CHAPTER 514 – COVERED SERVICES, LIMITATIONS, AND EXCLUSIONS, FOR NURSING FACILITY SERVICES

CHANGE LOG

Replace	Title	Change Date	Effective Date
Section 514.17.1	Minimum Data Set (MDS)	03/01/2010	04/10/2010
Section 514.31	Compensation	12/01/05	01/01/06
Section 514.31.1	Administrators	12/01/05	01/01/06
Section 514.8.2	Medical Eligibility	09/26/05	11/01/05
Section 514.9.2	Pre-Admission Screening (Level II)	09/26/05	11/01/05
Section 514.11	Transfer and Discharge Policies	09/26/05	11/01/05

April 10, 2010

Section 514.17.1

Introduction: Section 514.17.1, Minimum Data Set
Old Policy: The Minimum Data Set, Version 2.0 with the RUGs III 1997 Quarterly and the WV specific Section S are to be used by nursing facilities to fulfill the federally mandated requirements. These forms may be found in the RAI Manual as published and periodically updated by the Center for Medicare and Medicaid Services (CMS) and in Attachment 1 for the WV specific Section S.
New Policy: The Minimum Data Set, Version 2.0 with the RUGs III 1997 Quarterly and the WV specific Section S are to be used by nursing facilities to fulfill the federally mandated requirements. These forms may be found in the RAI Manual as published and periodically updated by the Center for Medicare and Medicaid Services (CMS) and in Attachment 1 for the WV specific Section S. Other State Required Assessment (OSRA) are no longer required to indicate a payer change. Other all MDS assessments need to be completed as warranted.

January 1, 2006

Section 514.14.31

Introduction: Clarification of the definition of ~~r~~easonable".

Change: The method used to calculate ~~r~~easonable" will be as follows: The 90th percentile of the hourly wage of the employee classification for each bed group will be used to determine ~~r~~easonable". No owners, operators and relatives will be included in the calculation.
Directions: Insert at the end of the first sentence of the second paragraph.

Section 514.31.1

Introduction: Clarification of the definition of ~~r~~easonable".
Change: The method used to calculate ~~r~~easonable" will be as follows: The 90th percentile of the hourly wage of the administrator for each bed group will be used to determine ~~r~~easonable". No owners, operators and relatives will be included in the calculation.

Directions: Insert at the end of the first sentence of the third paragraph.

November 1, 2005

Section 514.8.2

Introduction: First bullet point under ~~M~~edical Eligibility" clarified to correspond with PAS 2005 language
Change: Removal of statement ~~S~~tage 3 or 4 pressure ulcer" and replaced with ~~D~~ecubitus Stage 3 or 4"
Directions: Replace this section

Section 514.8.2

Introduction: Second bullet point under ~~M~~edical Eligibility" clarified to correspond with PAS 2005 language
Change: Removal of statement ~~I~~n the event of an emergency, the individual is mentally or physically unable to vacate a building" and replaced with ~~U~~nable to vacate a building – a person is physically unable at all times, requiring one person assistance with walking (Item 25i), or mentally incapable of leaving the building due to total disorientation, with a diagnosis of dementia, Alzheimer's, or related condition (Items 25g and 33)."

Directions: Replace this section

Section 514.8.2

Introduction: Third bullet point under ~~M~~edical Eligibility" clarified to correspond with PAS 2005 language
Change: Addition of the word ~~p~~hysical" to current language. Statement reads ~~T~~he individual needs hands-on, physical assistance with eating, bathing, grooming, dressing, transferring, and walking."
Direction: Replace this section

Section 514.8.2

Introduction: Forth bullet point under ~~"M~~edical Eligibility" clarified to correspond with PAS 2005 language
Change: Addition of the word ~~"t~~otally" to current language, removal of statement ~~"m~~ore than three (3) times a week", and the addition of the definition for ~~"t~~otal incontinence". The statement reads ~~"T~~he individual is totally incontinent of bowel or bladder. Total incontinence is when the individual has no control of bowel or bladder functions at any time."
Direction: Replace this section

Section 514.8.2

Introduction: Last bullet point under ~~"M~~edical Eligibility" clarified to correspond with PAS 2005 language
Change: Removal of the statement ~~"e~~ither mentally or physically" from the current language. The statement reads ~~"T~~he individual is not capable of administering his / her own medications."
Directions: Replace this section

Section 514.9.2

Introduction: Second paragraph under ~~"P~~re-Admission Screening (Level II)" clarified to include language from Program Instruction MA-03-16
Change: Addition of statement ~~"a~~nd prior to an individual's admission into a nursing facility."
Direction: Replace this section

Section 514.11

Introduction: Reference to addressed stamped envelope removed from Section 511, Paragraph Six (6)
Change: Removal of statement ~~"a~~n addressed stamped envelope for the mailing of the appeal to the State" from last paragraph

Directions: Replace this section

CHAPTER 514—COVERED SERVICES, LIMITATIONS AND EXCLUSIONS FOR NURSING FACILITY SERVICES

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INTRODUCTION

The West Virginia (WV) Medicaid Program offers a comprehensive scope of medically necessary medical and mental health services to diagnose and treat eligible residents. Covered and authorized services must be rendered by enrolled providers within the scope of their license and in accordance with all State and Federal requirements. Any service, procedure, item, or situation not discussed in the manual must be presumed non-covered unless informed otherwise in writing by the Bureau for Medical Services (BMS).

This chapter sets forth the BMS requirements for payment of services provided by Nursing Facilities (NFs) to eligible WV Medicaid residents.

The policies and procedures set forth herein are promulgated as regulations governing the provision of NF Services in the Medicaid Program administered by the WV Department of Health and Human Resources (DHHR) under the provisions of Title XIX of the Social Security Act and Chapter 9 of the West Virginia Code.

514.1 DEFINITIONS

Definitions governing the provision of all WV Medicaid services will apply pursuant to Chapter 200, Definitions, of the Provider Manual. In addition, the following definitions also apply to the requirements for payment of NF services described in this chapter.

Administrator is a person licensed in the State of West Virginia as a nursing facility administrator who is responsible for the day to day operation of the nursing facility.

Adult Abuse is the infliction or threat to inflict physical pain or injury on, or the imprisonment of, any incapacitated adult or NF resident.

Comprehensive Assessment is the process of identifying an individual's strengths, developmental needs and need for services. This should include identification of the individual's present developmental level and health status and where possible, the cause of the disability; the expressed needs and desires of the individual and his or her family; and the environmental conditions that would facilitate or impede the individual's growth, development, and performance. Additionally, this assessment must include the completion of the MDS and review of triggered RAPs, followed by development or review of the comprehensive care plan.

Capacity to make decisions is a person is able to comprehend and retain information which is material to a decision, especially as to the likely consequences; the person is able to use the information and weigh it in the balance as part of the process of arriving at a decision and is able to communicate the decision in an unambiguous manner.

Case Mix Reimbursement System is a payment system that measures the intensity of care and services required for each resident, and translates these measures into the amount of reimbursement given to the facility for care of a resident. Payment is linked to the intensity of

resource use.

Care Plan is a document, based on the comprehensive assessment and prepared by the interdisciplinary team in conjunction with the resident, which identifies measurable objectives for the highest level of physical, mental and psychosocial well-being the resident may be expected to attain.

Change of Ownership is any transaction that results in change of control over the capital assets of a nursing facility including, but not limited to, a conditional sale, a sale, a lease or a transfer of title or controlling stock.

Competent Person is a person who has not been adjudicated incompetent by a court of law.

Deemed Status is special consideration granted to a nursing facility that receives accreditation from an accrediting organization whereby an accreditation report may be used in place of an annual inspection by the State if the standards of the accrediting organization recognized by CMS are comparable to the Medicaid standards.

Deficiency is an entry on the federally required form that describes the specific requirements of the regulations with which the nursing facility failed to comply, an explicit statement that the requirement was not met, and the evidence to support the decision of noncompliance.

Discharge is the termination of a resident's affiliation with the NF, the permanent movement of a resident to another facility or setting that operates independently from the NF.

Discharge Planning is the organized process of identifying the approximate length of stay and the criteria for exit of a resident from the current service to an appropriate setting to meet the individual's needs. Discharge planning begins upon admission to the NF's services and includes provision for appropriate follow-up services.

Dually Certified Facility is a facility which is certified to participate in both the Medicare and Medicaid programs.

Enabler is any device that allows the resident to accomplish tasks that otherwise he or she could not accomplish, and maintains and improves a resident's ability to function.

Facility Certification is the official recommendation by the Office of Health Facility Licensure and Certification (OHFLAC) that the nursing facility meets Medicaid standards and regulations.

Family Council is a group of persons, family members or responsible parties of the residents, meeting as a group, having the right to express grievances in relation to the residents' well-being in general and to make recommendations concerning nursing facility policies and procedures.

Governing Body is a person or persons with the ultimate authority and responsibility to set policy and oversee the operations of the nursing facility.

Harm is noncompliance with rules and regulations that has negatively affected the resident so that the resident's physical, mental or psychosocial well-being has been compromised and is not transient in nature.

Health Insurance Prospective Payment System (HIPPS) is billing codes used when

submitting claims to the fiscal agent for Medicaid payment.

Immediate Jeopardy is a situation in which the nursing facility's noncompliance with one or more certification requirements has caused, or is likely to cause, serious injury, harm, impairment or death of a resident.

Minimum Data Set (MDS) is a core set of screening, clinical, and functional status elements, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare and Medicaid.

Neglect is the a) failure to provide the necessities of life to an incapacitated adult or NF resident with the intent to coerce or physically harm the incapacitated adult or resident and b) the unlawful expenditure or willful dissipation of the funds or other assets owned or paid to or for the benefit of an incapacitated adult or resident.

Nourishing Snack is two (2) or more food items from the basic food groups plus a beverage of milk, juice or the resident's preference.

Nursing Facility is a facility which primarily provides to residents' skilled nursing care and related services for the rehabilitation of injured, disabled, or sick, or on a regular basis, health related care services above the level of custodial care to other than mentally retarded individuals.

Nursing Personnel is the director of nursing, the charge nurse and all employees under the direct supervision of the director of nursing or charge nurse who attend to resident-oriented nursing functions, including registered professional nurses, licensed practical nurses and nursing aides, but excluding employees engaged in administration, dietetics, social services, activities staff, housekeeping, laundry and maintenance.

Ombudsman is any person or organization designated by the State Long Term Care Ombudsman as part of the West Virginia Long Term Care Ombudsman Program.

Resident is any individual residing in a nursing facility. For the purpose of Medicaid reimbursement only, the resident may be identified as a member of the Medicaid health insurance program. (A Medicaid eligible member who resides in a Medicaid certified nursing facility.)

Resident Assessment Instrument (RAI) is the designation for the complete resident assessment process mandated by CMS, including the comprehensive MDS, Resident Assessment Protocols (RAPs), and care planning decisions. The RAI helps facility staff gather definitive information on a resident's strengths and needs that must be addressed in an individualized care plan.

Resident Assessment Protocols (RAPs) is a problem-oriented framework for organizing MDS information and additional clinically relevant information about an individual's health problems or functional status.

Resident Council is a group of residents having the right to meet as a group and to express grievances in relation to the residents' well-being in general and to make recommendations concerning nursing facility policies and procedures.

Restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the person cannot remove at will and which restricts freedom from movement or normal access to one's body, or any drug used to limit movement by a resident or to limit mental capacity of a resident beyond the requirements of therapeutic treatment.

Sexual Abuse is the coercion of an incapacitated adult into having sexual contact with the perpetrator or another person. A caregiver of the incapacitated person must be involved either directly (i.e., as the perpetrator or sexual partner) or indirectly (by allowing or enabling the conditions which result in the sexual coercion).

Therapeutic Leave of Absence is a physician ordered temporary leave from the nursing facility for a reason other than acute care hospitalization, such as, trial home stay, family visit, or special event.

Transfer is moving the resident from the nursing facility to another legally responsible institutional setting.

Verbal Abuse is any use of oral, written, or gestured language by which abuse occurs. This includes demeaning and derogatory terms to describe persons with disabilities. Verbal abuse includes, but is not limited to, yelling or using demeaning derogatory, vulgar, profane, or threatening language; threatening tones in speaking; teasing, pestering, molesting, deriding, harassing, mimicking, or humiliating a resident in any way; or making sexual innuendo.

514.2 PROVIDER PARTICIPATION REQUIREMENTS

Providers of nursing facility services (NF) participating in the Medicaid Program must fully meet the standards established by the Secretary of the Department of Health and Human Services (HHS); all applicable State and Federal laws governing the provision of these services as currently promulgated or amended in the future; and all regulations contained herein or issued as a Medicaid Program Instruction. The Federal standards take precedence over State requirements except where State requirements are more restrictive.

514.2.1 STATE LICENSURE

As a condition of participation as a NF in the West Virginia Medicaid Program, a nursing facility must:

A. Meet fully all requirements for licensure as established by State law;

B. Be currently licensed as a nursing facility by the West Virginia Department of Health and Human Resources (WVDHHR) or be currently licensed by WVDHHR as a distinct part of another health the care institution; and,

C. A government operated facility must meet the licensing standards which apply to NF's owned by non-government entities.

A nursing facility determined to be out of compliance with licensing requirements may be terminated as a licensed provider except in those cases where a corrective action plan is implemented in a timely manner to meet the licensure standards.

514.2.2 COMPLIANCE WITH OTHER STATE AND LOCAL LAWS

The nursing facility must be in compliance with all State and local statutes and regulations affecting the health and safety of the residents. These include but are not limited to fire prevention, building codes, sanitation, medical practice acts, nurse practice acts, laws governing the drug utilization, licensing of nursing facility administrators, communicable and reportable diseases, postmortem procedures, and all other applicable laws and regulations as promulgated through time.

514.2.3 APPLICATION FOR PARTICIPATION

A licensed nursing facility must apply to the Bureau for Medical Services (the single state agency) for approval to participate in the Title XIX Program (Medicaid). Prior to approval as a provider, both a Certificate of Need (CON) must be approved by the Health Care Authority (HCA) and the facility must be in substantial compliance with Medicaid certification requirements as determined by the Office of Health Facility Licensing and Certification (OHFLAC). Upon approval of the application for participation and assignment of a provider number, payment for services will commence when all participation requirements are met.

514.2.4 FACILITY SURVEYS AND CERTIFICATION

The survey and certification agency designated by Secretary of WVDHHR and recognized by the Secretary of the Department of Health and Human Services (Federal) will conduct periodic and timely evaluations of nursing facilities for the purpose of certifying nursing facilities for participation in the Medicaid reimbursement program.

Prior to entering into an agreement of participation in the Title XIX (Medicaid) Program with a nursing facility, the single state agency (Medicaid) will obtain certification from the survey and certification agency that the NF is in substantial compliance with both State and Federal statutes and regulations

514.2.5 FACILITY CERTIFICATION WITH DEFICIENCIES

A nursing facility may be certified with correctable deficiencies if the deficiencies, as determined by the survey agency, individually or in combination do not jeopardize the resident's health, safety, quality of life and/or quality of care.

