaid and the Division is notified by form DMA-59. Medicaid payment will not be made for the days the individual was not eligible for Medicaid.

805.10. When a QMB recipient is admitted into or discharged from a nursing facility under Medicare Skilled Nursing Facility Care, the nursing facility should complete Form DMA-59 Sections I, II, III and fax to 404-463-2538. Please write across the top of the DMA-59: "Medicare SNF for QMB only."

805.11. Complete Section IV of Form DMA-59 when the QMB recipient is discharged and fax to DCH at 404-463-2538.

PHYSICIAN'S ATTESTATION STATEMENT

Patient's Name: _____ Medical Record No:_____

Physician's Name: _____

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

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

_____ _____
Physician's Signature Date

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

_____ _____
Physician's Signature Date

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

_____ _____
Physician's Signature Date

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

_____ _____

Physician's Signature Date

805.12. PASRR Limited Length of Stay

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

805.13. Transfer to/from Another Nursing Facility/Readmissions Documents

When a person is transferred from one nursing facility in Georgia to another, the admitting facility must secure a valid DMA-6 or P6A. The physician-signed DMA-6 certifies that the resident meets a nursing facility level of care as described in 801.3. For all readmissions and transfers, enter the restricted authorization code and date assigned by the Contractor on Item 9B: State Authority (MH and ID Screening) field of the DMA-6 or P6A.

In addition, documentation by the nursing facility is required for all referrals to community behavioral health service providers. Community Behavioral Health Service Provider Agency name and date of referral including follow up on the status of the referral is required. The following documentation should follow the resident/member to the new facility:

805.13.1. DMA-613

805.13.2. DMA-6

805.13.3. Resident's Diagnosis

805.13.4. Evaluation/Summary of Findings

805.13.5. CMH notes and information regarding resident's SMI information (Acquired from copy in NH chart):

805.13.5.1. Symptom's behaviors or skill deficits

805.13.5.2. Treatment Plan and Objectives

805.13.5.3. Interventions

805.13.5.4. On-going progress toward the objectives

805.13.5.5. Termination or discharge summary

805.14. Application for Medicaid

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

805.15. Joint Medicare/Medicaid Recipients

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

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

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

805.16. Medicare Part A Coverage for Nursing Facility Services

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

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

805.16.1. The person has not been approved (added to eligibility file) for Medicare.

805.16.2. The person was not admitted to the nursing facility within 30 days following hospitalization.

805.16.3. The available benefits under Title XVIII (Medicare) have been exhausted.

805.16.4. In addition, it should be noted that Medicare has more stringent criteria with regards to the practitioners that can serve these members through Specialized Services.

Note: Residents who are approved for Specialized Services through the Level 2 PASRR assessment who are Medicare only or dual eligible for Medicaid and Medicare must receive Specialized Services through Medicare

806. Home and Community-Based Services Option Requirements

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

It is the responsibility of the nursing facility to inform all potential and existing residents and/or their authorized representatives of home and community-based service options. This will be performed for all persons who are Medicaid eligible or potentially Medicaid eligible at the time of admission and on an annual basis at the time of the annual comprehensive reassessment (i.e., RAI/MDS) required by federal regulations. The nursing facility will advise applicants and residents of home and community-based service options through completion of the MDS/Section Q. The facility should document mailing of the booklet to the authorized representative if he/she was unavailable at the time of the annual comprehensive assessment. Use the DMA 385 form (Acknowledgement of Receipt of Home and Community Based Services Information) to document. However, Nursing Facilities are no longer required to submit the DMA 385 form to DCH.

To ensure applicants/residents and/or their representatives are given the information necessary to make an informed choice concerning service options, the nursing facility will provide each applicant/resident or authorized representative with the Department of Community Health (DCH) Home and Community Services booklet. The booklet is distributed upon admission and annually thereafter. The booklet may be ordered through the Georgia Health Partnership (GAMMIS) web portal by downloading and filling out a Request for Forms or Handbooks DMA-292 Form. Submission instructions are printed on the form and may be found at:

http://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public?ALL/FORMS/DMA%20292-Request%20for%20Forms%20011311%2013-02-2012%20212635.pdf

807. Pre-Admission/Prior-Approval Procedures for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/ID)

Before admission to an ICF/IID institution for the intellectually disabled or related conditions, an interdisciplinary team of health professionals makes a comprehensive medical and social evaluation and a psychological evaluation of each applicant's/recipient's need for care in the institution.

Evaluations made before admission include:

807.1. Diagnosis

807.2. Current medical, social, and developmental findings.

807.3. Mental/physical functional capacity

807.4. Prognoses

807.5. Services needed

807.6. Recommendation of admission to or continued ICF-ID care

807.6.1. A physician must legalize a written plan of care, the active treatment services, by personally signing the plan for each applicant or recipient before admission to an ICF-ID. Medical and social information is required to be submitted on the Plan of Care which contains the following elements:

807.6.1.1. Identification of the recipient

807.6.1.2. Name of the recipient's physician

807.6.1.3. Date of admission (if application is after admission in the institution)

807.6.1.4. Dates of application for and authorization of Medicaid benefits, if application is made after admission

807.6.1.5. Diagnoses, symptoms, complaints, and complications indicating the need for admission

807.6.1.6. Description of the functional level of the individual

807.6.1.7. Objectives

807.6.1.8. Orders for medications, treatments, restorative, and rehabilitative services, activities, therapies, social services, diet, and special procedures designed to meet the objectives of the plan of care

807.6.1.9. Plans for continuing care, including review and modification of the plan of care

807.6.1.10. Plans for discharge

807.6.2. The team must review and follow through each plan as required by 42 CFR 483.440. Persons seeking Medicaid payment for services in an ICF/IID must have the following information submitted to or provided by the Department of Community Health (DCH) for pre-admission review in a state-owned nursing facility or a non-state-owned nursing

facility.

807.6.2.1. Form DMA-6 (Physician's Recommendation Concerning Nursing Facility Care or Intermediate Care for the Intellectually Disabled [see Appendix E] or the DMA-P6A must be completed and must be signed by the attending physician within (30) days;

807.6.2.2. psychological evaluation, which must have been completed within one (1) year period prior to the review;

807.6.2.3. social evaluation within ninety (90) days; and

807.6.2.4. developmental care plan within ninety (90) days.

807.6.3. Before admission to an ICF-ID, if the physician recommends services for an applicant or recipient whose needs could be met by alternative services that are currently unavailable, the facility must enter this fact in the recipient's record and begin to look for alternative services.

Prior to admission to the ICF-ID, final evaluation is provided for each patient by the contractor who determines whether the applicant requires the level of care provided in an ICF/IID and the feasibility of meeting the recipient's health and rehabilitative needs through alternative arrangements shall also be discussed.

807.6.3.1. If the level of care provided in an ICF/IID is required, the contractor will complete fields 36 and 37 on the DMA-6. The length of stay will be given up to twelve (12) months. The approved time period will be specified in days. The individual may then be admitted to the ICF/IID. If the admission does not occur within 60 days, the approval will not be valid, and an updated DMA-6 must be resubmitted for preadmission review and approval. An updated psychological evaluation will be required if the one previously submitted was done more than (1) year prior to the new review.

807.6.3.2. If the level of care provided in an ICD/IID is not required, admission will be denied. This decision may be appealed (see Appendix I).

807.7. Payment Date

When the person is admitted to the ICF/IID, the facility must enter the admission date on the DMA-6 (field 8) and return the forms to the Contractor. If the forms are received by the Contractor, the payment date will be the date of admission.

Medicaid payment can only be made for services during an approved length of stay. No Medicaid payment can be made for services prior to the admission date. Additionally, Medicaid payment cannot be made until DFCS or the LTC Unit determines that the individual is eligible. Medicaid payment will not be made for those days the individual was not eligible for Medicaid.

807.8. ICF-ID Continued Stay

The contractor will do a review every six (6) months to determine the need for continued placement at this level of care; determine the adequacy, appropriateness and quality of services received, and whether the recipient is receiving active treatment for an intellectual disability or related condition.

The facility must submit a new DMA-6 or P6A to the contractor to obtain prior approval for continued stay in the facility beyond the designated date. The DMA-6 or P6A may be submitted up to 30 days prior to the expiration of the currently approved stay. The contractor conducts a desk evaluation of continued need of care for each Medicaid recipient in an ICF/IID in the State of Georgia once per year. Reviews are based on information submitted on the DMA-6 and a current developmental care plan. A current psychological examination must also accompany the forms if the resident is under the age of eighteen (18) every three (3) years.

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

807.9. Transfer from Another ICF/IID

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

807.10. Application for Medicaid

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

The State includes in nursing facility services provision for assuring necessary transportation of recipients to and from providers. Please see Appendix U of this manual for more information. You may also see detailed information for providers in the Part II Policy and Procedure Manual at www.mmis.georgia.gov regarding Non-Emergency Transportation Broker Services.

808. Mechanical Ventilation Services

Mechanical ventilation services are Nursing Facility-specific services available to members who meet the established eligibility requirements. Mechanical ventilation services may only be provided by Nursing Facilities approved by the Department. Eligibility requirements for members and enrollment requirements for providers are outlined below.

808.1. Mechanical Ventilation Provider Agreement

To participate in Mechanical Ventilation services, a nursing facility must meet all of the requirements outlined in this Section and enter into a Provider Agreement specifically for Mechanical Ventilation services. This agreement is in addition to the standard nursing facility provider enrollment approval and certificate of need process.

The Department reserves the right to award agreements at its discretion based on geographic coverage as evidenced by a demonstration of the demand for service in the specific service area of request. Other considerations involve market saturation and/or the ability of the nursing facility to demonstrate a history of high-quality performance based on survey results and Nursing Home Compare scores, and that requirements for providing mechanical ventilations services have been met. The award of an agreement is dependent upon successful completion of an application packet demonstrating appropriate policies have been established to support the operations of mechanical ventilation services and a pre-service site-visit by Healthcare Facility Regulation surveyors.

The Agreement includes attestations regarding required equipment and staffing ratios consistent with this policy. The Agreement also must document a formal relationship between the nursing facility and a local hospital that confirms the ability and willingness of the hospital to serve the acute care needs of members utilizing mechanical ventilation on an as-needed basis as well as in emergency situations where the entire population of the unit must be temporarily transferred to the hospital.

The Department reserves the right to terminate an agreement based on failure to comply with policy guidelines and/or citations by Healthcare Facility Regulation surveyors. Upon receipt of a termination notice, the facility has ten (10) days to submit a transfer plan for each resident which fully addresses their medical, social, and safety support needs in anticipation of and throughout the transfer process. Upon Department approval of the plan, all transfers that result from the termination of the agreement shall be completed within thirty (30) days from the date of the termination notice. Providers notified of termination may appeal this decision pursuant to Section 404.3 of Part I, Policies and Procedures for Medicaid/PeachCare for Kids manual. Should the compliance failure be so egregious in nature that the safety of residents is threatened, the Department reserves the right to enforce immediate transfer. If terminated, the provider may not reapply to provide mechanical ventilation services for one (1) year from the date of termination.

Failure to comply with any policy stated herein or failure to render services according to quality standards or practice will be considered cause for claims suspension and/or agreement termination. A provider Agreement application is available from the Department by contacting the Nursing Facility Program Specialist. This application must be completed and approved by the Department for a nursing facility to be considered as a mechanical ventilation services provider. A facility has thirty days from the date of receipt to complete the application process. Failure to provide the requested information or documentation within this 30-day timeframe will result in the application being closed. Once closed, a provider is not eligible to apply again for three (3) months.

808.2. Mechanical Ventilation Admission/Continued Stay Requirements

Individuals seeking placement in a nursing facility who require mechanical ventilation will meet the following eligibility requirements:

808.2.1. Have a health condition which requires close medical supervision, 24 hours a day of licensed nursing care, and specialized services or equipment

808.2.2. Require mechanical ventilation greater than 6 hours per day for greater than 21 days

OR

808.2.3. Have a tracheostomy with the potential for weaning but require mechanical ventilation for a portion of each day for stabilization,

808.2.4. Admission from the hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer.

AND

808.2.5. Require pulse oximetry monitoring to check stability of oxygen saturation levels

808.2.6. Require respiratory assessment and documentation daily by a Licensed Respiratory Therapist or Registered Nurse

808.2.7. Have a physician's order for respiratory care to include suctioning as needed

808.2.8. Require tracheotomy care at least daily

808.2.9. Admission from hospitalization or other location shall demonstrate two (2) weeks clinical and physiologic stability prior to transfer

808.3. Weaning and Discharge from Mechanical Ventilation

Mechanical ventilation services provide the necessary training for members to be weaned from their dependency on respiratory equipment. Only in situations where the potential for weaning is not viable may the member be admitted to the nursing facility for mechanical ventilation services without the inclusion of weaning in his or her plan of care. Weaning may not be considered viable when the duration of ventilation has been too long and/or the underlying health conditions requiring ventilation have not been and are unlikely to be resolved. It is incumbent upon the nursing facility ventilator unit clinical team to make and document the determination of viability according to standard practice guidelines available at the American Association of Respiratory Care.

Following successful weaning from mechanical ventilation with stabilization, members

are to be transferred from the mechanical ventilation unit. Members are considered stabilized after 72 hours of spontaneous breathing on their own (including with the trach if decannulation is not planned). In situations where the pulmonologist and respiratory therapist have recommended to also progress to decannulation of the tracheostomy, then stabilization is considered to be 72 hours after decannulation. Therefore, transfer/discharge from the mechanical ventilation unit into a standard nursing facility bed at the nursing facilities established per diem rate must occur accordingly at either the conclusion of 72 hours of stabilized, independent breathing or 72 hours post decannulation.

Any intervening medical illness such as a pneumonia or increased congestive heart failure could result in a need to return to mechanical ventilation. A transfer back to the mechanical ventilation unit in such situations may occur as needed. If a return to the mechanical ventilation unit occurs within a current ninety (90) day authorization period due to medical necessity according to eligibility guidelines, the member is considered eligible without reapplication unless the member has been discharged for more than thirty (30) days. A new prior authorization will be required if the transfer back to the mechanical ventilation unit occurs more than 30 days after discharge from the unit or if the previous prior authorization has expired. With the new prior authorization request, a new DMA-6 and any other necessary clinical documents and notes must be resubmitted for review.

808.4. Hospice and Mechanical Ventilation

When a member elects the hospice benefit and is receiving Medicaid Nursing Facility Services, § 1905(o) of Title XIX of the Social Security Act [42 U.S.C. § 1396d(o)] indicates the individual becomes a hospice patient and is no longer a Nursing Facility resident. Therefore, a member cannot be enrolled in the nursing facility program receiving mechanical ventilation services and also be enrolled in the hospice program at the same time.

Once the individual elects the hospice benefit, the individual is considered a hospice patient. As such, the hospice is responsible for providing all services as they relate to the terminal illness at established Hospice rates. A member who elects hospice may continue to utilize a nursing facility bed according to the rules of the Hospice Program. In such circumstances, the Hospice Program reimburses the Nursing Facility for room and board and in turn the nursing facility remains responsible for personal care services and other services and supports not related to the terminal illness as outlined in the Hospice Program Policies and Procedures Manual.

808.5. Nursing Facility Staffing, Equipment and Requirements

808.5.1. Nursing facilities that provide care to residents requiring mechanical ventilation must meet certain conditions. These conditions include the staffing and equipment resources as outlined below. When the required infrastructure is in place, the facility must submit an application to DCH to be approved as a provider of mechanical ventilation services. Only approved providers will be able to obtain prior authorization and submit claims for ventilator dependent members. Providers of mechanical ventilation services will provide the following as part of or in addition to the requirements for traditional nursing facility care:

808.5.2. Licensed nursing services on the ventilator unit 24 hours a day; at least 12 hours a day must be provided by a Registered Nurse. Nursing services will be provided in an appropriate ratio according to patient acuity not to exceed a ratio of 1:10 nurses per ventilator dependent resident.

808.5.3. For facilities with more than 10 filled beds but less than 15, this ratio may be satisfied by one RN plus one LPN rather than 2 RNs. For example:

1-10 patients = 1 RN
11-14 patients = 1 RN + 1 LPN 15-20 patients = 2 RNs

808.5.3.1. Respiratory services provided by a licensed Respiratory Therapist on site 24 hours a day. Respiratory Therapists will provide care in an appropriate ratio according to patient acuity not to exceed 1:10 Respiratory Therapist per ventilator dependent resident.

808.5.3.2. Oversight of the ventilator-dependent residents by a pulmonologist or physician experienced in ventilator care. A resume or curriculum vitae should indicate a minimum of 1-year cumulative experience working primarily with ventilator dependent patients; further documentation may include a copy of the physician's/pulmonologist's American Medical Association member profile indicating specialty, verified degrees and residency and absence of sanctions. On call, 24 hour a day availability of the Medical Director or designated physician for the facility or ventilator unit in the event that the resident's primary care physician is not available.

808.5.3.3. Dietary services at the level of complexity or sophistication that requires provision by a Registered Dietitian

808.5.3.4. Durable medical equipment and supplies to meet the needs of the ventilator dependent resident to include but not to be limited to:

808.5.3.4.1. Portable positive pressure mechanical ventilators with internal battery backup.

808.5.3.4.2. Pulse oximetry monitors

808.5.3.4.3. Endtidal CO2 analyzers

808.5.3.4.4. An audible, redundant external alarm system located outside the patient room to alert caregivers of ventilator failure

808.5.3.4.5. Supplies required to support the equipment such as suction catheters, tracheostomy supplies, oxygen, etc.

808.5.3.4.6. Oxygen delivery systems must be maintained per manufacturer's recommendation and FI02 must be verified and documented at least once daily for those on mechanical ventilation, and monthly for other oxygen delivery devices.

808.5.3.4.7. A backup ventilator unit for every ten (10) beds designated for ventilator care (minimum of one backup unit).

808.5.3.4.7.1. Policy and procedures for ventilator-dependent residents to include monitoring expectations, routine maintenance of equipment, and specific staff training related to ventilator use and care.

808.5.3.4.7.2. In order to maintain quality standards and reduce cross contamination, the facility policy and procedure for cleaning and maintain equipment must include a designated soiled utility room which will be used to clean soiled Respiratory Therapy equipment, as well as a separate area to store clean equipment.

808.5.3.4.7.3. The ventilator unit must have a designated clean and dirty room. This area may not be a mixed-use area. It must be separated from storage and/or office space.

808.6. Reimbursement for Mechanical Ventilation Services

Mechanical Ventilation is reimbursed at a per diem rate. The per diem rate received by the facility for providing Mechanical Ventilation Services is all inclusive for the resident's care as similarly described in the Basis for Reimbursement, Section 1008. No other medical billing is allowed for nursing services or routine care.

808.7. Pre-Admission Approval for Ventilator Services

Pre-admission approvals for services provided by nursing facilities is mandatory. Pre-admission approval includes the completion of 1) the physician's recommendation for nursing facility level of care (DMA-6, Appendix F), 2) the Pre-Admission Screening and Resident Review (DMA-613), and 3) a prior authorization for mechanical ventilation services. Copies of the DMA-6 may be obtained by ordering or downloading from: 1-800-414-4358 or 678-527-3010 www.mmis.georgia.gov/forms

The prior authorization for mechanical ventilation is obtained through the MMIS web portal from the Georgia Health Partnership (GHP)/Medical Management Contractor (Contractor) when an eligible provider is logged in securely to the web portal. Follow these instructions to enter a Mechanical Ventilation Services request:

808.7.1. Go to the Georgia Web Portal at www.mmis.georgia.gov and log in using your assigned username and password.

808.7.2. On the Secure Home page, select Prior Authorization; then Submit/View.

808.7.3. Select Nursing Facility Mechanical Ventilation Services.

808.7.3.1. The contractor has three (3) business days to complete medical review and make a determination.

808.7.3.2. When the prior authorization is granted, the effective date of payment will be the date of request. When the mechanical ventilation prior authorization request is submitted on the first working day following the weekend or holiday and the admission occurred on the weekend or holiday, the effective date of payment will be made retroactive to the date of admission. Weekends are defined as 12:00am Saturday morning through 11:59pm Sunday night. All other days of the week the DMA-6 must be submitted within the day of admission.

808.7.3.3. Each prior approval request is for ninety (90) day stay. Every ninety (90) days thereafter, a recertification for continued stay must be obtained through the Contractor. For purposes of continuity, thirty (30) days prior to the end of each 90-day span, providers shall send all necessary information and documentation required for continued stay review and approval. The nursing facility is required to contact the Contractor with a new DMA-6 for each annual request for extension of services when

mechanical ventilation services have been continuous. Failure to submit a new DMA-6 as required annually or following a break in stay as required by policy will result in denial of payment for the period not certified.

808.7.3.4. The Form DMA-59, Authorization for Nursing Facility Reimbursement, must be completed as instructed in Section 1102 of this policy.

808.8. Recommendations by the Contractor

The Contractor is responsible for determining whether or not ventilator care offered by the nursing facilities is required. The provider may track the Contractor determination and obtain the prior authorization status by secure login to the Provider Workspace in the web portal under the Prior Authorization tab. If the individual meets ventilator criteria and the Contractor approves services, Contractor will send the DMA-6 mailer to the facility and to DFCS or the LTC Unit within twenty-four (24) hours of the telephone call to Contractor. See Chapter 1002 for further details concerning patient liability.

808.9. Web Pre-Admission Approval

Web portal Web address: http://www.mmis.georgia.gov Upon receipt of the pre-admission approval, a DMA-6 "blue" mailer will be mailed to the facility with an approval level of care and a payment date assigned. No payment will be made for any services rendered prior to the date the DMA-6 was submitted to the Contractor by the facility.

The approval is effective for a period of ninety (90) days. A new DMA-6 Form must be completed for each ninety (90) day period the patient is receiving ventilator services. PRE-ADMISSION APPROVAL CANNOT BE UTILIZED FOR THE ADMISSION OF INDIVIDUALS WITH A MENTAL HEALTH OR INTELLECTUAL DISABILITY DIAGNOSIS. Pre-admission approval will be given for these individuals only following receipt and review of a completed DMA613 Form, and other required documentation.

Chapter 900: Scope of Services

901. Covered Services

Nursing facility residents are allowed to retain a personal needs allowance from their income each month which can be used for clothing and other personal needs while in an institution. The

personal needs allowance has been increased to $70.00 per month. (Rev. 07/2023)

Nursing facility residents are allowed ten (10) office or NF visits per calendar year for physician services; additionally, providers may bill ONE (1) preventive health visit (993XX) for a member annually (between January and December of the calendar year). Providers must use one of the following ICD-10 diagnosis codes when billing the preventive health visit code: Z00.00 or Z00.01 (Encounter for adult examination). Requests for prior approval for more than ten (10) physicians visits per calendar year for one member may be made if additional visits are deemed as medically necessary. Medical necessity visits include life-threatening situations and situations involving serious acute or serious chronic illnesses. Additional visit(s) are to be requested by the physician via DMA-81 form to Alliant Health Solutions as a Prior Authorization (PA) for medical necessity. The NF resident can receive physician services reimbursable through the Physician Services Program over and above the nursing facility reimbursement (See Physician's Manual Part I). (Rev. 01/2015-07/2016)

All levels of office and other outpatient E/M services as specified in the current CPT, including definitions and instructions, are incorporated herein by reference. In addition, the following limitations apply for members aged twenty-one years or older:

Reimbursement for office E/M services is limited to ten per member per calendar year, regardless of the number of physicians rendering care, unless prior approval has been obtained, or the visit is an emergency. Claims for emergency E/M services must be clearly marked --- EMERGENCY|| and describe the emergent condition. Office records or notes must be submitted with all claims marked --- EMERGENCY|| to support medical necessity. All emergency claims must be forwarded to: (Rev. 01/2016)

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Ga. 30348

Nursing facility covered services: The approved reimbursement rate established for each facility by the Division of Medical Assistance is an inclusive rate that covers the cost of the following services and items at no additional charge to the Division, the recipient, or the recipient's representative:

901.1. Resident's room and board including special diets and special dietary supplements used for tube or oral feedings, when specifically prescribed by a physician. Insofar as possible, privacy shall be accorded a recipient with a terminal illness; however, this shall not be interpreted to require a private room.

901.2. Laundry (including personal laundry)

901.3. Nursing and routine services:

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

901.3.1.1. Nursing services (excluding private duty nurses)

901.3.1.2. Medical social services

901.3.1.3. Activities program

901.3.1.4. Physical therapy

901.3.1.5. Speech therapy

901.3.1.6. Specialized rehabilitative services

901.3.1.7. Restorative nursing care

901.3.1.8. Hand feedings

901.3.1.9. Enemas

901.3.1.10. Occupational therapy

901.3.1.11. Assistance in personal care and grooming

901.3.1.12. Nursing supplies and dressings

901.3.1.13. Extra linens

901.3.1.14. Laboratory procedures not requiring laboratory personnel

901.3.1.15. Tray services

901.3.1.15.1.

901.3.1.15.2. Durable medical equipment such as, but not limited to beds, bedrails, walkers, wheelchairs, oxygen equipment, oxygen, and related supplies.

Note: Nursing homes who assess a resident and conclude their needs would best be served with a specialized/custom wheelchair in order to facilitate a resident's maximization of independence, must know it is the nursing home's responsibility to cover the expense of specialized/custom wheelchairs.

901.4. Incontinency care, Incontinency pads, diapers, and sanitary pads Special mattresses and pads

901.4.1. Routine personal hygiene items and services including, but not limited, to: shampoo, hair conditioner, comb, brush, bath soap, non-legend disinfecting soaps or specialized cleansing agents (when indicated to treat special skin problems or to fight infection), razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss,

petroleum jelly, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, towels, washcloths, hospital gowns, nail care, hair care, bathing, and shaving.

901.5. Over the Counter (OTC) Drugs and Related Items:

Each nursing facility shall as part of nursing and routine services supply clinically necessary over-the-counter drugs and related items to be used for members as ordered by the attending physician without additional charge to the Division, the member, or the member's representative. Each item must be available in adequate supply to assure the member's timely receipt of the items as ordered. These items will be provided generically or in a brand of a nursing facility's choosing unless the doctor has a clinically necessary reason to choose a particular brand. The resident may only be charged for over-the-counter drugs if, after

901.5.1. being informed of the options, he or she chooses to purchase a specific brand for non-clinical reasons from his/her personal needs allowance. The items to be supplied by the nursing facility shall include, but shall not be limited to the following:

901.5.1.1. Stool Softener and Laxative

901.5.1.1.1. Magnesium Hydroxide Liquid (Milk of Magnesia)

901.5.1.1.2. Glycerin Suppositories

901.5.1.1.3. tool Softener

901.5.1.1.4. Bulk Laxative

901.5.1.1.5. Stimulant Laxative o Antidiarrheal

901.5.1.1.6. Non-legend antidiarrheal product

901.5.1.1.7. Antacid Rev.

901.5.1.1.8. Antacid

901.5.1.1.9. Analgesic/Antipyretic

901.5.1.1.10. Acetaminophen – tablets, liquid, suppositories

901.5.1.1.11. Aspirin – tablets, suppositories

901.5.1.1.12. Ophthalmic

901.5.1.1.13. Artificial tears in multi-does containers labeled for specific patients' use

901.5.1.1.14. Diluents/Irrigants

901.5.1.1.15. Normal saline

901.5.1.1.16. Sterile water

901.5.1.1.17. Treatment Solutions

901.5.1.1.18. Chlorhexidine gluconate (Hibiclens)

901.5.1.1.19. Rubbing Alcohol

901.5.1.1.20. Nursing Facility Services IX-5

901.5.1.1.21. Providone-iodine 10% (Betadine)

901.5.1.1.22. Hydrogen Peroxide 3% (Peroxide)

901.5.1.1.23. Vaccines

901.5.1.1.24. Influenza Vaccine

901.5.1.1.25. Hepatitis B Virus Vaccine (ICF-ID only)

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

902. Drugs Eligible for Coverage By Full Benefit Dual Eligibles Receiving Medicare Part D Benefits

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

902.1. Cyanocobalamin Injection

902.1.1. Generic Megace Suspension*

902.2. Folic Acid 1mg

902.2.1. Hep-Lock Saline Flush

902.3. Legend prenatal vitamins for women

902.3.1. Legend Injectable Icon

902.3.2. OTC iron

902.3.3. Diphenhydramine

902.3.4. KLOUT, generic permethrin lotion 1%, pyrantel pamoate

902.4. OTC generic Loratadine and Loratadine D-

902.4.1. Enteric coated aspirin

902.4.2. Meclizine

902.4.3. ESRD vitamins and antacids:

902.5. Calcium Carbonate, Aluminum Hydroxide, calcium acetate, sodium bicarbonate. Calcium Carbonate with Glycine, Calcium Lactate, Docusate Calcium, Docusate Sodium, Niacin, Pyridoxine Hydrochloride, Thiamine Hydrochloride, Legend Vitamin D products, Vitamin B Complex (All Require Prior Approval)

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

902.6.1. Cough and cold products

902.6.2. CoEnzyme Q10

902.6.3. Vitamin E

902.7. Children's Multiple Vitamins in combination with Fluoride

902.7.1. OTC Multi-Vitamins and Multi-Vitamins with Iron (chewable or liquid drops)

902.7.2. Ibuprofen Suspension

902.7.3. *Generic Megace is covered for the duals "unless its use is for anorexia, or an unexplained, significant weight loss in patients with a diagnosis of acquired immunodeficiency syndrome (AIDS)."

