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7201

7201 Payment for Hospital Services - Medical and Psychiatric

Medicaid payment for covered ~~general hospital~~inpatient services is limited to the following ~~providers~~hospitals:

A Vermont ~~general~~ hospital approved for participation in Medicare; or

An out-of-state ~~general~~ hospital, which is approved either for Medicare participation or for Medical Assistance (Title XIX) participation by the single state agency administering the Title XIX program within the state where it is located. Except for the out-of-state ~~general~~ hospitals listed below, reimbursement will be made only if the admission receives prior authorization ~~from the Medicaid Division. For non-emergency inpatient care the prior authorization must be obtained prior to the provision of services; f~~For emergency emergent and urgent inpatient care services, prior to payment. Inpatient emergency is care to prevent death or serious impairment of the health of an eligible recipient, notification is required within 24 hours of admission or the next business day. For all other inpatient care an authorization must be obtained prior to the provision of services. Emergent and urgent care is defined in Medicaid Rule 7101.3.

The following ~~general~~ hospitals will be considered to be Vermont hospitals due to their close proximity to Vermont and the fact that it is the general practice of residents of Vermont to secure care and services at these ~~facilities~~hospitals:

Alice Peck Day Hospital, Lebanon, NH
Cottage Hospital, Woodsville, NH
Dartmouth Hitchcock Medical Center, Lebanon, NH
Glens Falls Hospital, Glens Falls, NY
Littleton Hospital, Littleton, NH
Mary Hitchcock Memorial Hospital, Hanover, NH
Mary McClellan Hospital, Cambridge, NY
North Adams Hospital, No. Adams, MA
Upper Connecticut Valley Hospital, Colebrook, NH
Valley Regional Hospital, Claremont, NH
Weeks Memorial Hospital, Lancaster, NH
~~Mary McClellan Hospital, Cambridge, NY~~
~~Mary Hitchcock Memorial Hospital, Hanover, NH~~
~~Littleton Hospital, Littleton, NH~~
~~Weeks Memorial Hospital, Lancaster, NH~~
~~Valley Regional Hospital, Claremont, NH~~
~~Cottage Hospital, Woodsville, NH~~
~~Upper Connecticut Valley Hospital, Colebrook, NH~~
~~Emma L. Stevens Hospital, Granville, NY~~
~~Glens Falls Hospital, Glens Falls, NY~~
~~North Adams Hospital, No. Adams, MA~~
~~Alice Peck Day Hospital, Lebanon, NH~~

~~Prior authorization is required for all admissions to the above hospitals if the diagnosis is related to~~

~~psychological or emotional disorders.~~

Payment for inpatient ~~general~~ hospital services is limited to those instances in which the admission and continued stay of the ~~patient~~ beneficiary are determined medically necessary by the appropriate utilization review authority.

Payment may also be made to a Vermont ~~general~~ hospital for inpatients who are determined no longer in need of hospital care but have been certified for care in a Skilled Nursing Facility ~~(Level I) or Intermediate Care Facility (Level II) services.~~ (See Medicaid Rule 76087606).

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7202.2 (M512)

7202.2 Dental Procedures

Payment of inpatient hospital services related to dental procedures is made only in the following situations:

For ~~recipients~~-beneficiaries age 21 and over:

When a covered surgical procedure is performed (see Section 7312); or

When prior authorization has been granted by the ~~Medicaid Division~~Office of Vermont Health Access in a case where hospitalization was required to assure proper medical management or control of non-dental impairment during performance of a non-covered dental procedure (e.g., a ~~patient~~-beneficiary with a history of repeated heart attacks must have all ~~his~~-their other teeth extracted) and need for such hospitalization is certified by the physician responsible for the treatment of the non-dental impairment. Should the ~~patient~~-beneficiary already be hospitalized for the treatment of a medical condition and a non-covered dental procedure is performed during the hospital stay, the prior authorization is not required. In these instances hospital and anesthesia charges are covered, but the services of the dentist performing the dental services are not.

For ~~recipients~~-beneficiaries under the age of 21:

When prior authorization has been granted by the ~~Office of Vermont Health Access~~Medicaid Division before the provision of services in cases where dental treatment was performed and the dental consultant certified that the ~~patient~~-beneficiary required hospitalization either for management of other medical conditions or to undergo dental treatment.

7202.3 Psychiatric Care

Inpatient psychiatric services provided in a ~~general~~-hospital are covered to the same extent as inpatient services related to any other type of care or treatment. ~~Prior authorization is required for such care rendered in an out-of-state or border hospital.~~Authorization requirements are defined in Rule 7201.