The nursing facility with deficiencies must submit to the survey and certification agency a written plan for correcting the deficiencies with credible evidence when applicable. This plan of correction (POC) may either be accepted as substantial compliance or a subsequent survey(s) may be necessary to identify substantial compliance with applicable rules and regulations.

514.2.6 PROVIDER AGREEMENT

A valid provider agreement must be in effect with a nursing facility prior to the authorization of monies to be paid for an individual qualifying for the Medicaid long term care benefit. The provider agreement will certify that the nursing facility will provide without additional charge to a Medicaid recipient:

A. Room/bed maintenance services;

B. Nursing services as required by the physician's orders and nursing care plan for the

individual based on the comprehensive assessment of the individual;

C. Dietary services as required by the physician's orders and nursing care plan for the individual based on comprehensive assessment of the individual;

D. An activities program addressing the needs of all of the residents as identified by comprehensive assessments;

E. Medical social services which assure quality of life for each resident of the nursing facility;

F. Therapy and any other specialized service(s) not reimbursable by another medical insurance program; and,

G. Routine personal hygiene items and services as required to meet the needs of residents, including but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins, and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing, and basic personal laundry.

Additionally, the provider agreement will certify:

A. The nursing facility will keep such records that are necessary to fully disclose the extent of the services provided to individual residents as well as the cost of these services;

B. The nursing facility will furnish the Department with such information regarding any payments claimed for recipients under the program as the Department may request; and,

C. The nursing facility will collect no more money than the established rate of payment for the services rendered and billed to the program, this means no additional charge will be made to the resident, any member of his/her family, or to any other source for supplementation of such payments.

Upon acceptance for participation as a nursing facility in the Medicaid program, the facility becomes responsible for remaining in compliance with the terms of the agreement and Medicaid rules and regulations. Payment to the nursing facility for covered items and services it furnishes on or after the effective date of the agreement will require that the facility have a record keeping capability sufficient for determining the cost of services furnished to Medicaid recipients.

As a provider participating in the Medicaid program, the nursing facility must agree to admit and provide care and services equitably no matter the payment source of the individual seeking care. Services provided by the nursing facility must be available to any one who is seeking admission.

514.2.7 PROVIDER ENROLLMENT

The procedure to enroll as a West Virginia Medicaid nursing facility provider may be found in Chapter 300, Provider Participation Requirements.

514.2.8 TIME LIMITATIONS

The agreement for participation in the Medicaid program by a nursing facility is limited by compliance with certification rules and regulations. The effective date of the agreement may not be earlier than the initial date of certification by the survey agency.

If a nursing facility is certified by the survey agency with deficiencies, a provider agreement may be issued to the nursing facility with a time limitation as identified by the survey agency for correction of the deficiencies. If the survey agency determines that substantial compliance has been achieved, the provider agreement with Medicaid is not time limited.

514.3 STANDARDS FOR NURSING FACILITIES

All providers participating as a nursing facility (NF) in the Medicaid Program must comply with Federal standards as published in the Federal Register and as later amended; as well as state laws and program regulations governing the single state agency (Medicaid)

Any NF participating in both the Medicaid program and the Medicare program must comply with the higher standards of either program. Additional requirements may be found in Chapter 42 of the Code of Federal Regulations.

The State survey agency is responsible for conducting a periodic survey in each nursing facility to ascertain compliance with standards of participation in the Medicaid program. Based on the recommendation of the survey agency, the authority to approve or terminate a NF provider agreement rests with either the Secretary of the Federal Department of Health and Human Services (HHS) or the Secretary of the State Department of Health and Human Resources (DHHR) or his/her delegated representative.

Determinations made on behalf of either of these Secretaries are final with respect to compliance with NF standards for participation in both programs. The determinations of the survey agency are the basis for acceptance of an agreement of participation in the Medicaid program as a nursing facility.

514.4 ENFORCEMENT

The state Medicaid agency is required by federal regulations to impose certain enforcement actions on nursing facilities which are not in substantial compliance with certification rules and regulations. The enforcement actions are termination of provider agreement, temporary management, denial of payment for new admissions, civil money penalty, state monitoring, transfer of residents, transfer of residents with closure of facility, and reduction of bed quota without reduction of staff. (See 42 CFR 488 Subpart F and W.V.N.H.R 64CSR)

Additionally, enforcement actions including the termination of the provider agreement may be taken by the Medicaid agency for failure to comply with all of the provisions of the provider agreement.

514.4.1 TERMINATION OF THE PROVIDER AGREEMENT

Termination of a provider agreement with a nursing facility may result for any of the following reasons:

A. Failure to comply with certification standards as identified by the survey agency;

B. Failure to implement the corrective action plan accepted by the survey agency for correction of non-compliance with certification standards; or

C. Failure to comply with all of the provisions of the provider agreement executed with the single state agency (Medicaid).

When an agreement is terminated, the Department (Bureau for Medical Services) may continue reimbursement to the nursing facility for a period not to exceed thirty (30) days from the date of termination. The thirty day continuation is only for Medicaid recipients admitted to the nursing facility prior to the date of termination of the provider agreement. It is responsibility of the nursing facility for the orderly transfer and quality care for all residents of the facility affected by the termination of the provider agreement.

The termination of participation in the Medicaid program does not immediately abrogate all of the nursing facility's statutory and regulatory responsibilities of its agreement for participation. The facility remains responsible for the repayment of any overpayment or debt related to the final program cost settlement as well as any other Federal and/or State statutory and/or regulatory mandates.

514.4.2 TEMPORARY MANAGEMENT

A temporary manager may be imposed any time a nursing facility is not in substantial compliance. However, when a nursing facility's deficiencies constitute immediate jeopardy or widespread actual harm and a decision is made to impose an alternative remedy to termination, the imposition of temporary management is required. It is the temporary manager's responsibility to oversee correction of the deficiencies and assure the health and safety of the nursing facility's residents while the corrections are being made. A temporary manager may also be imposed to oversee orderly closure of a nursing facility.

514.4.3 DENIAL OF PAYMENT FOR NEW ADMISSION

A nursing facility that no longer meets standards of certification as identified by the survey agency may be denied Medicaid payment for new admissions. If the nursing facility's deficiencies pose immediate jeopardy to the resident's health and safety, the provider agreement may be terminated and denial of payment for Medicaid recipients may also be implemented.

514.4.4 CIVIL MONEY PENALTY

A nursing facility may have a civil money penalty imposed if the survey agency recommends and the Bureau agrees that the deficient practice is of such a nature that the residents of the facility could suffer harm, either potential or immediate jeopardy.

514.5 ORGANIZATION

A NF may be a freestanding entity qualifying and serving as a long term care provider or it may be a distinct part of a larger institution. If the distinct part is operating as another part of an institution, the distinct part must be an identifiable unit and meet all of the requirements for a NF.

A hospital may serve as a NF providing the NF standards and regulations are met, a CON is approved, an agreement with DHHR is executed and the standards of acute care participation

are met.

514.5.1 OWNERSHIP

Nursing facilities that are in compliance with the requirements applicable to NFs may participate in the Medicaid program and receive payments irregardless of the ownership category**,** i.e., proprietary, voluntary, non-profit, etc. Each nursing facility must provide the state Medicaid agency, as well as the State licensing agency, full and complete information and documentation as to the identity of the following:

- Name and address of each person with an ownership or controlling interest in the facility or disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of five (5) percent or more;
- In case a NF is organized as a corporation, the name and address of each officer and director of the corporation and whether it is organized for profit;
- In case a NF is organized as a partnership, the name and address of each partner; and any changes which would affect the accuracy of the information recorded with the Medicaid Program as to ownership.

Administrators/Owners will be compensated for administrative duties performed. Where the cost of administrator/owner services are allowed, additional services performed by the administrator and/or owners considered rendered primarily to protect their investment are not allowed.

Compensation will not be allowed for owners, operators, or their relatives who claim to provide some administrative or other functions required to operate the facility, but who do not actually provide said service. Where functions claimed to be provided by owners, operators, or their relatives are merely a duplication of services already provided by other employees, or are functions which should reasonably be expected to be performed by other employees, such services are not reimbursable. For example, where a facility has a full-time administrator or where other full-time or part-time staff positions are filled and compensated by the program, owners, operators or their relatives claiming compensation for the same or similar functions will not be compensated by the program.

Where owners, operators, or their relatives are on salary at a facility, the program will reimburse the facility to the extent that said individuals salaries are not excessive compared to other individuals who perform the same or similar functions and who are not owners, operators or their relatives. Owners include any individual or organization with any financial interest in the facility operation and any member of such individual's family including the spouse's family. Owners also include all partners and all stockholders of organizations which have a financial interest in the facility.

514.5.2 CHANGE OF OWNERSHIP

A change in ownership of a nursing facility as documented with the Secretary of State of West Virginia requires the execution of a new provider agreement with the Medicaid Program as well as all of the rules and regulations associated with the conditions of a NH provider agreement. The change in ownership includes a change in control of the operating entity where the new

owners do not have any management experience in the facility. A purchase of interest in a nursing facility without a change in administrative personnel of that facility does not require the execution of a new provider agreement

514.6 GENERAL ADMINISTRATION

A provider participating in the Medicaid program as a nursing facility must maintain effective and efficient methods of administrative management including a qualified administrator, a professional nursing staff, licensed personnel for services provided and adequate staff for the services necessary as identified by the residents' needs.

Policies must be documented as to the provision of services to a resident to address quality of life, quality of care, residents' rights and any other services within the scope of NF services. The resident and/or his/her representative must be informed of the facility policies regarding care and document acceptance of facility policy.

514.6.1 GOVERNING BODY AND MANAGEMENT

The management of the NF must identify an individual or individuals to constitute the governing authority of the facility. The governing body must:

- Exercise general policy, budget, and operating direction over the NF
- Set the qualifications (in addition to those that may be set by WV State law, if any) for the administrator of the facility
- Appoint the administrator of the NF
- Provide, monitor, and revise, as necessary, policies and operating directions which ensure the necessary staffing, training resources, equipment and environment to provide residents with active treatment and for their health and safety.

514.6.2 QUALIFICATIONS OF THE ADMINISTRATOR

All NFs must be directed by an individual identified as an administrator who is licensed by the State Board of Nursing Home Administrators. An Administrator-in-training (AIT) may act as the administrator of a NF according to the rules and regulations promulgated by the NHA Licensing Board. The administrator may not be the director of nursing except when specifically approved by the survey agency and the Medicaid agency.

A licensed nursing facility administrator shall not administer or act or be administrator of more than two (2) nursing facilities at one time. An administrator may serve two (2) facilities which are within reasonable proximity (thirty minutes or less) provided that such administrator is not administering more than a total combined 120 beds. The administrator of two (2) facilities shall average not less than 20 hours per week at each facility. Each period of service is to be documented. Documentation consists of time cards, work logs or other reliable indicators that are agreed upon by the Department. Documentation must be made available upon the Department's request. On-Call time is not to be used in determining hours of service.

- The NF administrator is responsible for the overall management of the facility through employing an adequate number of appropriate and trained personnel and through the

appropriate delegation of duties. The administrator ensures that public information describing the services provided in the NF is accurate and fully descriptive and ensures each resident's right to fair and equitable treatment, self-determination, individuality, privacy, property and civil rights.

- An individual competent and authorized to act in the absence of the NF administrator shall be designated according to State regulations governing the licensing of administrators.

514.6.3 STAFFING

A NF is required to employ sufficient staff to meet the mental, physical and psycho social needs of each individual residing within or admitted to the nursing facility. Qualified staff must be employed to address the needs of any and all individuals who may require additional services due to a change in mental, physical, and/or psycho social needs even if transfer to another provider is initiated by the NF but not completed.

The West Virginia Medicaid Program identifies the rules and regulations promulgated by both State and Federal survey and certification agencies, which ever is more restrictive, as the standards of participation in the program as a nursing facility with regards to staffing requirements (Reference 42 CFR PART 483, 42 CFR 488 and 64CSR13.

514.6.4 EMPLOYMENT RESTRICTIONS

The NF must comply with the following requirements concerning the facility's employment practices:

- No one with a conviction or a prior history of abuse may be employed in a NF providing services under the auspices of the WV Bureau for Medical Services.
- Any staff working with NF residents must have a Criminal Investigation Bureau (CIB) Background Check. Individuals with any misdemeanor or felony conviction of abuse and neglect of a child and/or abuse and neglect of an incapacitated adult are prohibited from working in facilities that provide services to NF residents.

514.6.5 ADMINISTRATIVE POLICIES

A NF participating in the State Medicaid Program for nursing facility reimbursement must develop and make available to each resident and/or his/her representative admitted to the facility and periodically review with each resident and/or his/her representative all policies and procedures of the particular facility regarding all aspects of care and services provided by the facility. All of these policies must be written in a language that can be understood by any individual admitted to the facility. Additionally, all individuals residing within and/or admitted to the facility must be informed in a language the individual and/or his/her representative can understand of all rights and policies affecting their acceptance of services provided by the facility.

514.6.6 PROCEDURES FOR EMERGENCY CARE OF RESIDENTS

- The NF must establish written procedures for personnel to follow in an emergency.
- The NF's emergency care procedures must include:
  - Care of the resident

- Notification of the attending physician and other persons responsible for the resident
- Arrangements for transportation
- Arrangements for hospitalization
- Arrangements for other appropriate services.

- The NF's emergency care procedures must include arrangements for emergency physician services if the attending physician is not immediately available.
- The NF is required to complete a written report on any accident or unusual incident involving a resident.

514.6.7 DISASTER PREPAREDNESS PROCEDURES

- The NF must have a written plan for staff and residents to follow in case of fire, explosion, or other internal or external disaster and for the care of casualties arising from such disaster.
- The NF must regularly rehearse its disaster preparedness plan.

514.6.8 RESIDENT RIGHTS POLICIES

- The NF must establish a policy statement setting forth the rights of residents prohibiting the mistreatment or abuse of residents.
- The NF must make available its written policies concerning a resident's rights to staff, residents' families, or legal representatives.
- Written policies and procedures ensure that each resident admitted to the facility is fully informed of his/her rights and responsibilities as a resident in the facility.

514.6.9 UTILIZATION REVIEW

The NF must have in effect an approved plan for utilization review of the necessity of services as a condition of participation. The UR plan must comply with the medical criteria necessary for participation in the nursing facility eligibility requirements for Medicaid recipients. Any and all individuals not requiring the medical services provided by a NF must be transferred and discharged according to the regulations stipulated in Section 340.

514.6.10 IN-SERVICE EDUCATION PROGRAM

A written orientation program for all new employees is maintained that includes:

- Review of all policies for the NF
- An ongoing, in-service education program for development and improvement of skills of all personnel at the NF
- Records must be maintained which indicate the content of, and participation in, all such orientation and staff development programs.

514.7 ADMISSION POLICIES

A nursing facility must not require a resident, a potential resident or his/her representative to waive rights to Medicaid benefits or assure that the individual seeking services is not eligible for or will not apply for Medicaid benefits. The facility must not require a third party guarantee of payment to the facility as a condition of admission, expedited admission or continue stay for any individual admitted to a Medicaid certified nursing facility.