903. Prescription Drugs

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

As part of a member's care and service, it is important to remind all nursing facilities of their responsibilities associated with the drugs/medications prescribed by physicians. It is the Divisions expectation that Nursing Homes follow-up with each physician's order so as to facilitate the timely arrangement and delivery of drugs and medications. If a member wishes to exercise their right to choose their Pharmacy, the Nursing Home Provider must directly contact the pharmacy selected by the member to assist in navigating through the process and establishing a relationship between the member, pharmacy, and Nursing Facility.

Effective January 1, 2006, the Medicare Modernization Act (MMA) provides for Medicare prescription drug coverage to begin. Residents are eligible for the Medicare prescription drug benefit

if enrolled in Medicare Part A and/or Part B.

For the first time, Medicare will offer prescription drug coverage (Medicare Part D). Residents with Medicare who also have Medicaid coverage should have been informed that the new Medicare prescription drug plan will cover their prescriptions beginning January 1, 2006, and that drug coverage will be provided by Medicare rather than Medicaid. Full benefit dual-eligibles will be automatically enrolled into a Prescription Drug Plan (PDP) by the Center for Medicare and Medicaid Services (CMS). Members will have an opportunity to select a PDP of their choice once they receive notification from CMS of their assignment in November 2005.

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

Effective October 1, 2008 Therapeutic Duplication (TD) Edit and Quantity Level Limits (QLL) for select Benzodiazepines and Sedative Hypnotics *Revised October 1, 2008*

Effective October 1, 2008, the Department of Community Health (DCH) will implement therapeutic duplication edits and new quantity level limits for select benzodiazepines and sedative hypnotics. Therapeutic duplication (TD) edits will be activated within each category of the anxiolytic benzodiazepines and sedative hypnotic benzodiazepines (see Table 1). A (TD) edit will post if claims for more than one drug in a 34-day period are processed within each of the benzodiazepine categories. Claims that deny for therapeutic duplication are not covered and will NOT be overridden with a prior authorization (PA). Also, a quantity level limit (QLL) of 18 per 34 days across sedative hypnotics (benzodiazepine and non-benzodiazepine) will be enforced (see Table 2). The QLL edit will look for a combined quantity total of (18) per (34) days within the sedative hypnotic group. Requests to override the (QLL) edits only will require a prior authorization (PA). Providers may request a PA from the OptumRx Clinical Call Center at 1-866-525-5827. We appreciate your continued participation in the Georgia Medicaid & Peach Care for Kids Programs.

Table 1

Therapeutic Duplication Edit **only (1) product from each class allowed without PA*	
Anxiolytic Benzodiazepines	**Sedative Hypnotic Benzodiazepines**
alprazolam, chlordiazepoxide, clorazepate, diazepam, lorazepam and oxazepam	estazolam, flurazepam, midazolam syrup, temazepam and triazolam

Table 2

Sedative Hypnotic Group – Quantity Level Limit of (18) per 34 days (QLL applied across entire group for a combined total of 18 per 34 days)
estazolam, flurazepam, temazepam, triazolam, Ambien CR, Lunesta, Rozerem, zaleplon/Sonata and zolpidem/Ambien

903.1. Requests via Telephone or Facsimile

Requests for drugs to exceed therapy limitations or for drugs that require prior approval shall be directed to the agent, SXC Health Solutions, Inc. by phone. Contact by fax or mail is not preferable but allowed. The agent's Prior Authorization Department is staffed by associates and clinical pharmacists 24 hours/day, 365 days per year. (Clinical pharmacists are on call after normal business hours, from 7pm-9am Eastern Time). Prior Authorization requests may be made telephonically, via facsimile, or in writing via U.S. mail, to:

OptumRx
Prior Authorization Department
PO Box 3214
Lisle, IL. 60532-8214
Clinical and PA Support 866-525-5827
Fax Line 888-491-9742

903.2. Denial of Requests

Any request, which cannot be approved by the agent, will be communicated at the time of the request to the requester. (Rev. 10/2015)

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

If an appeal is denied by the agent, a provider may request a 2nd level appeal by DCH within ten (10) business days. 2nd level appeals must be faxed to SXC at 888- 491-9742. SXC will prepare the appeal for DCH's consideration.

903.3. Requests Returned for Additional Documentation

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

903.4. Null and Void Authorization

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

903.5. Appeal of Prior Approval Denials

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

904. Room Accommodations

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

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

A recipient who is transferred to or admitted to a private room because of a shortage of beds in semi-private rooms shall not be discharged because of the absence of a relative or other person who is willing and able to provide supplementation. If supplementation for a private room is available, the rate charged by the provider to the relative or other person providing that supplementation shall not exceed the difference between the maximum rate charged by the provider for a private room for a private pay patient and the amount which the provider receives, or will receive, from the Division as reimbursement for the recipient's care in a semi-private room.

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

905. Reserving Nursing Facility Bed While Recipient is on Leave or Hospitalized

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

905.1. Planned leave of a therapeutic nature away from the nursing facility, when authorized by the attending physician in the patient's plan of care, can be reimbursed with the facility's state payment rate (see Section 1006) under the program when a bed is held for the recipient. The Division cannot assume any portion of the cost for days exceeding the limits specified in Sections 904.1 through 904.3. Arrangements for holding a bed for a recipient for days exceeding the established limit must be made with the family or friend at a mutually agreed upon rate not to exceed the total allowable per diem billing rate that the facility would have been reimbursed had the recipient been in the facility. Any overnight stay away from the nursing facility will constitute one day. Hours away

from the facility are not cumulative. All planned visits must be supported by a written order by the attending physician.

905.2. The Division requires that each patient's record have an easily identifiable leave of absence form. The form should include Patient's name, Medicaid number, level of care, the date and time the patient leaves the facility and the date and time the patient returns to the facility. The facility staff must sign or initial the form when the patient leaves and returns. The DMA-356 (Nursing Facility Leave of Absence Form) may be used to satisfy this requirement (see Appendix F).

905.2.1. Planned Leave for Nursing Facility Residents

Effective April 1, 2003, a nursing facility resident may spend up to eight (8) days within a calendar year out of the facility for therapeutic purposes to improve the patient's physical or quality of life consistent with the plan of care. These visits are reimbursed according to the facility's state payment rate (see Section 1006) and according to the policy and related rate for planned leave. The attending physician must document in the plan of care that such visits are therapeutic in nature. A recipient's total visits cannot exceed a total of eight days in any calendar year. Payment will not be made to a facility on behalf of a recipient for any days exceeding the number of allowable visits per year.

905.2.2. Intermediate Care Facility for the Intellectually Disabled (ICF/IID)

A recipient in an ICF/IID may visit with a relative or friend up to thirty (30) days per calendar year without reduction in the amount of Medicaid Assistance payment to the facility provided that the attending physician documents in the plan of care that such visits are therapeutic in nature. There is no limit as to the number of days per visit as long as the total number of days does not exceed thirty (30) days per calendar year. Payment will not be made to a facility on behalf of a recipient for any days exceeding the number of allowable visits per year.

905.2.3. Hospitalization/Bed-hold Payment

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

906. Reporting and Billing Days of Care

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

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

Claim(s) must be submitted within six (6) months from the month of service. Claim(s) with third party resources must be submitted within twelve (12) months from the month of service.

907. Claim Submission

Claim must be filed on the required form with the appropriate information in specific blocks for payment. The correct claim(s) form for nursing facility is the UB-04 (National Uniform Billing Form). Claim(s) must be submitted within six (6) months from the month of service. Claim(s) with third party resources must be submitted within twelve (12) months from the month of service. The UB-04 claim form should be filed with the Medicare Notice of Admission or Explanation of Benefits attached. The attachment must state that the patient's benefits are exhausted and include the last date of Medicare entitlement. When filing the UB-04, Medicaid liability will not begin until after Medicare benefits are exhausted.

907.1. Claims may be submitted using several mechanisms:

907.1.1. Providers may either use Billing Agents/Clearing House who must register with Providers may submit their claims via Web. Effective May 1, 2015, the Department Gainwell Technologies to submit claims via EDI (Electronic Data Interchange). Providers may use the WINASAP software, after registering with Gainwell Technologies to submit claims will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to the provider. Refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more information.

907.2. Claims are required to include the prior authorization (PA) number on every claim:

907.2.1. Provider Electronic Solutions (PES) – Tab 3

907.2.2. EDI-2300 Loop, REF 01 segment with a qualifier of G1

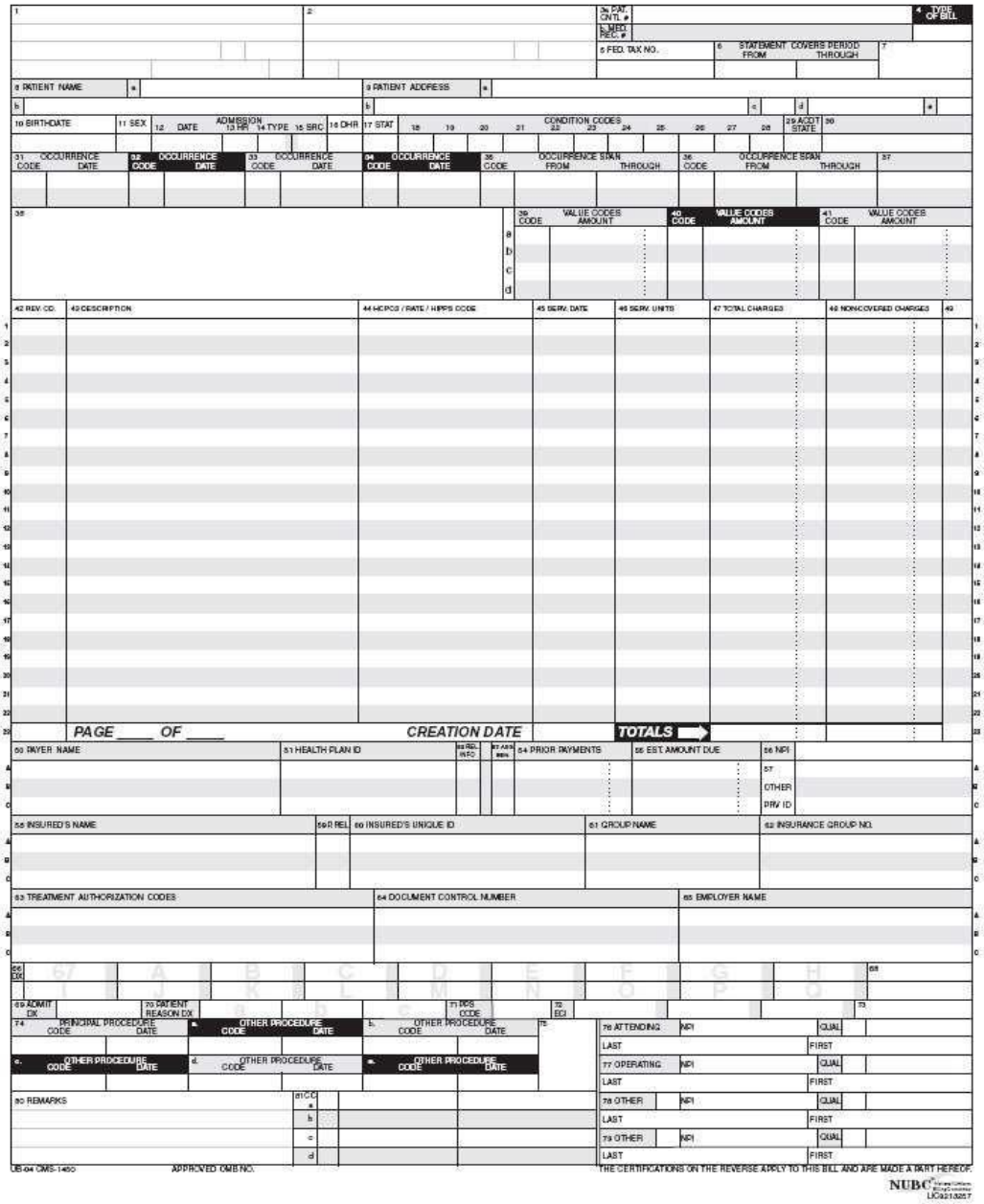
907.2.3. Web Portal – PA/Precert number field

907.2.4. UB-04 Paper Claim: Field locator 63

Note: A Nursing Facility must not submit claims for members with a TRANSFER OF RESOURCE (TOR) penalty. If a Nursing Facility has a Central Billing Office (CBO) the Nursing

Facility must immediately notify their CBO of the member's TOR penalty and instruct the CBO not to bill for that member until after the TOR penalty has ended.

Completion of the National Uniform Billing Claim Form (UB-04)



907.3. Fields that must be completed for Nursing Facility claims to be paid are:

Type of Bill	First and Secord Digits	Third Digit

Skilled Care	21	1,2,3, or 4
Intermediate Care	21	1,2,3, or 4
ICF/IID	66	1,2,3 or 4

907.4. The Third Digit Codes are:

1	Admit through Discharge	
2	Interim	First Claim
3	Interim	Continuing Claim
4	Interim	Last Claim

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

FL 4	Enter a code indicating the specific type of bill (e.g., interim, final)	
FL 5	Federal Tax Number	
FL 6	Statement Covers Period	Enter the beginning and ending service date (s) of the period included on this bill.
FL 8	Patient Name	Enter last name, first name, and middle initial of the patient. If the name on the Medicaid card is incorrect, the recipient or the recipient's representative should contact DFCS or the LTC Unit to have it corrected immediately
FL 10	Patient Birthdate	Record the date of birth exactly as it appears on the Medicaid Card. An unknown birth date is not acceptable. If the date on the Medicaid Card is incorrect, the recipient or the recipient's representative should contact DFCS or the LTC Unit to have it corrected immediately.
FL 12		For inpatient services, the date of admission is considered to be the date the patient began receiving care, including the observation period. Preadmission testing must be included on the inpatient claim.
FL 14	Type of Admission	Use Code 3 - Elective Elective – the patient's condition permits adequate time to schedule the availability of a suitable

		accommodation
FL 15	Source of Admission	Use Code 1. Physician Referral
FL 16	Discharge Hour	Enter the hour (00-23) that the patient was discharged from inpatient care if there is a discharge code in field 22.
FL 17	Patient Status	
FL 22	Status 30	Note: If the patient is being discharged from the facility with no expectation of holding the bed, please use a discharge status code. Note: In the past, providers have often used a Patient Status of B when a patient is discharged to a hospital with the expectation that the hospital stay will be an extended one (i.e. one well beyond the 7 bed hold days). If you are billing for that situation, use a Discharge Status 02 (FL 22). Medicaid does not pay for the Date of Discharge nor the Date of Death, so bill your claim, accordingly, using valid UB-04 Discharge or Death Status Codes.
FL 39-41	Value Code and Value amount	Reporting covered days: Enter the value code of 80 and the number of days covered by the primary payer in the value amount field. The value amount must be entered to the left of the dotted lines as a whole number. For example, 30 covered days would be reported as 30.00. Reporting non-covered days: Enter a value code of 81 and the number of days noncovered by the primary payer in the value amount field. The value amount must be entered to the left of the dotted lines as a whole number. For example, 30 non-covered days would be reported as 30.00.
FL 42	Revenue Code appropriate for Swing Bed	Enter the appropriate Revenue Code 190-Accommodations 182- Planned Leave

		185-Hospital Leave Revenue Code appropriate for Mechanical Ventilator Enter the appropriate Revenue Code 192-Accommodations Level II 183- Leave of Absence/Therapeutic
FL 43	Page of	If claim has multiple pages, enter the page number on each page. For example, page 1 of 3, page 2 of 3, page 3 of 3.
FL 46	Units of Service	Enter the number of days associated with Revenue Codes in FL 42
FL 47	Total Charges (by Revenue Category)	Enter the total charges pertaining to the related revenue code for the current billing period as entered in the statement coverage period. Only charges relating to the covered eligibility dates should be included in total charges.
FL 50	Payer	Enter payer name and carrier code* of any liable third-party payer other than Medicare. (*Carrier codes are located in the Third-Party Insurance Carrier listing). A reasonable effort must be made to collect all benefits from other third-party coverage. Federal regulation requires that Medicaid be the payer of last resort. (See Chapter 300 of the Policies and Procedures Manual applicable to all providers). When a liable third-party carrier is identified on the card, the provider must bill the third party.
FL 54	Prior Payments	Enter the amount that the hospital has received toward payment of this bill from the carrier.
FL 55	Estimated Amount Due	This is the field where the total charges will be captured.
FL 56	National Provider Identifier (NPI)	The provider must enter their NPI in this field.
FL 57(a-c)	Medicaid Provider number/Medicare ID/other	The provider must enter their Medicaid provider number in 57a

	identifier	
FL 58	Insured's Name	Enter the insured's last name, first name, and middle initial. Name must correspond with the name on the Medicaid card. If the name on the Medicaid card is incorrect, the recipient or the recipient's representative should contact the local DFCS/LTCU to have it corrected immediately.
FL 60	Certification/SSN/HIC/ID No.	Enter the Medicaid Recipient Client Number exactly as it appears on the Medicaid card
FL 61	Insured Group Name	Enter the name of the group or plan through which the insurance is provided to the insured if the patient has a third party. Medicaid requires the primary payer information on the primary payer line when Medicaid is secondary
FL 62	Insurance Group Numbers	Enter the identification number, control number, or code assigned by the carrier or payer if the patient has Third Party.
FL 67(a-q)	Diagnosis Code	Enter the ICD-9 CM (ICD-10 effective October 1, 2015) code for the principal diagnosis, and then enter the ICD-9-CM (ICD-10 effective October 1, 2015) diagnosis codes corresponding to additional conditions that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Codes prefixed in "E" or "M" are not accepted by the Department. A limited number of "V' codes are accepted.
FL 69	Admitting Diagnosis	Enter the ICD-9-CM (ICD-10 effective October 1, 2015) diagnosis code provided at the time of admission as stated by the physician.

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

Providers are allowed to bill Revenue Code 190 for accommodation charges alone. However, if a provider is billing for patient leave days (182 or 185), Revenue Code 190 is required on a separate detail line.

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

NOTE: Providers are not to submit a claim that crosses months/year's resulting in span billing. Our claims system cannot determine the correct per diem rate to apply. DCH expects claims to adjudicate successfully and accurately.

Example 1:

First Claim
Dates of Service: 01/01/2010 – 01/31/2010 (covered days 31)
Line 1 – 190 Revenue Code – 01/01/2010 (29 units)
Line 2 – 185 Revenue Code – 01/30/2010 (2 units)
Line 1 and Line 2 = total covered 31 days

Second claim, same member
Dates of service: 02/01/2010 – 02/05/2010 (covered days 5)
Line 1 – 190 Revenue Code – 02/01/2010 (0 units)
Line 2 – 185 Revenue Code – 02/01/2010 (5 units)
Line 1 and Line 2 = total covered 5 days

Example 2
Dates of service: 01/01/2006 – 01/16/2006 (covered days 16)
Line 1 – 190 Revenue Code – 01/01/06 – (10 units)
Line 2 – 185 Revenue Code – 01/11/06 – (6 units)
Total = Line 1 and Line 2 total = 16 days

Example 3
Dates of service: 01/01/06 – 01/16/06 (covered days 16)
Line 1 – 190 – 01/01/06 – (12 units)
Line 2 – 182 – 01/13/06 – (4 units)
Total = Line 1 and Line 2 total = 16 days

Example 4
Dates of service: 01/01/06 – 01/31/06 (covered days 31)
Line 1 – 190 – 01/01/06 (20 units)
Line 2 – 182 – 01/21/06 (6 units)
Line 3 – 185 – 01/27/06 (5 units)
Total = Lines 1, 2 and 3 total = 31 days

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

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

Note: Please Be sure you complete all required information on the claim form.

908. Patient Status Codes

908.1. Still a Patient

30	Replaces old patient code T: Note: Unless the patient is being discharge from the facility with no expectation of a return, please use a discharge state code.
Discharge	
01	Discharge to home or self-care
02	Discharge/Transferred to another short-term general hospital for inpatient care (Replaces old patient status code B
03	Discharged/Transferred to Skilled Nursing Facility
04	Discharged/Transferred to Intermediate Care Facility
05	Discharged/Transferred to another type of institution for inpatient care
06	Discharged/Transferred to home under care of organized home health service organization.
Deceased	
20	Replaces old patient status code G
Examples:	
Example 1	Billing for members still in the facility
Billing Period	04/01/2003 through 04/07/2003

Note: All UB-04 forms are to be completed in their entirety and uploaded to the Provider Workspace: www.mmis.georgia.gov Phone: 1-800-766-4456

908.2. Georgia Medicaid has transitioned to a paperless process to improve efficiencies for filing claims, appeals and other items. For more detailed information regarding the paperless initiative, refer to your Part I Policies & Procedures for Medicaid/PeachCare for Kids Manual, Chapter 100, Section 112.

Note: Keep your claims timely. The claim life cycle is the timeline for the total claim process from the date of service to original submission and through the last date by which resubmission (provider adjustment) must occur to remain timely.

908.3. Example:

DOS Original Submit/ 1st Resubmit/ 2nd Adjustment
Denied Date Adjustment
July 1, 2016, December 30, 2016, March 31, 2017, June 30, 2017
(365 days)

908.4. All claim submissions and adjustments for denied claims are to be completed according to policy by 365 days.

908.5. Other timely submission and resubmission system edits will remain in GAMMIS according to GA Medicaid policy (i.e., there is no time limit for adjusting a claim that reverses payment back to the Department).

908.6. During claim processing, you may need to FAX certain types of updates to Gainwell Technologies, including:

Member Services for lock-in
Patient Liability
Third Party Liability
Eligibility

908.7. Failure to file a claim so that it is received within six (6) months after the month in which service was rendered and/or failure to obtain prior approval or precertification when required will result in the denial of the claim.

908.8. If a member has a type of Medicaid in GAMMIS (SSI, QMB, SLMB, S99, etc), during the time in which a member is in a NH facility, the provider should bill and receive those denials, which will lock in their rendering service/span dates and prevent claims from denying untimely.

908.9. If a member has active eligibility with SSI or Title XIX, claims are to be submitted within 6 months and kept timely until the Nursing Home segment/Level of Care/Aid Category has been approved/updated. Retro eligibility will not be automatically granted if the member has active eligibility with Medicaid during the dates of service.

908.10. Once Long-Term Care eligibility is established, the claims will process in the cycle as the system is designed to do. Providers are not to wait for DFCS to change the category of service in order to bill when the member has Medicaid eligibility in the system. If providers do not bill on the active Medicaid that the member has in the system due to waiting for their provider information to show on GAMMIS, when the claims are filed and deny for timely, that timely denial will stand. Those claims will not be overridden.

908.11. Providers should complete the form 501 for patient liability (PL) adjustments on untimely claims.

908.12. All PL adjustments/updates made by DFCS have to have support from the DFCS Summary Notification, and this information must be sent to Gainwell Technologies.

908.13. There should be no adjustments made in GAMMIS of a paid claim for a PL update that is past timely as these funds are subject to denial and recoupment. Rather, complete the F501 and send to Gainwell Technologies to request the adjustment.

908.14. If there is a change to a patient liability amount after a provider's claim has already adjudicated, it will be at the provider's discretion to adjust the claim in order to capture the new PL amount.

908.15. If you FAX updated information to Member Services, make sure you keep a copy of the page with the date, time, and the FAX number for your records. After faxing the information, allow 10 to 15 business days for the updates to be made.

908.16. In the meantime, it is your responsibility to keep your claims timely. You must follow the policy guidelines for timeliness outlined in the Part I Policies and Procedures for Medicaid/PeachCare for Kids, Section 202.

909. Discharge Date

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

910. Nursing Facilities with Residents Having Diagnoses of Mental Disease

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

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

910.1.1. Facility location within a 25-mile radius of an existing mental hospital. If it is physically adjacent or near an existing mental hospital, and the facility regularly accepts a majority of its patients as transfers from a mental hospital, this is one indication that the facility is an IMD.

910.1.2. The age distribution of the patients. The age distribution should be substantially younger than the Georgia nursing facility average.

910.1.3. The facility's license as a mental health care facility.

910.1.4. The types of services and treatments the facility provides. If it provides psychological therapy and counseling on a regular basis to a majority of patients as part of an ongoing plan of care, this is another indication that the facility is an IMD.

910.1.5. The backgrounds, specialties and training of the facility's employees and medical staff. If the facility requires its employees to have a psychiatric background, this would indicate that the facility could be an IMD.

910.1.6. The diagnoses of the patients. If 50% or more of the patients have a primary diagnosis of mental disease, this is an indication that the facility is an IMD.

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

910.2.1. A patient with a physical problem necessitating nursing facility care who has no mental disability is considered a physical patient.

910.2.2. A patient with mental disability necessitating nursing facility care who has no significant physical problem is considered a mental patient.

910.2.3. A patient with physical problems that would not independently necessitate nursing facility care, but who has a mental disability that would preclude the proper handling of this physical problem outside a nursing facility and for whom nursing facility care is necessary due to the mental disability in functioning, is considered a mental patient.

910.2.4. A patient with a mental disability and physical problem, either of which would independently require nursing facility care, will generally fit into one of the following groups:

910.2.4.1. A patient with long-standing mental disability who develops major physical problems and vice-versa. When it is clear that nursing facility care resulted from one or the other, the patient will be classified according to the original basis for admission, physical or mental.

910.2.4.2. A patient for whom no clear-cut distinction is possible, as in group (1), will be considered a physical patient.

910.2.5. A patient not fitting into categories (a) through (d) who was admitted to a nursing facility from an inpatient psychiatric facility (i.e., state mental hospital) and who cannot be discharged because of his or her need for intellectual or physically related care, is considered a mental patient.

910.2.6. Mental diseases are those listed under the heading of mental disorders in the International Classification of Diseases, 9th and 10th Revisions – Clinical Modification ICD-9 CM (ICD-10 effective October 1, 2015), except for intellectual disabilities.

910.2.7. Organic brain syndrome, senile dementia and intellectual disabilities are excluded from the definition of mental disease.

911. Clinic Services to Residents in Nursing Facilities and ICFs/I

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

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

patients:

911.2.1. who for the purpose of receiving necessary health care go to a clinic, or other sites where the clinic staff is available; and

911.2.2. who on the same day leave the site from which the services are provided.

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

912. Advance Directive

In compliance with Section 1902 (a) (57) of the Social Security Act, nursing facilities must: Provide written information to residents regarding their rights under State law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.

Provide written information to individuals regarding the institution's written policies respecting the implementation of the right to formulate advance directives.