7202.4 Care of Newborn Child

For a period of seven days or until the mother is discharged, whichever is earlier, billing of post-delivery care for the newborn child of an eligible mother must be on a separate claim~~may be included with the mother's inpatient care~~ using the mother's Medicaid identification number. Nursery days of care must be identified separately in the itemized listing of services rendered to both mother and child.

Payment for medically-necessary, continuing inpatient care of an infant, beginning with the eighth day of post-natal care or the day of mother's discharge if earlier, requires application for and determination of the infant's eligibility, a separate Medicaid identification number and separate billing.

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7601

7601 Long-Term Care ~~Institutions~~Services

These regulations apply to all long-term care services for Medicaid beneficiaries of any age. For beneficiaries age 18 or over, rRegulations promulgated by the Department of Disabilities, Aging, and Independent Living (DAIL) ~~servicing aged and disabled individuals~~ through the “Choices for Care: 1115 Long-Term Care Medicaid Waiver” program (Social Security Act Section 1115 Demonstration Project Number 11-W-00191/1) shall be controlling if they conflict to the extent they are inconsistent with the provisions in the is 7600 chapter (7601-7606), including: 7601.2, 7605.2, 7605.5, 7605.6, 7605.7, 7606, 7606.1, and 7607.

~~7601.1~~ Definitions

The Medicaid Program (Title XIX) includes ~~vendor payments for~~ long-term care ~~of eligible recipients~~ in services provided to eligible beneficiaries in the following settings.

A. Skilled Nursing Facilities (SNF's)

A Nursing Facility provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24-hour a day basis to assist beneficiaries to reach their optimal level of functioning.

All nursing facilities, pursuant to Section 1910(2) of the Social Security Act, have been certified for participation in Medicare, or if not participating in Medicare, have been continuously certified since July 1, 1980 for participation as a nursing facility as evidenced by a valid certification agreement on file with the Office of Vermont Health Access.

An out-of-state ~~SNF~~ nursing facility must be participating in that ~~State's~~ state's Medicaid ~~Program~~ program as well as enrolled as a Vermont Medicaid provider. ~~An in-state nursing or a facility (or distinct part of a facility) licensed by the Vermont Department of Health DAIL, and which pursuant to Section 1910(2) of the Social Security Act, has been certified for participation in Medicare, or if not participating in Medicare, has been continuously certified since July 1, 1980 for participation as an SNF as evidenced by a valid certification agreement on file with the Department of Social Welfare. An SNF provides, directly or by contract, room, board, skilled nursing and rehabilitation services on a 24 hour a day basis to assist patients to reach their optimal level of functioning-enrolled as a Vermont Medicaid provider, in order to be reimbursed.~~

1. Rehabilitation Center Services

Coverage of ~~Rehabilitation~~ rehabilitation ~~Center-center~~ Services ~~services~~ is limited to Medicare- certified nursing facilities, licensed by, and approved for participation ~~in~~ by the ~~Medicaid program in the S~~ state in which the facility is located, and enrolled ~~as a in the~~ as a Vermont Medicaid ~~program~~ provider. These services include intensive sensory stimulation; intensive physical, speech and occupational therapy; adjustment counseling; training in the use of prosthetics, orthotics and durable medical equipment; and other medical services needed to improve the patient's daily living skills and/or to facilitate recuperation from disease, injury, or medical event. Care ~~is~~ must be supervised by physician specialists. The purpose of rehabilitation center services is to restore a ~~patient~~ beneficiary's functional abilities to the highest practical level of physical and/or mental self-sufficiency which will prepare the ~~patient~~ beneficiary for discharge. The discharge plan will provide for the active participation and training of family members, if appropriate.

~~Rehabilitation centers must receive authorization from the Medicaid Director or a designee prior to admission or for those with insurance benefits before the expiration of such benefits. Reauthorizations for continued Medicaid coverage are required at three-month intervals after initial authorization. Requests for reauthorization must be received no later than thirty days before the expiration of an authorized period of coverage.~~

Coverage is limited to one year ~~except that~~unless an extension beyond one year ~~may be~~is granted by DAIL when ~~there is~~ documented medical evidence shows that the ~~patient~~beneficiary is continuing to demonstrate significant physical and/or mental progress and can reasonably be expected to be discharged to the setting for care established in the discharge plan. Under no condition will authorization be made beyond two years.