A nursing facility must require an individual responsible for the financial affairs of the Medicaid recipient receiving nursing facility services remit to the facility the amount of money from income and resources identified by the eligibility requirements of the CMS approved State Plan applicable to care. The individual responsible for managing the finances of the Medicaid recipient may not incur a personal financial liability.

A nursing facility must not charge, solicit, accept or receive any gifts, money, donations or other consideration as a precondition of admission, expedited admission or continued stay in the facility for any person eligible for Medicaid LTC benefits.

514.7.1 ACCEPTANCE OF GIFTS

A nursing facility may solicit, accept, or receive a charitable, religious or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission or continued stay in the facility for a Medicaid eligible resident.

514.8 RESIDENT ELIGIBILITY REQUIREMENTS

The Department has established a process of evaluation to determine eligibility for long term care services under the Medicaid Program. The evaluation is made on each recipient from information supplied by a physician, recipient or family/representative, health care facility and/or eligibility worker in the local Department of Health and Human Resources office. This determination for the Medicaid benefit for nursing facility residents is based on both medical and financial criteria. The Bureau for Medical Services or its designee is responsible for the medical necessity determination and the Bureau of Children and Families is responsible for the financial determination.

The determination must occur prior to payment for services. The date the benefit starts is the later of one of the following dates:

- The date of application in the local DHHR office;
- The date of the physician signature on the medical assessment tool; or the date of admission to the nursing facility.

The local office is responsible for notifying the individual/representative, the Bureau and the nursing facility of the date Medicaid eligibility begins.

514.8.1 APPLICATION PROCEDURE

An application for nursing facility benefits may be requested by the resident, the family/representative, the physician, or a health care facility. The steps involved in approval for payment of nursing facility services are:

- The application for NF services is made to the local DHHR office. The determination of financial eligibility for Medicaid is the responsibility of the local office; and
- The medical eligibility determination is the responsibility of the Bureau for Medical Services based on a physician's assessment of the medical and physical needs of the individual. This assessment must have a physician signature dated not more than sixty days prior to the start of services.

514.8.2 MEDICAL ELIGIBILITY

To qualify medically for the nursing facility Medicaid benefit, an individual must need direct nursing care twenty-four (24) hours a day, seven (7) days a week. The Bureau has designated a tool known as the Pre-Admission Screening form (PAS) to be utilized for physician certification of the medical needs of individuals applying for the Medicaid benefit. See Attachment.

An individual must have a minimum of five (5) deficits identified on the PAS in order to qualify for the Medicaid nursing facility benefit. These deficits may be any of the following:

- #24: Decubitus - Stage 3 or 4
- #25: In the event of an emergency, the individual is c) mentally unable or d) physically unable to vacate a building. a) and b) are not considered deficits.
- #26: Functional abilities of individual in the home.
  Eating - Level 2 or higher (physical assistance to get nourishment, not preparation)
  Bathing - Level 2 or higher (physical assistance or more)
  Grooming - Level 2 or higher (physical assistance or more)
  Dressing - Level 2 or higher (physical assistance or more)
  Continence - Level 3 or higher (must be incontinent)
  Orientation - Level 3 or higher (totally disoriented, comatose)
  Transfer - Level 3 or higher (one person or two persons assist in the home)
  Walking - Level 3 or higher (one person assist in the home)
  Wheeling - Level 3 or higher (must be Level 3 or 4 on walking in the home to use Level 3 or 4 for wheeling in the home.) Do not count outside the home.
- #27: Individual has skilled needs in one or more of these areas - (g) suctioning, (h) tracheostomy, (i) ventilator, (k) parenteral fluids, (l) sterile dressings, or (m) irrigations.
- #28: Individual is not capable of administering his/her own medications.

The assessment tool designated by the Bureau for Medical Services must be completed and signed and dated by a physician. It is then forwarded to the Bureau or its designee for medical necessity review. The assessment tool must be completed and reviewed for every individual residing in a nursing facility no matter what the payment source for services.

Each nursing facility must have an original pre-admission screening tool to qualify the individual for Medicaid and to meet the federal PASRR requirements. Should the receiving nursing facility fail to obtain an approved assessment prior to admission of a Medicaid eligible individual, the

Medicaid program cannot pay for services. The individual cannot be charged for the cost of care during the non-covered period.

A Medicaid recipient who converts from Medicare Part A coverage to Medicaid does not need a new assessment to receive the Medicaid benefit. Medicaid coverage can be reinstated as long as a Medicaid denial letter has been issued.

A new medical assessment must be done for Medicaid eligibility for the nursing facility resident for all of the following situations:

- Application for the Medicaid nursing facility benefit;
- Transfer from one nursing facility to another;
- Previous resident returning from any setting other than an acute care hospital;
- Resident transferred to an acute care hospital, then to a distinct skilled nursing unit, and then returns to the original nursing facility; and
- Resident converts from private pay to Medicaid.

514.8.3 PHYSICIAN CERTIFICATION

A physician who has knowledge of the individual must certify the need for nursing facility benefit for each individual for whom payment is requested. Medical eligibility for persons in need of NF services is determined initially from the information supplied by the physician on the specified assessment tool. The information must be current as to the individuals need for NF care. With the physician's signature and date, this is considered the certification for NF services.

514.8.4 PHYSICIAN RECERTIFICATION

Recertification of the continuing need for NF care must be documented in the resident's medical record by the physician at 60 days, 180 days, then annually after the initial certification. The facility is responsible for obtaining recertification documentation from the physician for each NF resident for whom payment is requested under the Medicaid program. (Every thirty days for the first 90 days after admission and at least once every 60 days thereafter.)

514.8.5 CONTRIBUTION TO THE COST OF CARE

As a part of the financial eligibility determination for the Medicaid nursing facilities benefit, the DHHR calculates the dollar amount the individual must contribute to the cost of care every month. The monthly Medicaid payment to the nursing facility will be reduced by the dollar amount of the contribution to the cost of care (resource).

The nursing facility is responsible for collecting the monthly contribution to the cost of care. If the facility is unable to collect the money for any reason, that dollar amount may not be charged to the Medicaid program in any manner.

514.9 PREADMISSION SCREENING AND RESIDENT REVIEW

Pre-admission screening for medical necessity of nursing facility services is a two step process. The first step (Level I) identifies the medical need for NF services and screens for the possible presence of a major mental illness, mental retardation, and/or developmental disability. The second step (Level II) identifies if the individual needs specialized services for a major mental

illness, mental retardation, and/or developmental disability.

514.9.1 MEDICAL NECESSITY (LEVEL I)

All individuals admitted to a Medicaid certified nursing facility must be assessed for the possible presence of a major mental illness, mental retardation and/or a developmental disability (MI/MR/DD). The same preadmission screening tool utilized to assess the medical necessity for the Medicaid benefit in a NF is reviewed for the possible presence of MI/MR/DD. This review is identified as the Level I evaluation. Any individual identified with the possible presence of mental health issues must be further evaluated.

514.9.2 PRE-ADMISSION SCREENING (LEVEL II)

If the Level I evaluation found the possible presence of MI and/or MR/DD, further evaluation of the individual must be completed to obtain a definitive diagnosis and the need for specialized services for the mental health condition. This evaluation is identified as a Level II evaluation and must be done by an individual identified by the Bureau as a Level II evaluator. All Level II evaluators are either licensed psychologists or board certified psychiatrists.

It is the responsibility of the referring entity to arrange for an evaluation (Level II). This evaluation must be completed, including a report of the mental health status and whether specialized services are needed, within 7-9 days following the referral and prior to the individual's admission into a nursing facility. Upon completion of the evaluation, both the referring entity and the PASRR evaluator must provide the complete mental health evaluation and the original Level I evaluation to the receiving nursing facility. Additionally, the results of the evaluation should be sent to BMS on the applicable forms.

The Code of Federal Regulations at 42 CFR 483.106 States ~~-~~In cases of transfer of a resident with MI or MR from a NF to a Hospital or to another NF, the transferring NF is responsible for ensuring that copies of the resident's most recent PASRR Level II and resident reports accompany the transferring resident." This regulation applies to all residents of nursing facilities.

Repeat Level II evaluations are only necessary if there is an acute exacerbation of the mental illness or if the physical condition of the individual with MR/DD improves or declines, thus changing the need for specialized services. The nursing facility must complete the Level I evaluation tool indicating the status change and request the Level II evaluation by an evaluator.

514.9.3 SPECIALIZED SERVICES MR/DD

Specialized services for an individual identified as MR/DD are a continuous program for the individual who includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health and related services developed by an interdisciplinary team that is directed towards:

- The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and
- The prevention or deceleration of regression or loss of current optimal functional status.

These services are generally provided in an intermediate care facility for persons with MR or a

related condition (ICF/MR).

514.9.4 SPECIALIZED SERVICES MI

Specialized services for an individual with an acute exacerbation of a major mental illness are the continuous and aggressive implementation of an individualized plan of cares that:

- Is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals;
- Prescribes specific therapies and activities for the treatment of persons experiencing an acute episode of a major mental illness which necessitates supervision by trained mental health professionals; and
- Is directed toward reducing the individual's acute psychotic symptoms that adversely affect the person's ability to perform their activities of daily living. The long term goal of the specific therapies is to improve the individual's level of independent functioning and to achieve a functional level that permits reduction in the intensity of mental health services at the earliest possible time.

These services may only be provided in an acute psychiatric facility.

514.10 BED RESERVATION

A nursing facility may receive Medicaid per diem reimbursement to reserve a resident's bed (bed hold) during his/her temporary absence from the facility. This is paid at the facility's established rate. The facility's occupancy must be 95% or greater the midnight before the resident leaves and there must be a waiting list for admission. A day of leave is defined as a continuous twenty-four (24) period. At the time the resident leaves the facility, the primary payer for services must be Medicaid. Bed reservation days may be for acute care hospitalization or a therapeutic leave.

The resident whose bed is reserved is to be accepted by the facility immediately upon discharge from the hospital or return from therapeutic leave. Placement is to be in the same bed and living space occupied by the resident prior to the hospital or therapeutic leave of absence unless the resident's physical condition upon returning to the facility prohibits access to the bed previously occupied. If the nursing facility discharges a resident and return is not anticipated, the facility can not charge for a Medicaid bed hold.

When all hospital or therapeutic days have been used by a resident, a facility may charge a resident to reserve a bed only when there are no vacancies and other applicants are awaiting admission. Families that are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid purposes. A resident may use his or her personal allowance for reserving a bed if the resident has in excess of $200.00 in his or her personal allowance fund. The resident's contribution to the cost of care (resource) may not be used to pay to reserve a bed.

514.10.1 MEDICAL LEAVE OF ABSENCE

The medical leave of absence must be for a resident who is admitted to an acute care hospital for services that can only be provided on an inpatient basis, who is expected to return to the

facility, and whose stay is twenty-four (24) hours or greater. The maximum number of medical leave of absence days which may be reimbursed for an individual for a medical leave of absence is twelve (12) days in a calendar year.

The medical record must document the physician's order, the date and time the resident is transferred to the hospital and the date and time the resident returns to the reserved bed in the nursing facility. The day of transfer from a nursing facility to the hospital is counted as day one of the leave. If the Medicaid recipient returns to the nursing facility in less than 24 hours, this is not considered a leave day. The day a resident dies in the hospital, is transferred to another facility, or goes home must is considered the day of discharge from the nursing facility.

514.10.2 THERAPEUTIC LEAVE OF ABSENCE

A bed may be reserved for a therapeutic leave of absence such as a home visit and must be as a part of the resident's plan of care. The maximum number of therapeutic leave of absence days which may be reimbursed for an individual resident for a therapeutic leave of absence is six (6) days in a calendar year.

The medical record must contain a physician's order for therapeutic leave, the date and time of the beginning of the therapeutic leave, and the date and time the resident returns to the reserved bed in the nursing facility. For therapeutic leave, the date the recipient leaves the nursing facility is counted as a leave day and the day the resident returns to the facility is not a leave day.

514.11 TRANSFER AND DISCHARGE POLICIES

Transfer and discharge of an individual includes movement of a resident to a bed outside of the certified facility (area) whether or not that bed is in the same physical plant. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

The facility must permit each resident to remain in the facility, and not be transferred or discharged from the facility unless at least one of the following conditions is met:

- The transfer or discharge is necessary for the resident's welfare since the needs of the resident cannot be met by the facility;
- The transfer or discharge of the resident is appropriate because the health of the resident has improved sufficiently that the individual no longer meets the medical criteria for Medicaid nursing facility services;
- The safety of individuals in the nursing facility is endangered;
- The health of individuals in the nursing facility would otherwise be endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid) a stay at the nursing facility including but not limited to the amount of money determined by the financial eligibility evaluation as co-payment for the provision of services; and/or
- The facility ceases to operate or the residents are identified by the state and/or federal certification agency as in immediate and serious danger due to policies, practices and/or

services provided by the nursing facility.

Documentation must be recorded in the resident's medical record by a physician of the specific reason and /or condition requiring the transfer and/or discharge if due to health and safety issues of the resident or others, the needs of the resident cannot be met or the medical needs of the resident no longer qualify for nursing facility level of service. Documentation of the reason for discharge must also appear in the record of the resident if the facility ceases to operate or must discharge residents due to certification requirements or financial requirements are not met by the resident or his/her representative.

The facility must notify the resident and/or his/her representative both in a written language and verbal language that is understandable to the parties of the intent and reason for transfer or discharge. The same information must be recorded in the resident's clinical record. Except in the case of immediate danger to the resident and/or others as documented, the notice of transfer or discharge must be provided at least thirty (30) days prior to the anticipated move.

Waiver of thirty day requirement may be appropriate if the safety of individuals in the facility would be endangered, the immediate transfer is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for thirty (30) days.

The written notice must include the reason for the transfer or discharge; the effective date of the transfer or discharge; the location or person(s) to which or whom the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities and Bill of Rights Acts; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

514.11.1 HOSPITAL TRANSFER AGREEMENT

A written transfer agreement must be in effect with one or more hospitals sufficiently close to the nursing facility to make feasible the transfer of residents and their records for acute care treatment. The transfer agreement must stipulate that inpatient hospital care and/or other acute care services as required by residents of the nursing facility are provided promptly and efficiently to individuals needing the services.

Additionally the agreement must include at least the following:

An interchange of medical, psycho social and any other information necessary to provide quality care and continuation of services by either the hospital or the nursing facility to the individual transferred between entities. This transfer of information should include a copy of the Federally mandated Resident Assessment Instrument (MDS), the most current evaluation of an individual who may have a major mental illness or mental retardation (PASARR Level II), and a summary of the medical history of the individual;

Specifies the responsibilities assumed by both the transferring and the receiving facility for prompt notification regarding the safe orderly transfer of an individual; and

Specifies restrictions with respect to the type of services and/or the type of individuals or health conditions that will not be accepted by the receiving facility and other conditions relating to the transfer of individuals. These restrictions must be the same as applied to any individual seeking services of the receiving facility no matter payment source, referring institution or discharge potential from the receiving facility.