Document in the medical record whether or not an advance directive has been executed;

Comply with all requirements of State law respecting advance directives;

Provide (individually or with others) education for staff and the community on issues concerning advance directives;

Not condition the provision of care or otherwise discriminate against an individual who has executed an advance directive.

Chapter 1000: Basis For Reimbursement

1001. General

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

1002. Reimbursement Methodology

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

All LTC claims with units greater than zero must have a billed amount. There must be a quantity amount when units are more than zero (0).

1002.1. Definitions

1002.1.1. **Patient Income** is that dollar amount shown on the Summary Notification letter issued by the Department of Family and Children Services (DFCS) or the Long-Term Care Unit (LTC). The patient's income is deducted in full of the Medicaid reimbursement rate until the income has been exhausted.

1002.1.2. **Total Allowed Per Diem Billing Rate** is the amount derived from the rate setting process, as defined in Section 1002.2.

1002.1.3. A **nursing facility** is an institution licensed and regulated to provide nursing care services or intermediate care services for individuals with intellectual disabilities in accordance with the provisions of this Manual. For reimbursement purposes, nursing facilities including hospital-based facilities are divided into two types based upon the mix of Medicaid patients residing in the facilities. The type of classification of nursing facility may change as described in this chapter. The types are described below:

1002.1.3.1. **Nursing Facilities** – These facilities provide skilled and intermediate nursing care continuously, but do not provide constant medical and support services available in an acute care facility or hospital.

1002.1.3.2. **Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-ID)** – These facilities provide care to individuals with intellectual disabilities.

1002.1.4. **Cost Center** refers to one of five groupings of expenses reported on Schedule B-2 of the "Nursing Home Cost Report Under Title XIX," hereinafter referred to as the Cost Report. Specifically, expenses for the five cost centers are reported Routine and Special Services, Dietary,

Laundry and Housekeeping and Operation and maintenance of Plant, Administrative and General, Property and Related and Taxes and Insurance. See hospital-based and state institutions cost reports for appropriate cost center expense groupings.

1002.1.5. **Distinct Part Nursing Facilities** are facilities in which a portion operates as a nursing facility and another portion operates separately as an intermediate care facility for individuals with intellectual disabilities.

1002.1.6. **Total Patient Days** are the number of days reported by the facility on Schedule A, Line 13, Column 8 of the Cost Report subject to correction or adjustment by the Division for incorrectly reported data.

1002.1.7. **Hospital-Based Nursing Facilities** – A nursing facility is hospital-based when the following conditions are met:

1002.1.7.1. The facility is affiliated with an acute care hospital that is enrolled with the Division in the Hospital Services Program.

1002.1.7.2. The facility is subordinate to the hospital and operate as a separate and distinct hospital division that has financial and managerial responsibilities equivalent to those of other revenue producing divisions of the hospital.

1002.1.7.3. The facility is operated with the hospital under common ownership and governance. The long-term care facility, as a division of the hospital, must be responsible to the hospital's governing board.

1002.1.7.4. The facility is financially integrated with the hospital as evidenced by the utilization of the hospital's general and support services. A minimum of four services from Section A and two services from Section B below must be shared with the hospital.

1002.1.7.4.1. Section A

Employee benefits
Central services and supply
Dietary
Housekeeping
Laundry and linen
Maintenance and repairs

1002.1.7.4.2. Section B

Accounting
Admissions
Collections
Data processing
Maintenance of personnel

1002.1.7.5. Facilities must provide organizational evidence demonstrating that the above requirements of (4) have been met. This evidence will be used to determine which facilities will be hospital-based.

1002.1.7.6. Evidence that the required number of services in Section A and B are shared with the hospital must be included in the hospital's Medicare cost report.

1002.1.7.7. Appropriate costs should be allocated to the nursing facility, and the Medicare cost report must be approved by the Medicare intermediary.

1002.1.7.8. In making the determination that a long-term care facility is hospital based, collocation is not an essential factor; however, the distance between the facilities must be reasonable as determined by the Division or its agents. The Division will recover the monetary difference reimbursed to the facility between hospital-based and freestanding status for any time period the facility does not qualify for hospital-based status.

1002.1.7.9. To change classification to hospital-based from another class, or to enroll in the program as a hospital-based provider, the following restrictions apply in addition to the requirements described above:

1002.1.7.9.1. Only one hospital-based nursing facility per hospital is allowed.

1002.1.7.9.2. Any cost increases for the change to the hospital-based classification will be reimbursed when the first filed Medicare cost report is used for reimbursement, in accordance with 1002.6.1 and Appendix D, Section C (ix).

1002.1.7.9.3. Nursing facilities classified as hospital-based prior to July 1, 1994, will be exempt from the above additional requirements. Hospitals, which currently have more than one hospital-based nursing facility, will not be allowed to include any additional hospital-based facilities.

1002.1.8. **Property Transaction** is the sale of a facility or of a provider; the lease of a facility; the expiration of a lease of a facility; the construction of a new facility; an addition to the physical plant of a facility; or any transaction, other than change of ownership of a provider due solely to acquisition of capital stock, or the merger of a provider with another legal entity (statutory merger).

For purposes of reimbursement, a sale shall not include any transaction in which acquisition is less than 51% of a partnership or proprietorship or accomplished solely by acquisition of the capital stock of the corporation without acquisition of the assets of that corporation. The effective date of any Property Transaction shall be the latest of all the following events that are applicable to the transaction:

1002.1.8.1. The effective date of the sale or the lease.

1002.1.8.2. The first day a patient resides in the facility.

1002.1.8.3. The date of the written approval by the Division of Health Planning of the relevant proposal.

1002.1.8.4. The effective date of licensing by the Georgia Department of Community Health Standards and Licensure Unit.

1002.1.8.5. The effective date of the Statement of Participation in the Georgia Medical Assistance Program.

1002.1.8.6. The date on which physical construction is certified complete by whichever agency(s) is/are responsible for this determination.

1002.1.8.7. The date of approval of a Certificate of Need by the Division of Health Planning.

1002.1.9. **Gross Square Footage** is the outside measurement of everything under a roof, which meets the following criteria:

1002.1.9.1. Fully enclosed;

1002.1.9.2. Heated and/or cooled: and

1002.1.9.3. Construction of similar materials as the nursing facility and permanently affixed to a concrete slab.

1002.1.9.4. Gross square footage includes common areas, building core, and other areas of the building used for maintenance and operations. All buildings included in gross square footage must be within a reasonable distance (i.e. ¼ mile) to the nursing facility as determined by the Division or its agents. The nursing facility's square footage must be properly documented.

1002.1.9.5. The data received on gross square footage and age of a facility is subject to audit review (along with other parameters which affect the billing rate calculation). Documentation should include but not be limited to blueprints, architect plans, certified appraisals, etc.

1002.1.9.6. **Age** is defined in Section 1002.8.

1002.1.9.7. **Cost** is the expense incurred for goods and services used to operate a nursing facility. In the establishment of a per diem billing rate, most costs are allowable while certain other costs are not. A definition of cost and a discussion of allowable and non-allowable costs are contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1). In addition to those non-allowable costs discussed in CMS-15-1, the costs listed below are non-allowable.

1002.1.9.7.1. Costs related to lobbying and government relations, including costs for employees with duties related to lobbying and government relations, honorariums and reimbursement of travel or other expenses of elected officials.

1002.1.9.7.2. Membership in civic organizations.

1002.1.9.7.3. Out-of-state travel paid for by the provider for persons other than board members or those employed or contracted by the provider. Out-of-state travel for provider personnel must be related to patient care.

1002.1.9.7.4. Vehicle depreciation or vehicle lease expense more than the lesser of IRS limits per vehicle or the amount allowed under Medicare reimbursement

principles provided, however, such limits shall not apply to specialized patient transport vehicles (e.g. ambulances);

1002.1.9.7.5. Air transport vehicles that are not used to transport patient care staff or patients. If these vehicles are sometimes used for patient care staff or patient transport, the portion of cost that is unrelated to patient care staff or patient transport is non-allowable. For purposes of this provision, patient care staff includes only those who are transported to provide direct medical care to an individual patient.

1002.1.9.7.6. Fifty percent (50%) of membership dues to national, state, and local associations;

1002.1.9.7.7. Legal services for an administrative appeal or hearing, or court proceedings involving the provider and the Division or any other state agency when a judgement or relief is not granted to the provider. Legal services associated with certificate of need issuance reviews, appeals, disputes or court proceedings are not allowable regardless of outcome. Legal services associated with a provider's initial certificate of need request shall be allowable.

1002.1.9.7.8. Advertising costs that are (a) for fundraising purposes, (b) incurred in the sale or lease of a facility or agency or in connection with issuance of the provider's own stock, or the sale of stock held by the provider in another corporation, (c) for the purpose of increasing patient utilization of the provider's facilities; (d) for public image improvement, or (e) related to government relations or lobbying;

1002.1.9.7.9. Funds expended for personal purchases.

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

1002.2.1. For dates of service beginning July 1, 2026, the June 30, 2024, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.

1002.2.2. For dates of service beginning July 1, 2025, through June 30, 2026, the June 30, 2023, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.

1002.2.3. For dates of service beginning July 1, 2024, through June 30, 2025, June 30, 2022, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related. The Department will update the Medicaid Cost Report as the basis for the nursing facility reimbursement rate a minimum of every two years provided budget appropriations.

1002.2.4. For dates of service beginning July 1, 2023, through June 30, 2024, the June 30, 2021, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.

1002.2.5. For dates of service beginning July 1, 2022, through June 30, 2023, June 30, 2020, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.

1002.2.6. For dates of service beginning July 1, 2021, through June 30, 2022, June 30, 2019, Medicaid Cost Report is the basis for the nursing facility reimbursement rate for all cost centers EXCEPT Property and Related.

1002.2.6.1. A hold-harmless provision for the first year of the transition period will apply. Nursing facilities whose calculated rate using June 30, 2019, Medicaid Cost Report is less than their rate on June 30, 2021, will continue to be reimbursed at their June 30, 2021, Medicaid reimbursement rate. This hold-harmless provision will apply to the following quarterly rate setting periods: July 1, 2021, October 1, 2021, January 1, 2022, and April 1, 2022.

1002.2.7. For dates of service beginning July 1, 2018, through June 30, 2021, June 30, 2012, Cost Report is the basis for reimbursement for all nursing facilities except those nursing facilities reimbursed in accordance with the rules applicable to nursing facilities purchased from an unrelated party between January 1, 2012, and June 30, 2014. For those facilities, the June 30, 2012, June 30, 2014, or December 31, 2014, cost report is the basis for reimbursement.

1002.2.8. Effective July 1, 2019, through June 30, 2021, the minimum nursing facility per diem billing rate shall be $147.

1002.2.9. Effective July 1, 2026, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2024 GL-PL Insurance Supplemental Report.

1002.2.10. Effective July 1, 2025 through June 30, 2026, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2023 GL-PL Insurance Supplemental Report.

1002.2.11. Effective July 1, 2024 through June 30, 2025, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2022 GL-PL Insurance Supplemental Report.

1002.2.12. Effective July 1, 2023, through June 30, 2024, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2021, GL-PL Insurance Supplemental Report.

1002.2.13. Effective July 1, 2022, through June 30, 2023, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2020, GL-PL Insurance Supplemental Report.

1002.2.14. Effective July 1, 2021, through June 30, 2022, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2019, GL-PL Insurance Supplemental Report.

1002.2.15. Effective July 1, 2018, through June 30, 2021, the basis for reimbursement for the Supplemental Administrative and General – General and Professional Liability Insurance cost center will be the June 30, 2018, GL-PL Insurance Supplemental Report.

1002.3. Total Allowed Per Diem Billing Rate is the summation of the Allowed Per Diem + Growth Allowance + Efficiency Per Diem + Other Rate Adjustments

1002.3.1. **Allowed Per Diem** is the summation of the Net Per Diem or Standard Per Diem, whichever amount is less as to the facility; for Nursing Facilities, the resulting per diem amount for Routine and Special Services is multiplied by a facility's quarterly case mix score as determined by the Division for Medicaid patients during the most recent calendar quarter for which information is available.

For each of the four Non-Property Cost Centers (including the Supplemental Administrative and General and Professional Liability Insurance cost center) plus the Net Per Diem for the Property and Related Cost Center. The Property and Related Cost Center reimbursement for those facilities whose cost reimbursement is the

facility's computed Fair Rental Value per diem.

1002.3.2. **Growth Allowance** is an adjustment to the adjusted allowed per diem to account for inflation or increased costs of operations.

1002.3.2.1. Effective July 1, 2022, and thereafter, a growth allowance summation of 0% of Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operations and Maintenance of Plant; and Administrative and General).

1002.3.2.2. Effective July 1, 2021, through June 30, 2022, a growth allowance summation of 5% of Allowed Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operations and Maintenance of Plant; and Administrative and General).

1002.3.2.3. Effective July 1, 2019, through June 30, 2021, a growth allowance summation of 13.37% of Allowed. Per Diem for each of the four Non-Property and Related cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operations and Maintenance of Plant; and Administrative and General).

1002.3.3. **Efficiency Per Diem** is the summation of (Standard Per Diem minus Net Per Diem) x 75% up to the Maximum Efficiency Per Diem for each of the five cost centers. See 1002.4.12 for further explanation.

1002.4. Further explanation of the reimbursement formula terms is included below:

1002.4.1. In general, the New Per Diem is determined from the costs of operation of the individual facility in which eligible patients reside. These reports are determined by utilizing the information submitted by the facility on its Cost Report.

1002.4.2. All amounts and supporting data submitted on the Cost Report are subject to verification and adjustment by the Division. These modifications concern mathematical calculation errors; limitations placed on allowable costs, and the documents, principles, and criteria referenced therein; reasonableness limitations placed on salaries paid employees of the facility; reasonableness limitations using the principles contained in CMS-15-1; or other parameters placed on reasonable cost by the Division. These modifications basically concern what expenses are attributable to the care received and the reasonableness of the amounts of expenses that are attributable to care. See Appendix Q for appellate procedures to resolve disputes of specific contested adjustments. Specifically, the Net Per Diem for each of the five cost centers is determined as follows (all Schedule references are to the Cost Report):

See Section 1002.8 for additional description of such limitation.

1002.4.3. Allowable Home Office salary costs are limited to an appropriate maximum. Fringe benefits are also limited to an appropriate maximum. (A per bed salary ceiling also is imposed, based on the 70th percentile of costs per the 1988 home office cost reports, plus an allowance for inflation. Home Office salaries and related fringe benefits are subjected to a $100,000 maximum salary for CEO, COO, CFO and other Home Office personnel. Therefore, in addition to the per bed salary ceiling, we have incorporated a position maximum of $100,000 to be applied only to owners of nursing facilities and related parties). Reimbursement for the cost of home office vehicles is eliminated, except to the extent that home office vehicle costs can be included with related home office salaries as a fringe benefit, and in total, fall below any designated maximums.

1002.4.4. Routine and Special Services Net Per Diem

1002.4.4.1. Nursing Facilities Net Per Diem is the audited historical Routine and Special Services costs divided by Total Patient Days; for Nursing Facilities, the resulting per diem amount is divided by a case mix index score as determined by the Division for all residents in the facility during the base period, the cost reporting period identified in Section 1002.2 of the manual. The method by which a case mix index score is calculated is described in Appendix D of the manual.

ICF-ID Net Per Diem is the Historical ICF-ID Routine and Special Services divided by Total ICF-ID Patient Days.

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

1002.4.4.2. **Dietary Net Per Diem** is the audited historical Dietary, Divided By Total Patient Days.

1002.4.4.3. **Laundry and Housekeeping and Operation and Maintenance of Plant Net Per Diem** is the audited historical Laundry, Housekeeping, Operation and Maintenance of Plant Divided by Total Patient Days.

1002.4.4.4. **Administrative and General Net Per Diem** is the audited historical Administrative and General, less the audited Supplemental Administrative and General – General and Professional Liability Insurance, Schedule Divided by Total Patient Days.

1002.4.4.5. **Supplemental Administrative and General – General and Professional Liability Insurance Net Per Diem** is the audited historical Administrative and General – General and Professional Liability Insurance, Schedule Divided by Total Patient Days.

1002.4.4.6. **Property and Related Net Per Diem** is the Property and Related net per diem calculated under the Fair Rental Value System.

1002.4.4.7. **Taxes and Insurance Net Per Diem** is the audited historical Taxes and Insurance cost Divided by Total Patient Days.

1002.4.4.8. The Return on Equity Percent is 0% for all facilities

1002.4.5. Standard Per Diem for each of the five cost centers (Routine and Special Services; Dietary; Laundry and Housekeeping and Operation and Maintenance of Plant; Administrative and General; and Taxes and Insurance is determined after facilities with like characteristics concerning a particular cost center are separated into distinct groups. Once a group has been defined for a particular cost center, facilities in a group shall be ordered by position number from one to the number of facilities in the group, arranged by Net Per Diem from the lowest (Number "1") to the highest dollar value Net Per Diem.

1002.4.6. The number of facilities in the applicable group shall be multiplied by the Maximum Percentile, or a median net per diem may be chosen, with the Maximum Cost per day being determined as a percentage of the median. The Maximum Cost per day for the Administrative and General costs of all nursing facilities eligible for an efficiency incentive payment is 105% of the median cost per day within each peer group. The Maximum Percentile is the eighty-fifth for Laundry and Housekeeping and Operation and Maintenance of Plant cost centers. The Maximum Percentile is the ninetieth percentile for the Routine Services and Special Services, and the Property and Related cost centers. For the Dietary cost center, the Maximum Percentile is the sixtieth percentile for the Hospital-Based Nursing Facility group and the ninetieth percentile for the Free-Standing Nursing Facility group and the Intermediate Care Facility for individuals with intellectual disabilities group. If the Maximum Percentile does not correspond to a specific value in the array of net per diem amounts, the maximum percentile is determined by interpolation (i.e., finding the mid-point between whole integers).

1002.4.7. The grouping will be done using Net Per Diem for each cost center that has been reported by the facility and calculated by the Division in each facility's rate sheet.

Effective July 1, 2018, the Administrative and General cost center standard per diem will be recalculated in the rate sheet by removing general and professional liability insurance cost and determining a new

Net Per Diem amount. General and professional liability insurance costs will be recorded in the rate sheet in the Supplemental Administrative and General – General and Professional Liability Insurance cost center which will not have a standard per diem calculated.

Subsequent to the recalculation of the Administrative and General cost center standard, there will not be any recalculation of standards based upon changes in rates due to subsequent determination of additional allowable costs, disallowance of previously allowable cost or any change in the Net Per Diem in any cost center. The following examples show groupings by Net Per Diem.

1002.4.8. Maximum Percentiles

1002.4.8.1. Routine and Special Services Maximum Percentile at 90%

Nursing Home Net Per Diem for 10 nursing homes from lowest to highest:
$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

1002.4.8.2. Maximum Percentile Standard Determination

(10 net per diems) X (90th percentile) = 9th position or $135

1002.4.8.3. Administrative and General Maximum Cost at 105% of Median

Nursing Home Net Per Diems for 11 nursing homes from lowest to highest:
$90, $95, $95, $100, $115, $120, $120, $130, $135, $140, $150

1002.4.8.4. Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the per diem amount that falls in the middle of the group or $120
$120 x 105% = $126

1002.4.8.5. Administrative and General Maximum Cost at 105% of Median (Interpolation)

Nursing Home Per Diems for 10 nursing homes from lowest to highest:
$90, $95, $95, $100, $115, $120, $120, $130, $135, $140

1002.4.8.6. Maximum Cost Standard Determination at 105% of Median

Median Net Per Diem is the average of the two-middle net per diem amounts that fall in the middle of the group
($115 + $120/2 = $118)
$118 x 105% = 124

1002.4.9. There are several instances where a facility could fall in more than one group. Intermediate care facilities for individuals with intellectual disabilities which are also nursing facilities are classified as intermediate care facilities for individuals with intellectual disabilities and not grouped with other nursing facilities.

1002.4.10. If a facility changes classification to hospital-based or grouping on January 1 through June 30 of any calendar year, it will be grouped into its new category for reimbursement purposes for dates of services July 1 of that year and thereafter. If a facility changes classification as described above on July 1 through December 31 of any calendar year, regrouping will occur from January 1 of the following year.

1002.4.11. For the purpose of determining the Standard Per Diem and the Allowed Per Diem for each cost center, a facility is grouped according to the type of facility (e.g., nursing facility, hospital-based nursing facility, or intermediate care facility for individuals with intellectual disabilities) it is as of the date the Standard Per Diem is calculated.

1002.4.11.1. Routine and Special Services Standard Per Diem - For this Standard Per Diem, all nursing facilities shall be grouped as follows:

1002.4.11.1.1.1. Nursing Facility

1002.4.11.1.1.2. Intermediate Care Facility for Individuals with Intellectual Disabilities

1002.4.11.2. Dietary Standard Per Diem - For this Standard Per Diem, all nursing facilities shall be grouped as follows:

1002.4.11.2.1. Free Standing Nursing Facility

1002.4.11.2.2. Hospital-Based Nursing Facility

1002.4.11.2.3. Intermediate Care Facility for Individuals with Intellectual Disabilities

1002.4.11.3. Laundry and Housekeeping and Operation and Maintenance of Plant Standard Per Diem - For this Standard Per Diem, all nursing facilities shall be grouped as follows:

1002.4.11.3.1. Nursing Facility

1002.4.11.3.2. Intermediate Care Facility for Individuals with Intellectual Disabilities

1002.4.11.4. Administrative and General Standard Per Diem - For this Standard Per Diem, all nursing facilities shall be grouped as follows:

1002.4.11.4.1. Nursing Facility

1002.4.11.4.2. Intermediate Care Facility for Individuals with Intellectual Disabilities

1002.4.11.5. Supplemental Administrative and General – General and Professional Liability Insurance Standard Per Diem - Costs for general and professional liability insurance expense, as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to the Administrative and General cost center Standard Per Diem.

1002.4.11.6. Property and Related Standard Per Diem - Cost for property taxes and property insurance as defined in the Uniform Chart of Accounts, are calculated separately and are not subject to property related cost center Standard Per Diem.

1002.4.12. The Efficiency Per Diem represents the summation of the Efficiency Per Diem for each of the five cost centers. If the Net Per Diem is equal to or exceeds the Standard Per Diem in any cost center, or if the Net Per Diem is equal to or less than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is zero ($0.00). If the Net Per Diem is less than the Standard Per Diem in any cost center, and if the Net Per Diem is more than 15% of the Standard Per Diem, the Efficiency Per Diem for the cost center is calculated by subtracting the Net Per Diem from the Standard Per Diem for that cost center and then multiplying the difference by .75. The product represents the Efficiency Per Diem for that cost center subject to the following maximums which have been established through legislative authority:

Cost Center	**Maximum Efficiency Per Diem**
Routine and Special Services	$0.53
Dietary Services	$0.22
Laundry and Housekeeping and Operations and Maintenance	$0.41
Administrative and General	$0.37
Property and Related	$0.40

1002.5. Total Allowed Per Diem Billing Rate for Facilities Purchased from An Unrelated Party Between January 1, 2012, And June 30, 2014, through June 30, 2021

Facilities purchased from a party not related to the new owner between January 1, 2012, and June 30, 2014, will have their per diem rates effective July 1, 2015, through June 30, 2021, determined based on the cost of the new owner.

Immediate family members including the previous owner's spouse, child, sibling, parent, grandparent, or grandchild. Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and

1002.5.1. A business corporation, general partnership, limited partnership, limited liability company, joint venture, nonprofit corporation, or any other or profit or not-for-profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner.

1002.5.2. A definition of related party ownership is contained in Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS-15-1004) states the existence of an immediate family relationship will create an irrebuttable presumption of relatedness through control or attribution of ownership or equity interests where the significance tests of sections 1002.5.2 and 1002.5.2.2 above are met. Even through a purchase which converts the entity from a proprietary to a nonprofit status, the initial owners maintain the related party status.

1002.5.3. The new owner's rate effective July 1, 2015, through June 30, 2021, will be determined as follows:

1002.5.3.1. The first cost report ending June 30th that contains at least six months of cost under the new owner will be used to establish the provider's rate effective July 1, 2015.

1002.5.3.2. If there is not a cost report ending June 30th that contains at least six months of cost under the new owner available when establishing July 1, 2015, cost report information covering from the date of the change in ownership through December 31, 2014, will be used.

1002.5.3.3. Rates determined based on cost report information sub sequent to June 30, 2014, will be reconciled and retroactively adjusted upon review of the information.

1002.5.3.4. The cost ceilings used when establishing the rate effective July 1, 2015, will be determined using the same June 30th year end used for determining cost. The June 30, 2014, cost reports will establish ceilings for cost data submitted for the period ending December 31, 2014.

1002.5.3.5. The Administrative and General cost center per diem

shall not increase because of the rate adjustments.

1002.5.3.6. The Property and Related per diem as determined through the Fair Rental Value Reimbursement methodology shall not change because of the rate adjustment.

1002.5.3.7. Providers will continue to receive rates based on the new owner's cost report until a later cost report is approved for rebasing.

1002.6. Total Allowed Per Diem Billing Rate for Facilities for Which A Cost Report or Case Mix Score Cannot Be Used To Set A Billing Rate

If the Division determines that a cost report/GL-PL Insurance Supplemental Report cannot be used to set a billing rate per diem rate will be established, as follows:

1002.6.1. When changes in ownership occur, new owners will receive the prior owner's per diem until a cost report basis can be used to establish a new per diem rate. See Appendix D.

1002.6.2. Newly enrolled facilities will be reimbursed the lower of projected cost; or 90% of the appropriate cost center ceilings, plus a growth allowance and the appropriate Property and Related Net Per Diem until a cost report is submitted which can be used to establish a rate. The Allowed Per Diem for general and professional liability insurance will be the lower of projected costs or 90% of 105% of the median Net Per Diem in the current Supplemental Administrative and General – General and Professional Liability Insurance cost center.

1002.6.3. In all other instances (except as noted below for newly constructed facilities) where the Division determines that a cost report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for un-auditable cost reports.

The Total Allowed Per Diem Billing Rate for facilities with more than 50 beds determined by the Division to be newly constructed facilities is equal to 95% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem. The Allowed Per Diem for general and professional liability insurance will be the lower of projected costs or 90% of 105% of the median Net Per Diem in the current Supplemental Administrative and General – General and Professional Liability Insurance cost center.

The Property and Related Net Per Diem referred to in subsections (a) through (c) above is equal to the Fair Rental Value Rate as determined under Section 1002.8.2.

1002.6.4. In all other instances where the Division determines that a cost

report/GL-PL Insurance Supplemental Report cannot be used to set a reimbursement rate, the Total Allowed Per Diem Billing Rate will be resolved as described in the provisions discussed below for un-auditable cost reports. If the Division determines that a cost report/GL-PL Insurance Supplemental Report which was to be used to set a reimbursement rate is un-auditable (i.e., the Division's auditors cannot render an opinion using commonly accepted auditing practices on the filed cost report, either on the desk review or on-site audit), or unreliable (See Appendix Q), the Division may reimburse the facility the lower of the following:

1002.6.4.1. The last Total Allowed Per Diem Billing Rate issued prior to the reimbursement period to be covered by un-auditable cost report/GL-PL Insurance Supplemental Report.

1002.6.4.2. The Total Allowed Per Diem Billing Rate calculated from the un-auditable cost report; or

1002.6.4.3. The Total Allowed Per Diem Billing Rate calculated according to 90% of the four Non-Property and Related Standard Per Diem amounts plus the appropriate growth allowance and Property and Related Net Per Diem. The Allowed Per Diem for general and professional liability insurance will be the lower of projected costs or 90% of 105% of the median Net Per Diem in the current Supplemental Administrative and General – General and Professional Liability Insurance cost center.

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

1002.6.5. If a case mix score cannot be determined for a facility, the average score for all facilities may be used in a rate calculation. If a facility's number of MDS assessments for Medicaid patients in a quarter is limited so as to make the resulting average case mix score unreliable for rate calculations, the Department may elect to use the average score for all facilities.