~~Reimbursement for authorized periods of coverage for rehabilitation center services is made at the lowest of a) the amount charged, b) a negotiated rate, or c) the Medicaid rate as paid by at least one other State Medicaid agency in HCFA Region I.~~

~~Intermediate Care Facilities (ICF's)~~

~~A facility (or distinct part of a facility) which is licensed by the Vermont Department of Health and certified for participation in the Vermont Medicaid Program (or an out-of-state facility participating in that state's Medicaid Program) for the provision of Intermediate Care Facility (ICF) services as evidenced (for in-state facilities) by a valid certification agreement on file with the Department of Social Welfare executed under Section 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and F. An ICF provides directly or by contract, health-related care and services to individuals who do not require the degree of care and treatment that an SNF is designed to provide but who do require care above the level of room and board that can be made available only in institutional facilities.~~

~~Psychiatric Facilities~~

~~A facility or program provided in accordance with the requirements of 42 CFR Subpart D of Part 441 and accredited by JCAH for the purpose of serving children and adolescents under 21 years of age.~~

~~Mental Hospitals~~

~~An institution for mental disease as defined in 1905(a)(14) of the Social Security Act, which is located in Vermont and certified for participation in Medicare which is primarily engaged in providing inpatient psychiatric services for the diagnosis and treatment of mentally ill patients.~~

~~Rehabilitation Center Services~~

~~Coverage of Rehabilitation Center Services is limited to Medicare-certified nursing facilities, licensed by, and approved for participation in the Medicaid program in the State in which located and enrolled in the Vermont Medicaid program. These services include intensive sensory stimulation; intensive physical, speech and occupational therapy; adjustment counseling; training in the use of prosthetics, orthotics and durable medical~~

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7601 pg 2B. Intermediate Care Facilities for the Mentally Retarded (ICF-/MR's)

A public or private institution (or distinct part thereof) ~~which is licensed by the Vermont Department of Health and~~ certified for CMS participation by DAIL's Division of Licensing and Protection, in the Vermont Medicaid Program for the provision of Intermediate Care Facility services for the Mentally Retarded (ICF-/MR), as evidenced by a valid certification agreement on file with the ~~Department of Social Welfare~~Office of Vermont Health Access (OVHA) executed under 1902(a)(27) of the Social Security Act and 42 CFR 442, Subparts A, B, C, E and G. ~~An ICF-MR provides directly or by contract, health-related care and services to mentally retarded individuals who do not require the degree of care and treatment that an SNF is designed to provide but who do require care above the level of room and board that can be made available only in institutional facilities.~~ An ICF/MR provides, directly or by contract, health-related care and services to individuals with mental retardation.

C. Home and Community-Based Services

Home and Community-Based Services include long-term care services provided in a home setting or an enhanced residential care setting. An individualized written service plan shall be developed for each participant. Services may include assistance with Activities of Daily Living, Instrumental Activities of Daily Living, Adult Day Service, Respite, Companion Service, Personal Emergency Response System, Home Modification/Assistive Devices, and other such services as DAIL may include (Choices for Care Regulations).

~~Vermont
Social Welfare~~

~~POLICY~~

~~Medicaid~~

~~10/1/83~~

~~Bulletin No. 83-14~~

~~7601.2~~

~~7601.2~~ Medical Review Systems

~~Vermont Department of Health—Medical Care Regulation Division—The Medical Care Regulation Division of the Vermont Department of Health performs reviews in SNF's and ICF's (excluding ICF-MR's) to determine that:~~

- ~~—Health care services are medically necessary;~~
- ~~—The quality of such services meet professionally recognized standards of health care; and~~
- ~~—These services are provided in the most economical setting.~~

~~Mental Health Professional Review Team—Professional Review Teams are composed of members with experience in mental illness, medical care and/or mental retardation as appropriate who review admissions and continued stays in ICF/MR's and psychiatric facilities to assure that:~~

- ~~—Services are medically necessary;~~
- ~~—No less restrictive alternative exists; and,~~
- ~~—For the purpose of recertification, the quality of such services meet professionally recognized standards of care.~~

7602

Per Diem Rates and Payment Conditions

~~The Division of Rate Setting of the Agency of Human Services, pursuant to 33 VSA §193, certifies to the Commissioner of Social Welfare prospective per diem rates to be utilized in reimbursing for care in each participating Skilled Nursing Facility, and Intermediate Care Facility.~~

~~Payment for authorized care furnished to a Vermont Medicaid recipient by a certified out-of-state SNF or ICF will be made at the per diem rate established by that state's single state agency for Medicaid. However, no retroactive adjustments will be made in payments to an out-of-state facility for recipients admitted after July 1, 1982.~~