The transfer of an individual from a nursing facility must be ordered by a physician based on the acute medical needs of the individual as documented in the medical record of the resident of the nursing facility

Short term treatment of a resident of a nursing facility in a section of an acute care facility identified as a holding bed is not considered as a transfer from the NF to the hospital; this is considered as emergency room visit rather than an admission to a hospital.

514.11.2 SERVICES PROVIDED BY OUTSIDE SOURCES

If a NF does not provide a required service, it may enter into a written agreement with an outside service, program, or resource to do so. These services include laboratory, x-ray and other diagnostic services and special rehabilitative services (such as physical therapy). The agreement must State clearly the following:

- The responsibilities, functions, objectives, the term of the agreement and any other terms are agreed to and signed by both parties.
- Provide that the NF is responsible for assuring that the outside services meet the standards for quality of services.
- The NF must assure that the vendor and its staff meets all mandatory educational, licensing and certification requirements for the specific area of service furnished.
- The NF must assure that outside services meet the needs of each resident.

514.12 STAFFING REQUIREMENTS

In order to participate in the WV Medicaid program and receive payment from the Bureau, a NF must comply with the following requirements:

514.12.1 GENERAL

Only qualified staff is allowed to provide services in a NF. The NF is required to employ staff sufficient in number and in qualifications as required to meet the needs of residents pursuant to their plan of care and to protect their health and safety.

- There must be on duty all hours of each day sufficient staff in number and qualifications to carry out the policies, responsibilities, and program of the facility. The number of residents, including Medicaid residents, determines the number and categories of personnel.
- The NF must employ and maintain sufficient staff on duty, awake and accessible.
- The facility must assume responsibility for the provision of services directly or through outside resources to meet the needs of the residents. The facility must not depend upon the residents or volunteers to perform direct care services for individuals.

- At a minimum, a NF is required to furnish the following services:

  Physician Services

  Nursing Services

  Pharmacy Services

  Dietary Services

  Social services

  Activities Services

514.12.2 PHYSICIAN AND PHYSICIAN EXTENDER SERVICES

A physician must personally approve in writing a recommendation that a person be admitted to a nursing facility. Each resident's care must be supervised by a physician and another physician must supervise the care when the attending physician is unavailable.

The physician must review the resident's total program of care, including medications and treatments, and examine the resident personally at each visit. The physician must write, sign and date progress notes at each visit and sign and date all orders.

The resident must be seen within five (5) days prior to admission or within seventy-two (72) hours following admission and at least every thirty (30) days for the first ninety (90) days after admission and as the resident's condition warrants. After the ninety (90) day requirement has expired, the physician must visit every sixty (60) days and as the resident's condition warrants.

After the initial visit, the physician may then delegate alternate visits to a physician's assistant (PA), a nurse practitioner (NP) or a clinical nurse specialist (CNS) who is licensed as such by the state and performing within the scope of practice in that state and is under the direct supervision of the physician.

A nursing facility must provide or arrange for the provision of physician services twenty-four (24) of every day in case of an emergency.

514.12.3 NURSING SERVICES

The administrative management of the NF must provide health services which assure that each resident receives treatments, medications, diets and other health services as prescribed and planned all hours of each day in accordance with the following:

- There are on duty all hours of each day sufficient staff in number and qualifications to carry out the policies, responsibilities, and programs of the NF. The number of residents determines the number and categories of personnel and their particular needs in accordance with Medicaid regulations.
- There must be on duty and awake a sufficient number of responsible staff members at all times immediately accessible to all residents and qualified by training and experience to assure prompt, appropriate action in case of injury, illness, fire or other emergencies.
- The primary duties of nurses' aides consist of direct resident care and services as distinguished from housekeeping, laundry and dietary functions.

- Where residents are located in a distinct part of a NF, each part must be separately staffed with adequate nursing personnel regardless of size.
- Twenty-four hour health service requires that the number and type of personnel is sufficient to meet the total needs of the resident in terms of:
  - Maintaining physiological functions and nutritional status
  - Assisting residents to learn to live with their condition and to care for themselves
  - Giving assistance in maintaining optimal physical and psychological functioning
  - Encourage activities as permitted
  - Protecting from accident and injury by appropriate safety measure
  - Assuring that the routine, special and emergency needs of all residents are met at all times including the need for safety in the event of fire or other disaster.

514.12.4 DIRECTOR OF NURSING (DON)

A nursing facility must designate in writing a registered nurse to serve as the director of nursing services on a full-time basis, who must be on duty at least five (5) days a week, eight (8) hours a day during the day shift. The director must require staffing ratios which are necessary to meet the residents' needs.

514.12.5 LICENSED NURSE

A nursing facility must have a registered nurse on duty in the facility for at least eight (8) consecutive hours seven (7) days a week. In facilities with fewer than sixty (60) beds the director of nursing may serve to meet this requirement. If there is not a registered nurse on duty, there must be a registered nurse on call.

A nursing facility must designate a licensed nurse to serve as a charge nurse on each shift.

514.12.6 PHARMACY SERVICES

A nursing facility shall provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. All drugs shall be provided in conformance with the requirements of federal, state and local laws, regulations and rules.

The nursing facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. The pharmacist must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation of the drugs and determine that drug records are in order and an account of all controlled drugs is maintained and periodically reconciled.

The drug regimen of each resident must be reviewed by a licensed pharmacist monthly and must include substances that are regarded as herbal products or dietary supplements. The pharmacist must report any irregularities to the attending physician and the director of nursing who must act upon these reports. The NF's pharmacist consultant should be available to advise the NF regarding Medicaid drug coverage and limitations.

Drugs and biologicals used in the nursing facility must be labeled in accordance with the requirements of federal, state and local laws, rules and regulations. The labels must include the appropriate accessory and cautionary instructions with the expiration date when necessary.

In accordance with state and federal laws the nursing facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys. The nursing facility must provide separately locked, permanently affixed compartments for the storage of drugs subject to abuse and controlled drugs as identified by federal regulations. An exception to this requirement would be if the nursing facility used single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

The nursing facility must establish a policy to assure that resident' requests will be honored for obtaining prescription medications from sources other than the contracted pharmacy.

514.12.7 REHABILITATIVE SERVICES

If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, respiratory therapy and psychological or psychiatric rehabilitative services, are required in the resident's comprehensive plan of care, the nursing facility must provide the required services as a covered service included in the reimbursement from Medicaid.

514.12.8 FOOD AND DIETARY SERVICES

The nursing facility must employ a qualified dietitian either full-time, part-time or on a consultant basis. A qualified dietitian is one who is registered by the Commission on Dietetic Registration and licensed by the West Virginia Board of Licensed Dietitians or is qualified by the WV Board of Licensed Dietitians, and is licensed by that board to provide professional nutritional services in West Virginia.

Consultation will be based upon the residents' needs and will occur at intervals of no less than every thirty (30) days and for no less than eight (8) hours. A dietary manager must be employed if a dietitian is not employed full-time and may be one of the following:

- A dietetic technician registered by the American Dietetic Association;
- A certified dietary manager as certified by the Dietary Manager's Association; or
- A graduate of an associate or baccalaureate degree program in foods and nutrition or food service management.

The dietary manager under the direction of the dietitian is responsible for the daily operation of the dietetic service. A nursing facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

The nursing facility must meet the nutritional needs of residents in accordance with the Recommended Dietary Allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences. All residents must have a physician's order for the specific type of diet he or she is to receive as set forth in the nursing facility's diet manual.

Rules regarding the frequency of meals, sanitary conditions and emergency supplies may be

found at 64CSR13 and 64CSR17.

514.12.9 SOCIAL SERVICES

The NF administrator must designate a staff member suited by training or experience to provide or arrange for the provision of social services as needed by the residents to promote the residents' highest physical, mental and psycho-social well being. These services must be integrated with other elements of the overall plan of care.

The designated staff member should be an individual who has some background, knowledge or experience related to social service activity in order to perform this function. If the facility does not employ an individual qualified by training or experience, arrangements must be made through written agreement with an outside resource (a person or agency) to provide direct social services as needed by the residents or to act as a consultant.

The chief function of the social worker or the designated staff member is to help with those problems which inhibit or prevent the resident's social adjustment and, because of this, affect his/her ability to benefit by his/her stay in the NF.

Social service activity is not limited to the resident alone, but will usually include contact with the resident's family, possibly close friends, and the coordination of services with other agencies; such as the Department of Health and Human Resources, Social Security Administration (SSA), Veteran's Administration (VA), community service organizations, etc. A good working knowledge of community resources is a valuable asset for the social worker.

Another important function of the social worker is to provide indirect services to the resident through staff education both by participation in the NF's in-service training program and through conferences with staff members concerned with the resident's care. To carry out this function, the social worker will need to have a thorough knowledge of the NF's method of operation and its practices and policies.

514.12.10 ACTIVITIES DIRECTOR

The NF must designate a staff member qualified by experience or training in directing group activity to be responsible for the direction and supervision of the activities program. The director should be responsible for developing programs which provide constructive supervision and services directed toward restoring and maintaining each resident at his best possible functional level including activities designed to encourage self-care and independence.

The activities director shall develop a plan for independent and group activities for each resident in accordance with his/her needs and interests. The plan is incorporated in the overall plan of care and is reviewed with the resident's participation at least quarterly and revised as needed.

The NF shall provide opportunities for meaningful activities and social relationships. These may include holiday celebrations, parties, indoor and outdoor games, or personal hobbies. Educational or recreational activities sponsored by groups within the community should be encouraged and planned with the community groups or agencies.

514.13 PHYSICAL ENVIRONMENT REQUIREMENTS

In order to participate in the WV Medicaid Program and receive payment from the Bureau, NFs must be equipped and maintained to provide a functional, sanitary and comfortable environment for residents admitted for care.

The nursing facility must be in compliance with the 2000 Life Safety Code and mandatory references issued by the Center for Medicare and Medicaid Services as currently published or modified in the future. Additionally, the Bureau requires adherence to the Guidelines for Design and Construction of Hospital and Health Care Facilities in establishing the Standard Appraised Value for the capital component of the nursing facility rate

514.14 RESIDENTS' PERSONAL FUNDS

The resident has the right to manage his or her own financial affairs and the nursing facility shall not require residents to deposit their personal funds with the nursing facility. Upon written authorization of a resident, the nursing facility shall hold, safeguard, manage and account for the personal funds of the resident deposited with the nursing facility as specified in the following sections.

514.14.1 DEPOSIT OF FUNDS

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

A nursing facility must maintain a resident's personal funds that do not exceed fifty (50) dollars in a non-interest bearing account, interest bearing account or petty cash fund.

514.14.2 ACCOUNTING AND RECORDS

The nursing facility must establish and maintain a system that assures a complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the nursing facility. The system shall preclude any co-mingling of a resident's personal funds with nursing facility funds or with the funds of any person other than another resident.

The individual financial record shall be available through quarterly statements and on request of the resident or his/her legal representative. For any transaction from a resident's account, the nursing facility shall provide the resident with a receipt and retain a copy of the receipt.

The nursing facility shall administer the funds on behalf of the resident in the manner directed by the resident or in the case of incapacity, the legal representative.

514.14.3 NOTICE OF CERTAIN BALANCES

A nursing facility shall notify each resident or his/her legal representative who receives Medicaid benefits when the amount in the resident's account reaches two hundred dollars ($200) less than the Supplemental Security Income (SSI) resource limit for one person. Since the amount in the account in addition to the value of the resident's other non-exempt resources may reach the SSI resource limit for one person, it may result in the individual loosing eligibility for Medicaid and SSI.

514.14.4 CONVEYANCE UPON DEATH OR DISCHARGE

Upon the death or discharge of a resident with personal funds deposited with the nursing facility, the nursing facility shall convey, within thirty (30) days, the resident's funds to the discharged resident or to the person or probate jurisdiction administering the resident's estate. A final accounting of the funds must be provided at the time of conveyance.

514.15 RESIDENT CHARGES

- Eligible residents are entitled to have payment made on their behalf for NF services in a Medicaid participating facility.
- The NF is expected to provide all services and treatment as prescribed by the attending physician for each resident admitted to the NF for care.

514.15.1 ALLOWABLE RESIDENT CHARGES

General categories and examples of items and services that the facility may charge to the resident or resident's funds if they are requested by a resident, if the facility informs the resident that there will be a charge, and that payment is not made by Medicaid are telephone, television/radio for personal use, personal comfort items, including smoking materials, notions and novelties, and confections, cosmetic and grooming items and services in excess of those for which payment is made under Medicaid, personal clothing, personal reading matter, gifts purchased on behalf of a resident, flowers and plants, social events and entertainment offered outside the scope of the activities program, non-covered special care services such as privately hired nurses and aides, and private rooms except when therapeutically required. Specially prepared food requested by the resident that are not a substitute for the regular menu or are not religiously or culturally directed.

Commercial laundry or dry cleaning expenses for personal items of clothing may be borne by the resident out of his/her personal expense allowance. The facility must maintain receipts for these expenses when paid out of the resident's personal allowance.

Payment for reserved days is a non-covered charge. A facility may charge a resident to reserve a bed only when there are no vacancies and a waiting list. Families that are willing and able are free to pay these charges, and the amount paid is not considered as a resource or income for Medicaid. However, the resident's personal allowance or contributions to cost of care (resource) cannot be used for this purpose. The facility also may not request payment from the Bureau for any period the resident is absent from the facility.

514.15.2 RESIDENT CHARGES NOT ALLOWED

- The NF shall not charge the resident, the resident's family, guardian sponsor(s), or any other source over and above the established rate of payment to the NF for those services covered under the Medicaid program.
- Reimbursement by the Medicaid program for NF services determined to be medically necessary and appropriate constitutes payment in full for services.

514.16 RESIDENT RIGHTS AND RESPONSIBILITIES

All rights and responsibilities of the resident, as specified herein, devolve to the resident's family or legal representative whenever the resident has been determined, in accordance with State law, to be incompetent or his/her physician has documented in the resident's medical record the specific impairment that has rendered the resident incapable of understanding these rights.

State and Federal regulations provide for the establishment of written policies and procedures regarding resident rights in all NFs. Each facility is responsible for both the development and adherence to these policies which govern all areas of service provided. The NF staff must be trained and involved in the implementation of these policies.

Such policies must be made available to residents, the resident's family or legal representative, any sponsoring agencies, representative payees, and the general public. The NF must comply with the policy and procedure requirements of this section for each resident admitted to the facility.

514.16.1 NOTICE OF RIGHTS

The resident has a right to a dignified existence, self-determination, and communication and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, including each of the rights defined below. Written policies and procedures for each facility must be implemented to ensure that each resident or his/her representative in the facility at admission is fully informed of his/her rights and responsibilities as a resident of the facility. Notification of resident rights must be provided periodically during the stay to the resident/representative.

The nursing facility must encourage and assist the resident throughout the period of stay to exercise rights as a resident and a citizen including the right to vote, formulate advanced directives and meet and organize in resident/representative groups to voice grievances and recommend changes in policies and services to facility staff and/or other representatives of choice free from restraint, interference, coercion, discrimination or reprisal. The facility must assure each resident civil and religious liberties, privacy of telephone and written communications, provide services and care consistent with special needs and individual preference, and respond promptly to requests.