1002.7. Other Rate Adjustments

1002.7.1. Quality Improvement Initiative Program

Facilities must enroll in the Quality Improvement Program to receive the following incentives. The Department will use the most current data available to determine the add-on percentages.

1002.7.1.1. A staffing adjustment equal to 1% of the Allowed Per

Diem for Routine and Special Services may be added to a facility's rate. To qualify for such a rate adjustment, a facility's Nursing Hours and Patient Days Report must demonstrate that the facility meets the minimum staffing requirements presented in section 1003.1.

1002.7.1.2. Brief Interview for Mental Status (BIMS) scores for Medicaid patients will be measured, as determined by the Division. An adjustment factor may be applied to a facility's Routine and Special Services Allowed Per Diem based on the percentage of Medicaid patients whose BIMS scores are less than or equal to 5. The adjustments factors are as follows:

% of Medicaid Patients	Adjustment Factor
<20%	0%
20% - <30%	1%
30% - <45%	2.5%
45% - 100%	5.5%

1002.7.2. A quality add-on adjustment may be added to a facility's rate utilizing the following set of indicators:

To qualify for a quality incentive adjustment equal to 1% of the Allowed Per Diem for Routine and Special Services for the most recent calendar quarter, the facility must obtain a minimum of three (3) points in the following combination: One (1) point must come from clinical measures, one (1) point from the non-clinical measure, and a third point from either the clinical or non-clinical measures.

To qualify for a quality incentive adjustment equal to 2% of the Allowed Per Diem for Routine and Special Services, for the most recent calendar quarter, the facility must obtain a minimum of six (6) points in the following combination: Three (3) points must come from the clinical measures, one (1) point from the non-clinical measures, and two (2) points from either the clinical or non-clinical measures.

1002.7.2.1. Clinical Measures

The source of data is the Center for Medicare and Medicaid Services (CMS) website. Each measure is worth 1 point if the facility-specific value is in excess of the statewide average.

Percent of High Risk Long-Stay Residents Who Have Pressure Sores
Percent of Long-Stay Residents Who Were Physically Restrained

Percent of Long-Stay Residents who Self-Report Moderate to Severe Pain
Percent of Short-Stay Residents with Pressure Ulcers, New/Worsened
Percent of Residents Who Received Influenza Vaccine
Percent of Residents Experiencing One or More Falls with Major Injuries

1002.7.2.2. Alternative Clinical Measures:

Facilities that do not generate enough data to report on the CMS website (due to not meeting the minimum number of assessments for a reporting in a quarter) will use the following measures from NRC Health Quality Profile. The values used from NRC Health Quality Profile will be compared to the NRC Health Georgia average values for those measures. Each measure is worth 1 point if the facility-specific value is in excess of the NRC Health Georgia average.

Chronic Care Pain – Residents with unplanned weight loss/gain
Percentage of long-stay residents assessed and appropriately given the seasonal influenza vaccine
Percentage of long-stay residents who experience one or more falls with major injury
High Risk Pressure Ulcer – Residents without acquired pressure ulcers.
Physical Restraints – Residents without acquired restraints.
Residents with pressure sores worsened.

1002.7.2.3. Non-Clinical Measures

Each measure is worth 1 point as described.

Participation in the Employee Satisfaction Survey
Most Current Family Satisfaction Survey Score for "Would you recommend this facility?" Percentage of combined responses either "excellent" or "good" to meet or exceed the state average of 85% combined.
Quarterly average for RNs/LVNs/LPNs Stability (retention) to meet or exceed the state average
Quarterly average for CNAs/NA Stability (retention) to meet or exceed the state average
AHCA Active Bronze Quality Award winner per the AHCA Active Bronze Quality Award winner list.

1002.7.2.4. Additional Quality Points Available:

The following measures are worth the specified number of points as described in the three criteria below in addition to the 1% or 2% available incentive.

AHCA Active Silver Quality Award winner per the AHCA Active Silver Quality Award winner List will earn an additional incentive equal to 1%.
AHCA Active Gold Quality Award winner per the AHCA Active Gold Quality Award winner List will earn an additional incentive equal to 2%.
A Nursing Center who has earned and is currently accredited as a Joint Commission Accredited Nursing Care Centers will earn an additional incentive equal to 2%.

1002.7.2.5. Maximum Quality Incentive Points

An additional 1% incentive, not to exceed a total quality add-on of 4% can be earned by a facility that is an active AHCA Silver Award winning center
An additional 2% incentive, not to exceed a total quality add-on of 5% can be earned by a facility that is an active AHCA Gold Award winning center.
An additional 2% incentive, not to exceed a total quality add-on of 7% can be earned by a facility that is an active Joint Commission Accredited facility.

1002.7.3. Facilities placed on the Special Focus List generated by CMS will not earn the DCH 1% Quality Incentive until the following conditions have been met:

1002.7.3.1. The facilities next standard survey and/or compliant survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; and

1002.7.3.2. The facilities second standard survey and/or compliant survey, after being placed on the list, does not have a deficiency cited over Level E scope and severity; or

1002.7.3.3. If the facility is removed from the special focus list by CMS for any other reason

1002.8. Property and Related Reimbursement

1002.8.1. Effective for dates of service on and after July 1, 2012, the Property and Related Net Per Diem shall be the amount computed using the Fair Rental Value (FRV reimbursement system described below. Under a

FRV system, a facility reimbursed on the basis of the established current value of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest, and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility, its location, and its total square footage.

1002.8.2. The Property and Related Net Per Diem initially established under the FRV System shall be calculated as follows:

1002.8.2.1. The **Value per Square Foot** shall be adjusted by using the RSMeans Location factors based on the facility's zip code as well as by a Construction Cost Index which is set at 1.0. The resulting product is the Adjusted Cost per Square Foot.

1002.8.2.1.1. Effective for dates of service on and after July 1, 2025, the value per square foot shall be based on the $244.83 construction cost for nursing facilities, as derived from the 2023 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.1.2. Effective for dates of service on and after July 1, 2024, the value per square foot shall be based on the $225.26 construction cost for nursing facilities, as derived from the 2022 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.1.3. Effective for dates of service on or after July 1, 2023, through June 30, 2024, the value per square foot shall be based on the $202.49 construction cost for nursing facilities, as derived from the 2021 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.1.4. Effective for dates of service on and after July 1, 2022, through June 30, 2023, the value per square foot shall be based on the $198.86 construction cost for nursing facilities, as derived from the 2020 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.1.5. Effective for dates of service on and after July 1, 2021, through June 30, 2022, the value per square foot shall be based on the $187.12 construction cost for nursing facilities, as derived from the 2012 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.1.6. Effective for dates of service on and after July 1, 2014, through June 30, 2021, the value per square foot shall be based on the $187.12 construction cost for nursing facilities, as derived from the 2012 RSMeans Building Construction cost data for Nursing Homes (national index for open shop construction).

1002.8.2.2. A **Facility Replacement Value** is calculated by multiplying the Adjusted Cost per Square Foot by the Allowed Total Square Footage. The latter figure is the lesser of a nursing facility's actual square footage (computed using the gross footage method) compared to the number of licensed beds time 700 square feet (the maximum allowed figure per bed).

1002.8.2.3. An **Equipment Value** is calculated by multiplying the number of licensed beds by $6,000 (the amount allowed per bed) and by an initial Equipment Cost Index of 1.000.

1002.8.2.4. A **Depreciated Replacement Valu**e is calculated by depreciating the sum of the Facility Replacement value and the Equipment Value. The amount depreciated is determined by multiplying the Adjusted Facility Age discussed in all of Section 1002.8.5 by a 2% Facility Depreciation Rate. The Initial Adjusted Facility Age will be the lesser of the calculated facility age or 25 years.

1002.8.2.5. The **Land Value** of a facility is calculated by multiplying the Facility Replacement value by 15% to approximate the cost of the land.

1002.8.2.6. A **Rental Amoun**t is calculated by summing the facility's Depreciated Replacement Value and the Land Value and multiplying the figure by a Rental Rate which is 9.0% effective July 1, 2009.

1002.8.2.7. The **Annual Rental Amount** is divided by the greater of the facility's actual cumulative resident days during the 2023 cost reporting period or 85% of the licensed bed

capacity of the facility multiplied by 365. The resulting figure constitutes the Property and Related Net Per Diem established under the FRV system. An example of how the Property and Related Net Per Diem is calculated is presented in the table shown in Appendix D, Exhibit 3.

1002.8.3. The Property and Related New Per Diem may be updated annually on July 1, effective for dates of service on or after July 1, 2010, as follows:

1002.8.3.1. The value per square foot shall be based on the construction cost for nursing facilities, as derived from the most recent RSMeans Building Construction cost data available on June 1st of each year. The Value per Square Foot shall be adjusted by using the RSMeans Location factors based on the facility's zip code and by using a cost index to correspond to annual state appropriations.

1002.8.3.2. A complete facility replacement, which includes either relocating to a newly constructed facility or gutting a complete facility and rebuilding it, will result in a new base year correlating to the date in which the facility went into operation.

1002.8.3.2.1. A Gut and rebuild must include taking all walls down to the studs (exposing the structural skeleton of the existing building), removing and replacing flooring, existing interior doors and trim, cabinets, sinks, wiring, etc.

1002.8.3.2.2. All partial replacements will be treated as renovations which includes cosmetic or structural improvements to a wing or section of the facility (i.e. painting walls, adding nursing stations, new flooring, changing layout of existing floorplan, replacing bathroom fixtures, windows, exterior doors, the roof, and most or all plumbing, and electrical) and will have their base year adjusted based on the methodology prescribed for a renovation.

1002.8.3.2.3. Parking lots and landscaping costs are not included as allowable construction renovation costs for fair rental value.

1002.8.4. A Renovation Construction Project shall mean a capital expenditure (as defined in Section 1002.5(4a)) that exceeds $500 per existing licensed bed. Applications must be filed with the Office of Health Planning as a

New Construction Project under the authority of Ga. Comp. R. & Regs. r. 290-5-8 for renovation projects for that are requesting complete facility replacement and/or gut rebuild "deemed new" consideration.

1002.8.4.1. Allowable capital expenditures include the costs of buildings, machinery, fixtures, and fixed equipment (see Table 5 in Estimated Useful Lives of Depreciable Hospital Assets Revised 2008 Edition, published by Health Forum, Inc., for a complete listing of allowable items) constituting any New Construction Project as referenced in 1002.8.4 above. The exception, to this requirement is for telemedicine terminals, solar panels, tankless water heaters, and low flow toilets. Capital expenditures are asset acquisitions that meet the criteria of §108.1 of the Provider reimbursement Manual (CMS-15-1) or are betterments or improvements which meet the criteria of §108.2 of the Provider Reimbursement Manual (CMS-15-1) or which materially (a) expand the capacity, (b) reduce the operating and maintenance costs, (c) significantly improve safety, or (d) promote energy conservation.

1002.8.5. For purposes of the FRV calculation, the age of the facility shall be determined as follows:

1002.8.5.1. The age of each facility shall be determined as of July 1, 2025, comparing 2025 rate setting year to the later of the facility's year of construction or the year the building was first licensed as a nursing facility; provided, however, that such age will be reduced for Construction Projects, or bed additions that occurred subsequent to the initial construction or conversation of the facility, but prior to July 1, 2025.

1002.8.5.2. For periods subsequent to July 1, 2023, the FRV adjusted age determined in Section 1002.8 of a facility will be reduced on a quarterly basis to reflect new Renovation Construction Projects or bed additions that were completed after July 1, 2023, and placed into service during the preceding quarter. The rate adjustment for Renovation Projects or bed additions will be effective the first day of the calendar quarter subsequent to the Department's final approval of the completed project. Bed reductions will not be used to determine a facility's adjusted age.

1002.8.5.3. Once initial rates are established under FRV reimbursement system, subsequent calculations of the FRV adjusted age will be determined by subtracting the adjusted base year (derived by calculating the impact of bed additions and facility renovations) from the rate

setting year. The FRV adjusted age will be recalculated each July 1 to make the facility one year older, up to the maximum age of 25 years and will be done in concert with the calculations of the Value per Square Foot as determined in Section 1002.8.3. Age adjustments and Rate adjustments are not synonymous.

1002.8.5.4. If a facility has added beds, the age of these additional beds will be averaged in with the age of the remaining beds, and the weighted average age of all beds will be used as the facility's age. An example of how an addition would reduce the age of the facility is presented in the table at Appendix D, Exhibit 4:

1002.8.6. If a facility performed a Renovation Construction Project as defined in Section 1002.8.4 the cost of the Project will be converted to an equivalent number of replacement beds by dividing the value of the renovation by the depreciable bed replacement value.

1002.8.6.1. The renovation completion date will be used to determine the year of the renovation.

1002.8.6.2. An Age Index factor will be used to calculate a bed replacement cost for any renovation occurring prior to July 1, 2009. The Age Index factor is derived by using the 2009. The Age Index factor is derived by using the 2009 Edition of the RSMeans and dividing the Historical Cost Index for 2009.

1002.8.6.3. To determine the accumulated depreciation per bed, 2 percent per year will be used for a maximum number of 25 depreciable years.

1002.8.6.4. In no case will the consideration of a Renovation Construction Project be converted to an equivalent number of replacement beds and a new base year is presented in the table shown in Appendix D, Exhibit 5:

1002.9. Overall Limitations on Total Allowed Per Diem Billing Rate

In no case shall the Total Allowed Per Diem Billing Rate, whether determined under either Section 1002.2 ,Section 1002.3, Section 1002.4, or Section 1002.5 Nursing Facility Manual, exceed the facility's customary charges to the general public for those services reimbursed by the Division.

1002.10. Payments in Full for Covered Services

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

1002.11. Adjustments to Rates

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

1003. Additional Case Services

1003.1. Required Nursing Hours

The minimum required number if nursing hours per patient day for all nursing facilities is 2.00 actual working hours. The minimum expected nursing hours are 2.50 to qualify for the 1% add-on (See 1002.7).

1003.2. Failure to Comply

1003.2.1. The minimum standard for nursing hours is 2.00.

1003.2.2. Facilities found not in compliance with the 2.00 nursing hours will be cited for being out of compliance with a condition of participation. This will lead to imposition of a civil monetary penalty, denial of reimbursement for newly admitted patients or suspension or termination whichever is appropriate as determined by the Division.

1003.2.3. The minimum expected for nursing hours is 2.50 for participation in the Quality Improvement Program.

1004. Medicare Crossover Claims

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

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

For payments on or after January 1, 2001, State government –owned or operated facilities and non-State government owned or operated facilities will be eligible for rate payment adjustments, subject to federal upper payment limits and will be based on amounts that would be paid for services under Medicare payment principles. These rate payment adjustments will be made on a quarterly basis in a manner that will not duplicate compensation provided from payments for individual patient claims.

1006. Payment Rates for Patient Leave Days or Bed Hold Days

Effective for dates of service on and after July 1, 2004, payments for patient leave days or for bed

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

1007. Nurse Aide Training and Testing Costs

The Division will reimburse nursing facilities, on a full time equivalent (FTE) basis, up to $738 for each individual who has completed a state-approved training and competency program for nurse aides. At the facilities' request, interim payments of $.25 per Medicaid patient day will be made quarterly to the facility to cover the cost of providing nurse aide testing and training.

1008. Nursing Facility Rate Determination for Ventilator Dependent Residents

1008.1. Effective for dates of service on and after July 1, 2023, the nursing facility per diem for a ventilator dependent resident will be $707.54.

1008.2. The per diem costs of providing services to the ventilator dependent residents shall be maintained separately (as a distinct part) of each facility's annual cost report beginning November 13, 2009.

1008.3. Ventilator dependent per diem rates will cover all skilled nursing care services and will be all-inclusive.

1008.4. No additional amount above the current nursing facility daily rate shall be allowed until the service is prior authorized by the Department's Medical Management Contractor.

1008.5. The resident's clinical condition shall be reviewed every 90 days to determine if the resident's medical condition continues to warrant services at the ventilator dependent nursing facility rate. Prior authorization through the Department's Medial Management Contractor spans a 90-day maximum time period. The nursing facility is required to resubmit requests for continued stay prior to expiration of the current PA. If a resident no longer requires the use of a ventilator, the provider shall not receive additional reimbursement beyond the Georgia Medicaid nursing home per diem rate determined for the facility.

1009. Supplemental Quality Incentive Payments

1009.1.1. Effective August 13, 2021, the Division will provide supplemental quality incentive payments to eligible skilled nursing facilities that demonstrate improvement in the quality of care rendered to members. Utilizing calendar year 2020 data as the baseline, nursing facilities that demonstrate improvement in the CMS Long Stay Quality Measure identified by the Department no later than September 30th preceding the start of the upcoming evaluated calendar year Nursing facilities must demonstrate improvement in at least one or more of the CMS Long Stay Quality Measures and have a minimum of 50% Medicaid utilization to receive the supplemental payment.

The supplemental payment will be based on each nursing facility's overall ranking in each CMS Long Stay Quality Measure resulting in the nursing facility receiving a payment proportional to their improvement (e.g., a facility with the highest improvement will receive the highest supplemental payment for that measure).

1009.1.2. Supplemental payments will be distributed to eligible nursing facilities once per year. For each subsequent year after calendar year 2020, the base year will be adjusted annually to reflect improvement against the prior year. For example, CY2021 would be paid out against improvement against CY2020, CY2022 would be paid out against CY2021, and CY2023 against improvement in CY2022. Only those facilities who demonstrate improvement in at least one or more of the CMS Long Stay Quality Measures and have a minimum of 50% Medicaid utilization to receive the supplemental payment..

Chapter 1100: Claims Processing

1010. General

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

1011. General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Providers

The Affordable Care Act (ACA) requires physicians and other eligible practitioners who order, prescribe and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program, as a result, CMS expanded the claim editing requirements in Section 1833(q) of the Social Security Act and the providers' definitions in section 1861-r and 1842(b)(18) C. Therefore, claims for services that are ordered, prescribed, or referred must indicate who the ordering, prescribing, or referring (OPR) practitioner is. The department will utilize an enrolled OPR provider identification number for this purpose. Any OPR physicians or other eligible practitioners who are NOT already enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the participating, i.e., rendering, provider. If the NPI of the OPR Provider noted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim cannot be paid.

Effective 4/1/2014, DCH will edit claims for the presence of an ordering, referring or prescribing provider as required by program policy. Effective 6/1/2014, the ordering, prescribing and referring information will become a mandatory field and claims that do not contain the information as required by policy will begin to deny. Effective May 1, 2015, the Department will only accept electronic claims. Any paper claims submitted to the fiscal agent for payment will be returned to provider. Please refer to the Medicaid and PeachCare for Kids Part I Policies and Procedures manual, Section 112, for more Information.

1011.1. For the NEW CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

1011.2. For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

1011.3. For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information. The following resources are available for more information:

1011.3.1. Access the department's DCH-i newsletter and FAQs at http://dch.georgia.gov/publications

1011.3.2. Search to see if a provider is enrolled at https://www.mmis.georgia.gov/portal/default.aspx

1011.3.2.1. Click on Provider Enrollment/Provider Contract Status. Enter Provider ID or NPI and provider's last name.

1011.3.3. Access a provider listing at https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Notices/tabId/53/Default.aspx

1011.3.3.1. Click on Georgia Medicaid FFS Provider Listing or OPR Only Provider Listing

1012. Form DMA-59 "Authorization for Nursing Facility Reimbursement"

The Form DMA-59 (See Appendix F) is used by nursing facilities and intermediate care facilities for Individuals with Intellectual Disabilities (ICFs/ID) in requesting vendor payments. All initial admission requests continued stay requests, and terminations/discharges require a Form DMA-59 to be initiated by the facility. The form must be sent to DFCS or the LTC Unit. The form MUST BE LEGIBLE when submitted by the facility. Any illegible forms will be returned by the county to the facility for resubmission or destroyed. (Rev. 07/2015)

If the person is not a Medicaid recipient (does not have a Medicaid number), the facility must instruct the individual's family or representative to make an application on https://gateway.ga.gov/access. The form DMA-59 is then completed and sent to DFCS or the LTC Unit with a letter identifying the family member or representative as having made an application. The Form DMA-59 will not be processed by DFCS/LTC Unit until an application if filed.

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

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

1012.1. All Form DMA-59s are completed by the facility in duplicate. The copy is kept by the facility and placed in the recipient's case folder. The original is sent to DFCS or the LTC Unit.

1012.2. The DFCS/LTC Unit will use the information reported on the DMA-59 to process the changes reported by the facility including new admissions.

1012.3. The DMA-6 is no longer sent to DFCS/LTCU. As long as the facility has an approved DMA 6 on file, The DMA 59, which is the authorization for Nursing Facility Reimbursement Form, will serve as the evidence that the resident meets an approved nursing facility level of care. The DMA 6 is the only document that determines a level of care approval. The DMA 59 is only used as a tool to communicate admissions, status changes and terminations.

1012.4. At this point, the assistance payment worker takes action based on the individual's eligibility. If the individual is determined ineligible, DFCS/LTC Unit will issue a Summary Notification letter to the facility reporting denied eligibility. Conversely, if the individual is determined eligible for Medicaid, DFCS/LTC Unit will issue a Summary Notification letter to the facility reporting the effective date of eligibility. The DFCS/LTC Unit will not return the Form DMA-59 to the facility.

1012.5. The DFCS/LTC Unit will retain their copy of the Form DMA-59 as documentation of information reported by the facility

1012.6. When the DFCS/LTC Unit has a need to update the recipient's data such as Income and Status (ineligibility), the DFCS/LTC Unit will issue a Summary Notification letter to the facility reporting changes to patient liability or eligibility.

1012.7. A change from one level of care to another in the same facility is no longer necessary. The nursing facility staff will mark "skilled care" on the DMA-59 form. The skilled block on the DMA-59 form is for record keeping purposes of residents meeting a nursing facility level of care. DCH and DFCS/LTC Unit will consider the resident eligible for nursing facility admission via the admitting physician's signature on file within the facility. No additional information is needed by the DFCS/LTCU to substantiate a resident's eligibility for a nursing facility level of care.

1013. Electronic Media Billing

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

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

Electronic Media Billing is available for nursing facility providers who have data processing equipment or who contract for data processing services. Three methods of electronic media billing are available: dial-up transmission, magnetic tape and diskette 3½ and 5 ¼.

1014. Nursing Home Remittance Advice

For complete description of the Remittance Advice, please go to www.mmis.georgia.gov and select the Billing Manual for UB-04.

1015. Mailing Addresses for Completed Forms

1015.1. Form DMA-59 is mailed/faxed to the Department of Family and Children Services or the Long-Term Care Unit.

Appendix A
Medicaid Member and PeachCare for Kids

Appendix B
Provider Enrollment

Georgia Medicaid has transitioned to a paperless process to improve efficiencies for filing claims, appeals and other items. For more detailed information regarding the paperless initiative, refer to your Part I Policies & Procedures for Medicaid/PeachCare for Kids Manual, Chapter 100, Section 112.

All paper claims, appeals, certain forms, prior authorization/pre-certifications and provider enrollment documents are to be submitted as instructed.

Download: http://www.mmis.georgia.gov, click on “Provider Information”, then “Documents and Forms”

Email: http://www.mmis.georgia.gov, click on “Contact Us”

Apply Online: http://www.mmis.georgia.gov, “Provider Information” then “Enroll as an Individual”

Facsimile: 1.866.483.1044

Appendix C
Directory For Inquiry Information and/or Form Reordering

A. Georgia Medicaid has transitioned to a paperless process to improve efficiencies for filing claims, appeals and other items. For more detailed information regarding the paperless initiative, refer to your Part I Policies & Procedures For Medicaid/PeachCare for Kids Manual, Chapter 100, Section 112.

Long-Term Care Contractor – Noted throughout the Manual as the "Contractor"
Phones: 1-800-766-4456

Nurse Aide Registry
1-800-414-4358 or 678-527-3010

Nurse Aide Training Programs
1-800-414-4358 or 678-527-3010

Billing Rates/Cost Reports
Georgia Department of Community Health, Office of Reimbursement
2 Martin Luther King Jr Dr SE East Tower - 17th Floor
Atlanta, GA 30334 nhcostreport@dch.ga.gov

Policies and Procedures for Nursing Facility Services
Department of Community Health Program Specialist
2 Peachtree Street, N.W.
Atlanta, Ga. 30303-3159
Phone (404) 657-9324 Fax: (404) 656-8366

Provider Enrollment

Phone: 1-800-766-4456

Billing Questions
Phone: 1-800-766-4456

Forms Request and Reorders
Forms DMA-6, DMA-P6A, DMA-59, DMA-292, DMA-355, DMA-356, DMA-385, DMA-501, DMA-520, DMA-613

PASRR
Fiscal Agent
1-800-414-4358 or 678-527-3010

Appendix D
Uniform Chart of Accounts, Cost Reporting, Reimbursement Principles and Other Reporting Requirements

A. General

This appendix discusses the use of a Uniform Chart of Accounts, the annual submission of a cost report, the principles of reimbursement which comprise the basis for the financial reporting requirements of facilities participating in the Georgia Medicaid Program and other reporting requirements. The Georgia Division of Medical Assistance Uniform Chart of Accounts as comprised on the date of service is incorporated by reference herein. A copy is available from the Division upon request. Cost reports and instructions are made available to each facility near the end of the reporting period. The reimbursement principles discussed in this appendix are selected from the Centers for Medicare and Medicaid Services Provider Reimbursement Manual (CMS151). Copies of the Manual, which provide a detailed description of allowable costs, are available from the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

B. Uniform Chart of Accounts

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

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

C. Cost Reporting

Reimbursement of expenses incurred by nursing facilities in the provision of care to Medicaid recipients is accomplished through them mechanism of the cost report. This document reports historical costs and details recipient occupancy data experienced during the fiscal year. The following cost reporting requirements apply to providers of nursing facility services and all home offices who allocate costs to nursing facilities:

i. Each nursing facility must annually file a cost report with the Division of Medical Assistance which covers a twelve-month period ending June 30th. Cost reports must be emailed to the Division on or before September 30th. (See Hospital-based facility exception in C(iv) below).

ii. If such cost reports are not filed by September 30th, the Division shall have the option of either terminating the provider agreement upon thirty days written notice or imposing a penalty of $50.00 per day for the first thirty days and a penalty of $100.00 per day for each day thereafter until an acceptable cost report is received by the Division. The only condition in which a penalty will not be imposed is if written approval for an extension is obtained from the Program Manager of Nursing Home Reimbursement Services prior to September 30.

iii. If a cost report is received by the Division prior to September 30th, but is unacceptable, it will be returned to the facility for proper completion. No penalty will be imposed if the properly completed report is filed by the September 30th deadline. However, the above-described penalties may be imposed after the September 30th deadline until an acceptable cost report is received by the Division.

iv. Hospital-based facilities using Medicare fiscal year ending dates between July and April must submit cost reports to the Division on or before September 30. Facilities using fiscal year ending dates between May and June must submit cost reports on or before November 30. The financial information to be included on the Medicaid cost report must be taken in total from the provider's most recent Medicare cost report that precedes June 30. The rules regarding unacceptability and timeliness described above in sections C(ii) and Ciii) also apply to hospital-based facilities' cost reports.