~~Effective July 1, 1983, a per diem rate for the purpose of reimbursing for Level I or Level II care furnished in Vermont general hospitals (see 7201) will be established by the Division of Rate Setting. The rate will be in effect for care provided during the fiscal year beginning on that date. These per diems will be recalculated for each successive fiscal year. No retroactive adjustments will be made in payments to Vermont general hospitals for Level I and Level II care.~~

~~Per diem rates for Intermediate Care Facilities for the Mentally Retarded, Brandon Training School, and Vermont State Hospital are established by the Secretary of Human Services or his/her designee.~~

~~Payment will not be authorized for Level I care provided in a "Medicaid Only" (i.e., one which is not concurrently participating in Medicare) SNF if it is deemed such care would have been covered, in whole or in part, by Medicare were the SNF participating in Medicare. Recovery will be sought in cases where payment was incorrectly made under this provision.~~

~~In accordance with 42 CFR 441.11 payment may be made for care furnished no more than 30 days following termination or expiration of a facility's provider certification agreement.~~

7602.1 Billings for Long Term Care

Long term care is paid for through a monthly invoice system, based on authorization and per diem rates established for each facility.

~~Long term care facilities shall bill the fiscal agent each month on invoice forms provided. After audit against eligibility files and current authorizations, bills are paid through regular fiscal agent disbursement procedures. Similarly, the facility will reconcile adjustments arising from incorrect patient share payments, erroneous per diem rate, etc., through the fiscal agent billing process.~~

~~Any balance of patient applied income remaining for any reason other than an error which must be corrected through the adjustment process with the fiscal agent shall be reimbursed to the Department of Social Welfare. Patient share payment balance remaining at the time of transfer, discharge or death shall be reimbursed to the Department of Social Welfare provided that the Department has paid benefits on behalf of that recipient in an amount equal to or greater than the amount of the balance. When the Department has not paid Medicaid benefits on behalf of a recipient in an amount equal to or greater than the credit balance, an appropriate return will be made to the recipient, his legal guardian, or to the client's estate.~~

~~Any credit balance of the patient's share because of payment at the wrong per diem rate or incorrect applied income taken must be corrected.~~

7602.2 Supplementation Prohibition

Federal regulations requires ~~that all Medicaid~~ providers of long-term care services to ~~Medicaid beneficiaries~~ accept the Medicaid payment as payment in full. For example, if a facility elects to serve Medicaid beneficiaries and the facility's customary charge for a semi-private ~~bed room~~ is \$~~110250.00~~, but the Medicaid payment is \$~~100200.00~~ per day, the Medicaid payment must be accepted as payment in full. The facility cannot collect any supplemental amount for the semi-private ~~bed room~~ from the ~~patient beneficiary~~ or anyone else acting on behalf of the ~~patient beneficiary~~. If the beneficiary, or anyone acting on behalf of the beneficiary, requests to have a private room, the facility cannot charge more than the difference between the charges for a semi-private and a private room. In no case can the total payments for a private room exceed the charge for a private room.

Federal regulations also describe ~~the specific~~ items and services for which a facility may charge residents extra. Beyond these items and services, supplementation by the ~~patient beneficiary~~, family, friends or any other source is prohibited.

~~If the patient, or anyone acting on behalf of the patient, wishes to have a private room, the facility cannot charge more than the difference between the "charges" for a semi-private and a private room. In no case can the total payments for a private room exceed the charge for a private room.~~

Federal regulations also require that Medicaid ~~residents beneficiaries~~ be informed, in writing, by the facility, at the time of admission to the nursing facility or when they become eligible for Medicaid, of the items and services that the facility offers and for which the ~~resident beneficiary~~ may be charged, as well as the amount of charges for those services. The Division of Licensing and Protection within ~~the Department of Aging and Disabilities~~ DAIL is responsible for enforcing this ~~requirement~~ regulation.

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7603 Daily Care Services Covered in a Nursing Facility

The following covered services are included in the p~~Per diem rates established in accordance with Section 7602 cover the following daily care services:~~ for nursing facilities.