In the case of a resident adjudged to be incompetent, the rights described in this provision shall be exercised by the individual's guardian or committee as applicable under State Law to act on the resident's behalf. If the resident has not been adjudged incompetent by the State, any legal surrogate designated in accordance with State Law may exercise the resident's rights to the extent provided by State Law.

The facility must inform each resident and/or his/her representative both orally and in writing, in a language that the resident understands of his/her rights and of all rules and regulations governing patient conduct and responsibilities. Such information must be provided prior to or at the time of admission, or in the case of residents already in the facility, upon the facility's adoption or amendment of resident right's policies. Written acknowledgment of the receipt of resident rights information must be maintained within the facility.

The facility will keep all personal and medical records private and refuse to allow access to these records without written authorization by the resident/representative unless State and/or

Federal regulations regarding release of information supersedes. The resident or his/her representative will have access to all records pertaining to the resident including clinical record. Upon receipt of an oral or written request by the resident or his/her representative, the facility will provide within two (2) working days copies of all records requested at a cost not to exceed the community standard for photocopies.

The resident has the right to receive adequate, appropriate health care and appropriate protection and support services with reasonable accommodation of individual need and preference including, but not limited to selection of personal physician. The resident or his/her representative has the right to be fully informed in a language that he/she can understand of his/her total health status. The resident or his/her representative has the right to refuse treatment, and to refuse to participate in experimental research.

The resident or his/her representative has the right to be present and participate in the formulation of a care plan as well as be consulted in advance about any changes in treatment or care. Self medication by residents must be allowed if individual capabilities are assessed and documented by professional staff.

Outside of the formal plan of care, the resident has the right to plan personal daily activities and participate in activities both inside and outside the facility

Residents who are entitled to Medicaid benefits or become eligible for Medicaid benefits must be informed in writing the items and services under the State plan for which the resident may not be charged as well as the items for which the resident may be charged and the amount of the charges. This information must also be provided to the resident periodically during the resident's stay in the nursing facility

The facility must not require a resident to perform work unless written agreement is provided by the individual to provide specific services (work). If a resident does perform work, a written refusal of wage payment must be signed by the resident. This statement must include but is not limited to the amount of wages for the service and the effect on financial coverage for nursing facility services by any insurer of the resident. Any resident may perform volunteer services based on desire and ability.

A resident of a nursing facility must be provided a room as homelike as possible according to individual tastes, desires and medical necessities. Personal furnishings including furniture must be allowed depending on space, and a private storage space within the personal room for clothing and possessions must be provided. The nursing facility must take reasonable precautions to protect and treat personal possessions with respect, as well as investigate incidents of loss, damage or misappropriation of property promptly.

The facility must provide a written description of legal rights including:

1. Manner of protection of personal funds;
2. Name, addresses, and telephone numbers of all pertinent State advocacy groups;

3. Statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and/or misappropriation of funds or property in the facility;
4. The name, specialty and way of contacting the physician responsible for the care of the resident; and,
5. Procedures for applying for and using Medicare and Medicaid benefits as a resident of a nursing facility.

514.17 RESIDENT ASSESSMENT INSTRUMENT (RAI)

Nursing facilities are required to complete a comprehensive assessment for each resident as currently implemented by the Center for Medicare and Medicaid Services or modified in the future. This assessment is identified as the Resident Assessment Instrument (RAI). It consists of the Minimum Data Set (MDS), the Resident Assessment Protocols (RAPs) and the Care Plan (CP).

Regulations and instructions regarding the completion of the RAI are to be found at www.cms.hhs.gov.

514.17.1 MINIMUM DATA SET (MDS)

The Minimum Data Set, Version 2.0 with the RUGs III 1997 Quarterly and the WV specific Section S are to be used by nursing facilities to fulfill the federally mandated requirements. These forms may be found in the RAI Manual as published and periodically updated by the Center for Medicare and Medicaid Services (CMS) and in Attachment 1 for the WV specific Section S. Other State Required Assessment (OSRA) is no longer required to indicate a payer change. All other MDS assessments need to be completed as warranted.

514.17.2 RESIDENT ASSESSMENT PROTOCOLS (RAPs) As per federal regulations, the Resident Assessment Protocols (RAPs) must be completed when indicated by information documented on the MDS. The RAPs and the process for completion are published and periodically updated by CMS and may be found in the RAI Version 2.0 manual.

514.17.3 CARE PLAN (CP)

A comprehensive care plan must be developed for each resident based on information from the RAPs as well as all additional medical and psycho social needs of the resident.

514.18 DESCRIPTION OF COVERED SERVICES

Except for the limitations and exclusions listed below, the Bureau will pay an all-inclusive per diem rate. This rate represents payment for all medically necessary and medically appropriate services and items that are required to be provided by the NF to achieve optimum quality care and quality of life for each resident.

514.18.1 NURSING SERVICES

Covered services include general nursing and restorative nursing care such as but not limited to medication administration, treatments, assessment and care planning, and restorative programs

The general nursing care consists of, but is not limited to, personal care services rendered by the nursing staff and assistance with activities of daily living rendered by any staff including hair and nail hygiene, bathing and routine foot care.

514.18.2 REHABILITATIVE SERVICES

Covered services include physical therapy, speech-language pathology, occupational therapy, respiratory therapy and psychological and psychiatric rehabilitative services. The services must be ordered by the resident's physician and included in the plan of care.

Rehabilitative services whether provided either directly or through qualified outside resources must be designed to preserve and improve abilities for independent function, to prevent progressive disabilities and restore maximum function.

514.18.3 PHARMACY SERVICES

Covered services as a part of the nursing facility per diem include over-the-counter drugs with the exception of insulin, Prilosec OTC and over-the-counter Claritin products. Additionally, diabetic testing supplies and syringes/needles are covered in the facility per diem.

514.18.4 MEDICAL SUPPLIES, ACCESSORIES AND EQUIPMENT

Facilities may not charge a resident for routine personal hygiene items and services as required to meet the needs of residents, including but not limited to, hair hygiene supplies; comb; brush; bath soap; disinfecting soaps or specialized cleansing agents when indicted to treat special skin problems or to fight infection; razor; shaving cream; toothbrush; toothpaste; denture adhesive; denture cleaner; dental floss; moisturizing lotion; tissues; cotton balls; cotton swabs; deodorant; incontinence care and supplies; sanitary napkins and related supplies; towels; washcloths; hospital gowns; hair services including shampoos, trims and simple hair cuts; nail services including routine trimming, cleaning, filing, and care for ingrown or damaged nails; bathing and basic personal laundry.

Additionally, nursing supplies including over the counter wound care items, sterile saline, pressure ulcer treatment supplies, dressings, bandages, tape and any other wound care supplies prescribed by the physician. Also, syringes and needles, dietary supplements, salt and sugar substitutes, tube feedings, disposable diapers, and supplies such as catheters and colostomy and ileostomy bags and any other incontinence supply items prescribed by a physician.

Medical supplies, accessories and equipment that the NF is required to have available include, but are not limited to, hospital beds, standard wheelchairs, walkers, Geri-chairs, crutches, canes, bedside commodes, traction equipment, blood pressure equipment, protective restraints, lifts, nebulizers, air mattress, weight scales and gait belts.

514.18.5 ROOM AND BOARD

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

514.18.6 LAUNDRY

Covered services include laundry services such as basic personal laundry, and regular and wash and wear items.

514.18.7 FOOD AND DIETARY SERVICES

Covered services are all nutritional services meals, snacks, food supplements, tube feedings, supplies and equipment required for tube feedings, and food substitutes needed for special diets.

514.18.8 ACTIVITIES PROGRAM

Covered services include the cost for the provision of an activities program for residents.

514.18.9 SOCIAL SERVICES

Covered services include the provision of social services and coordination with other social service agencies in the resident's community and the resident's family.

514.19 OTHER AVAILABLE MEDICAID SERVICES

In addition to the covered services furnished by a NF and included in the per diem rate of the facility, there are other medical services available to Medicaid residents residing in a NF.

In order for these additional services to be covered, the services must be provided by Medicaid participating providers, the provider must submit and file the claims directly to the Bureau, and the provider will be reimbursed directly for their services. Such services are subject to limitations, exclusions, and prior authorization requirements found in the corresponding provider manual.

The NF should furnish these providers with the resident's 11-digit Medicaid identification number when services are requested for a resident.

514.19.1 PHYSICIANS' SERVICES AND PHYSICIAN EXTENDER SERVICES

Direct physician services provided by a doctor of medicine or doctor of osteopathy to Medicaid residents residing in a NF are covered and payable to the physician. Services provided by physician assistants, nurse practitioners or clinical nurse specialists who are under the direct supervision of a physician are also covered services. The resident's record must reflect the kind and extent of services rendered by the physician and billed to the program.

Routine visits are considered every 30 days. More frequent visits must be medically justified and documented in the resident's medical record, and on the claim form.

The NF, the resident, or other entities acting on behalf of the resident may not supplement Medicaid reimbursement to the physician for professional services rendered to the resident.

Deductible and coinsurance charges under Medicare Part B for Medicare/Medicaid residents are also covered and payable to the physician.

514.19.2 PRESCRIPTION DRUGS

Prescription drugs are covered for residents of nursing facilities when prescribed by the attending physician and furnished by a Medicaid participating pharmacy. The coverage rules and regulations may be found in the WV Medicaid Pharmacy Manual.

Specific nursing facility resident exceptions are the following:

- Nursing facility residents are not eligible for in-home parenteral therapy services.
- Non-covered drugs are not payable under any circumstance.
- Residents residing in a NF are exempt from all co-pay requirements.
- In those instances where the physician has determined that the Medicaid drug coverage does not meet a resident's therapeutic needs, the resident or family may pay the pharmacy for the prescription.

514.19.3 PROSTHESES AND APPLIANCES

Covered prostheses and appliances may be found in the appropriate Medicaid Manual.

514.19.4 DENTAL SERVICES

Covered dental services may be found in the appropriate Medicaid Manual.

514.19.5 VISION CARE SERVICES

Covered vision services may be found in the appropriate Medicaid Manual.

514.19.6 PODIATRY SERVICES

The Medicaid Program covers podiatry services, with certain limitations, furnished to a resident when referred by the attending physician.

Routine foot care is not a covered service, except for residents referred by the physician because of a metabolic disease (such as diabetes). Routine foot care includes the cutting or removal of corns or calluses, the trimming of nails, observation and cleaning of the feet, nail care not involving surgery, and other hygienic and maintenance care. Routine foot care is considered a part of the nursing services.

The regulations detailed in the Podiatry Services Manual for the Medicaid program apply to nursing facility residents.

514.19.7 LABORATORY, X-RAY, AND OTHER DIAGNOSTIC SERVICES

The NF must have formal arrangements for provision of ancillary services.

Laboratory and x-ray services are covered as ancillary services when provided by a certified and participating hospital or laboratory upon the order of the attending physician as needed to diagnose or treat an illness, accident, or injury.

The resident's initial medical evaluation required within 48 hours after admission or within five days prior to admission may include a chest x-ray and other routine laboratory work in order to safeguard against the spread of disease and to ensure adequate medical care.

514.19.8 AMBULANCE SERVICES

Ambulance services are covered when the following criteria are met:

- To obtain a service which is not normally provided within a NF, such as x-rays, blood transfusions, casting, and specialist consultation when ordered by the attending physician.
- The resident's physical condition requires ambulance service as defined in the transportation Services Manual. Use of an ambulance is not merely for the resident's nursing facility's convenience.
- Service is to be to the nearest hospital with appropriate facilities as provided in the NF transfer agreement.
- Transfer to another facility or general hospital when medically indicated.

Ambulance services are not covered for the following:

- To obtain routine laboratory diagnostic test or personal services, such as changing dressing, catheters, etc.
- To a physician's office or clinic, except as provided in above.

514.20 HOSPICE/NURSING FACILITY RESIDENTS

West Virginia Medicaid maintains a separate program of Hospice Services for members who are residents of nursing facilities. If a member electing hospice care is a resident of a West Virginia Medicaid certified nursing facility, the nursing facility may contract with a Medicare/ Medicaid certified hospice agency to provide room and board for dually eligible individuals who qualify medically for both the hospice benefit and Medicaid nursing facility benefits. Medicare certification of a nursing facility is not a requirement of this program. The hospice agency must enroll with the Medicaid agency to be a provider of this benefit in nursing facilities.

The room and board component provided by the nursing facility shall include the provision of a living space, nutrition, and ancillary services normally provided for residents. Ancillary services may include, but are not limited to the basic activities of daily living, social and activity programs, laundry and housekeeping.

The hospice provider is responsible for specialized services covered by Medicare including but not limited to, medications associated with the terminal illness and assistance with care planning, emotional support for the member and the member's family. The hospice must bill Medicare/ Medicaid for all covered services, as well as nursing facility room and board

514.20.1 DOCUMENTATION REQUIREMENTS FOR NF AUTHORIZATION

For each individual who applies for hospice coverage in a nursing facility, election of services and physician certification are required. The hospice provider must submit to the Bureau for Medical Services for review the following information:

- An agreement between the specific nursing facility and the hospice provider that each will provide its appropriate services to members who qualify, and
- Documentation to support the medical necessity of the individual for each covered service and the financial eligibility documentation for the specific individual regarding the Medicare and the Medicaid programs.

As with hospice services provided in other settings, those provided in nursing facilities apply only to the terminal condition or disease. For health needs not related to the terminal diagnosis, ordinary West Virginia Medicaid policies and procedures are to be followed.

The authorization information must be submitted with the first claim for payment.

514.20.2 NURSING FACILITY REIMBURSEMENT

To be billed under Medicare Revenue Code 0658:

The WV Medicaid Program will remit to the hospice provider 95 percent of the daily rate which would have been paid to the nursing facility for care of this member had they not elected hospice coverage. The hospice will then reimburse the nursing facility for the cost of room and board, as identified in their contract. The amount of reimbursement will be based on the nursing facility base per diem rate with the Medicaid adjustment for the acuity of the beneficiary. The claim form for billing is the UB-92. A printout of the computerized report identifying the specific case mix class of the individual must be attached.

514.21 DOCUMENTATION AND RECORD RETENTION REQUIREMENTS

The NF must comply with the documentation and maintenance of records requirements described in Chapter 100, General Information; Chapter 300, Provider Participation; and Chapter 800, General Administration, of the Provider Manual. In addition to the documentation requirements described in those chapters, the following requirements also apply to payment of NF services:

514.21.1 RESIDENT RECORD SYSTEM

An organized resident record system is maintained which assures that it is available to professional and other staff directly involved with the resident as well as authorized representatives of the Department of Health and Human Resources or the Department of Health and Human Services.

Resident records must be safeguarded against destruction, loss, or unauthorized use. Records should be retained for a minimum of 5 years following a resident's discharge. All information contained in the resident record is privileged and confidential, and written consent of the resident or his/her legal representative is required for release of information to other than authorized representatives of the Department of Health and Human Resources and the Department of Health and Human Services.