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

vi. To be acceptable, a cost report must be complete and accurate, include all applicable schedules, and be correctly internally cross-referenced. Further, the amount per book column for Schedule B and C must agree with the amounts recorded in the facility's general ledger; however, there may have to be certain groupings of the general ledger amounts to agree with the cost report line items. Estimated amounts used for a conversion to a June 30th year-end are not acceptable. Reported costs of interest paid to non-related parties must be reduced by an amount equal to the lesser of: (1) interest paid to non-related parties; or (2) investment income other than the exceptions identified in CMS-15, Section 202.2. Reported costs of special services must be reduced, as indicated on Schedule B1A, by an amount resulting from revenue received from sources other than the Division for these services. Adjustments will be based on auditable records of charges to all patients as required by cost report instructions.

vii. Any changes to the amount of or classification of reported costs and patient day information must be made within 30 days after the applicable September 30th, November 30th, or approved extended submission deadline. Amended cost reports submitted after these deadlines will not be accepted unless they have been requested by the Division. If the original cost report is used to set reimbursement rates, the provider has up to 30 days from the implementation of the original cost report to request changes to the amount of or classification of reported costs and patient day information in accordance with the appeal procedures outlined in Appendix Q (Billing Rate and Disallowance of Cost from the Cost Report). Adjustments to amounts or changes in classification of reported costs in prior years will not be considered.

viii. Late cost report penalties will be invoiced through the Accounting Section of the Division for the total amount of the assessed penalty. The provider must submit payment to the Division. Penalties not properly paid will be deducted from the monthly reimbursement check. The assessments will not be refunded.

ix. New facilities, which have less than twelve but not less than six months of actual operating cost experience, will only submit cost data for their actual months of operation as of June 30. New facilities that have less than six months of actual operating cost experience are not required to submit a cost report. Facilities in which there has been a change of ownership must submit a separate report for each owner. The subsequent owner will be reimbursed based on the previous owner's cost report (with an adjustment in the property cost center only) until a new cost report is received from the new owner and determined reliable and appropriate. The Division will determine whether each submitted cost report is appropriate and reliable as a basis for computing the Allowed Per Diem billing rate and may calculate a facility's Allowed Per Diem billing rate in accordance with Section 1002.3.

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

x. Reported costs must conform to Divisional instructions, or in the absence of specific instructions, to the allowable costs discussed in the CMS-15-1. Reported costs are subject to audit verification by the Division, State or Federal auditors or their agents. Providers using computerized information systems for accounting or other purposes must make this information available in a suitable electronic format if requested by the Division or its agents. Where such audit verifications determine that the cost report was prepared based upon inadequate accounting records, the facility will be required to correct its records and submit a corrected cost report. A penalty will be imposed on the facility for the costs incurred by the Division for any additional audit work performed with the corrected cost report.

xi. For audit examinations described in (x) above, it is expected that a facility's accounting records will be available within the State. Should such records be maintained at a location outside the State, the facility will be required to pay for travel costs incurred for any examination conducted at the out-of-state location.

xii. Should a cost report submitted to the Nursing Home Unit for review need explanation or clarification, appropriate work papers or letters of explanation should be attached.

xiii. All cost reports and reimbursement rate appeals should be emailed to nh.appeals@dch.ga.gov with supporting documentation. Correspondence and documentation regarding appeals may also be mailed to the following address:

Georgia Department of Community Health,
Office of Reimbursement
2 Martin Luther King Jr Dr SE
East Tower-17th Floor
Atlanta, GA 30334

D. Reimbursement Principles

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

E. Case Mix Index Reports

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

xv. Patient Driven Payment Model (PDPM) Classification – For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a PDPM classification. The PDPM classification system will be used to determine a patient's PDPM category

xvi. Payer Source – For each patient included in the quarterly Case Mix Index Report, a payer source will be identified. As described in section D.E(i), a facility will have the opportunity to submit updated payer source information for changes that may occur by the last day of the calendar quarter.

xvii. Relative Weights and Case Mix Index Scores for All Patients – For each patient included in the quarterly Case Mix Index Report, a relative weight will be assigned by the Division. Appendix D – Exhibit 1 identifies the relative weights for each PDPM category. That data will be used to determine a case mix score for all patients in a facility.

xviii. Relative Weights and Case Mix Index Scores for Medicaid Patients – For each Medicaid patient included in the quarterly Case Mix Index Report, a Medicaid relative weight will be assigned by the Division. Appendix D – Exhibit 1 identifies the relative weights for each PDPM category. This data will be used to determine a case mix score for Medicaid patients in a facility.

xix. BIMS Scores – For each patient included in the quarterly Case Mix Index Report, the most recent MDS assessment will be used to determine a Brief Interview for Mental Status (BIMS) score.

xx. Corrections to MDS and Payer Source Information Corrections to MDS and payer source information used in payment rate calculations applicable to prior dates of service that result from appeals or audit adjustments may be processed as adjustments to rate calculations in a subsequent period. If the impact of the correction is significant, the Division may elect to process the correction by a retrospective adjustment to prior payments.

F. Nursing Hours and Patient Day Report

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

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

G. Fair Rental Value System

A request for a fair rental value rate review as a result of a Renovation Construction Project, bed addition or replacement subsequent to July 1, 2009, must be submitted to the Department after completion of the project or after each phase of a multi-phase project that will extend beyond a 12-month period (i.e. gut and rebuild).

Effective July 1, 2013, the Department will have sixty (60) days to approve or deny any such request. Any corresponding Fair Rental Value rate increase shall take effect at the beginning of the quarter following the quarter in which the request for a Fair Rental Value rate increase is approved by the Department. The request must be completed on the Initial Start Up and Fair Rental Value System Reimbursement (FRVS) Update Request Form. The request must be submitted electronically FRVS@dch.ga.gov. The documentation may also be submitted to:

Georgia Department of Community Health,
Office of Reimbursement
2 Martin Luther King Jr Dr SE
East Tower-17th Floor
Atlanta, GA 30334

An electronic version of the Initial Start Up And Fair Rental Value System Reimbursement (FRVS) Update Request Form should also be emailed to FRVS@dch.ga.gov along with supporting documentation for the renovation project or bed addition (Nursing Home License, Certificate of Occupancy, Approved County/City Records, Fixed Asset Schedule, Invoices, General Ledger Listing of Invoices/Listing of Invoices, Appraisal, Construction Contract, Blueprints, and Certificate of Need (CON) approval).

Appendix D: Exhibit 1
PDPM Case Mix Scores - 2022 Indices

Category	RUG IV Code	PDPM Nursing Component	PDPM Index for All Patients	PDPM Index for Medicaid Patients
Extensive Services	ES3	A	3.95	4.03
Extensive Services	ES2	B	2.99	3.05
Extensive Services	ES1	C	2.85	2.91
Special Care High/Low	HDE2	D	2.33	2.38
Special Care High/Low	HDE1	E	1.94	1.98
Special Care High/Low	HBC2	F	2.18	2.22
Special Care High/Low	HBC1	G	1.81	1.85
Special Care High/Low	LDE2	H	2.02	2.06
Special Care High/Low	LDE1	I	1.68	1.71
Special Care High/Low	LBC2	J	1.67	1.70
Special Care High/Low	LBC1	K	1.39	1.42
Cognitive Impairment	CDE2	L	1.82	1.86
Cognitive Impairment	CDE1	M	1.58	1.61
Cognitive Impairment	CBC2	N	1.51	1.54
Cognitive Impairment	CA2	O	1.06	1.08
Cognitive Impairment	CBC1	P	1.3	1.33
Cognitive Impairment	CA1	Q	0.91	0.93
Behavior Issue	BAB2	R	1.01	1.03
Behavior Issue	BAB1	S	0.96	0.98
Physical Functioning	PDE2	T	1.53	1.56
Physical Functioning	PDE1	U	1.43	1.46
Physical Functioning	PBC2	V	1.19	1.21
Physical Functioning	PA2	W	0.69	0.70
Physical Functioning	PBC1	X	1.1	1.12
Physical Functioning	PA1	Y	0.64	0.65

Appendix D: Exhibit 2

Detailed Description of Data Presented in Case Mix Index Reports

Selection criteria for quarterly "Listing of Residents" reports – Residents are determined by identifying individuals for whom an MDS assessment has been received and for whom no subsequent discharge tracking document has been received. It is assumed that residents for whom a periodic assessment is more than 3 months past due have been discharged and these individuals are not included in this report.

The following data elements are selected from the most recent assessment data for patients residing in the nursing home on the last day of a calendar quarter:

Data Element	Description
AO310a	Reasons for assessment as reported in section AO310 of the MDS Section a, primary reason for assessment
1	admission assessment
2	quarterly review assessment
3	annual assessment
4	significant change in status
5	significant change to prior comprehensive assessment
6	significant correction to prior quarterly assessment
99	not OBRA required assessment

Section b, codes for assessments required for Medicare PPS or the State

Data Element	Description
1	5 day scheduled assessment
2	14 day scheduled assessment
3	30 day scheduled assessment
4	60 day scheduled assessment
5	90 day scheduled assessment
6	readmission/return assessment
7	unscheduled assessment used for PPS
99	Not PPS assessment
Resident Name	Self-explanatory
SSN	Resident's social security number

Data Element	Description
Completion Date (ZO500b)	For assessments, this is the date completed as reported in section ZO500b of the MDS. For discharge tracking, this is the date of discharge. For re-entry tracking, this is the date of re-entry.
RUG Code	RUG classification code (see "Case Mix Index for All Patients" in Exhibit D-1) from application of 34 grouper with index maximizing.
RUG Category	Description of RUG classification (see Exhibit D-1)
Resident ID	Identification number assigned to resident by MDS reporting system
Medicaid Cognitive Add-On	Identifies residents with Brief Interview for Mental Status (BIMS) scores less than or equal to 5. In the absence of BIMS scores, identifies residents with Cognitive Performance Scale (CPS) scores of moderately severe to very severe.

Data Element	Description
Payment Source	Primary source of payment for services to residents based on information included in MDS assessment data. If the MDS data includes a Medicaid identification number or Medicaid pending designation, Medicaid is assumed to be the resident's payment source. If a Medicaid identification number is not present and a Medicare identification number is present, Medicare is assumed to be the payment source. If neither a Medicaid nor Medicare identification number is present, the payment source is identified as "other." A facility may submit a correction entry to the Division to note any changes to a patient's payment source that may not be reflected in MDS data. Such correction entries for payment status will be assumed to be permanent unless a subsequent correction entry is submitted for a resident.
Number of Residents, Overall CMI Averages and Medicaid CMI Average	The number of residents and average case mix index score, based on relative weights for "Case Mix Index for All Patients" in Exhibit D-1, are listed for 3 categories of residents by payment source – Medicaid, Medicare, and Other. For Medicaid patients, an average case mix index score, based on relative weights for "Case Mix Index for Medicaid Patients," is also listed.
Number and % of Residents Included in Cognitive Add-On	The number and percentage of Medicaid residents with BIMS scores less than or equal to 5 and residents with Cognitive Performance Scale scores of moderately severe to very severe.

Appendix D: Exhibit 3

Example Calculation of Initial Fair Rental Value Per Diem

Ref.	Data Element	Example Data	Source of Data
A	Rate Setting Year	2023	Department Criteria
	Medicaid Provider ID	12345678A	
B	Facility Name	XYZ Nursing Home	Department Data
C	Year of Construction	1967	Department Data
D	Beds as of 7/1/2023	56	Department Data
E	Licensed Nursing Facility Beds	56	Department Data
F	Non-Nursing Facility Beds	N/A	Department Data
G	Bed Days at Minimum Occupancy	17,374	E ×365
H	Total Patient Days	14,616	Department Data
I	Medicaid Patient Days	13,692	Department Data
J	Nursing Facility Square Footage	17,982	Department Data
K	Actual Sq Ft per Bed	321	J ÷ E
L	Allowed Total Square Footage	17,982	Lesser of J or E × 700
M	Rate year RS Means Cost per Square Foot	$202.49	RS Means lookup based on Rate Yr
N	Facility Cost Prior to Adjustments	$3,641,175	L × M
O	Nursing Facility Zip Code	31082	Department Data
P	RS Means Location Factor	0.863	RS Means lookup based on Zip code (O)
Q	Construction Cost Index	1	Department Criteria
R	Adjusted Cost per Square Foot	$174.75	M x P x Q
S	January RS Means Cost Per Sq Ft	$236.70	RS Means lookup based on Rate Yr.
T	Initial Age Depreciation Rate	2%	Department Criteria
U	Facility Replacement Value	3,142,334	L × R
V	Land Percentage	15.00%	Department Criteria
W	Land Value	471,350	U × V
X	Equipment Allowance	6,000	Department Criteria
Y	Equipment Cost Index	1	Department Criteria
Z	Equipment Value	$336,000	X × Y × E
AA	Facility Value Excluding Land	$3,478,334	U + Z
AB	Facility Actual Age	56	2022 - C
AC	Facility FRV Adjusted Age	25	2022- New Base Yr
AD	Depreciation Rate per Year	2%	Department Criteria
AE	Depreciation using the FRV Adj Age	$1,739,167	AA × AC × AD
AF	Depreciation Replacement Value	$1,739,167	AA - AE
AG	Depreciation Replacement Value & Land	$2,171,577	AF + W
AH	Return (Rental) Rate	9.00%	Department Criteria
AI	Return Amount	$198,947	AA × AH

Ref.	Data Element	Example Data	Source of Data
AJ	Higher of Min Occup or Total Patient Days	17,374	Higher of G or H
AK	Fair Rental Value per Diem	$11.45	AI ÷ AJ

Appendix D: Exhibit 4

Example Calculation of the Impact of an Addition on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Rate Setting Year	2023	Department Criteria
	Medicaid Provider ID	12345678A	Department Data
B	Facility Name	XYZ Nursing Home	Department Data
C	Year of Construction	1967	Department Data
D	Bed as of 7/1/20xx	56	Department Data
E	Licensed Nursing Facility Beds	60	Department Data
F	Non-Nursing Facility Beds	N/A	Department Data
G	Bed Days at Minimum Occupancy	18,615	E×365
H	Total Patient Days	14,616	Department Data
I	Medicaid Patient Days	13,692	Department Data
J	Nursing Facility Square Footage	17,982	Department Data
K	Actual Sq Ft per Bed	300	J ÷ E
L	Allowed Total Square Footage	17,982	Lesser of J or E × 700
M	Rate Year RS Means Cost Per Square Foot	$202.49	RSMeans lookup based on Rate Year
N	Facility Cost Prior to Adjustments	$3,641,175	L × M
O	Zip Code	31082	Department Data
P	Location Factor	0.863	Department Criteria
Q	Construction Cost Index	1	Department Criteria
R	Adjusted Cost Per Sq Ft	$236.70	Department Criteria
S	January 2020 RS Means Cost Per Sq Ft	$239.10	Department Criteria
T	Initial Age Depreciation Rate	2.00%	Department Criteria
U	Facility Replacement Value	$3,142,334	Department Criteria
V	Land Percentage	15%	Department Criteria
W	Land Value	$471,350	U × V
X	Equipment Allowance	$6,000	Department Criteria
Y	Equipment Cost Index	1	Department Criteria
Z	Equipment Value	$360,000	E × Q × R
AA	Facility Value Excluding Land	$3,502,334	U + Z
AB	Facility Actual Age	56	2022 - C
AC	Facility FRV Adjusted Age	25	Department Criteria
AD	Depreciation Rate per Year	2.00%	Department Criteria
AE	Depreciation Using the FRV Adj Age	$1,751,167	AA × AC × AD
AF	Depreciation Replacement Value	$1,751,167	AA - AE
AG	Depreciation Replacement Value & Land	$2,222,517	AF + W

Ref	Data Element	Example	Source of Data
AH	Return (Rental) Rate	9.00%	Department Criteria
AI	Rental Amount	$200,027	AA × AH
AJ	Higher of Min Occup or Total Patient Days	18,615	Higher of G or H
AK	Fair Rental Amt Per Patient Day	$10.75	AI ÷ AJ

Fair Rental Value Age Adjustment			
A	Activity	Addition	Department Data
B	Year of Activity	2023	Department Data
C	Beds Added	4	Department Data
D	Beds Replaced	N/A	N/A
E	Existing Beds Not Added	56	Department Data
F	Age of Beds Not Added	56	(b) -Base Yr
G	Existing Beds Weighted Average	3,360	(e) × (f)
H	Base Year Age	52.27	(g) ÷ [(c) + (e)]
U	New Base Year	1971	(b) – (t) (rounded)
V	Total Beds	60	(c) + (e)

Appendix D: Exhibit 5

Example Calculation of the Impact of a Renovation on a Nursing Facility's Base Year

Ref	Data Element	Example	Source of Data
A	Rate Setting Year A	2023	Department Criteria
	Medicaid Provider ID	12345678A	
B	Facility Name	XYZ Nursing Home	Department Data
C	Year of Construction	1967	Department Data
E	Licensed Nursing Facility Beds	56	Department Data
F	Non-Nursing Facility Beds	56	Department Data
G	Bed Days at Minimum Occupancy		
H	Total Patient Days	N/A	Department Data
I	Medicaid Patient Days	13,692	Department Data
J	Nursing Facility Square Footage	17,982	Department Data
K	Actual Sq Ft per Bed	321	J ÷ E
L	Allowed Total Square Footage	17,982	Lesser of J or E × 700
M	Rate Year RS Means Cost Per Square Foot	$202.49	RSMeans lookup based on Rate Year
N	Facility Cost Prior to Adjustments	$3,641,175	L × M
O	Zip Code	31082	Department Data
P	Location Factor	0.863	Department Criteria
Q	Construction Cost Index	1	Department Criteria
R	Adjusted Cost Per Sq Ft	$174.75	Department Criteria
S	January 2020 RS Means Cost Per Sq Ft	$236.70	Department Criteria
T	Initial Age Depreciation Rate	2.00%	Department Criteria
U	Facility Replacement Value	$3,142,334	L × R
V	Land Percentage	15%	Department Criteria
W	Land Value	$471,350	U × V
X	Equipment Allowance	$6,000	Department Criteria
Y	Equipment Cost Index	1	Department Criteria
Z	Equipment Value	$336,000	E × Q × R
AA	Facility Value Excluding Land	$3,478,334	U + Z
AB	Facility Actual Age	56	2022 - C
AC	Facility FRV Adjusted Age	8	Department Criteria
AD	Depreciation Rate per Year	2.00%	Department Criteria
AE	Depreciation Using the FRV Adj Age	$556,533	AA × AC × AD
AF	Depreciation Replacement Value	$2,921,801	AA - AE
AG	Depreciation Replacement Value & Land	$3,393,151	AF + W

Ref	Data Element	Example	Source of Data
AH	Return (Rental) Rate	9.00%	Department Criteria
AI	Rental Amount	$305,384	AA × AH
AJ	Higher of Min Occup or Total Patient Days	17,374	Higher of G or H
AK	Fair Rental Amt Per Patient Day	$17.58	AI ÷ AJ

Fair Rental Value Age Adjustment			
A	Activity	Renovation	Department Data
B	Year of Activity	2023	Department Data
I	Renovation Amount	$1,500,000	Department Data
J	Bed Totals at Renovation	56	Department Data
K	Age of Beds at Time of Renovation	56	(b) -Base Yr
L	Renovation Year RS Means Cost Index	261.6	RSMeans lookup based on Rate Year
M	Age Index Factor	1.11	(l) ÷ S
N	Bed Replacement Cost	62,016	[N × P × (m)] ÷ (j)
O	Depreciation Adjustment	50%	(k) × T
P	Adjusted Bed Replacement Cost	31,008	(n) – [(n) × (o)]
Q	New Bed Equivalent	48.37	(i) ÷ (p)
R	Total Beds to be Weighted	7.63	(j) – (q)
S	Weighted Average of Beds	427.02	(k) × (r)
T	Base Year Age Adjustment	7.63	(s) ÷ (j)
U	New Base Year	2015	(b) – (t) (rounded)

Appendix E

Instructions For Completing Forms (DMA-6, DMA-6A, DMA-613 and DMA-59)

A. Form DMA-6 Instructions

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

Completion of Form DMA-6 (Revised 2/91) "Recommendation Concerning Nursing Facility Care or Intermediate Care for the Intellectually Disabled" must be completed prior to completion of the Form DMA-613.

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

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

B. Section A – Identifying Information

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

Items	Instructions
Items 1	Facility's Name and Address Enter the complete name and address of the facility including the zip code and county.
Item 2	Medicaid Case Number Enter the Medicaid case number exactly as it appears on the Medical Assistance Eligibility Certification (this number may change so it is imperative that you review the Certification during each month of service.) A valid Medicaid case number will be formatted in one of two ways as follows: If the client is an SSI recipient, the client ID number will be the 9-digit social security number plus an "S", e.g., 123456789S. If the client is a recipient of Medical Assistance Only, the ID number will be the 9-digit PARIS number plus a "P", e.g., 123456789P. The entire number, including all zeros, must be placed on the form correctly or it will be rejected. In exceptional instances, the case number may be obtained from the county Department or Family and Children Services office.
Items 3	Social Security Number Enter the recipient's nine-digit social security number
Items 4 & 4A	Enter the recipient's sex whether male or female and age and date of birth.
Items 5	Type of Facility Enter a check in the box corresponding to the type of facility.
Items 6	Type of Recommendation Enter a check in the box corresponding to the type of recommendation being made. If the recommendation is for a recipient's initial admission or readmission to the facility, the box corresponding to initial should be checked. If the recommendation is for continued placement, the box corresponding to continued

	placement should be checked on the subsequent recommendation form.
Items 7	Patient's Name Enter the recipient's full last name, first name, and middle initial in that order.
Items 8	Date of Nursing Facility Admission Enter the date of the recipient's admission to the nursing facility.
Items 9	Patient Transferred From Enter a check in the box corresponding to either hospital, private pay, home, another nursing facility, or Medicare, according to the recipient's status immediately preceding admission to the facility. Enter the recipient's home address, mother's maiden name, and the date of Medicaid application.
Items 9A	State Authority (MH and ID Screening) Enter the restricted authorization code and date assigned by the Contractor. This field is for new admissions only.
Items 9B	State Authority (MH and ID Screening) Enter the restricted authorization code and date assigned by the Contractor originally (new admission 9A). This field should be used for a readmission or transfer to another nursing facility.
Items 10-11	Authorization for Facility or Attending Physician to Provide Necessary Information Including Medical Data to Georgia Division of Medical Assistance and the Division of Family and Children Services of the Department of Human Services. Have the patient, his/her spouse, parents, or other relative or legal representative sign and date (Item 11) the authorization.

C. Section B – Physician's Examination Report and Recommendation

Items	**Instructions**
Item 12	Diagnosis on Admission to Facility (Hospital Transfer Record may be Attached) Describe the primary, secondary, and any third diagnoses relevant to the recipient's condition in the appropriate blocks. Leave the blocks labeled ICD blank.
Item 13	Treatment Plan (Attach a Copt of the Order Sheet if More Convenient) The hospital admitting diagnoses (primary, secondary, and other) and dates of admission and discharge must be recorded. The treatment plan also should include all medications the recipient is to receive. Names of drugs with dosages, routes, and frequencies of administration are to be included. Any diagnostic or treatment procedures and frequencies should be indicated.
Item 14	Recommendation Regarding Level of Care Considered Necessary

	Enter a check in the correct box for Skilled or Intermediate Care for the Intellectually Disabled. The Skilled box is appropriated as the nursing facility level of care
Item 15	Length of Time Care is Needed Enter the length of time as permanent.
Item 16	Is Patient Free of Communicable Diseases? Enter a check in the appropriate box (Yes or No).
Item 17	Alternative to Nursing Home Placement The admitting or attending physician must indicate whether the patient's condition could be managed by provision of Community Care or Home Health Services. Enter a check in the box corresponding to "could" and either/both the box (es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.
Item 18	Certification by Physician Regarding Patient's Level of Care The admitting or attending physician must certify that the patient requires the level of care provided by a nursing facility or an intermediate care facility for the intellectually disabled. The physician must sign the form. Signature stamps are not acceptable
Item 19	Physician's Name and Address (Print) Enter the admitting or attending physician's name and address in the spaces provided.
Item 20	Date Signed by Physician Enter the date that the attending or admitting physician signs the form.
Item 21	Physician's License Number and Physician's Phone Number Enter the Georgia license number for the attending or admitting physician and phone number.

D. Section C – Evaluation of Nursing Care Needed

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

Item 22	Diet Enter the appropriate diet for the recipient. If "other" is checked, please specify type of diet.
Item 23	Bowel Check the appropriate box to indicate bowel habits of recipient.
Item 24	Overall Condition Check the appropriate box to indicate the recipient's

	overall condition.
Item 25	Restorative Potential Check the appropriate box to indicate the recipient's restorative- potential.
Item 26	Mental and behavioral Status Check all appropriate boxes to indicate the recipient's mental and behavioral status.
Item 27	Decubiti Check the appropriate box to indicate if recipient has decubiti. If "yes" is checked and "surgery" is also checked, the date of surgery should be included in the space provided.
Item 28	Bladder Check the appropriate box to indicate bladder habits of the recipient
Item 29	Miscellaneous Indicate the number of hours the recipient is to be out of bed per day in the space provided. Check other treatment procedures the recipient requires.
Item 30	Indicate Frequency Per Week If applicable, indicate the number of treatment or therapy sessions per week the recipient received or needs.
Item 31	Record Appropriate Legend Enter appropriate number indicating the level of impairment or the level of assistance needed in the boxes provided.
Item 32	Remarks Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form.
Item 33	Pre-admission Certification Number This space is not to be used. Effective April 1, 2003, Nursing Facilities are no longer required to make contact with the Contractor for precertification of the DMA-6.
Item 34	Signed The person completing Section C should sign in this space.
Item 35	Date Signed Enter the date this form is signed.

Physician's Recommendation for Pediatric Care

A. Instructions For Completing the Pediatric Care Form DMA-6 (A)

This section provides detailed instructions for completion of the Form DMA-6 (A). Before payment can be made, a Form DMA-6 (A) must be completed by the Primary Care Physician (PCP) and the parent or legal representative and signed by the PCP. The Form DMA-6 (A) is considered valid only if is signed by the Primary Care Physician and date.

B. Section A – Identifying Information

It is the responsibility of the responsible party to see that Section A of the form is completed with the applicant's name and address.

Item	Instructions
Item 1	Applicant's Name and Address Enter the complete name and address of the applicant including the city and zip code. The caseworker in the Department of Family and Children Services (DFCS) will complete the mailing address and county of the originating application.
Item 2	Medicaid Number Enter the Medicaid number exactly as it appears on the Medicaid card or Form 962. A valid Medicaid number will be formatted in one of three ways: If the member or applicant is in the Medicaid System, the ID number will be the 12-digit number, e.g., 111222333444; If the member or applicant was previously determined eligible by DFCS staff or making application for services, the number will be the 9-digit SUCCESS number plus a "P", e.g., 123456789P; or If the individual is eligible for Medicaid due to the receipt of Supplemental Security Income (SSI), the number will be the 9-digit Social Security number plus an "S", e.g., 123456789S. The entire number must be placed on the form correctly. In exceptional instances, it may be necessary to contact the caseworker in the DFCS office for the Medicaid number.
Item 3	Social Security Number Enter the applicant's nine-digit Social Security number.
Item 4 & 4A	Enter the applicant's sex, age, and date of birth.

Item 5	Primary Care Physician Enter the entire name of the Primary Care Physician (PCP).
Item 6	Telephone Number Enter the telephone number, including area code, of the applicant's parent or the legal representative.
Item 7	Does the parent or legal representative think the applicant should be institutionalized? Please check the appropriate box.
Item 8	Does the child attend school? Please check the appropriate box if the member attends school.
Item 9	Date of Medicaid Application Enter the date the family made application for Medicaid services.
Item 10	Read the statement below the name(s) of the caregiver(s) and then; Signature The parent or legal representative for the applicant should sign the DMA-6 (A).
Item 11	Please include the date the DMA-6 (A) was signed by the parent or the legal representative.

C. Section B – Physician's Examination Report and Recommendation

Items	Instructions
Item 12	**History (attach additional sheet(s) if needed)** **Describe the applicant's medical history (Hospital records may be attached).**
Item 13	Diagnosis (Add attachment(s) for additional diagnoses) Describe the primary, secondary, and any third diagnoses relevant to the applicant's condition on the appropriate lines. Leave the blocks labeled ICD blank. The Contractor's staff will complete these boxes.
Item 14	Medications (Add attachment(s) for additional medication(s) The name of all medications the applicant is to receive should be listed. Name of drugs with dosages, routes, and frequencies of administration are to be included.