- A. ~~Room and board;~~
- B. ~~Required nursing services (except private duty nurses);~~
- C. ~~Therapy services (physical, occupational, inhalation, recreational, etc.) furnished on the premises by staff employed by the facility;~~
- D. ~~Modification of diet (i.e., salt free, low-fat, diabetic and other special diets and including sugar substitutes and food supplements).~~
- E. ~~Other special care~~ charges services including, but not limited to: ~~often listed as~~ hand feeding, incontinency incontinence care, total care, full-time care, etc.;
- F. ~~Washing personal clothing and provision of clean bedding;~~
- G. ~~Bathroom supplies including toothbrush, comb, soap, shampoo, tissue, rubbing alcohol, toothpaste, lotions, talcums and similar preparations used in daily care;~~
- H. ~~Bedding, sheets, disposable pads, etc.;~~
- I. ~~All~~ prescribed ~~over-the-counter~~ medicinals drugs ~~prescribed by the physician;~~
- J. ~~Sterile water, saline solution, etc.;~~
- K. ~~All medical supply items ordered by the physician; and~~
- L. ~~Use of durable medical equipment with whatever frequency is medically indicated.~~

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7603.1

7603.1 Drugs in Long-Term Care Facilities

For those Medicaid beneficiaries entitled to Medicare Part A or enrolled in Medicare Part B and enrolled in a Medicare prescription drug plan, this section applies only to drugs not included in a Medicare-covered prescription drug class.

Drugs prescribed by the attending physician for a beneficiary in a ~~NF~~nursing facility; ~~or an~~ ICF/MR ~~or a~~ psychiatric facility are covered in the same manner as for a beneficiary living in the community. Covered drugs are those available only with a prescription, ~~secured~~obtained from a participating pharmacy, and billed directly by that pharmacy to the Medicaid fiscal agent; the pharmacy cannot bill the nursing ~~home~~facility and the ~~home~~facility then re-bill Medicaid. An exception is made for a ~~Medicare-Medicare~~-participating ~~NF~~nursing facility which must collect first from Part A for covered drugs supplied as an ancillary service during the period a beneficiary is receiving ~~NF~~nursing facility benefits under Medicare Part A.

All prescribed over-the-counter drugs ~~ordered by physicians~~ for their ~~patients~~residents are to be furnished and paid for by each nursing facility~~NF~~; ~~or~~ ICF/MR ~~or psychiatric facility~~. The facility will ~~secure~~obtain these drugs from a pharmacy or drug wholesaler and enter the charges incurred in the cost report submitted for purposes of calculating the per diem rate. The facility ~~may~~shall not make a charge either to the program or to the beneficiary for prescribed over-the-counter drugs.

A pharmacy may, however, receive payment directly from a nursing facility~~NF~~; ~~or an~~ ICF/MR; ~~or Psychiatric Facility~~ for reasonable costs incurred for unit dose or other systems, consulting services, or other costs incurred by the pharmacy in complying with Medicaid Rule 7501.7 and the facility shall include this cost in its cost report.

~~7603.2~~ ~~Drugs in the Vermont State Hospital~~

~~Prescription and over-the-counter drugs prescribed or ordered by a physician for a beneficiary shall be furnished by the facility and entered in its cost report for purposes of calculating the per diem rate.~~

7603.~~3~~2 Personal Comfort Items

Radio, television, telephone, air conditioners, beauty and barber services, and similar personal comfort items are excluded from coverage under Medicaid. The beneficiary may be charged for any personal comfort item when the beneficiary has requested it and has been advised that he or she will be charged. The facility may also charge the beneficiary for store items secured on the beneficiary's behalf such as magazines, newspapers, candy, tobacco, dry cleaning, denture cream, hairbrush, and deodorant.

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7603.3

~~7603.4 — Services in a Non-Medicare Facility (ICF's)~~~~An ICF may contract for certain covered services and receive reimbursement through the daily patient rate mechanism. The facility must exercise professional responsibility over the arranged for services.~~7603.53 Ancillary Services in a Medicare-Participating Nursing Facility (SNF)

A ~~Skilled Nursing-nursing Facility facility (SNF)~~ participating in Medicare must bill under Medicare Part B of that program for the following services provided to ~~its inpatient~~beneficiaries when that ~~inpatient~~beneficiary has exhausted his or her extended care coverage under Medicare Part A. For beneficiaries not covered by Medicare, billing Medicaid for these ancillary services is allowed.

- A. ~~diagnostic X-ray, diagnostic laboratory and other diagnostic tests;~~
- B. ~~X-ray, radium and radioactive isotope therapy;~~
- C. ~~surgical dressings, splints, cast and other devices used to reduce fractures;~~
- D. ~~prosthetic devices;~~
- E. ~~leg, arm, back and neck braces;~~
- F. ~~"outpatient" physical therapy and speech therapy services. Payment for outpatient physical therapy and speech therapy services requires certification by a physician that:~~
 1. ~~Therapy services are or were required on an outpatient basis; and~~
 2. ~~A plan for furnishing the therapy services is or was established and reviewed periodically by the physician; and~~
 3. ~~The services are or were furnished while the patient was under care of a physician.~~

Therapy services furnished by a provider's employees to its ~~own inpatients~~residents may not be billed as outpatient services.