A separate clinical record shall be maintained for each resident at a location that is accessible to appropriate NF staff with all entries kept current, dated, and signed.

514.21.2 IDENTIFICATION INFORMATION

The clinical record must include at a minimum the following information:

- Name of resident (first, middle, and last)
- Date and time of admission
- Social Security identification number
- Medicare identification number (where applicable)
- Medicaid identification number (where applicable)
- Marital status
- Date of birth
- Gender
- Home address
- Religion
- Name, address, and telephone number of referral agency (including institution from which admitted, where applicable)
- Attending physician and dentist
- Next of kin or other responsible person
- Admitting diagnosis
- Final diagnosis (or cause of death)
- Condition on discharge and disposition (where applicable)
- Inventory of personal effects.

514.21.3 MEDICAL INFORMATION

The clinical record must include at a minimum the following information:

- Physician's certification reflecting the need for NF services upon admission and upon application for medical assistance.
- An overall plan of care based on a comprehensive assessment setting forth goals to be accomplished, prescribing an integrated program of individually designed activities, therapies and treatments necessary to achieve such goals, and indicating which professional service or individual is responsible for each element of care or service prescribed in the plan.
- Initial medical evaluation including medical history, physical examination, diagnosis, and estimation of restoration potential done on admission or within 5 days prior to admission.
- Physician's orders including all medications, treatments, diets, and special restorative medical procedures.
- Medication and treatment record including all medications, treatments, and special procedures performed.

- Physician's progress report noted for each visit or consultation describing resident's health status and/or significant changes in resident's condition.
- Nursing note records should be written as necessary depending on the condition of the resident or, when there is no change, a monthly summary which indicates the continued observations made by the nursing personnel (entries made by attendant personnel are acceptable, but must be reviewed and co-signed by the supervising nurse in charge).
- Physician re-certification must include documentation by the physician substantiating the resident's need for continued services in the NF.
- A written report completed in duplicate (one to the administrator and one in the record) is required on an accident or unusual incident involving a resident which is to include the name of the resident, witnesses if indicated, time, extent of the accident, the circumstances under which it occurred, and the action taken.
- Hospital transfer information (where applicable).
- Discharge summary completed by the physician prior to the resident's discharge for transmittal to the receiving institution at the time the resident is discharged, if applicable.
- A record of the resident's major grievances, if any, and the disposition
- X-ray and laboratory reports dated and signed.
- Medications given to the resident upon discharge.

514.22 PAYMENT AND BILLING PROCEDURES

NF providers must comply with the payment and billing procedures and requirements described in Chapter 600, Reimbursement of the Provider Manual.

Nursing facilities must bill for services using either the UB92 paper form or the 837i electronic institutional format. The services may not be billed until the month after which the services were provided.

The following are the revenue codes and the HIPPS codes that must be billed in order to receive appropriate payment for services provided:

Revenue Code 0190 is the room and board (fixed portion of the rate);

Revenue Code 0550 in skilled nursing (nursing portion of the rate) and must have HIPPS/RUGs Code attached;

HIPPS/RUGs Codes are AAA01-AAA29 to identify the WV specific case mix class

HIPPS/RUGs Code AAA00 is to identify there is no MDS available

Revenue Code 0183 is the therapeutic bed hold leave of absence;

Revenue Code 0185 is the hospital bed hold leave of absence; and

Revenue Code 0189 is the non-covered leave of absence.

Nursing facilities will use bill type 21x.

514.23 REIMBURSEMENT REQUIREMENTS

Cost related reimbursement for nursing facility services was mandated by Section 249 of P. L. 92-603, the 1972 amendments to the Social Security Act. The West Virginia State Plan to meet these requirements was implemented October 1, 1976. The State Plan was amended to allow an acuity adjustment to the nursing component of the reimbursement. This case mix adjustment was effective October 1, 1993.

The West Virginia LTC reimbursement system is prospective with semi-annual rate adjustments. It is designed to treat all parties fairly and equitably, i.e., the resident, taxpayer, agency and facility. To meet these goals, complete and accurate cost data must be maintained by each facility with cost reports accurately prepared and submitted on a timely basis.

The basic principles and methodology for the system are described in this chapter. Detailed instructions and guidelines are published in the revised West Virginia Medicaid Long Term Care Users Guide to Reimbursement, which is hereby incorporated by reference into these regulations.

Federal and State law and State Plan and Medicaid regulations cover reimbursement principles in the following order. When Medicaid regulations are silent and Medicare cost principles and regulations are silent, then generally accepted accounting principles (GAAP) will be applied. None of these secondary applications will serve to reduce the Department's ability to apply ~~r~~easonable cost" limits under Medicaid.

514.24 COST FINDING AND REPORTING

All participating facilities are required to maintain cost data and submit cost reports according to the methods and procedures specified in this chapter and the Medicaid Reimbursement Guide for Long Term Care Nursing Facilities which ever is more restrictive.

514.25 CHART OF ACCOUNTS

The Medicaid Chart of Accounts (MCOA) is mandated by the West Virginia Department of Health and Human Resources for nursing facility service providers who are required to complete the Financial and Statistical Report for Nursing Homes (Medicaid Cost Report) as part of their participation in the Medicaid program. The MCOA details the account number, account name, file/field specification (FIELD), page and line reference (MAP) and description of items applicable for each account. The FIELD column contains the file and field layout for submission of the Medicaid Cost Report.

It is not mandatory for the provider's to use the MCOA for internal reporting purposes. However, the provider must submit a trial balance using the MCOA as part of the automated cost reporting process. This is accomplished in the cost reporting software by assigning the appropriate MCOA number to the provider's internal account number. It is the provider's responsibility to secure and maintain acceptable cost report software. The MCOA is maintained by Financial Analysis and Rate Setting (FARS) unit of the Bureau for Medical Services and is periodically updated. Cost reports should be submitted in accordance with the MCOA .

514.26 FINANCIAL AND STATISTICAL REPORT

Facility costs must be reported on the Financial and Statistical Report for Nursing Homes, which

must be completed in accordance with generally accepted accounting principles (GAAP) and the accrual method of accounting. The reports need to be submitted to the Department in the form of a hard copy and on a 3.5" 1.44 high density diskette. The report must also be accompanied by The Medicaid grouping report trial balance that matches the costs on the report. These reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the facility for correction.

514.26.1 COST REPORTING AND FILING PERIODS

Facility costs are reported semi-annually with the two reporting periods being January 1 through June 30, and July 1 through December 31, respectively. Cost reports must be filed with the Department within 60 days following the end of the reporting period. The due dates are August 29th for the June 30th closing date and March 1st for the December 31st closing date.

514.26.2 EXTENSION REQUESTS

An extension of time for filing cost reports may be granted by the Department for extenuating circumstances where requested and justified by the facility in writing by the close of business on the due date. Extension requests will be limited to a maximum of 15 calendar days and should be addressed to the Director, Financial Analysis and Rate Setting, Bureau for Medical Services, 350 Capitol Street, Room 251, Charleston, WV 25301.

514.26.3 PENALTY - DELINQUENT REPORTING

Failure to submit cost reports by the due dates, where no extension has been granted to the facility or within the time constraints of an extension, will result in a ten percent **(**10%**)** reduction in reimbursement to that facility. The penalty will be assessed for a full month for each month, or part thereof, during which the cost report is delinquent. If incomplete cost reports are not corrected and resubmitted within ten (10) calendar days, the facility may be subject to these penalty provisions at the discretion of the Department.

514.26.4 CORRECTION OF ERRORS

Errors in cost report data identified by the facility may be corrected and resubmitted to the Department. If submitted within thirty (30) days after the original rate notification, those corrections will be considered for rate revision. The Department will make rate revisions resultant from computational errors in the rate determination process.

514.26.5 CHANGES IN BED SIZE

A cost adjustment may be made during a rate period where there has been a change in the facility bed size if the change affects the appraisal value of the facility. In this instance, an appraisal of the facility will be completed after the bed size change has been certified.

514.27 PROJECTED RATES

A projected rate will be established for new facilities with no previous operating experience. A change of location with the same ownership does not constitute a new facility. A projected rate will last no longer than eighteen (18) months from the opening date of the facility. The facility may choose to go off the projected rate at any time after a full six (6) months of operating experience in a cost reporting period has been established. Each facility on a projected rate

must submit the calendar semi-annual cost reports during the projected rate period even if the first report is a partial report (less than 6 months).

514.27.1 CHANGE OF OWNERSHIP – PROJECTED RATES

A projected rate may be established where there has been a change of ownership and control of the operating entity and the new owners have no previous management experience in the facility. When a stock purchase has occurred and the new owners have previous experience in the industry and there has been no turnover of key personnel in the facility, a projected rate is not established. If a change of ownership and control has occurred because there has been a complete purchase of assets, a projected rate is established.

At the end of the projected rate period, the audited cost report of the facility will be reconciled with the projected cost reimbursement using actual occupancy and tested for reasonableness against the cost standard established for the bed groups (0-90 beds and 91+ beds). Overpayment identified in the reconciliation process will be recovered by the Department in accordance with the provision of Chapter 800.

A projected rate for a new facility or a facility with a recognized change of ownership and control will be established as follows:

a. Standard Services - The cost standard (CAP) established for the bed group

b. Mandated Services - The cost standard (CAP) established for the bed group

c. Nursing Services - The average of the cost established for the bed group

d. Cost of Capital - The Standard Appraised Value (SAV) methodology is applied to a new facility or the SAV established for the facility if a change of ownership occurs

514.28 MAINTENANCE OF RECORDS

A desk review of the cost report will be done prior to rate setting and an on-site audit of facility records will be conducted periodically. Financial and Statistical records must be maintained by the facility to support and verify the information submitted on the cost reports. Such records must be maintained for a minimum of five (5) years from the ending date of the report. Upon request by the Department all records will be made available within ten (10) working days. If not produced within that time frame, the records will be considered non-existent. The Department reserves the right to name the site as to where the records are to be made available. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.

514.29 ALLOWABLE COSTS

Reimbursement for nursing facility services is limited to those costs required to deliver care to residents. These are facility operating costs, resident direct services costs and costs for the physical setting.

514.30 ALLOWABLE COSTS FOR COST CENTERS

The cost centers are standard services, mandated services, nursing services and capital. A cost standard is developed for each cost center which becomes the maximum allowable cost for reimbursement purposes. Allowable costs are determined by the following methodologies:

514.30.1 STANDARD SERVICES

The Standard Services component is comprised of four departmental cost centers: Dietary, Laundry & Housekeeping, Medical Records and Administration. A separate cost standard is calculated for each of these cost centers by bed group based on bed size (0-90 beds and 91+ beds). Within each cost center, the per patient day (PPD) allowable costs are arrayed assuming 100% occupancy on a facility specific basis. Extremes are eliminated by including only those values falling within plus or minus one standard deviation. This establishes a cost average point (CAP), i.e., average cost per bed group. The CAP is then adjusted by a 90% occupancy level. The Standard Services cost standard is the sum of the cost center CAP for Dietary, Laundry & Housekeeping, Medical Records and Administration. The cost standard then establishes the maximum allowable cost by bed group for Standard Services.

514.30.2 MANDATED SERVICES

The Mandated Services component is comprised of four departmental cost centers: Activities, Maintenance, Utilities and Taxes & Insurance. A separate cost standard is calculated for each of these costs centers by bed group. Within each cost center the PPD allowable costs are arrayed from highest to lowest. The 90th percentile value of each cost center is then selected as the CAP. The Mandated Services cost standard is the sum of the cost center CAP for Activities, Maintenance, Utilities and Taxes & Insurance. The cost standard then establishes the maximum allowable cost by bed group for Mandated Services.

514.30.3 NURSING SERVICES

The cost standard for Nursing Services is shown as the Resident Assessment calculation on the rate sheet. This calculation provides for professional staffing levels and supply costs that are recognized as representative of those necessary for delivery of the core level of resident needs. It incorporates all minimum Federal and State mandates for licensure and certification of nursing facilities.

The professional staffing hours on the Resident Assessment calculation serve as a benchmark and are held constant over time. A factor of .35 hours PPD is included in the LPN hours for 0-90 beds and .30 hours PPD for 91+ beds to account for restorative services. Additionally, .05 hours PPD is included in the standard Aides hours for restorative services.

The standard hours PPD, by bed group, for each of the professional levels of nursing staff are as follows:

Staff	1-90 Beds	91+ Beds
RN	0.20	0.20
LPN	0.85	0.80
Aides	1.85	1.85
Total hours PPD	2.90	2.85

The cost standard for nursing wage rates uses total compensation and is calculated by bed

group. Hourly wage rates, by professional level, are derived from the cost reports of each facility and arrayed from highest to lowest in each bed group. The 70th percentile value is then selected as the bed group CAP. The CAP is multiplied by the hour benchmark to yield the salary component of the Nursing Services cost standard. Nursing and restorative supply costs are summed for each facility and converted to a PPD cost. These PPD costs are then arrayed, by bed group, from highest to lowest, and the 70th percentile is selected as the Nursing Supplies CAP.

The Director of Nursing (DON) salary is selected at the 70th percentile, by bed group, as derived from the submitted cost reports. An additional factor is added for the DON by dividing the DON salary by each facility's beds at 100% occupancy.

The cost standard for Nursing Services is derived as the sum of the above factors (RN, LPN, Aide, Supplies and DON). The CAP is then adjusted to a facility specific CAP based on the facility's average Medicaid MDS score from the six month reporting period. The average Medicaid MDS score is divided by 2.5 and then multiplied by the base constant to arrive at an adjusted Nursing Services CAP for each facility. The adjusted Nursing Services CAP cannot exceed 112% (MDS average of 2.8) or be less than 80% (MDS average of 2.0) of the base constant. The facility actual allowable PPD nursing costs are reimbursed up to the level of the nursing services CAP.

An add-on factor allows for monthly adjustments to this base nursing reimbursement during the rate period when the case mix score derived from the MDS, as determined at the time of monthly billing, indicates a higher level of need and care delivered to a specific resident. A base case mix score of 2.9 is established as a threshold. For residents with a monthly case mix score of 2.9 or less, there is no add-on factor. If the monthly case mix score exceeds 2.9, then an add-on factor is determined by dividing the excess of the case mix score over 2.9 by the threshold factor of 2.25. The resulting factor is then multiplied by the Nursing Rate to derive a PPD Nursing Services add-on.