Item 15	Diagnostic and Treatment Procedures Any diagnostic or treatment procedures and frequencies should be indicated.
Item 16	Treatment Plan (Attach copy of order sheet if more convenient or other pertinent documentation) List previous hospitalization dates, as well as rehabilitative, and other health care services the applicant has received or is currently receiving. The hospital admitting diagnoses (primary, secondary, and other diagnoses) and dates of admission and discharge must be recorded. The treatment plan may also include other pertinent documents to assist with the evaluation of the applicant.
Item 17	**Anticipated Dated of Hospitalization** List any dates the applicant may be hospitalized in the near future for services
Item 18	Level of Care Recommended Recommendation regarding the level of care considered necessary. Enter a check in the correct box for hospital, nursing facility, or an intermediate care facility for the mentally retarded.
Item 19	Type of Recommendation Indicate if this is an initial recommendation for services, a change in the member's level of care, or a continued placement review for the number.
Item 20	Patient Transferred from (Check one) Indicate if the applicant was transferred from a hospital, private pay, another nursing facility or lives at home.
Item 21	Length of Time Care Needed Enter the length of time the applicant will require care and services from the Medicaid program. Check the appropriate box on the length of time care is needed either permanent or temporary. If temporary, please provide an estimate of the length of time care will be needed.
Item 22	Is Patient Free of Communicable Diseases? Enter a check in the appropriate box.
Item 23	: Alternatives to nursing Facility Placement The admitting or attending physician must indicate whether the applicant's condition could or could not be managed by provision of the Community Care or Home Health Care Services Programs. Enter a check in the box corresponding

	to "could" and either/both the box(es) corresponding to Community Care and/or Home Health Services if either/or both is appropriate. Enter a check in the box corresponding to "could not" if neither is appropriate.
Item 24	Physician's Name and Address Print the admitting or attending physician's name and address in the spaces provided.
Item 25	Certification Statement of the Physician and Signature The admitting or attending physician must certify that the applicant requires the level of care provided by a nursing facility, hospital, or an intermediate care facility for the mentally retarded. Signature stamps are not acceptable.
Item 26	Date signed by the physician Enter the date the physician signs the form.
Item 27	Physician's Licensure Number Enter the Georgia license number for the attending or admitting physician.
Item 28	Physician's Telephone Number Enter the attending or admitting physician's telephone number including the area code.

D. Section C – Evaluation of Nursing Care needed (Check Appropriate box only)

Licensed personnel involved in the care of the applicant should complete Section C of this form.

Item	Instructions
Item 29	Nutrition Check the appropriate box(es) regarding the nutritional needs of the applicant.
Item 30	Bowel Check the appropriate box(es) to indicate the bowel and bladder habits of the applicant
Item 31	Cardiopulmonary Status Check the appropriate box(es) to indicate the cardiopulmonary status of the applicant.
Item 32	Mobility Check the appropriate box(es) to indicate the applicant's mental and behavioral status.
Item 33	Behavioral Status Check all appropriate box (es) to indicate the applicant's mental and behavioral status.
Item 34	Integument System Check the appropriate box(es) to indicate the integument system of the applicant.
Item 35	Urogenital Check the appropriate box(es) for the urogenital

	functioning of the applicant.
Item 36	Surgery Check the appropriate box regarding the number of surgeries the applicant has had to your knowledge or obtain this information from the parent or other legal representative.
Item 37	Therapy/Visits Check the appropriate box to indicate the amount of therapy visits the applicant receives
Item 38	Neurological Status Check the appropriate box(es) regarding the neurological status of the applicant.
Item 39	Other Therapy Visits If applicable, indicate the number of treatment or therapy sessions per week the applicant receives or needs.
Item 40	Remarks Indicate the patient's vital signs, height, weight, and other pertinent information not otherwise indicated on this form or any additional comments.
Item 41	Pre-admission Certification Number Indicate the pre-admission certification number (if applicable).
Item 42	Date Signed Enter the date this section of the form is completed.
Item 43	Print Name of MD or RN The individual completing Section C should print their name and sign DMA-6 (A).
Items 44-52	Do Not Write Below This Line Are completed by Contractor staff only.

Appendix F

Form DMA-613 Instructions

A. Completion of Form Dma-613 "PASRR Level I Application Resident Identification Screening Instrument"

i. This section provides detailed instructions for completion of the Form DMA-613. Before a resident is admitted and payment can be made, a form DMA-6 must be completed in its entirety and signed by a physician, prior to completion of the Form DMA-613. The Form DMA-613 must be completed in its entirety. A nursing facility cannot admit any new resident without this preadmission Level I identification screen by the DCH Level I Contractor. A transferred resident into another nursing facility must have the original DMA-613 (the transferring facility should keep a copy on the patient's record file). This screen is part of the Preadmission Screening/Resident Review (PASRR) and determines whether each applicant to a nursing facility has indicators for a related condition of mental illness, intellectual disability or developmental disability and requires additional evaluation by DBHDD (Level II).

ii. The original form should be kept at the facility of residence for the patient. It is the responsibility of the admitting facility to see that the form is completed and evaluated by Level I screen prior to resident's admission.

iii. The Form DMA-613 must be completed and a copy kept in the resident's file. The DMA-6 will serve as authorization by the physician that the resident meets the "nursing facility level of care". The Form DMA-613 is considered valid only if the DMA 6 is signed by a physician and dated no more than thirty (30) days before the date of evaluation by the Contractor. The physician does not need to sign the DMA-613, but the person completing the form should attest to the accurateness of the "foregoing" information submitted.

iv. The DMA-613 is considered valid for resident's admission into the nursing facility for no more than sixty (60) days after the Contractor's Level I decision with an issued pre-cert number (the precert number must be recorded on either 9A or 9B on the DMA-6 or A).

v. Complete Applicant's Identifying Information and Sections 1 thru 5. Check that all information provided is true for each section.

vi. If Yes was answered for numbers 1, 2 or 3, the Contractor may pend for Level II review or issue a Level I pre-certification number based on their review and the patient may be admitted.

vii. If questions #4 and #5 are answered "yes," do not admit the patient to the nursing facility until GHP and PASRR Determination Unit approves the admission and issues a pre-certification number or authorization code.

viii. If all questions were answered "No" and there is no further evidence to indicate the possibility of mental illness, intellectual disability or related condition, the nursing facility may admit the patient if approved with a valid pre-certification number or authorization code.

ix. The DMA-613 form, as well as a copy of the DMA-6, must be placed in the front of each resident's file in the facility.

B. Section 1 – SMI Assessment

x. Does the individual have a primary diagnosis of Dementia?

If Yes, the individual will be subject to a Level II screen. ICD-10 Diagnosis & Date of Onset, if known should be provided.

1. If Yes, check the type of dementia.

2. If No, is there presenting evidence to indicate Dementia as a/an:
1. Undiagnosed condition? Answer Yes or No or 2. Suspected diagnosis? Answer Yes or No

C. Section 2 – SMI assessment

xi. Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from *specialized services? Answer Yes or No

xii. If Yes, specify the physical illness. ICD-10 code(s) & Date of Onset, if known should be provided.

1. Severe Physical Illness likely to continue? Answer Yes or No

2. Likely to interfere with mental/cognitive capacity/function? Answer Yes or No

D. Section 3 – SMI assessment

xiii. Does the individual have a Terminal Illness which includes a medical prognosis that his/her life expectancy is 6 months or less? Answer Yes or No

1. Diagnosis & Date of Onset, if known should be provided.

E. Section 4 – SMI assessment

xiv. Does the individual have a Primary Diagnosis of Serious Mental Illness or Mental Disorder? Answer Yes or No

xv. Diagnosis, ICD-10 code(s) & Date of Onset, if known should be provided. If Yes, check all that apply.

1. Does the treatment history indicate that the individual has received, is receiving, or has been referred to receive services from an agency for a serious mental illness or mental disorder? Answer Yes or No

2. Does the treatment history indicate the individual has experienced at least ONE of the following?

   (a) In-patient psychiatric treatment/crisis stabilization unit within past 5 years. Answer Yes or No

   (b) An episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. Answer Yes or No

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

   (a) Interpersonal Symptoms. The individual may have serious difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others. Answer Yes or No

   (b) Completion of Tasks. The individual may have serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks, requires assistance with tasks, lack concentration or persistence. Answer Yes or No

   (c) Adapting to change. This individual may be self-injurious, self-mutilating, suicidal, or have episodes of physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, or withdrawal. Answer Yes or No

F. Section 5 – ID/DD assessment

xvi. The individual has a Diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) [prior to age 18] or a Related Condition [prior to age 22]. Answer Yes or No

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

2. Diagnosis, ICD-10 code(s) & Date of Onset, if known should be provided.

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

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

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

3. Is likely to continue indefinitely.

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

   (a) Self-care

   (b) Understanding and use of language

   (c) Learning

   (d) Mobility

   (e) Self-direction; and

   (f) Capacity for independent living

5. If no, is there presenting evidence to indicate a suspected diagnosis for an undiagnosed condition as indicated by substantial functional limitations in THREE or more of the following areas of major life activities: (Refer to Section (4) Above). Answer Yes or No

6. Does the treatment history indicate that the individual has received, is receiving, or has been referred to services for ID/DD/RC from DBHDD or another agency? Answer Yes or No

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

   (b) Has received Inpatient residential treatment. Answer Yes or No

   (c) The signed DMA-6 will serve as authorization by the physician that the resident meets the "nursing facility level of care". The physician does not need to sign the DMA-613, but the person completing the form should attest to the accurateness of the "foregoing" information submitted.

Form DMA 59 Instructions

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

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

ii. When making the initial request for an authorization of vendor payments for a new admission or readmission, the entire Section I of the Form DMA-59 is completed. When reporting a status change, Section I should be completed.

1. Enter the name and location of the provider.

2. Enter the nine-character Medicaid provider number.

3. Enter recipient's social security number.

4. Enter the name of the recipient (last name, space, first name, space, middle initial, space any title like Jr., Sr., etc.).

5. Enter the recipient's identification number (Medicaid identification number) exactly as it appears on the Medicaid Card.

6. Enter the primary ICD-9-CM (ICD-10 effective October 1, 2015) diagnosis code.

7. Enter the secondary ICD-9-CM (ICD-10 effective October 1, 2015) diagnosis code.

8. Enter recipient's date of birth

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

1. Enter the physician's recommended level of care based on Form DMA-6. Skilled for nursing facility level of care or ICF/IID the intermediate care for individuals with intellectual disabilities 1 – Skilled 2 – ICF 3 – ICF/IID

2. Enter admission date to the facility.

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

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

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

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

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

1. The new level of care and level of care effective date are required fields, and both must be completed. Skilled for the nursing facility level of care, ICF/IID for facility of the intellectually disabled.

(a) Enter the new level of care offered to the recipient. 1 – Skilled 2 – ICF 3 – ICF/ID

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

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

1. Enter the reason why the recipient's services were terminated.

E- Ineligible (Leave this field blank)
F-Discharged
G-Died

2. Enter the date in MMDDYY format on which the recipient's services were terminated due to death or discharge.

3. Enter the destination of the recipient following termination, including the recipient's discharge into Institutional Hospice (IH). Indicate this in Discharge Destination – D, Other, enter IH on the line.

A-Home with a Health Plan	D-Other (Please specify)
B-Hospital	E-Own Home
C-Nursing Facility (NF)	F-SNF Medicare
L-Limited Stay Expired	

vi. Section V of the Form DMA-59 must be completed every time the form is used for any reason by the facility.

1. Enter the signature of the facility administrator.

2. Enter the date the facility administrator signed the Form-59 in MMDDYY format.

vii. 1. Leave Section VI blank

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

Type of Program: ☐ Nursing Facility ☐ GAPP ☐ TEFRA/Katie Beckett

PEDIATRIC DMA 6(A)
PHYSICIAN'S RECOMMENDATION FOR PEDIATRIC CARE

Section A – Identifying Information

1. Applicant's Name/Address:

DFCS County_____

_____
Mailing Address

2. Medicaid Number: ----------

3. Social Security Number

4. Sex | Age | 4A. Birthdate

5. Primary Care Physician

6. Applicant's Telephone #

7. Does guardian think the applicant should be institutionalized? ☐ Yes ☐ No

8. Does child attend school? ☐ Yes ☐ No

9. Date of Medicaid Application / /

Name of Caregiver #1: _____ Name of Caregiver #2: _____

I hereby authorize the physician, facility or other health care provider named herein to disclose protected health information and release the medical records of the applicant/beneficiary to the Department of Community Health and the Department of Human Resources, as may be requested by those agencies, for the purpose of Medicaid eligibility determination. This authorization expires twelve (12) months from the date signed or when revoked by me, whichever comes first.

10. Signature:_____ 11. Date:_____
(Parent or other Legal Representative)

Section B – Physician's Report and Recommendation

12. History: *(attach additional sheet if needed)*

13. Diagnosis
1)_____ 2)_____ 3)_____
(Add attachment for additional diagnoses)

1. ICD	2. ICD	3. ICD

14. **Medications**

Name	Dosage	Route	Frequency

15. **Diagnostic and Treatment Procedures**

Type	Frequency

16. Treatment Plan **(Attach copy of order sheet if more convenient or other pertinent documents)**

Previous Hospitalizations:_____ Rehabilitative Services:_____ Other Health Services:_____

Hospital Diagnosis: 1)_____ 2) Secondary_____ 3) Other_____

17. Anticipated Dates of Hospitalization: _____/_____ / /

18. Level of Care Recommended: ☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

19. Type of Recommendation:
☐ Initial
☐ Change Level of Care
☐ Continued Placement

20. Patient Transferred from (check one):
☐ Hospital ☐ Another NF
☐ Private Pay ☐ Lives at home

21. Length of Time Care Needed _____Months
1) ☐ Permanent
2) ☐ Temporary _____ estimated

22. Is patient free of communicable diseases? ☐ Yes ☐ No

23. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services

24. Physician's Name (Print):

Physician's Address (Print):

25. I certify that this patient requires the level of care provided by a nursing facility, IC/MR facility, or hospital
_____Physician's Signature

26. Date signed by Physician

27. Physician's Licensure No.

28. Physician's Telephone #: ( )

Section C– Evaluation of Nursing Care Needed (check appropriate box only)

29. Nutrition	30. Bowel	31. Cardiopulmonary Status	32. Mobility	33. Behavioral Status
☐ Regular ☐ Diabetic Shots ☐ Formula-Special ☐ Tube feeding ☐ N/G-tube/G-tube ☐ Slow Feeder ☐ FTT or Premature ☐ Hyperal ☐ IV Use ☐ Medications/GT Meds	☐ Age Dependent Incontinence ☐ Incontinent - Age > 3 years ☐ Colostomy ☐ Continent ☐ Other _____	☐ Monitoring ☐ CPAP/Bi-PAP) ☐ CP Monitor ☐ Pulse Ox ☐ Vital signs > 2/days ☐ Therapy ☐ Oxygen ☐ Home Vent ☐ Trach ☐ Nebulizer Tx ☐ Suctioning ☐ Chest - Physical Tx ☐ Room Air	☐ Prosthesis ☐ Splints ☐ Unable to ambulate > 18 months old ☐ Wheel chair ☐ Normal	☐ Agitated ☐ Cooperative ☐ Alert ☐ Developmental Delay ☐ Mental Retardation ☐ Behavioral Problems (please describe, if checked) ☐ Suicidal ☐ Hostile

34. Integument System	35. Urogenital	36. Surgery	37. Therapy/Visits	38. Neurological Status
☐ Burn Care ☐ Sterile Dressings ☐ Decubiti ☐ Bedridden ☐ Eczema-severe ☐ Normal	☐ Dialysis in home ☐ Ostomy ☐ Incontinent – Age > 3 years ☐ Catheterization ☐ Continent	☐ Level 1 (5 or > surgeries) ☐ Level II (< 5 surgeries) ☐ None	Day care Services ☐ High Tech - 4 or more times per week ☐ Low Tech – 3 or less times per week or MD visits > 4 per month ☐ None	☐ Deaf ☐ Blind ☐ Seizures ☐ Neurological Deficits ☐ Paralysis ☐ Normal

39. Other Therapy Visits
☐ Five days per week ☐ Less than 5 days per week

40. Remarks

41. Pre-Admission Certification Number

42. Date Signed

43. Print Name of MD or RN:_____
Signature of MD or RN:_____

DO NOT WRITE BELOW THIS LINE

44. Continued Stay Review Date:_____ Admission Date _____ Approved for _____Days or _____Months

45. Are nursing services, rehabilitative services or other health related services requested ordinarily provided in an institution? ☐ Yes ☐ No

46A. State Authority MH & MR Screening)
Level I/II
Restricted Auth. Code Date

46B. This is not a re-admission for OBRA purposes
Restricted Auth. Code Date

47. Hospitalization Precertification ☐ Met ☐ Not Met

48. Level of Care Recommended by Contractor
☐ Hospital ☐ Nursing Facility ☐ IC/MR Facility

49. Approval Period	50. Signature (Contractor)	51. Date / /	52. Attachments (Contractor) ☐ Yes ☐ No

DMA-6A (10/2004)

Appendix H
PASRR Level I Application (DMA-613)

I understand that submission of this application is in accordance with Section 1919(b)(3)(f) of the Social Security Act, which requires that a Medicaid certified nursing facility can neither admit nor retain any individual with serious mental illness and/or intellectual disability unless a thorough evaluation indicates that such placement is appropriate and that services will be provided. The Level I screen is part of the Preadmission Screening/Resident Review (PASRR) and identifies whether an applicant to a nursing facility has indicators for mental illness, intellectual disability, developmental disability or a related condition. The nursing facility is not authorized to admit initial applicants without completion of this preadmission nursing facility policy procedure which includes physician certified completion of the DMA-6 for a level of care determination. Both the DMA-6 and the DMA-613 are permanent documents to be placed in the resident's chart and made readily available for professional review. Georgia Medicaid will not reimburse the admitting nursing facility for claims prior to the completion date of all proper documentation; this includes Level II PASRR documentation that was not completed prior to the Medicaid or no Medicaid eligible resident's admission into the nursing facility (NF). The nursing facility is responsible for ensuring that the form is complete and accurate before admission.

The Physician's Recommendation Concerning Nursing Facility Care DMA-6 signed by the physician ◘ Yes ◘ No

Does the individual applying for admission, directly from a hospital discharge, require NF services for the condition received while in the hospital and whose attending physician has certified that the NF stay is likely to require less than 30 days?
□ Yes ◘ No Date of Certification_____

*Do Not Proceed If Physician has not certified a DMA-6 For A Level Of Care or If Physician has certified that NF Services are for 30 days or less.

_____	_____	_____
Physician's Name on DMA-6	Date Signed	Physician's Telephone #
_____	_____	_____
Name of applicant / Sex: □ M □ F	Date of birth	Social Security Number

_____
Applicant Medicaid ID # or System Generated ID #

_____
Facility or Office Name Submitting Application FAX #

_____	_____	_____
Name, Title of Representative Submitting Application	Submission Date	Telephone#

Has the applicant been admitted into the Nursing Facility? ◘ Yes ◘ No

Admitting Nursing Facility: _____ Facility Provider number: _____

Anticipated Date of Admission: _____

Current location of applicant: ◘ Acute hospital ◘ Psychiatric inpatient ◘ Residential Nursing Facility

□ Home Address_____ Contact Person_____ Phone_____

□ Other_____

Check all that apply to the applicant/resident:

□ New admission

□ Readmission to NF from acute hospital

□ Transfer between NF's

□ Respite care, less than 30 days

□ Significant status change

□ Other:

◘ Readmission to NF from psychiatric hospital

◘ Transfer from residence to NF

◘ Emergency, Requiring Protective Services

◘ Out-of-state resident (OOS)

□ Referral from ID/DD agency/DBHDD

***Resident's OOS PASRR Contact information**:

_____

Name Telephone #

CHECK ALL DIAGNOSES THAT APPLY TO PATIENT

1. Does the individual have a primary diagnosis of Dementia?

□ Yes ◘ No **ICD-10 Diagnosis** _____ **Date of Onset, if known** _____

a. If yes, check the type of Dementia, due to:

□ Alzheimer's Disease

□ Parkinson's Disease

□ Huntington's Disease

□ HIV

□ Other

◘ Head Trauma

◘ Vascular changes

◘ Pick's Disease

◘ Creutzfeldt-Jakob (ABE)

b. If no, is there presenting evidence to indicate Dementia as a/an:

1**. Undiagnosed condition? ◘ Yes ◘ No or 2. Suspected diagnosis? ◘ Yes ◘ No**

Is there current and accurate data found in the patient record to indicate that there is a severe physical illness that is so severe that the patient could not be expected to benefit from *specialized services?

□ Yes ◘ No

Specialized Services under Georgia's PASRR Program are any services or support recommended by an individualized Level II determination that a particular nursing facility resident requires due to mental illness, intellectual disability or related condition, that supplements the scope of services that the facility must provide under reimbursement as nursing facility services, which result in the implementation of an individualized plan of care that necessitates supervision by trained mental health personnel and is directed toward stabilization and restoration. The services include crisis intervention, training/counseling, physician assessment & care, In-Service training services, skills training with rehab supports & therapy, day/community support for adults, and case management which involves assertive community treatment. For more information, see Nursing Facility Part II Medicaid Policy Manual, Appendix H.

Please specify the Physical Illness: _____

ICD-10 code(s), if known _____ Date of Onset, if known_____

- Severe Physical Illness likely to continue? ◘ Yes ◘ No
- Likely to interfere with mental/cognitive capacity/function? ◘ Yes ◘ No

Does the individual have a Terminal Illness which includes a medical prognosis that his/her life expectancy is 6 months or less? ◘ Yes ◘ No

Diagnosis_____ Date of Onset, if known _____

****

Check All Diagnoses That Apply to Patient

4.Does the individual have a Primary Diagnosis of Serious Mental Illness or Mental Disorder?
□ Yes ◘ No

Diagnosis_____ Date of Onset, if known _____ ICD-10 code(s)

If yes, check all that apply:

□ Schizophrenia, Paranoid Type □ Schizophrenia, Disorganized Type

□ Depressive Disorder

□ Bipolar Disorder

□ Anxiety Disorder

□ Somatoform Disorder

□ Other Mental Disorder

□ Schizophrenia, Catatonic Type

□ Schizophrenia, Undifferentiated Type

□ Schizophrenia, Residual Type

□ Substance Use Related Disorder

Does the treatment history indicate that the individual has received, is receiving, or has been referred to receive services from an agency for a serious mental illness or mental disorder? □ Yes ◘ No

Does the treatment history indicate the individual has experienced at least ONE of the following?

(1) In-patient psychiatric treatment/crisis stabilization unit within past 5 years. ◘ Yes ◘ No

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

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

(1) Interpersonal Symptoms. The individual may have serious difficulty interacting with others; altercations, evictions, unstable employment, frequently isolated, avoids others. □ Yes ◘ No

Completion of Tasks. The individual may have serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks, requires assistance with tasks, lack concentration or persistence.
□ Yes ◘ No

Adapting to change. This individual may be self-injurious, self-mutilating, suicidal, or have episodes of physical violence or threats, appetite disturbance, hallucinations, delusions, serious loss of interest, tearfulness, irritability, or withdrawal. □ Yes ◘ No

Comments: _____

_____

The individual has a Diagnosis of Intellectual Disability (ID) or Developmental Disability (DD) [prior to age 18] or a Related Condition [prior to age 22]. □ Yes ◘ No

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

Diagnosis_____ Date of Onset, if known _____ICD-10 code(s)_____

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

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

It is manifested before the person reaches age 22.

Is likely to continue indefinitely

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

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

If no, is there presenting evidence to indicate a suspected diagnosis for an undiagnosed condition as indicated by substantial functional limitations in THREE or more of the following areas of major life activities: (Refer to Section (4) Above) ◘ Yes ◘ No

Does the treatment history indicate that the individual has received, is receiving, or has been referred to services for ID/DD/RC from DBHDD or another agency? ◘ Yes ◘ No

Has experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. □ Yes ◘ No

(2) Has received Inpatient residential treatment. ◘ Yes ◘ No

Comments:

_____

_____

_____

****

Do not admit the applicant to the nursing facility until the DMA Medical Management Vendor and/or the PASRR Determination Unit approves this admission and issues the PASRR authorization code number. *Admissions into a facility prior to the issued authorization code will result in the Department's denial of payment prior to the date that the PASRR authorization code is issued. The authorization code must be documented on the applicant's DMA-6 form, in the appropriate 9A or 9B section.

The Level I screen is part of the Preadmission Screening/Resident Review (PASRR) and identifies whether an applicant to a nursing facility has indicators for a related condition of mental illness, intellectual disability or developmental disability. If there is no further evidence to indicate the possibility of mental illness, intellectual disability or related condition, prior to admission into the nursing facility, the nursing facility may admit this applicant. If the nursing facility admits the applicant and discovers information that was not disclosed to the PASRR screeners, the nursing facility is required to contact the DMA Medical Management Vendor immediately.

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

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

Comments:

_____

_____

_____

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

Appendix I
Authorization for Nursing Reimbursement

AUTHORIZATION FOR NURSING FACILITY REIMBURSEMENT

DATE OF RECEIPT

FOR DMA USE ONLY

SECTION I - IDENTIFICATION

NAME OF FACILITY | CITY | MEDICAID PROVIDER NO | SOCIAL SECURITY NO

RECIPIENT'S NAME | RECIPIENT'S MEDICAID NO. | PRIMARY ICD-9-CM | SECONDARY ICD-9-CM | DATE OF BIRTH (M M D D Y Y)

SECTION II - ADMISSION

LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

PATIENT ADMITTED FROM: A-Hospital, B-Nursing Facility (NF), C-State Instit., D-Own Home, E-Other _____, F-SNF Medicare

ADMISSION DATE (M M D D Y Y)

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

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME

SECTION III - STATUS CHANGES

NEW LEVEL OF CARE: 1-Skilled, 2-IC, 3-IC/MR

LOC EFFECTIVE DATE (M M D D Y Y)

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

DMA-6 ATTACHED: ( )Yes ( )No

QMB ELIGIBLE: ( )Yes ( )No

PAYMENT EFFECTIVE DATES (M M D D Y Y) THRU (M M D D Y Y)

PATIENT INCOME

SECTION IV - TERMINATIONS

REASON: E-INELIGIBLE, F-DISCHARGED, G-DIED

EFFECTIVE DATE (M M D D Y Y)

DISCHARGE DESTINATION: A-Home with a Health Plan, B-Hospital, C-Nursing Facility (NF), D-Other _____, E-Own Home, F-SNF Medicare, L-Limited Stay Expired

SECTION V - FACILITY CERTIFICATION

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

Signature of Facility Administrator X _____ DATE (M M D D Y Y)

SECTION VI - AUTHORIZATION

Signature of Assistance Payments Worker X _____ County Code _____ DATE (M M D D Y Y)

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(Revised 6-93)

Appendix J
Physician's Recommendation Concerning Nursing Facility Care

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

Section A — Identifying Information

1. Facility's Name and Address

County _____

2. Medicaid Case Number — 3 Digits | 2 digits

Case No. has 5 or 6 in this Block after

3. Social Security Number

4. Sex | Age | 4A. Birthdate

7. Patient's Name (Last, First, Middle Initial)

5. Type of Facility (Check One)
1. ☐ Nursing Facility
2. ☐ ICF/MR

6. Type of Recommendation
1. ☐ Initial
2. ☐ Level Change
3. ☐ Continued Placement

8. Date of Nursing Facility Admission / /

9. Patient Transferred from (check one)
☐ Hospital ☐ Home ☐ Another Nurs. Home
☐ Private Pay ☐ Medicare

Recipient's Home Address _____
Recipient's Telephone Number _____

Date of Medicaid Application / /

9A. State Authority (MH's MR Screening)

Mother's Maiden Name:

Level I/II

This is to certify that the facility or attending physician is hereby authorized to provide the Georgia Department of Medical Assistance and the Division of Family and Children Services, Department of Human Resources with necessary information including medical data.