~~7603.5~~ Services Provided By a Medicare Participating Facility (SNF) (Continued)

~~Billing for any of these services furnished to Medicaid recipients concurrently covered by Medicare Part B will be done on form SSA-1483; for Medicaid recipients not covered by Medicare Part B billing will be done on the appropriate Vermont Medicaid outpatient billing form.~~

A ~~Skilled N~~nursing ~~F~~rfacility participating in Medicare may provide, under arrangements with another provider, certain covered outpatient services to its ~~inpatients~~residents. Under the arrangements the ~~SNF~~SNF nursing facility must exercise professional responsibility over the arranged-for services. The services would be treated just as though they were furnished directly by the ~~SNF~~SNF nursing facility. ~~The supplier bills the facility for the ancillary or auxiliary services provided under arrangements, itemizing each service by individual patient and by date and charge. The facility will in turn bill the Medicare Program for the services provided to each patient.~~

~~When services are provided without special arrangements, the participating supplier of covered outpatient services may bill directly for services furnished to inpatients of a nursing home. For example, a hospital would bill directly for an X-ray taken in its outpatient department of an individual who was an inpatient of a nursing home. In such an instance, the inpatient of one medical facility (the nursing home) is deemed to be an outpatient of another facility (the hospital). The standard outpatient billing forms are utilized.~~

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7604

7604 Duration of Coverage

Payment on behalf of an eligible ~~recipient~~beneficiary, for the period(s) ~~(s)he~~the beneficiary is determined to be in need of institutional care, will begin on admission to the facility or the first day of Medicaid eligibility, whichever is later. Payment will end on the day before the day of discharge or death, the last day ~~(s)he~~the beneficiary is determined to need institutional care or the last day of eligibility, whichever is earliest.

Payment ~~is discontinued~~will end for any absence from ~~any~~ facility for an inpatient stay in another medical facility (i.e., ~~general~~ hospital, psychiatric hospital, another nursing ~~home~~facility) except as provided ~~in~~below (7604.~~2~~1.B).

7604.1 Nursing Home-Leave of Absence from a Nursing FacilityA. Home Visit

Payment to a nursing ~~home~~facility on behalf of an eligible Medicaid ~~recipient~~beneficiary is continued during an absence for the purpose of a "home visit" (not including hospital stays) for up to 24 home visit days in a calendar year. ~~No payment will be made for home visit days beyond 24 in a calendar year.~~A home visit is defined as a visit that includes an overnight stay. Such absences must be included in the beneficiary's plan of care.

~~Each home visit day is counted as a patient day for cost reporting purposes.~~

B. Hospitalization

Pursuant to the Nursing Home Residents' Bill of Rights (33 V.S.A. §§7301-7306), a Medicaid beneficiary has the right to retain his or her bed in a nursing facility while absent from the facility due to hospitalization provided such absence does not exceed ten (10) successive days.

Medicaid payment will be made to a nursing facility that is not a swing bed facility for up to a maximum of six (6) successive days when the bed of a beneficiary is retained because the beneficiary is admitted as an inpatient to a hospital subject to the following conditions:

1. the nursing facility would otherwise be at its maximum licensed occupancy if the operator were not obligated to hold the bed open;
2. the recipient continues to meet Medicaid eligibility criteria;
3. the beneficiary has been an inpatient resident of the nursing facility and was admitted directly to the hospital;
4. the nursing facility has a valid provider agreement in effect on the dates of service for which payment is made;
5. the beneficiary's attending physician attests that the beneficiary is expected to be readmitted to the nursing facility from the hospital in ten (10) days or less, or, upon notice supplied by the hospital discharge planning unit to the nursing facility that the beneficiary will be discharged with an absence which shall not exceed ten successive days; and

6. documentation as required above (#3) is provided to OVHA, and is on file at the nursing facility.

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7604.1

7604.2-1 Leave of Absence from a Nursing Facility (Continued)~~Absence Due to Hospitalization~~

~~Pursuant to 33 V.S.A. 7301(19), Nursing Home Residents' Bill of Rights, and the 1995 Budget Act authorized by the General Assembly, a Medicaid recipient has the right to retain his or her bed in a nursing home while absent from the facility due to hospitalization provided such absence does not exceed ten successive days.~~

~~Medicaid payment will be made to a nursing home that is not a swing bed facility for up to a maximum of six successive days when the bed of a recipient is retained because the recipient is admitted as an inpatient to a hospital subject to the following conditions:~~