514.30.4 COST OF CAPITAL

Reimbursement for cost of capital is determined using an appraisal technique to establish a Standard Appraised Value (SAV). This value includes the necessary real property and equipment associated with the actual use of the property as a nursing facility. The Standard Appraised Value (SAV) uses the cost approach to value modified by the Model Nursing Facility Standard. This valuation is the basis for capitalization to determine a PPD cost of capital. This allowance replaces leases, rental agreements, depreciation, mortgage interest and return on equity in the traditional approach to capital cost allowance.

a. Cost Approach to Value

The value of a property is derived by estimating the replacement or reproduction cost of the improvements, deducting from them the estimated accrued depreciation and adding the market value of the land (actually used if required for use as if vacant and available for development of such use). Established sources of cost information are used to supply costs to reproduce the structure. Construction indexes used are Marshall Valuation Services and Boeckle Building Valuation Manual.

b. Accrued Depreciation

Accrued depreciation in a cost approach is the difference between the value of a building or other improvement at a certain date and its cost of reproduction as of the same date. The method used to measure accrued depreciation is known as the ~~"b~~reakdown" method which involves an analysis of loss in value from the following sources:

1. Physical deterioration; curable and incurable
2. Functional obsolescence; curable and incurable
3. Economic obsolescence

The nursing facility appraisal method modifies the property value by deducting accrued depreciation. Those facilities meeting the appraisal criteria will receive their maximum standard appraisal value; those not meeting a standard will have their plant valuation reduced by the amount reflected in physical and functional depreciation. This includes both physical depreciation, curable and incurable, as well as functional obsolescence, curable and incurable. The summation of each component of the process results in a final Standard Appraised Value. This value will then be treated as a cost of providing patient care.

c. Model Nursing Facility Standard

The Model Nursing Facility Standard is a composite of current regulations and criteria derived from several sources which include "~~M~~inimum Requirements of Construction and Equipment for Hospital and Medical Facilities" - HHS Publication No. (HRS) 81-14500 and West Virginia Department of Health and Human Services Nursing Home Licensure Rules.

These criteria form a living document drawn from Federal and State regulations and guidelines, as well as from accepted industry practice. They will be updated periodically to reflect changes which foster improved resident care or cost effective measures which do not compromise resident care.

The Model Nursing Facility Standard also sets an upper reasonable cost limit for constructing a nursing facility. This effectively discourages the creation of unnecessarily costly facilities. Currently, land is being appraised at its "~~h~~ighest and best" use. This occasionally results in land values in excess of the building and equipment appraisal.

d. Appraisal Technique

A complete appraisal of each new facility will be performed after certification and approval for Medicaid program participation by a qualified appraisal firm under contract with the Department. Updates of the initial appraisal will be performed annually and used in the October 1st rate setting period, in addition to the following April 1st rate setting period. Updates may be performed at any time during the annual period when there have been major changes to the bed size of the facility and such changes would affect the SAV for rate setting purposes. Initial and annual appraisals must include onsite inspections. Prior to rate setting, the updated appraisals will be indexed to June 30, as a common point valuation, based on the Consumer Price Index. All appraisals will include an on-site evaluation.

A copy of the facility appraisal report is furnished to the facility for its records.

514.30.5 CAPITALIZED ASSETS

Assets that have a value equal to or greater than $3,000 with an estimated useful life of 2 years or more should be capitalized. The cost of the asset includes, but is not limited to, installation, delivery and acquisition costs. A repair of an asset that exceeds $3,000 per project and extends the useful life of the asset more than 2 years should be capitalized. The cost of the repair includes, but is not limited to labor and materials. Renovation type projects where small amounts of material at a time are purchased, over an extended period of time, should be capitalized to reflect the true nature of the project.

514.30.6 WORKING CAPITAL INTEREST

Working Capital Interest (WCI) is limited to short term loans (normal term of less than six months) taken out to meet immediate needs of daily operations. To be allowable, there must be a genuine effort by the provider to repay these notes. If no evidence of repayment is apparent and these notes are merely renewed throughout the year, the Program will not consider these to be bone fide working capital notes and the interest incurred on them will not be allowed if no justification can be made for nonpayment of the note.

514.30.7 VEHICLE EXPENSES

The cost of operating all licensed vehicles will be limited to the per mile rate approved by the West Virginia Travel Management Office. The per mile rate is computed to include the following costs: rental or lease payments, interest, repairs, routine maintenance, inspections and licenses, insurance and depreciation. Detailed mileage logs must be maintained to support the miles reported. All travel must be included in the mileage log.

514.30.8 ALLOCATED COSTS

Hospital based nursing facilities and nursing facilities associated with personal care homes that use allocated costs must show reasonableness and be comparable to other facilities in the industry

514.30.9 HOME OFFICE COSTS

Home office costs are includable in the provider's cost report and are reimbursable as part of the provider's costs. Where the home office of the chain provides no services related to patient care, neither the costs nor the equity capital of the home office may be recognized in determining the allowable costs of the providers in the chain. Management fees charged between related organizations are not allowable costs and such fees must be reported as nonallowable on the provider's cost report. Thus, allowable cost is limited to the lesser of (1) allowable costs properly allocated to the provider (2) the price for comparable services, facilities, or supplies that could be purchased elsewhere, taking account the benefits of effective purchasing that would accrue to each member provider because of aggregate purchasing on a chain wide basis.

Home office costs that are not otherwise allowable costs when incurred directly by the provider cannot be allowable as home office costs to be allocated to providers. Costs related to nonmedical enterprises are not considered allowable home office costs. All allocated central office costs are considered administrative in nature and, therefore, must comply with regulations

governing allowability at individual facility locations.

Starting with its total costs, including those costs paid on behalf of providers (or components in the chain), the home office must delete all costs which are not allowable in accordance with program instructions.

Where the home office incurs costs for activities not related to patient care in the chain's participating providers, the allocation basis used must provide for the appropriate allocation of costs such as rent, administrative salaries, organization costs, and other general overhead costs which are attributable to nonresident care activities, as well as to patient care activities. All activities and functions in the home office must bear their allocable share of home office overhead and general administrative costs.

The basis for allocation of allowed costs among long-term care facilities should be patient days. However, another basis may be considered appropriate and more accurate. The home office must make written request, with its justification, to the Department for approval of the change. The written request must be received no later than 120 days after the beginning of the home office accounting period to which the change is to apply.

The Department's approval of a home office request will be furnished to the home office in writing. Where the Medicare intermediary approves the home office request, the change must be applied to the accounting period for which the request was made, and to all subsequent home office accounting periods unless the intermediary approved a subsequent request for change by the home office. The effective date of the change will be the beginning of the accounting period for which the request was made.

514.31 COMPENSATION

Compensation to be allowed must be reasonable for services that are necessary, related to patient care and pertinent to the operation of the facility. The services must actually be performed and paid in full less any withholding required by law. The hours worked must be documented as well as the compensation received. This information must be reported to all appropriate State and Federal authorities for income tax, Social Security and unemployment compensation purposes.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the bed group. The method used to calculate ~~r~~easonable" will be as follows: The 90th percentile of the hourly wage of the employee classification for each bed group will be used to determine ~~r~~easonable". No owners, operators and relatives will be included in the calculation. If the services are provided less than full time, the compensation must reflect this fact. Full time is considered approximately 1040 hours per cost report period worked in resident related duties and includes documented vacation and sick time.

Compensation must include the total benefits paid for the services rendered, i.e., fees, salaries, wages, payroll taxes, fringe benefits and other increments paid to or for the benefit of those providing the services.

If bonuses are a part of an employee's compensation a clearly established non-discriminatory bonus plan (covering owners and related parties of owners) must be set in writing to employees before the cost reporting period begins. Otherwise the bonus or bonus plan will not be

considered allowable. The amount of the bonus must be accrued to the period earned.

514.31.1 ADMINISTRATORS

The nursing facility administrator is responsible for the performance of any act or the making of any decision involved in the planning, organizing, directing and/or control of the operation of a nursing facility.

A licensed nursing facility administrator shall not administer or act or be administrator of more than two (2) nursing facilities at one time. An administrator may serve two (2) facilities which are within reasonable proximity (30 minute travel times) provided that such administrator is not administering more than a total combined 120 beds. The administrator of two (2) facilities shall average not less than 20 hours per week at each facility. Each period of service is to be documented. Documentation of hours worked consists of time cards, work logs or other reliable indicators that are agreed upon with the Department. Documentation must be made available upon request from the Department. On-Call time is not to be used in determining hours of service.

Reasonable means that the compensation must be comparable for the same services provided by facilities in the bed group. The method used to calculate ~~r~~easonable" will be as follows: The 90th percentile of the hourly wage of the administrator for each bed group will be used to determine ~~r~~easonable". No owners, operators and relatives will be included in the calculation. Full time is considered at least 1,040 documented hours which include vacation and sick time, per cost reporting period for resident related duties. If the services are provided less than full time, the compensation must reflect this fact. The administrator can not act as Director of Nursing.

514.31.2 OWNERS

Administrators/Owners will be compensated for administrative duties performed. Where the cost of administrative services are allowed, additional services performed by the administrator and/or owner is considered rendered primarily to protect their investment and are not allowed.

Compensation will not be allowed for owners, operators or their relatives who claim to provide some administrative or other function required to operate the facility, but who do not actually provide said service. Where functions claimed to be provided by owners, operators or their relatives are merely a duplication of services already provided by other employees or are functions which should reasonably be expected to be performed by other employees, such services are not reimbursable. For example: if a facility has a full-time administrator or other full-time or part-time staff position filled and compensated, the facility owner, operator or their relative claiming compensation for the same or similar functions will not be allowed by the program.

Where owners, operators, or their relatives are on salary at a facility, the program will reimburse the facility to the extent that said individuals salaries are not excessive compared to other individuals who perform the same or similar functions and who are not owners, operators or their relatives. Owners include any individual or organization with any financial interest in the facility operation and any member of such individual's family including the spouse's family. Owners also include all partners and all stockholders of organizations which have a financial

interest in the facility.

514.32 NON-ALLOWABLE COSTS

Non-allowable costs are those costs which are not related to patient care or for which a separate charge is made. This includes, but is not limited to, bad debts, charity and courtesy allowances, Medicare Part B chargeable items, flowers and retirement gifts for employees. Refer to the Chart of Accounts for other non-allowable costs. Other items not referred to in the Chart of Accounts may be specified in State or Federal regulations as non-allowable costs.

514.32.1 TRAVEL: OUT OF STATE

The cost of travel and associated expenses outside the State for conventions, meetings, assemblies, conferences or any related activities are non-allowable costs. However, costs (excluding transportation costs) for training or educational purposes out of State may be allowable. Proof of conference attendance is required. Expenses for non-employees will not be considered allowable.

514.32.2 AUTOMOBILES: CENTRAL OFFICE

Automobiles used by Central/Home Office personnel are nonallowable.

514.32.3 LEGAL FEES

Legal fees on failed appeals against the Department are nonallowable.

514.32.4 REORGANIZATION/REFINANCING COSTS

Organization and reorganization costs are the costs incurred in the creation or restructuring of an entity. These costs are considered to be nonallowable for cost reporting and reimbursement purposes.

514.33 PURCHASES FROM RELATED COMPANIES OR ORGANIZATIONS

All related companies or organizations involved in any business transactions with the facility must be identified on the cost report. Detailed data must be available in the facility records which describe the kind and extent of such business transactions. Cost for purchase of any items or services from related companies or organizations will be allowed at the actual cost of providing the service or the price of comparable services purchased elsewhere, whichever is less.

514.34 FILING REPORTS - REQUESTS FOR ASSISTANCE

Financial and Statistical Reports and questions regarding cost reporting are to be addressed to the Director, Financial Analysis and Rate Setting, 350 Capitol Street, Room 251, Charleston, WV 25301-3706.

514.35 RATE DETERMINATION

Individual facility rates are established on a prospective basis, considering cost to be expected during the rate period. The rate is not subject to retrospective revision. This does not exclude corrections for errors of omissions of data or reconciliation of audit findings related to falsification or misreporting of costs or census. The basic vehicle for arriving at each facility's

rate is the uniform Financial and Statistical Report for Nursing Homes.

The reported costs are subject to desk review and then converted to cost per patient day. Rates will be issued for six (6) month periods beginning April 1 and October 1 based on each facility's reported costs and adjustments for the applicable reporting period.

514.36 COST ADJUSTMENT

Reported facility costs are subject to review and analysis through desk review process. Adjustments are made to exclude non-allowable costs and by application of the agency's established cost standards using the following methodologies:

514.36.1 STANDARD SERVICES

Total reported allowable costs in the standard services area are compared against the total cost standard for these cost centers using the appropriate bed group for the facility. If the total reported allowable exceeds the total cost standard, then the facility rate is limited to the standard services CAP.

514.36.2 MANDATED SERVICES

Total reported allowable costs in the mandated services area are fully recognized for these cost centers, providing they do not exceed the 90th percentile of total reported costs by bed group.

514.36.3 COST OF CAPITAL

Capital costs will be determined on a facility-by-facility basis applying the Standard Appraisal Value (SAV) methodology.

A. Capitalization Rate

A capitalization rate is established to reflect the current SAV of the real property and specialized equipment. This overall rate includes an interest rate for land, building and equipment, an allowance for return on the equity investment in the land, building and equipment, and an appraisal factor used to index all facilities to the cost reporting period ending June 30.

The Band of Investment approach is used to blend the allowable cost of mortgage money (fixed income capital) and the allowable cost of equity money (venture or equity capital) which produces a rate which may be changed annually or semi-annually to reflect current money time values in the mortgage market. This band of investment sets a 75:25 debt service to equity ratio.

The yield of equity allowance (for proprietary facilities) is based on the average Medicare Trust Fund return on equity allowable during the cost reporting period.

The interest rate for the mortgage component is based on the Federal National Mortgage Association (FNMA) current at the time of the facility's original indebtedness, modified by the use of the constant percent for non-profit facilities.

The appraisal factor is based on the Consumer Price Index (CPI) for the cost reporting period in which the facility is appraised.

B. Capital Allowance

For proprietary facilities, the capital allowance per patient day is determined by applying the capitalization rate for mortgage, equity component and appraisal factor to the valuation of the facility determined by the Standard Appraised Value methodology.

514.36.4 NURSING SERVICES

Allowable costs and reimbursement for nursing services will be determined on a facility by facility basis by the kind and amount of services needed and being delivered to the residents. The staffing required to deliver the care and the restorative and rehabilitative programs offered by the facility will be based on the application of a minimum staffing pattern and adjustments to reflect needs determined by the case mix characteristics.

Monthly billing information for services rendered to nursing facility residents will include data derived directly from the computerized assessment instrument for each resident, which may be used to determine case mix scores for each resident and composite score for the facility. These case mix scores will measure the relative intensity and service need of the facility residents and will comprise the basis for determining allowable adjustments to per diem staffing and nursing costs required to deliver the kind and amount of services needed.

514.36.5 MINIMUM OCCUPANCY STANDARD

Cost adjustments will be made by applying a minimum occupancy standard of 90% to all cost centers. Actual facility occupancy is used to determine allowable costs per patient day if equal to or greater than 90%. However, if the actual occupancy level is less than 90%, the per patient day allowable cost will be adjusted to assume a 90% occupancy level.

514.37 EFFICIENCY INCENTIVE

An efficiency incentive will be allowed where the standard services area allowable costs are less than the total of the cost standard. Fifty percent (50%) of the difference between the total allowable cost and the total cost standard will be applied to the prospective rate for the standard services area. The total of the calculated efficiency incentive may not exceed $2.00 per patient day. A facility qualifying for efficiency incentive shall not have any deficiencies related to standard services or substandard care, quality of life, and/or quality of care, during the reporting period. Survey and licensure agency reports are reviewed to determine compliance with licensure, certification and agency standards. If it has been determined that a facility has significant deficiencies, the facility may be denied efficiency incentive for that period. When an audit disallowance results in the allowable costs in the Standard Services component to be less than the cost standard, no increase in the efficiency incentive will be made.