10. Signed _____ (Patient, Spouse, Parent, or other Relative or Legal Representative) 11. Date _____

Restricted Auth. Code | Date

9B. This is not a re-admission for OBRA purposes

Restricted Auth. Code | Date

Section B — Physician's Examination Report and Recommendation

	1. ICD	2. ICD	3. ICD
12. Diagnosis on Admission to Facility (Hospital Transfer Record May Be Attached) 1. Primary _____ 2. Secondary _____ 3. Other _____			

13. Treatment Plan (Attach copy of order sheet if more convenient)

Hospital Dates: _____ to _____

Hospital Diagnosis 1. Primary _____ 2. Secondary _____ 3. Other _____

Medications				Diagnostic and Treatment Procedures	
Name	Dosage	Route	Frequency	Type	Frequency

14. Recommendation Regarding Level of Care Considered Necessary
1. ☐ Skilled 2. ☐ Intermediate 3. ☐ Intermediate care for the Mentally Retarded

15. Length of Time Care Needed
1. ☐ Permanent 2. ☐ Temporary _____ Months estimated

16. Is Patient free of communicable diseases? 1. ☐ Yes 2. ☐ No

17. This patient's condition ☐ could ☐ could not be managed by provision of ☐ Community Care or ☐ Home Health Services.

18. I certify that this patient requires the level of care provided by a nursing facility or an intermediate care facility for the mentally retarded.

Physician's Signature

19. Physician's Name (Print)

Physician's Address (Print)

20. Date Signed By Physician / /

21. Physician's Licensure No

Physician's Phone No. ( )

Section C — Evaluation of Nursing Care Needed (check appropriate box only)

22. Diet
☐ Regular
☐ Diabetic
☐ Formula
☐ Low Sodium
☐ Tube Feeding
☐ Other

23. Bowel
☐ Continent
☐ Occas. Incontinent
☐ Incontinent
☐ Colostomy

24. Overall Cond.
☐ Improving
☐ Stable
☐ Fluctuating
☐ Deteriorating
☐ Critical
☐ Terminal

25. Restorative Pot.
☐ Good
☐ Fair
☐ Poor
☐ Questionable
☐ None

26. Mental & Behavioral Status
☐ Agitated ☐ Noisy ☐ Dependent
☐ Confused ☐ Nonresponsive ☐ Independent
☐ Cooperative ☐ Vacillating ☐ Anxious
☐ Depressed ☐ Violent ☐ Well Adjusted
☐ Forgetful ☐ Wanders ☐ Disoriented
☐ Alert ☐ Withdrawn ☐ Inappropriate Reaction

27. Decubiti
☐ Yes ☐ Surgery
☐ No Date
☐ Infected
☐ On Admission

28. Bladder
☐ Continent
☐ Occas. Incontinent
☐ Incontinent
☐ Catheter

29. Hours Out of Bed Per Day _____
☐ Intake ☐ IV
☐ Output ☐ Bedfast

☐ Catheter Care
☐ Colostomy Care
☐ Sterile Dressings
☐ Suctioning

30. Indicate Frequency Per Week

	Physical Therapy	Occupational Therapy	Remotive Therapy	Reality Orientation	Speech Therapy	Bowel and Bladder Retrain	Activities Program
Received							
Needed							

31. Record Appropriate Legend
1. Severe
2. Moderate
3. Mild
4. None

IMPAIRMENTS: Sight ☐ Hear ☐ Speech ☐ Ltd. Motion ☐ Paralysis ☐

ACTIVITIES OF DAILY LIVING
1. Dependent
2. Needs Asst.
3. Independent
4. Not App.

Eats ☐ Wheelchair ☐ Transfers ☐ Bath ☐ Ambulation ☐ Dressing ☐

32. Remarks

33. Pre-Admission Certification Number

34. Signed

35. Date Signed / /

Do Not Write Below This Line

Continued Stay Review Date: _____ Payment Date _____ Approved For _____ Days Only!

36. Level of Care Recommended by G.M.C.F.: | LOB | 37. Signature (G.M.C.F.) | Date / / | 38. Attachments (G.M.C.F.) 1. ☐ Yes 2. ☐ No

DMA-6 (Rev. 2-81)

Appendix K
Nursing Facility Leave of Absence Form

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

Appendix L
Acknowledgements of Receipt of Home and Community Based Services Information

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

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

Verification

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

_____

Signature of Informant Date

Acknowledgement

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

_____

Signature of Applicant/Consumer Date

or

_____

Signature of Authorized Representative Date

(DMA-385)

Appendix M
Adjustment Request Form

Transaction Control Number TCN/Internal Control Number ICN	Member Medicaid Information	Provider Information	Reason for Adjustment (check one box)	
Paid claim to be adjusted as shown on the Remittance Advice	Member Number, Member Name (Last, First, Initial)	Provider Name/Address Provider Number Phone Number	Appy COB (indicate amount in Block #5D) Change information as indicated in Block 5 below Void claim Medicare adjustment (attach all EOMB's that apply to this adjustment)	

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

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

Explanation for Adjustment	
FOR DCH USE ONLY CCN_____	FS Line Amount $_____

Provider Signature_____ Date_____

Appendix N
Request for Forms

Completion Instructions:
Quantity – Indicate quantity requested in the Quantity Ordered column.

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

Upload this form to: – Provider Workspace – www.mmis.georgia.gov

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

DMA-634	Notice of Action	
DMA-635	Post-Partum Home Visit Mother Assessment	
DMA-637	Post-Partum Teaching Guide	
DMA-638	Letter of Understanding	
DMA-639	Model Waiver Assessment	
DMA-641	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (6-7month visit)	
DMA-642	Pregnancy-Related Services/Health Check-Related Assessment and Teaching Guide (11–12-month visit)	

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

Appendix O
Procedure Roles

A. Nursing Facility Provider

Prior to admission of any resident, the Nursing Facility (NF), Hospital or Physician's office must have a completed Physician's Recommendation (DMA-6 form) for all NF applicants. A completed RASRR Level I (DMA-613 form) for all NF applicants with expected stay of more than thirty (30) days is also required.

The completed DMA-613/Level I form for applicant must also be electronically submitted for review at www.mmis.georgia.gov. The Level I electronic review process begins by selecting Provider Information and scrolling down to select "PASRR Request". The request is the Online DMA-613 (PASRR) application that is completed by answering each applicable question. The review will either (1) issue a real-time pre-cert number or (2) "Pend" for further review. "Pend" notifications mean that a NF cannot admit individual. The originator of the Level I request must contact the Division's Medical Management Contractor (MMC) at 1-800-766-4456 for further review on "Pend" status. The requestor's contact with the MMC can progress to receiving an issued Level I Prior Authorization (PA) number or notification that a Level II assessment by the Georgia Department of Behavioral Health and Developmental Disability (DVHDD) must be completed before a PA number for NF admission may or may not be issued for applicant's admission into the NF. PA numbers issued for approved individuals should be recorded by the requestor on DMA-6, appropriate 9A or 9B field. The DMA-6 & DMA-613 must always be kept on the front of a resident's medical chart to be readily available for HFR Surveyors. The original DMA-613 must be sent with any resident transferring out of a facility and a copy must be kept in the facility's patient record.

NF staff must contact area Community Behavioral Health Services Provider (CBHS) for individuals identified as having a serious mental illness (SMI) that requires Specialized Services (SS). The CBHS provider will obtain a PA to provide services for each individual and maintain provider documentation. See Appendix H for list of CBHS providers.

B. Level I

The Division's Medical Management Contractor (MMC) reviews the DMA-613, initiating the Pre-Admission Screening (PAS) and determines:

i. If the DMA-613 does not reveal indicators for serious mental illness or intellectual disability, no further screening is necessary. MMC issues PA number for NF admission.

ii. If the DMA-613 does reveal indicators for serious mental illness or intellectual disability, MMC proceeds with request to DBHDD for additional screening to determine if applicant can be admitted into NF.

iii. The Level I PAS process is completed when an Authorization Code (PA) is issued by MMC based on the Level I. If MMC cannot complete the process, the agency will pend to DBHDD for further assessment, which is a Level II. The requestor should begin PASRR processes as quickly as possible to ensure timely admission into a NF; this is because DBHDD may take up to nine days to complete Level II assessment.

C. Level II

DBHDD will proceed with further screening of the individual after the MMC makes the request for the Level II. The DBHDD will contact individual and/or guardian prior to assessing the individual. Assessment and Level II Documentation may take up to nine (9) days to complete. Therefore, the NF should begin PASRR processes as quickly as possible. The PAS process is completed when DBHDD informs the originator of preadmission request and individual or guardian of findings based on the Level II assessment. DBHDD may issue PA for NF admission
with or without recommendation for Specialized Services. DBHDD may also deny NF admission based on Georgia's policy and/or the Level II assessment.

The State of Georgia policy requires that services be delivered in the least restrictive and appropriate manner to address the service needs of the individuals while enhancing the promotion of social and community integration (See Section 802 of this manual). A denial by the DBHDD for NF admission may be based on (1) Individual has a serious mental illness or is ID/DD and assessed as not appropriate for SNF level of care; (2) Requires specialized services for SMI or ID/DD in alternative community setting; (3) Individual should be considered for less restrictive alternative community setting (4) Individual and/or their authorized representative make an informed choice concerning NF placement or community services or home.

D. CHBS Providers

Following a DBHDD PA for a NF resident's admission with recommendation for Specialized Services, the NF will begin with resident care planning by contacting a CBHS provider with the Level II PA number for members identified as needing SS.

The initial NF contact to the CBHS provider with an authorized Level II number will occur for every new Medical resident or a current resident that has a status change. CBHS providers should always verify with the NF that the Level II PA number is valid for current dates of service.

Effective 7/1/12, all claims submitted for Behavioral Health Specialized Services to nursing facility residents (sometimes referred to as PASRR-authorized services) will require a prior authorization (PA). Specialized Services are dependent upon an approved Level II prior authorization (PA) number in the Medicaid Management Information System (MMIS). This means the assignment of a PA for Specialized Services and payment for delivery of Specialized Service require the member to also have an active Level II PA issued and entered into the MMIS. Following the NF initial contact to the CBHS provider with the member's Level II PA number, the CBHS provider will request authorization to provide the required SS to identified residents in the NF. This request is to obtain a Community Nursing Facility (CN) PA to provide the SS.

The CN PA is obtained through Beacon's Provider Connect at www.GeorgiaCollaborative.com. Other resources that may be helpful to CN providers are, (1) Alliant Health Solutions regarding Level I information at 1-800-766-4456, choose option 5; (2) Beacon Health Options regarding Level 2 information at 1-855-606-2725.

After receiving the CN PA, CBHS providers must collaborate with facility staff regarding the residents' plan of care (POC). The CN PA is valid for one year to provide SS in the NF and must be renewed annually. A nurse Practitioner (NP), Clinical Nurse Specialist (CNS), or Licensed Professional Counselor (LPC) acting within the scope of practice as defined by State law under the supervision of a physician, may provide SS according to the resident's POC.

Appendix P
PASRR Process and Specialized Services

A. PASRR Process and Specialized Services

All nursing facilities (NFs) must be in compliance with Federal Regulations 42CFR483.100-138, Subpart C the Preadmission Screening and Resident Review (PASRR) function. Applicants and residents with suspected serious mental illness (SMI) and intellectual disability/related condition (ID/RC) are required to be evaluated by Department of Behavioral Health and Developmental Disabilities (DBHDD) regardless of the pay source, prior to admission into the facility or due to a resident's change in condition. DBHDD will evaluate the applicant or resident to determine:

i. There is a diagnosis of SMI and/or ID/RC

ii. The individual requires the level of care appropriately provided by a nursing facility

iii. The individual requires specialized services for the determined diagnosis.

B. Specialized Services (SS)

Specialized Services (SS) are services provided by the NFs in combination with other service providers to implement an individualized plan of care (POC). The POC is developed to contribute to the prevention of regression or loss of current functional status through treatment to stabilize and/or restore the level of functioning that preceded any acute episode for the resident. The POC is also directed toward the acquisition of behaviors necessary for the resident to function with as much independence as possible.

Information regarding "Dual Eligible" (Medicaid and Medicare) member's access to Community Mental Health Services:

iv. Those residents with dual eligibility in the Medicare and Medicaid programs will receive mental health care reimbursed through the Medicare program, with Medicaid as the payer of last resort.

v. Though not available in all areas of the State, Medicare-funded mental health services are currently provided to nursing home residents via telemedicine, face-to-face visits by providers in the nursing home, and nursing home resident visits to psychiatric/mental health clinics/offices for those individuals able to travel outside the nursing facility.

NOTE: Though 440 codes allow for Medicaid members to have a variety of mental health professionals serve members in nursing facilities, please note that Medicare has more stringent requirements regarding these professionals to serve the Medicare eligible members in nursing facilities. (Please review the approved practitioner levels listed later in this appendix). When Nursing Facilities refer/coordinate Specialized Services for the PASRR approved resident, Nursing Facility staff should communicate to the Community Behavioral Health Service Provider (CBHSP), the DCH enrolled MH provider that the member is either dual eligible or Medicare
only.

NOTE: The listing of Community Behavioral Health Service Providers are listed at the end of this appendix

C. Preadmission Screening (PAS)

The PAS process begins with a Level I Assessment (DMA-613). The Division's Medical Management Contractor (MMC) evaluates the DMA-613 and Level I and refers applicants requiring a Level II assessment (i.e., those who are suspected of or diagnosed with SMI, ID/RC) to the DBHDD PASRR contractor. The Level II assessment is a comprehensive medical, psychosocial and functional assessment. There are two (2) Level II instruments used by DBHDD for both SMI and ID/RC for PASRR determinations: (a) the record review for all assessments; and (b) the Face-to-Face assessment for applicants or residents when the record review is insufficient to make a conclusive determination.

DBHDD may apply categorical determinations for the PAS based on certain diagnoses, levels of severity of illness, or need for a particular service that indicate that admission to a NF is warranted. DBHDD may also determine provisional admissions, with time limits, pending further assessment due to delirium, for emergency protective services placement not more than 7 days, or for respite. (Longer stays would require a Level II Resident Review).

A PAS is required prior to the initial entry into the nursing facility and for current residents who present a behavioral health change or status change as identified by the MDS 3.0 A1500. The PAS as identified by the MDS 3.0 status change is a Residential review (RR). A PAS is also required for re-entry of a resident that has a "break in service" due to discharge of resident out of the system to home and then seeks to return to a nursing facility.

Individuals discharged from a hospital directly to a nursing facility for a stay of less than 30 days for treatment of a condition for which they were hospitalized, will not require a PAS, provided the attending physician certified before the admission that the admission is for an anticipated stay of not more than thirty (30) days and treatment continues for the same acute care diagnosis. However, IF the provider will expect to be able to bill Medicaid for any of those 30 days, a PASRR Request should be submitted since that submission will trigger the creation of the required L1 or L2 Prior Authorization for nursing facility stay.

No PAS will be required for readmission to a nursing facility within one (1) year of a previous Level II for an individual or for an individual transferred to an acute care hospital for treatment, with the exception of mental health stabilization. A PAS is required for re-admission of individuals who meet any one of the following criteria regardless of date for previous Level II:

vi. Is diagnosed with a new SMI condition.

vii. Is transferred to an acute care hospital for SMI treatment.

viii. Any Hospitalization over one year in length.

D. PASRR Assessors (Level II)

ix. Level II screening is triggered by a diagnosis or suspicion of SMI/ID/RC on the Level I and is performed by the DBHDD contractor.

x. Assessors complete Level II assessments on any individual referred with a confirmed or suspected SMI/ID/RC diagnosis for first time admissions or for residents (RR) with identified

SMI or ID, who demonstrates a significant change in physical or psychological status (the Status Change Assessment as identified by the MDS 3.0).

xi. Assessors make initial contact with the hospital or nursing facility staff for the patient's record for clinical review (a record review).

xii. If a determination can be made from the clinical review that the patient does not have a serious MI or ID/DD, then NF approval may be given dependent on the record review.

xiii. Categorical determinations permit the Assessors to omit the full Level II Evaluation in certain circumstances that are time-limited or where need is clear.

xiv. If the record review finds that the patient does have MI or ID/DD, then an on-site Face-to-Face evaluation must be made.

xv. Assessors contact the individual listed on the intake referral from (PAS assessments) or a nursing facility staff member to schedule a convenient time to conduct Face-to-Face assessment.

xvi. Assessments are completed during regular/customary working hours (excluding official State holidays and weekends). Assessments may be conducted outside normal business hours only for the convenience of the facility, applicant or resident, or the resident's family.

xvii. The assessor arrives at the hospital or nursing facility with appropriate identification which includes a letter of introduction from DBHDD contractor identifying the assessor as an agent of DBHDD.

xviii. Nursing facility or hospital staff will make available copies of the most recent physical examination performed or signed by a physician, the most recent care plan and any other pertinent information.

E. Level II Assessment

In order to complete the Level II assessment, the assessor will need access to the individual's medical record and will need copies of pertinent medical data. The assessor is responsible for conducting a face-to-face interview with the individual within five (5) days of Level II request. The assessor should meet with the facility staff who is knowledgeable of the individual, as well as available family members (if permission is obtained from the resident or legal guardian).

Federal law requires each Level II assessment to include a physical examination signed by a physician. If a physician does not conduct the physical examination, a physician must review and concur with the findings presented in a previous examination's documentation. In order to fulfill this requirement, the assessor will need a copy of the resident's most recent physical examination performed and/or signed by a physician.

The Level II assessment will determine and report the following:

xix. The individual's diagnoses

xx. Whether the individual meets criteria for a nursing facility level of care;

xxi. Whether the individual requires specialized services

If the individual needs SMI or ID/RC services, treatment recommendations will be included. The Level 2 assessor will make every attempt to discuss the findings with the requesting entity, usually the hospital or nursing facility.

The DBHDD contractor will send a Summary of Findings, including the determinations made to the nursing facility and the member. A Prior-Authorization (PA) number is generated and issued out to the admitting nursing facility. The nursing facility must ensure that the PA number is documented in the appropriate section 9A or 9B on the DMA-6. The DMA-6 and the Summary of Findings should be placed in the front of the resident's file so that the PA number and medical data are available to review by surveyors from the Department's, Healthcare Facilities Regulation Division (HFR) (formerly known as the Office of Regulatory Service) and other professionals.

Additionally, all Level 2 findings are used in development of the residents' plan of care. The nursing facility must request a copy of an individual's Summary of Findings from DBHDD contractor once an individual has been admitted to the facility. Contact information for the Level II assessment staff:
Phone: 1-855-606-2725
Website: www.GeorgiaCollaborative.com

The DBHDD contractor is required to notify applicants and residents both verbally and in writing, of the outcome of the assessment and interpret the assessment findings. Verbal notification is made by phone to applicants and residents or their legal representatives. A written notice is mailed to applicants and residents or their legal representatives, as well as to the individual's primary care physician and hospital (if applicable).

F. Transfers

When a resident transfers from one nursing facility to another, there is specific information that must be communicated to the new facility by the current facility to ensure coordination and continuity of care for the resident receiving Specialized Services as approved through PASRR. In addition, documentation by the nursing facility staff is required for all referrals to community mental health service providers. Community Behavioral Health (CBH) Service Provider Agency name and date of referral, including follow up on the status of the referral is required. The following documentation should follow the resident/member to the new facility:

xxii. DMA-613

DMA-6 – with Prior-Authorization number as assigned by Alliant Health Solutions or Beacon Health Options for new facility to share with CBH provider to coordinate specialized services and Medicaid facility reimbursement.

xxiii. Resident's Diagnosis

Beacon Health Options' Evaluation/Summary of Findings CBH notes and information regarding resident's SMI information (Acquired from copy in NH chart):

1. Symptom's behaviors or skill deficits

2. Treatment Plan and Objective

3. Interventions

4. On-going progress toward the objectives

5. Termination or discharge summary

G. Out-of-State Applicant/Resident

As PASRR assignments are state specific, PASRR requests must be submitted for all newly institutionalized Georgia residents who previously resided in another state. For any individual who desires nursing facility placement in Georgia, the individual must initially request a PASRR number from the Georgia Department of Community Health Level I contractor, Alliant Health Solutions. From there, the PASRR process remains the same. For those requiring Level II/Specialized Services, the Level II contractor, Beacon Health Options will arrange for the PASRR contractor in the applicant's state of residence to complete a PASRR screening. The Level II assessment will be forwarded to the Department of Behavior Health and Developmental Disabilities (DBHDD) for determination. The PA number will be issued in the state of Georgia using the same process as in state resident admissions and documented in the appropriate section 9A or 9B on the DMA-6.

H. Denials, Alternative Placements and Appeals

Applicants have the right to appeal PASRR Level II findings. A letter of denial will be issued by the Level 2 assessor to individuals who do not meet criteria for a nursing facility level of care. If a Level II denial is determined for a current resident of a nursing facility following a change in condition, the resident will not be discharged based on a PASRR denial until a discharge notice is issued by the Division of Medical Assistance. Residents or their family member will be advised of their appeal rights in the denial letter. Alternative placements for residents requiring discharge will be coordinated with DBHDD in accordance with federal regulations.

xxiv. Any applicant requesting an appeal must do so in writing within 10 working days following the receipt of the Medical History Assessment/Summary of Findings. The appeal must detail the rationale for the 'ineligible' decision. If additional documentation needs to be sent, the provider may fax or mail this information. The appeal should be addressed to:

1. PASRR Project Director

   Beacon Health Options
   Phone: 1-855-606-2725
   Website: www.GeorgiaCollaborative.com

2. The PASRR Project Director, Medical Director, or the designee will review the appeal, review the evaluator's Summary of Findings, and interview the appropriate Level II Healthcare Evaluator. A response will be sent to the applicant within 5 business days of receipt of the PASRR Level II appeal. The response will include:

   (a) A determination to uphold or overturn the decision

   (b) If overturned, what steps will be taken to correct the decision

   (c) If upheld, the rationale to maintain the decision

3. The applicant may request an appeal through DBHDD. Upon receipt of the second written appeal notification, Beacon Health Options will contact DBHDD. The DBHDD designee may request additional information from either party if deemed necessary. The DBHDD designee has 5 business days to make a determination and respond in writing to the applicant and to Beacon Health Options.

I. Nursing Facility Specialized Services

Effective July 1, 2009, the Department has approved Community Behavioral Health Service Providers (CBHS) to provide specialized services to residents in the PASRR SMI and dually diagnosed (SMI and ID/RC) population; services which are beyond those services typically provided in a nursing home. Nursing facilities are required to maintain the most recent copies of the Level II assessment and the Summary of Findings for all residents in the PASRR population residing in the facility.

Once resident is admitted to the nursing facility, nursing home staff will contact enrolled community mental health service providers to arrange an assessment or treatment plan development and collaboratively determine the need for ongoing mental health services. The CBHS Providers will be responsible for providing specialized services to Medicaid recipients that are above and beyond those services typically provided in a nursing facility. The NF is responsible for scheduling appointment and ensuring member's presence at each appointment, as well as obtaining or providing services of a lesser intensity than specialized services to appropriate non-Medicaid and Medicaid residents. Refer to section on "dually" eligible recipients on page H-4 of this appendix.

The NF and CBHS providers will communicate to arrange for the provision of specialized services to residents either in the nursing facility, via telemedicine, or at the Community Behavioral Health location. The service location will be determined by the condition of the resident, ability to travel to the nearest clinic, and evaluation of both nursing facility and mental health staff regarding the most appropriate service delivery venue for the individual resident. If the nursing home resident can be assessed and treated in the outpatient clinic, NEMT transportation can be used to facilitate this visit. Those residents whose interest is best served by receiving mental health services in the nursing facility or in a nearby telemedicine site can receive services in either of those locations, with the practitioner using out-of-clinic or telemedicine procedure codes.

The CBHS provider documents the specific services provided to residents in the nursing facility chart to include the individual's treatment plan, progress, and goals. The CBHS provider consults with NF staff regarding the resident's behaviors, progress in the treatment plan, and outcomes to ensure continuity of care and to involve nursing facility staff in the behavioral intervention plan.

J. For Resident's Requiring ID/RC Care:

Effective July 1, 2009, Medicaid Certified Nursing Facilities must contact the appropriate Region through DBHDD to communicate when a new resident with a diagnosis of ID/RC enters the nursing facility. With the consent of the member, the nursing facility contacts the appropriate Region Board and specifically the Intake and Evaluation (I & E) manager to notify of the member's presence (See end of this appendix after Community Behavioral Health listing for the Regional Board contact information). The I & E Manager will then communicate with the member and the nursing facility to schedule an assessment to determine eligibility for the appropriate waiver program and, per the member's choice, assist with the individual's placement on the waiting list for services should the member choose community placement.

Effective July 1, 2009, when a nursing home resident covered under PASRR experiences a behavioral health crisis, the nursing facility team plays a critical role in contacting the Crisis and Access Line (G-CAL) at 1-800-715-4225 for crisis assistance which may include assessment and management of the situation to achieve stabilization of the resident. G-CAL is staffed and can be accessed 24 hours a day for urgent and immediate crisis intervention for PASRR identified residents. In the event that hospitalization is required, the G-CAL clinical team will evaluate and assist in the hospitalization process to ensure an effective flow of information to the receiving facility.

A behavioral health crisis is defined as an event, behavior, situation or vocalization by a covered resident that is primarily non-medical in nature, but that involves potential danger to the resident peers or staff. The crisis can be reported by any staff of the nursing home.

Examples of crisis where G-CAL should be contacted include, but are not limited to:

i. Suicidal statements and/or actions of a high risk in intent or lethality.

ii. Homicidal statements and/or actions of a high risk in intent or lethality.

iii. Acute psychosis rendering the resident unsafe to self or others.

iv. Disorganization from mental illness resulting in a resident unable to control their actions.

v. Acute and potentially life-threatening deterioration in the resident's medical condition as a result of mental illness (such as paranoia causing non-compliance with required medical interventions and medications, or refusal to eat causing medical decline from depression or psychosis).

vi. Potentially dangerous, threatening, violent, self-harming, destructive, or suicidal behavior which has been evaluated by a qualified NF staff who feels that emergent hospitalization is necessary for psychiatric reasons.

vii. Violence, either impulsive or premeditated.

viii. Strange, bizarre, or unusual behaviors and symptoms that have not been previously evaluated or treated.

1. Effective July 1, 2009, the following procedure is to be used when a resident does not want to be seen by a particular SMI or ID/RC professional:

(a) Upon written or verbal notification from a resident or the resident's responsible party that the resident does not want to be seen by a particular SMI or ID/RC professional, the nursing facility staff must document the request in the medical record at the nursing facility and assist the member with locating either a new provider or a new professional with the current provider.

(b) The request as written by the resident or documented by nursing facility staff must be placed in the resident's medical record and be retained until the resident withdraws/rescinds the request.

(c) The nursing home must notify the CBHS provider by phone of the resident's request within 24 hours and then begin to work with the member to assist in locating a new professional.

(d) The CBHS provider must comply with all such requests from residents.

K. Documentation:

Documenting for the PASRR qualified member receiving Specialized Services must include documentation located with the nursing facility provider as well as with the Community Mental Health provider.

i. Practitioner Type

Level 1:	Physician, Psychiatrist
Level 2:	Psychologist, Physician's Assistant, Nurse Practitioner, Clinical Nurse Specialist, Pharmacist
Level 3:	Registered Nurse, Licensed Dietician, Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT)
Level 4:	Licensed Practical Nurse (LPN); Licensed Associate Professional Counselor (LAPC); Licensed Master's Social Worker (LMSW); Licensed Associate Marriage and Family Therapist (LAMFT); Certified/Registered Addictions Counselors (e.g. CAC-I/II, CADC, CCADC, GCADC, MAC), Certified Peer Specialists, Trained Paraprofessionals and Certified Psychosocial Rehabilitation Professionals (CPRP) with Bachelor's degrees or higher in the social sciences/helping professions
Level 5:	Trained Paraprofessionals, Certified/Registered Addiction Counselors (CAC-I, RADT), Certified Peer Specialists, Certified Psychosocial Rehabilitation Professionals, and Qualified Medication Aides with at least a high school diploma/equivalent

ii. PROCEDURE CODES:

1. KEY: Code Modifiers Used:

(a) GT = Via interactive audio and video telecommunication systems

(b) U1 = Practitioner Level 1 (see below for description of all practitioner levels)

(c) U2 = Practitioner Level 2

(d) U3 = Practitioner Level 3

(e) U4 = Practitioner Level 4

(f) U6 = In-Clinic

(g) U7 = Out-of-Clinic

Note: For all procedures noted on the next page, practitioners must hold the license appropriate to the activity.