- ~~(a) — the nursing home would otherwise be at its maximum licensed occupancy if the operator were not obligated to hold the bed open,~~
- ~~(b) — the recipient continues to meet Medicaid eligibility criteria,~~
- ~~(c) — the recipient has been an inpatient resident of the nursing home and was admitted directly to the hospital.~~
- ~~(d) — the nursing home has a valid provider agreement in effect on the dates of service for which payment is made,~~
- ~~(e) — the recipient's attending physician attests that the recipient is expected to be readmitted to the nursing home from the hospital in ten days or less, or, upon notice supplied by the hospital discharge planning unit to the nursing home that the recipient will be discharged with an absence which shall not exceed ten successive days, and~~
- ~~(f) — documentation as required in (e) above is provided to the Medicaid Division, and is on file at the nursing home.~~

Payment for the days the bed is retained for the recipient beneficiary will be made at the certified Medicaid per diem rates established for the nursing home facility reduced by the amount, if any, of the recipient's beneficiary's share.

No payment will be made when a physician or hospital discharge planning unit makes a determination that the recipient beneficiary will be hospitalized for more than ten (10) successive days, ~~or~~ will never return to the nursing home facility, or ~~either~~ the recipient beneficiary, the next of kin, or legal representative guardian agrees to waives the right to have his or her bed retained.

When a redetermination about the length of stay is made because of a change in the recipient beneficiary's medical condition, payment will be made in accordance with the redetermination.

Each day reimbursed under this regulation is counted as a patient day for cost reporting purposes and must be reported separately from home visit days.

~~The Department will grant exceptions to the documentation requirements to allow payment to be made in cases where the patient was absent due to hospitalization and the bed was retained by the nursing home for dates of service covered by the period preceding the adoption of this rule.~~

7604.32 Leave of Absence ~~in~~ from an ICF/MR's

Payments to an ICF/MR on behalf of an eligible beneficiary is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the beneficiary's current service agreement. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per year shall be obtained in advance from DAIL.

~~Requirements for Medicaid payment shall be made to an ICF/MR for an eligible beneficiary during a leave of absence, subject to the following conditions include:~~

- A. Any day for which the facility is paid to hold a bed open must be counted as a patient day and the revenue must be accounted for as a patient revenue.
- B. The day of departure shall be counted as one day of leave and the day of return shall be counted as one day of inpatient care.
- C. The facility shall hold the bed vacant during leave.
- D. The beneficiary's return from leave shall not be followed by discharge within 24 hours.
- E. ~~Form DSW 289A, Leave of Absence Report, shall identify the inclusive dates of leave.~~ The facility shall identify the inclusive dates of leave in the manner designated by the Department.
- F. Leave shall be terminated on the day of death.

~~Payments to an ICF/MR on behalf of an eligible recipient is continued for an absence of up to fifteen (15) days per quarter or sixty (60) days per year for the purpose of "home visit" providing it is consistent with and part of the resident's current habilitation plan. Approval for an absence for the purpose of a "home visit" in excess of fifteen (15) days per quarter or sixty (60) days per annum shall be obtained in advance from the Commissioner of Mental Health.~~

~~The Department of Mental Health shall withhold such approval if:~~

- ~~— The resident's habilitation plan does not specifically provide for the amount of absence requested; or~~
- ~~— The extent of absence suggests that continued ICF/MR placement is inappropriate; or~~
- ~~— The resident's habilitation plan is not current or has not been reviewed in accordance with federal regulations.~~

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7605 Patient Classifications

~~Patient classification shall be determined by the appropriate medical review system and will determine the need for one of the following levels of care:~~

~~———— Level I (SNF) care (Vermont Department of Health, Medical Care Regulation Division review).~~

~~———— Level II (ICF) care (Vermont Department of Health, Medical Care Regulation Division review).~~

~~———— ICF/MR (Mental Health Professional Review Team).~~

~~———— Inpatient Psychiatric Care (Mental Health Professional Review Team or Agency Physician).~~

~~———— Mental Hospital Care (Physician).~~

7605.1 Authorization for Long-Term CareA. Nursing Facilities

After DAIL has determined clinical eligibility for long-term care, the Department for Children and Families - Economic Services Division (ESD) determines financial eligibility for long-term care. ESD then~~The Department of Social Welfare~~ furnishes written authorization to long-term care facilities-service providers of financial eligibility for long-term care. Eligibility for long-term care is based on income available for care~~financial eligibility, admission-discharge status, and need for the level of care provided~~clinical eligibility as determined by DAIL. Updated or revised authorizations are issued whenever required by a change in one of the applicable~~se~~ factors changes. The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. Where applicable, such statements shall be reviewed by DAIL in making its determination.