514.38 INFLATION FACTOR

After combining the various components, a factor is assigned to costs as a projection of inflation during the next rate-setting cycle. The amount of change in the Consumer Price Index (CPI) experienced during the six-month reporting period becomes the inflation factor applied to the next six month period. The inflation factor, once set for a given rate period, is not adjusted as it represents what is a reasonable expectation for cost increases.

Regulatory costs, such as minimum wage increases, tax changes, FICA increase, Workers' Compensation changes, etc., will be considered an inclusive component of the inflation factor.

514.39 AUDITS

Department staff will perform a desk review of cost reports prior to rate setting and will conduct on-site audits of facility records periodically.

514.39.1 DESK REVIEW

Financial and statistical reports submitted by the participating facilities will be subjected to desk review and analysis for rate setting within 60 days of receipt. Incomplete and inaccurate cost reports are not accepted.

514.39.2 FIELD AUDIT

Periodic on-site audits of the financial and statistical records of participating facilities will be conducted to assure the validity of reported costs and statistical data. Facilities must maintain records to support all costs submitted on the Financial and Statistical Report and all data to support payroll and census reports. These records must be maintained at the facility or be made available at the facility for review by Department staff (or their representatives) for audit purposes upon notice. **Records found to be incomplete or missing at the time of the scheduled on-site visit must be delivered to the Department within 48 hours or an amount of time agreed upon with audit staff at the exit conference. Costs found to be unsubstantiated will be disallowed and considered as an overpayment.**

514.39.3 RECORDS RETENTION

Audit reports will be maintained by the Department for five years following date of completion.

514.39.4 CREDITS AND ADJUSTMENTS

The State will account for the return of the Federal portion of all overpayments to CMS in accordance with the applicable Federal laws and regulations.

CHAPTER 514
NURSING FACILITY SERVICES
JANUARY 1, 2005

ATTACHMENT 1
PRE-ADMISSION SCREENING
PAGE 1 OF 7

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

PRE-ADMISSION SCREENING

Reason for Screening: **Facility/Agency/Person making referral:**

Check Only One

A. Nursing Home Only ☐ Initial ☐ Transfer NAME:_____

B. Nursing Home waiting Waiver ☐ yes ADDRESS:_____

C. A/D Waiver Only ☐ Initial ☐ Re-Evaluation

D. Personal Care ☐ Initial ☐ Re-Evaluation CONTACT PERSON:_____

PHONE:(___) _____ - _____

FAX: (___) _____ - _____

1. DEMOGRAPHIC INFORMATION

1. Individual's Full Name	2. Sex		3. Medicaid Number	4. Medicare Number
	F	M		
5. Address (Including Street/Box, City, State & Zip)				6. Private Insurance
7. County	8. Social Security Number	9. Birthdate (M/D/Y)	10. Age	11. Phone Number
12. Spouse's Name		13. Address (If different from above)		

14. Current living arrangements, including formal and informal support (i.e., family, friends, other services)

_____

_____

15. Name and Address of Provider, if applicable:

_____

_____

16. Medicaid Waiver Recipient a. ☐ Yes b. ☐ No c. ☐ Aged/Disabled d ☐ MR/DD

17. Has the option of Medicaid Waiver been explained to the applicant? a. ☐ Yes b. ☐ No

18. For the purpose of determining my need for appropriate services, I authorize the release of any medical information by the physician to the Department of Health and Human Resources of its representative.

✗_____ / _____ / _____

SIGNATURE - Applicant or Person acting for Applicant Relationship Date

19. Check if Applicant has any of the following:

a. ☐ Guardian d. ☐ Power of Attorney g. ☐ Other _____

b. ☐ Committee e. ☐ Durable Power of Attorney

c. ☐ Medical Power of Attorney f. ☐ Living Will

Name & Address of the Representative_____

_____

_____

Phone: (____) _____ -_____

DATE:_____

II. MEDICAL ASSESSMENT

NAME:_____

20. Health Assessment - Include infectious diseases, nutritional needs, prior treatments, degenerative conditions, recent hospitalization(s), and/or surgery(ies) with dates - Date of most recent office visit. (Attach most recent Hospital Discharge Summary and Physical, if available)

_____
_____
_____
_____

21. Normal Vital Signs for the individual:

a. Height	b. Weight	c. Blood Pressure	d. Temperature	e. Pulse	f. Respiratory Rate

22. Check if Abnormal:

a. ☐ Eyes
b. ☐ Ears
c. ☐ Nose
d. ☐ Throat
e. ☐ Mouth
f. ☐ Neck
g. ☐ Breasts
h. ☐ Lungs
i. ☐ Heart
j. ☐ Arteries
k. ☐ Veins
l. ☐ Lymph System
m. ☐ Extremities
n. ☐ Abdomen
o. ☐ Hernia(s)
p. ☐ Genitalia-male
q. ☐ Gynecological
r. ☐ Ano-Rectal
s. ☐ Musculo-Skeletal
t. ☐ Skin
u. ☐ Nervous System
v. ☐ Allergies (Specify)_____

Describe abnormalities and treatment:

_____
_____
_____

23. Medical Conditions/Symptoms: [Please Grade as : (1) - Mild, (2) - Moderate, (3) - Severe]

a. ☐ Angina-rest ___
b. ☐ Angina-exertion ___
c. ☐ Dyspnea ___
d. ☐ Significant Arthritis ___
e. ☐ Paralysis ___
f. ☐ Dysphagia ___
g. ☐ Aphasia ___
h. ☐ Pain ___
i. ☐ Diabetes ___
j. ☐ Contracture(s) ___
k. ☐ Mental Disorder(s) ___
l. ☐ Other (Specify) _____

24. Decubitus a. ☐ Yes b. ☐ No If yes, check the following:

A. Stage _____ B. Size _____ C. Treatment _____

Location: a. ☐ Left Leg b. ☐ Left Arm c. ☐ Right Leg d. ☐ Right Arm e. ☐ Left Hip f. ☐ Left Buttock g. ☐ Right Hip h. ☐ Right Buttock

Other _____ Developed at: a. ☐ Home b. ☐ Hospital c. ☐ Facility

25. In the event of an emergency, the individual can vacate the building: (check only one)

a. ☐ Independently b. ☐ With Supervision c. ☐ Mentally Unable d. ☐ Physically Unable

DATE: _____
NAME: _____

26. Indicate individual's functional ability in the home for each item with the level number 1, 2, 3, 4, or 5. Nursing care plan must reflect functional abilities of the client in the home.

Item	Level 1	Level 2	Level 3	Level 4
a.__ Eating (not a meal Prep)	Self/Prompting	Physical Assistance	Total Feed	Tube Fed
b.__ Bathing	Self/Prompting	Physical Assistance	Total Care	
c.__ Dressing	Self/Prompting	Physical Assistance	Total Care	
d.__ Grooming	Self/Prompting	Physical Assistance	Total Care	
e.__ Cont./Bladder	Continent	Occas. Incontinent*	Incontinent	Catheter
f. __ Cont./Bowel	Continent	Occas. Incontinent* *less than 3 per wk.	Incontinent	Colostomy
g.__ Orientation	Oriented	Intermittent Disoriented	Totally Disoriented	Comatose (Level 5)
h.__ Transferring	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
i.__ Walking	Independent	Supervised/Assistive Devise	One Person Assistance	Two Person Assist.
j.__ Wheeling	No Wheelchair	Wheels Independently	Situational Assistance (Doors, etc.)	Total Assistance
k.__ Vision	Not Impaired	Impaired /Correctable	Impaired/Not Correctable	Blind
l.__ Hearing	Not Impaired	Impaired/Correctable	Impaired/Not Correctable	Deaf
m.__ Communication	Not Impaired	Impaired/Understandable	Understandable with Aids	Inappropriate/None

27. Professional and technical care needs (check all that apply).

a. ☐ Physical Therapy
b. ☐ Speech Therapy
c. ☐ Occupational Therapy
d. ☐ Inhalation Therapy
e. ☐ Continuous Oxygen
f. ☐ Ostomy
g. ☐ Suctioning
h. ☐ Tracheostomy
i. ☐ Ventilator
j. ☐ Dialysis
k. ☐ Parenteral Fluids
l. ☐ Sterile Dressings
m. ☐ Irrigations
n. ☐ Special Skin Care
o. ☐ Other _____

28. Individual is capable of administering his/her own medications (check only one).

a. ☐ Yes b. ☐ With Prompting/Supervision c. ☐ No Comment:_____

29. Current Medications	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

DATE:_____

III. MI/MR ASSESSMENT

NAME:_____

30. Current Diagnoses (Check all that apply)

a. ☐ None
b. ☐ Mental Retardation
c. ☐ Autism
d. ☐ Seizure Disorder (Age at onset: _____)
e. ☐ Cerebral Palsy
f. ☐ Other Developmental Disabilities (Specify: _____)
g. ☐ Schizophrenic Disorder
h. ☐ Paranoid Disorder
i. ☐ Major Affective Disorder
j. ☐ Schizoaffective Disorder
k. ☐ Affective Bipolar Disorder
l. ☐ Tardive Dyskinesia
m. ☐ Major Depression
n. ☐ Other related conditions (Specify:_____)

Date of last PASARR Level II Evaluation_____

31. Has an individual ever received services from an agency serving persons with mental retardation/developmental disability and/or mental illness? ☐ Yes ☐ No If yes, specify agency

Name_____ Address_____
Admission Date _____ Discharge Date _____

32. Has the individual received any of the following medications on a regular basis within the last two years? ☐Yes ☐ No

33. Was this medication used to treat a neurological disorder? ☐Yes ☐ No

☐ Chlorpromazine	☐ Thorazine	☐ Perphenazine	☐ Trilafon	☐ Haloperidol	☐ Haldol
☐ Promazine	☐ Sparine	☐ Fluphenazine	☐ Prolixin	☐ Molindone	☐ Moban
☐ Trifupromazine	☐ Vesprin	☐ Fluphenazine HCl	☐ Permitil	☐ Loxapine	☐ Loxitane
☐ Thioidazine	☐ Mellaril	☐ Trifluphenazine	☐ Stelazine	☐ Clozapine	☐ Clozaril
☐ Mesoridazine	☐ Serentil	☐ Chlorprothixene	☐ Taractan	☐ Procholorperazine	
☐ Actiphenazine	☐ Tindal	☐ Thiothixene	☐ Navane	☐ Compazine	

Medication	Dosage/Route	Frequency	Reason Prescribed	Diagnosis

34. Clinical and Psychosocial Data - Please check any of the following behaviors which the individual has exhibited in the past two years.

a. ☐ Substance Abuse (Identify_____)
b. ☐ Combative
c. ☐ Withdrawn/Depressed
d. ☐ Hallucinations
e. ☐ Delusional
f. ☐ Disoriented
g. ☐ Bizarre Behavior
h. ☐ Bangs Head
i. ☐ Sets Fires
j. ☐ Displays Inappropriate Social Behavior
k. ☐ Seriously Impaired Judgment
l. ☐ Suicidal Thoughts, Ideations/Gestures
m. ☐ Cannot Communicate Basic Needs
n. ☐ Talks About His/Her Worthlessness
o. ☐ Unable to Understand Simple Commands
p. ☐ Physically Dangerous to Self and Others, if Unsupervised
q. ☐ Verbally Abusive
r. ☐ Demonstrates Severe Challenging Behaviors
s. ☐ Specialized Training Needs
t. ☐ Sexually Aggressive

Does the individual have Alzheimer's, multi-infarct, senile dementia, or related condition? ☐ Yes ☐ No
Other (Specify) _____

DATE: _____

IV. PHYSICIAN RECOMMENDATION NAME: _____

35. Prognosis - Check one only: a__ Stable b__ Improving c__ Deteriorating d__ Terminal

Other _____

36. Rehabilitative Potential (Check one only) a ___ Good b ___ Limited c___ Poor

37. Diagnosis:

a. Primary _____

b. Secondary _____

c. Other medical conditions requiring services _____

38. Physician Recommendations

A. FOR NURSING FACILITY PLACEMENT ONLY
On the basis of present medical findings, the individual may eventually be able to return home or be discharged.

a ___ Yes b___ No

If yes, check one of the following:

a. □ Less than 3 months
b. □ 3-6 months
c. □ Over 6 months
d. □ Terminal illness

B. I recommend that the services and care to meet these needs can be provided at the level of care indicated.

a. □ Nursing Home
b. □ Nursing Home waiting A/D Waiver
c. □ A/D Waiver
d. □ Personal Care

39. To the best of my knowledge, the patient's medical and related needs are essentially as indicated above (Must be signed by M.D. or D.O.)

_____
Physician's Signature MD/DO

_____
Date This Assessment Completed:

TYPE OR PRINT Physician's name/address below:

_____
_____
_____
_____

DISCLAIMER: Approval of this form does not guarantee eligibility for payment under the State Medicaid Plan.
NOTE: Information gathered from this form may be utilized for statistical/data collection.

V. ELIGIBILITY DETERMINATION DATE: _____

NAME:_____

DEPARTMENT USE ONLY
LEVEL I (Medical Screen)

Medical and other professional personnel of the Medicaid Agency or its designees MUST evaluate each individual's need for admission by reviewing and assessing the evaluations required by regulation.

Exemptions from requirements for Level II Assessment

40. Does the individual have or require:

a. Diagnosis of dementia (Alzheimer's or related disorder)?	**□ Yes**	**□ No**
b. Thirty days of respite care?	**□ Yes**	**□ No**
c. Serious Medical Condition?	**□ Yes**	**□ No**

41. Medical Eligibility Determination:

a. □ Nursing Facility Services/Aged/Disabled Waiver **b. □ Personal Care Services**

c. □ No Services Needed **d. □ Optional Services**

42. PASARR Determination:

a □ Level II required **b □ Level II not required**

_____ _____

Nurse Reviewer's Signature - Title **Date** **Control Number**

Printed Name_____

WAIVER ONLY: Level of Care:_____ **Number of Hours:**_____

DEPARTMENTAL USE ONLY
LEVEL II (MI/MR Screen)
(Completed by PASARR Provider)

43. DETERMINATION:

a. Nursing facility services needed - Specialized services not needed.
b. Nursing facility services needed - Specialized services needed.
c. Alzheimer's or related disorder identified.
d. Thirty day Respite care needed.
e. Terminal illness identified.
f. Serious illness identified.
g. Nursing facility services not needed.

44. RECOMMENDED PLACEMENT:

a. Nursing Facility Services/Aged/Disabled Wavier
b. Psychiatric Hospital (21 years or under)
c. ICF/MR or MR/DD Waiver
d. Other-Identify:_____

_____ _____

PASARR Reviewer's Signature **Title** **Printed Name**

_____ _____

Agency Name **Date**

A COPY OF THIS FORM MUST BE IN THE INDIVIDUAL'S MEDICAL RECORDS