The following procedure codes may be used for service delivery and claims billing for specialized behavioral health services provided to nursing home residents: (Daily/Annual Max units are effective 4/1/2013)

Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
Psychiatric Diagnostic Assessment (session) Or Via Telemedicine Report with 90785 for interactive complexity when appropriate	90791, 90792 (Formerly 90801, 90802) 90791, 90792	U2 U6, U2 U7 U3U6, U3U7 (Encounter) GT U1, GT U2, GTU3	10103	1 Encounter	1	12
Mental Health Assessment (15 min unit)	H0031	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10101	10	10 4	80
Mental Health Assessment (15 min unit)	H0032	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10160	1	10	
Individual Outpatient Therapy (30 min unit) Report with 90785 for interactive complexity when appropriate	90832 (Formerly 90804)	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7 U5 U6, U5 U7	10180	8	10	52

Family Outpatient Therapy (15 min unit)	90846, 90847	U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10180	8	10		192
Crisis Intervention (Encounter)	H2011	U1 U6, U1 U7 U2 U6, U2 U7 U3 U6, U3 U7 U4 U6, U4 U7	10110	10	20		144
Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units		Max Year Units
	90839 90840	U1 U6, U1 U7 U2 U6, U2 U7 U3 U6, U3 U7			1 8	1 8	
Psychiatric Treatment Therapy with Evaluation and Management (session) Or Via Telemedicine Report with add-on code for psychotherapy time	Appropriate Evaluation and Management Code – See below (Formerly 90805) Appropriate Evaluation and Management Code-see below (Formerly 90862)	U1 U6, U1 U7 U2 U6, U2 U7 U1 U6, U1 U7 U2 U6, U2 U7 GT U1, GT U2	10120 see above	2 see above	2 see above		24
Evaluation and Management Codes							
E&M (New Pt - 10 min)	99201	U1 U6, U2 U6 U1 U7, U2 U7 GT U1, GT U2	10120	1	2		24
E&M (New Pt - 20 min)	99202						
E&M (New Pt - 30 min)	99203						
E&M (New Pt - 45 min)	99204						
E&M (New Pt - 60 min)	99205						
E&M (Estab Pt - 5 min)	99211						

E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 10 min)	99212					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 15 min)	99213					
E&M (Estab Pt - 25 min)	99214					
E&M (Estab Pt - 40 min)	99215					
E&M - 30 minute add-on code	90833	U1 U6, U2 U6 U1 U7, U2 U7		1		
Interactive Complexity Codes (billed at $0)						
Interactive Complexity	90785	With or without	10104	4		76
Description	Procedure Code	Modifier	Service Group	Max Daily Units	Max Month Units	Max Year Units
Interactive Complexity		TG				

*Note: The maximum units noted here are claims limits on units. The units on the prior authorization may differ slightly due to information system limitations.

L. MI/ID/DD PASRR Level II Determination Codes

Code	OBRA Status	Explaination
1.0	PAS Approval SNF Approval, Serious Mental Illness, No Specialized Services	-Individual has a serious mental illness; -Is appropriate for SNF level of care; -Does NOT need specialized services for SMI; -SNF to provide routine MI services of lesser intensity. (i.e. Basic Mental Health Services).
1.1	PAS Approval SNF Approval, Serious Mental Illness, Specialized Services	-Individual has a serious mental illness -Is appropriate for SNF level of care; -NEEDS specialized services

		for SMI; (i.e. A continuous and aggressive individualized plan of care that is developed and supervised by an interdisciplinary team, prescribes specific therapies and activities by trained personnel to treat acute episodes of serious mental illness, and is directed towards outcomes that increase functional level and reduce the need for specialized services and institutionalization).
1.2	PAS Approval SNF Approval, No Serious Mental Illness	Individual does not have a serious mental illness; Is appropriate for SNF level of care.
2.0	PAS Non-Approval SNF Non-Approval, Serious Mental Illness, Community with Specialized Services	Individual has a serious mental illness; -Is NOT appropriate for SNF level of care and should be considered for alternative community setting; -NEEDS specialized services for SMI in alternative community setting.
2.1	PAS Non-Approval SNF Non-Approval, Serious Mental Illness, Inpatient Psychiatric Hospital	Individual has a serious mental illness; -Is NOT appropriate for SNF level of care and should be considered for psychiatric hospitalization since Applicant's needs are such that they may only be met in an inpatient setting.
2.2	PAS Non-Approval SNF Non-Approval, No Serious Mental Illness	-Individual does not have a serious mental illness; Is NOT appropriate for SNF level of care.
3.0	PAS Approval SNF Approval, Developmental Disability, No Specialized Services	Individual is ID/DD; -Is appropriate for SNF level of care; -Does NOT need Specialized Services for ID/DD;

		-SNF to provide routine ID/DD services for individuals who require services of a lesser intensity (Basic ID/DD Services).
3.1	PAS Approval SNF Approval, Developmental Disability, Specialized Services	-Individual is ID/DD; -Is appropriate for SNF level of care; -NEEDS Specialized Services for ID/DD (i.e. a demonstration of severe maladaptive behaviors that place the person or others in jeopardy to health and safety, the presence of other skill deficits or specialized training needs that necessitate the availability of trained ID personnel, 24 hours per day, to teach the person functional skills).
3.2	PAS Approval SNF Approved, No Developmental Disability	-Individual is not ID/DD; -Is appropriate for SNF level of care.
4.0	PAS Non-Approval SNF Non-Approval, Developmental Disability, Community with Specialized Services	Individual is ID/DD; -Is NOT appropriate for SNF level of care and should be considered for alternative community setting; -NEEDS specialized services for ID/DD in alternative community setting.
4.1	PAS Non-Approval SNF Non-Approval, Developmental Disability, ICF/IID	-Individual is ID/DD; -Is NOT appropriate for SNF level of care and should be considered for ICF/IID since Applicant's needs are such that they can be met only in an ICF/IID. (Please see Intermediate Care Facility (ICF/IID) Level Of Care Criteria).
4.2	PAS Non-Approval SNF Non-approval, No Developmental Disability	-Individual is not ID/DD; -Is NOT appropriate for SNF level of care.

M. Community Behavioral Health Service Providers (CBHSP) By Region and Counties

Agency Name	Address	Phone	Counties Served	Region
Malinda Graham & Associates, Inc.	1518 Airport Road Hinesville, Ga. 31313	912-559-5536 Fax: 614-388-3712	Bryan, Bulloch, Camden, Chandler, Emanuel, Evans, Glynn, Laurens, Liberty, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne	(South/SW)
Psych On Site of GA	1765 Temple Ave Atlanta, GA 30337-2736	713-528-2328 Fax: 713-533-1408	Statewide	Multiple Regions
United Psychology Ctr DBA United Behavioral Health Solutions	2900 Chamblee Tucker Road Suite 16 Atlanta, GA 30341	770-939-1288 Fax: 866-545-8645	Statewide	Multiple Regions
AKC Healthcare	1180 McKendree Church Road Suite 207 Lawrenceville Georgia 30043	770-676-6741 Cell: 770-337-2037	Statewide	Multiple Regions
CareNow Services, LLC	401 Bombay Ln Roswell, GA 30076	770-664-1920 Fax: 866-373-5426	Statewide	Multiple Regions

NOTE: Providers of the PASRR Specialized Services program are required to submit accurate and current contact information to DCH. Any discrepancies or changes in contact information housed in GAMMIS and/or this policy manual should be reported via change of information instructions at www.mmis.ga.gov.

Appendix Q
Nursing Facility Administrative Reviews

A. Application

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

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

B. Pre-Admission Approval

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

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

Attn: Program Specialist
Department of Community Health
Medicaid Policy & Provider Services
2 Martin Luther King Jr Dr SE
East Tower – 19th Floor
Atlanta, GA 30334

i. A decision on the request for reconsideration will be accomplished within fifteen (15) working days of its receipt by the Specialist. The applicant/recipient and the nursing facility will be notified in writing of the reconsideration decision by the Division.

ii. If an applicant/recipient disagrees with the Division's decision, that person, or an authorized representative, may file a request for a hearing. All such requests must be received by the local county Department of Family and Children Services Office or the Fair Hearings Unit of the Department of Human Services no later than thirty (30) days after the date of the notice of decision.

iii. An initial decision on any matter with respect to which a hearing is requested shall be rendered in writing by a Hearing Officer of the Fair Hearings Unit. Should such a decision be adverse to the medical assistance applicant/recipient, that person or representative may appeal the decision by filing an appeal with the Hearing Office for Final Appeals in accordance with directions from the Fair Hearings Unit.

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

C. Billing Rate and Disallowance of Cost from the Cost Report

Reimbursement rates (billing rates) for nursing facilities (NF and ICF/IID) are established pursuant to the provisions discussed in Chapter 1000 of this manual. A billing rate calculation notice will be sent to a provider each time a rate is initially calculated for a given cost report period or is subsequently adjusted as a result of audit or review by the Division or its agent. A billing rate calculation will also be sent to a provider on a quarterly basis for rate changes that are a result of the case-mix reimbursement methodology (i.e. BIMS, CMI, and nursing hour changes). Nursing facilities rates and percentiles will be based on costs reported by the providers which are reviewed by the Division or its agent. Cost reports and adjustments determined appropriate by the Division will be used to establish rates. Those cost reports and adjustments determined appropriate prior to initial establishment of the annual percentile ceilings (as described in Chapter 1000 of this manual) shall be used in calculation of the percentiles. Those cost reports and adjustments determined appropriate subsequent to initial establishment of the annual percentile ceilings shall be used to adjust rates only; percentile ceilings will not be adjusted.

Any provider wishing to appeal its rate as initially established, its subsequent rate change as a result of audit or review, or its quarterly rate change as a result of the case-mix reimbursement methodology must follow the process set out in subsections below:

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

ii. The written request must be submitted on letterhead and address all questioned disallowance(s) and other specific point(s) of dispute and must be accompanied by supporting documents or other evidence to justify reconsideration. Requests for reconsideration must be submitted electronically to nh.appeals@dch.ga.gov. May also be directed to:

Georgia Department of Community Health,
Office of Reimbursement
2 Martin Luther King Jr Dr SE
East Tower - 17th Floor
Atlanta, GA 30334

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

time frames described herein will result in approval of the nursing facility's request.

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

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

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

If the provider disagrees with the reconciliation conference decision, the provider may obtain a hearing on the matter by filing a written request with the Legal Services Section of the Division in accordance with O.C.G.A §49-4-153.

D. Sanctions

In addition to the termination and suspension as a Medicaid provider, the Division may impose the sanctions described below.

i. Nursing Facilities

1. The Division may sanction a nursing facility for failure to submit the required cost report as outlined in Appendix D.

2. The Division may deny reimbursement for services to ICF/IID recipients admitted to a facility on or after the effective date specified on written notice to that facility that it is not in compliance with Subsection 107.

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

The Division's action shall be predicated on a report from the agent, under its contract with the Division to perform on-site reviews of nursing facilities, which takes into account the medical, safety, environmental, and physical needs of the facility's residents. The denial of reimbursement shall remain in effect until such time as the Division determines, after subsequent on-site review, that the facility is meeting the aforementioned needs of its residents and is no longer damaging or endangering the health, safety, or welfare of any recipient. This denial shall not apply to temporarily

hospitalized recipients previously residing in a facility, placed on such notice, who return to the facility after the date of notice. Neither shall it apply to persons who resided in the facility prior to the date of notice and subsequently become Medicaid eligible.

3. A facility which has received notice of the Division's denial of reimbursement for newly admitted patients may appeal such action in the manner described in O.C.G.A. §49-4-153. However, nothing in this provision shall impede the authority of the Division to deny payment for new admissions or suspend or terminate a facility's participation under Section 402, Part I of the Policies and Procedure Manual.

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

   The Division may impose any or all the remedies when a nursing facility fails to meet a Program Requirement as defined therein.

Appendix R
Provider Preventable Conditions, Never Events, and Hospital Acquired Conditions

Effective July 1, 2012, the Centers for Medicare and Medicaid Services (CMS) directed all state Medicaid agencies to implement its final rule outlined in 42 CFR 447.26, regarding PROVIDER PREVENTABLE CONDITIONS (PPCs), NEVER EVENTS (NEs), and HOSPITAL ACQUIRED CONDITIONS (HACs) acquired in ALL hospital settings and other non-inpatient health care settings.

HACs are defined as diagnoses determined by either the state and/or Medicare to be reasonably preventable, i.e., Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following a total knee replacement or hip replacement surgery, and PPCs, i.e., the wrong body part and surgical invasive procedures performed by a practitioner or provider to the wrong patient that should never happen in an admission to treat a medical condition. CMS, specifically in Section 2702 of the Patient Protection and Affordable Care Act, prohibits payment to providers for Other Provider-Preventable Conditions (OPPPCs) as specified in 42 CFR 434, 438, and 447 of the Federal Register, page 32816.

The Hospital Services Manual in Section 1102(e) outlines the Department's policies and procedures on HACs as identified by Medicare's federal regulations published in October 2010. The Georgia Medicaid Management System (GAMMIS) was configured on July 1, 2011, with the HACs edits. The Department of Community Health will not reimburse inpatient facilities (if applicable) or enrolled Medicaid practitioners/providers for treatment of any HACs and/or PPCs identified through the claims adjudication and/or medical records review process. NEs in Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners and providers regardless of the healthcare setting are required to report NEs. Refer to the Reimbursement sections of the Hospital Services and Physician Services Policies and Procedures Manuals for additional information.

Claims will be subject to retrospective review in accordance to CMS' directive and the State Plan Amendment, Appendix 4.19. When a claim's review indicates an increase of payment to the provider for an identified PPC, HAC, or NE, the amount for the event or provider preventable condition will be excluded from the provider's total payment. No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

Appendix S
Provider Relations Field Services Representatives (FSR)

A. Regional Fax Number for Community Partners

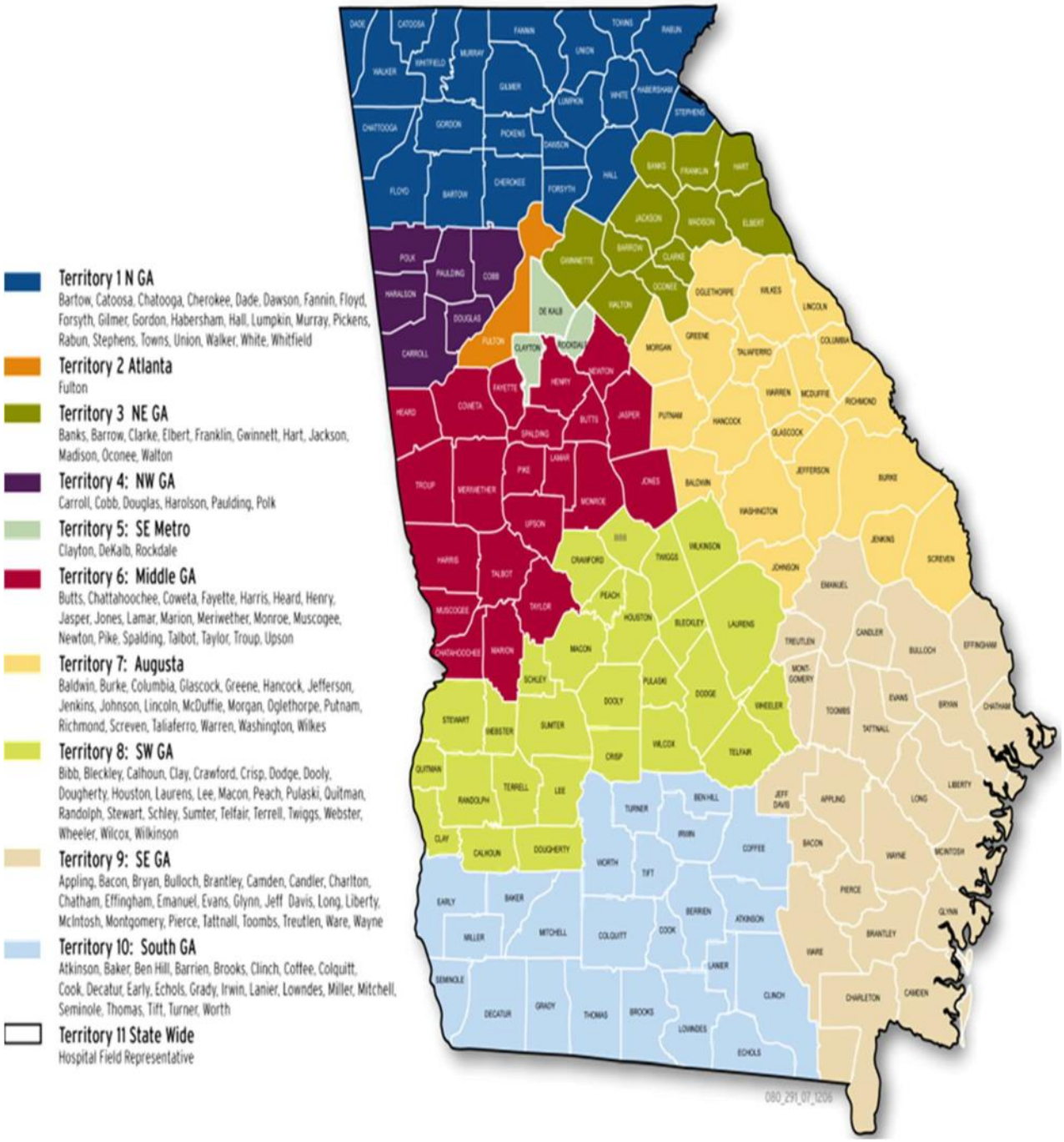
i. To submit DFCS/LTCU Forms for Processing

1. Aged/Blin/Disabled Medicaid

Region	Fax Number
1	770-342-7049
2	770-344-5950
3	678-717-0914
4	706-672-4342
5	706-688-0451
6	478-314-2856
7	706-434-6195
8	706-256-9390
9	888-704-9391
10	229-238-0131
11	229-238-2403
12	912-544-7622
13	770-898-7527
14 (DeKalb)	404-478-1871
14 (Fulton)	404-206-5664
15 (Cobb)	678-605-6921
15 (DeKalb)	678-747-6814

Appendix T
Georgia Field Territories

A. Georgia Field Territories



B. Provider Relations Field Service Representatives (FSR)

i. Territory 1 – N. Georgia – Mercedes Liddell • Territory 2 – Fulton – Deandre Murray

ii. Territory 3 – NE Georgia – Carolyn Thomas

iii. Territory 4 – NW Georgia – Tierra Johnson

iv. Territory 5 – SE Metro – Ebony Hill

v. Territory 6 – Middle Georgia – Shawnteel Bradshaw

vi. Territory 7 – Augusta – Jessica Bowen

vii. Territory 8 – SW Georgia – Jill McCrary

viii. Territory 9 – SE Georgia – Kendall Telfair

ix. Territory 10 – South Georgia – Anitrus Johnson

x. South – Hospital Rep – Janey Griffin (Territories 6-10)

xi. North – Hospital Rep – Sherida Banks (Territories 1-5)

1. Consultants- Statewide:

   (a) Brenda Hulette

   (b) Sharèe Daniels

   (c) Danny Williams

2. CVO/Provider Enrollment Field Representatives:

   (a) Albrean Woods- NORTH

   (b) Darlene Bonner –SOUTH

3. Field Inspectors:

   (a) Felicia Bennett- NORTH

   (b) Jarvon Brown- SOUTH

Field Reps can be reached through the following options: Submit a request through the Provider Services Contact Center at 800-766-4456

Submit a "Contact my provider rep" request through the "Contact US" feature on the GAMMIS Web Portal. The Rep has 6 days to call the provider after the request is made and a Contact Tracking Number (CTN) for their request will be provided for each contact initiation.

Appendix U
Radiological/Portable X-Ray Services

A. Radiological/Portable X-Ray Services

Codes for radiological services have three formats: professional component, technical component, and complete procedure. Not all procedures have all three components. In general, these components should be used as follows:

i. Professional Component: (26 modifier)

Radiology services should be billed as professional component when:

1. The physician provides only the professional service for the procedure; or

2. The service is provided in a hospital; or

3. The technical portion of the service is performed by someone other than the physician's salaried employee.

ii. Technical Component: (TC modifier)

Radiology services should be billed as technical component when the physician is providing the technical portion of the service only. This component has very limited application under current Medicaid policy.

iii. Radiology Component: (FX modifier)

iv. Complete Procedure

To bill for complete radiological procedures, which include charges for actually processing and developing the x-ray (technical component), and evaluating the x-ray (professional component), submit the codes as defined in
the CPT without a modifier.

The physician may bill for complete procedure when one of the conditions outlined in Section 601.5 of the Part II Physician Services Manual is met.

When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form with the number of X-rays taken being placed in the "unit" space. To bill for identical bilateral procedures where there is not an all-inclusive code bill the procedure code with a 50 modifier' on one line indicating one unit of service.

Use of the 50 modifiers will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the all-inclusive charge for the procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

v. Computerized Tomography - (CAT SCANS)

The Division reimburses for medically necessary CAT scans.

vi. Low Osmolar Contrast Media

Payment will be made for medically necessary low osmola (non-trast material (LOCM) used in conjunction with intrathecal, intra-arterial, and intravenous radiological procedures when provided for non-hospital patients. The physician's medical records must support the medical necessity of low osmolar contrast material.

The following procedure codes must be used when billing for Low Osmolar Contrast Media:

1. Q9960 High Osmolar Contrast Material, 200-249 mg/ml Iodine Concentrate, per ml (replacement for A4645).

2. Q9961 High Osmolar Contrast Material, 250-299 mg/ml, Iodine Contrast, per ml (replacement for A4645).

3. Q9962 High Osmolar Contrast Material, 300-349 mg/ml, Iodine Concentration, per ml (replacement for A4646).

4. Q9963 High Osmolar Contrast Material, 350-399 mg/ml, Iodine Contrast Material Concentration, per ml (replacement for A4646).

5. Q9965 Low Osmolar Contrast Material, 100-199 MG/ML Iodine Concentration, per ML (replaces Q9946)

vii. Magnetic Resonance Imaging (MRI)

Medically necessary MRI is covered by the Division when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity.
Reimbursement for follow-up visits by the radiologist is included in the reimbursement for the MRI. Please note that only enrolled Medicaid providers may be reimbursed for MRI procedures.

CT scans or MRIs that do not require contrast, or are of a lower acuity, may be done under the general supervision of the physician. CT scans and MRIs that require contrast, or are at an increased level of acuity, must be performed under the direct supervision of the physician.

viii. Portable X-Ray and CT Scan

Effective July 1, 2017, the Department of Community Health provides payment of medically necessary portable diagnostic x-ray and CT scan services to Medicaid eligible members who are unable to travel to radiological
facilities.

Specific diagnostic radiology services for an eligible member may be provided in a Home Community Based Services, Skilled Nursing Facility Services, in Home Health and Hospice

Services to include the member's home
by an enrolled portable x-ray provider. The X-ray and CT scan services are only considered for payment when they are medically necessary and ordered by the member's physician. Portable x-ray services are allowable only in Home Community Based Services, Skilled Nursing Facility Services, in Home Health and Hospice Services (POS 31,32 or 33) or in a home setting (POS 12) as medically necessary and appropriate, and under the supervision of a physician.

GA Medicaid does not reimburse for technical components for these services as a separate part of the service. Providers billing for these services must bill a full component only. GA Medicaid will not reimburse for set-up fee of the equipment (Level II HCPCS code Q0092).

Transportation of portable x-ray equipment is reimbursable only when the equipment used is actually transported to the location where x-ray services are provided. GA Medicaid will not reimburse for the transportation of the
portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

GA Medicaid will only pay for single transportation payments per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable X-ray transportation fee is allocated among the members who receive portable X-ray services in a single trip.

GA Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment), per trip to facility or location for portable X-ray providers, more than one member seen. The Division also reimburse procedure code R0070 (Transportation of portable X-ray equipment), per trip to facility or location, one member seen.

When submitting a claim for procedure code R0075, the provider is required to use a modifier to indicate the total number of Medicaid members served at the location. The provider is required to submit a separate claim for each Medicaid member. A claim with procedure code R0075 will be denied if it is submitted without an appropriate modifier. Each claim for a single location and data of service must indicate the same X-ray transportation procedure code and modifier for all members seen during that visit.

ix. R0070 Portable x-ray equipment and personnel to the member's home or nursing home, per trip to a facility or other location.

x. R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one member seen, per trip to facility or location. The following modifiers are to be billed with R0075:

1. Modifiers:

(no modifier if one patient served)

(a) UN - Two patients served

(b) UP - Three patients served

(c) UQ - Four patients served

(d) UR - Five Patients served

(e) US - Six or more patients served

The written order must be written and ordered by the member's primary care physician before any portable or mobile x-rays and /or CT scan services are provided. The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made.

Portable X-ray services may be provided to a member in his or her place of residence. The member place of residence is defined by the Division of Medicaid as the member's own dwelling, a residential care facility or nursing facility. Portable X-ray services are not covered in hospital settings.

Note: GA Medicaid will only pay for a single transportation payment per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location.

All providers, including their staff, contracted staff and volunteers must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service. Portable x-ray providers must keep the following records for each member for a period of at least 7 years:

(i) A copy of the written, signed and dated order by the member's physician,

(ii) The date of the x-ray examination,

(iii) The name of the physician who performed the professional interpretation of the procedure, and

(iv) The date the radiograph was sent to the physician.

(v) Portable x-ray providers will not be reimbursed for the following services:

(vi) Procedures involving fluoroscopy,

(vii) Procedures involving the use of contrast media,

(viii) Procedures requiring the administration of a substance to the member, the injection of a substance, or the spinal manipulation of the member,

(ix) Procedures requiring special technical competency and/or special equipment or materials,

(x) Routine screening procedures such as annual physicals,

(xi) Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments, and

(xii) Annual x-ray

xi. Fee Schedule

Information regarding the Fee Schedule to be used for Portable X-rays and CT Scan can be obtained on www.gammis.com following the links under "Provider Manual", "Provider Information", and "Fee Schedules."

xii. Mammography

All mammograms must be performed at a state certified center, and the results must be interpreted by a physician certified by the American Board of Radiology, or the American Osteopathic Board of Radiology, or certified as qualified to interpret the results of mammograms as determined by the Secretary of Health and Human Services. Contact the office below with questions on obtaining certification.

Office of Regulatory Services
Health Care Services
Georgia Department of Community Health
2 Peachtree Street, N.W., 19th Floor
Atlanta, Georgia 30303
(404) 657-5407

The Division must have an updated and valid copy of your certification. Please fax new certification to Gainwell Technologies Technology at 1-866-483-1044 or 1866- 483-1045 or forward to:

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Georgia 30348
800-766-4456 (Toll free)

When billing for mammography on the CMS 1500 claim form, enter the radiology center's 6-digits certification number on field 24a, with the preceding EW qualifier.

Please refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for billing instructions.

Appendix U
Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

A. Georgia Families, Georgia Families 360, and Non-Emergency Medical Transportation

For information on the Georgia Families, Georgia Families 360, or Non-Emergency Medical Transportation program, please access the overview document at the following link:

i. Georgia Families Overview:
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

ii. **Georga Families 360 Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx

iii. **Non-Emergency Medical Transportation Overview:**
https://www.mmis.georgia.gov/portal/PubAccess.Provider%20Information/Provider%20Manuals/tabId/18/Default.aspx