Authorization for payment will be made on behalf of an eligible ~~recipient~~ beneficiary based on a determination of financial eligibility (~~see Sections Medicaid Rules 4100-4400~~), and ~~determinations of medical necessity made by the appropriate review system. The authorization forwarded to the facility by District Office Staff is a duplicate of the notification of benefits sent to the recipients~~clinical eligibility made by DAIL.

No Medicaid payment will be made for services provided by any out-of-state nursing facilities, other than those mentioned below, unless the facility has been enrolled by the OVHA, and the admission authorized by DAIL.

~~For purposes of authorization, the following nursing homes will be treated as in-state facilities and can be utilized by Vermont residents without prior authorization from the Medicaid Division: Some out-of-state nursing facilities are regarded the same as any participating Vermont facility. No prior authorization is needed. The current list of approved facilities can be found on the DAIL web site (<http://dail.vermont.gov/dail-programs/dail-programs-providers/dial-providers-list-ooanf/dail-ooanf-providers-default-page>) or can be requested from the DAIL.~~

Information regarding nursing facility care in a hospital (swing beds), is located in Medicaid Rule 7606.

- ~~Adams Nursing Home, Adams, MA & Williamstown, MA.~~
- ~~Claremont Nursing Home, Claremont, NH.~~
- ~~Coos County Ins., West Stewartstown, NH.~~
- ~~Country Village Health Care Center, Lancaster, NH.~~
- ~~Country Way, Keene, NH.~~
- ~~Crotched Mountain, Greenfield, NH.~~
- ~~Hanover Terrace, Hanover, NH.~~
- ~~Hoosick Falls Health, Hoosick Falls, NY.~~
- ~~Indian River Nursing Home, Granville, NY.~~
- ~~Sweetbrook Nursing Home, Williamstown, MA.~~

~~No Medicaid payment will be made for utilization of any other out-of-state nursing homes unless authorization has been granted by the Medicaid Division prior to admission.~~

~~7605.21. Level Of Care—SNFs, ICFs~~

~~The Vermont Department of Health DAIL has review authority in all SNF's and ICF's (excluding ICF-MRs) for all nursing facilities. In accordance with criteria established by the Vermont Department of Health and approved by the Department of Social Welfare, the Department of Health will determine~~The determination by DAIL shall control notwithstanding any statement by a physician or other health care professional to the contrary. DAIL shall consider:

- The need for a beneficiary's admission to the facility.
- The need for continued stay.
- The level of care required.
- The appropriateness and quality of care received.

~~The individual's continuing need for nursing care or a specific level of care is subject to review, either at such intervals specified by the Utilization Review Plan or upon observation of significant change in his condition and subsequent request by a social worker, by staff of the nursing home or by the recipient or his family. New or updated medical, nursing and social information supplied by the appropriate sources will serve as the basis for a review. Reviews may include face to face observation of the patient in the nursing home.~~

2. Pre-Admission Screening and Resident Review (PASARR)

Pre-admission Screening and Resident Review shall be completed for certain individuals who have been or will be admitted to a nursing facility, as required by federal regulations at 42 CFR §483(c). PASARR shall determine if a person with a diagnosis of mental illness, mental retardation or a related condition requires the care provided in another type of facility, home and community-based care, or specialized services while residing in a nursing facility. The Department of Mental Health shall be responsible for PASARR for those individuals suspected of having a mental illness, or with a diagnosis of mental illness. DAIL shall be responsible for PASARR for those individuals suspected of having mental retardation or a related condition, or

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with a diagnosis of mental retardation or a related condition.

~~7605.3~~ Level of Care – ICF/MRs; Psychiatric Facilities

~~Need for initial admission and continued stay in an ICF-MR shall be made by Mental Health Professional Review Team established by the Department of Mental Health in accordance with appropriate state and federal regulations.~~

~~7605.4~~ Level of Care – Mental Hospitals

~~Admissions to an inpatient psychiatric hospital shall be made in accordance with Title 42 CFR 405.160 and 1814(a)(2)(A) of the Social Security Act. No level of care determination is necessary for purposes of determining eligibility.~~

~~7605.5~~ Pre-Admission Review from Hospitals

~~Level of Care determinations (on Transfer Form 51035) shall be made at the hospital level for a Medicaid recipient or applicant prior to discharge from a hospital to nursing home. Those hospitals with binding review authority (delegation by the PSRO) shall make the level of care determination and that determination shall be binding for payment purposes. Those hospitals who do not have binding review authority shall make determinations, but such determinations are not binding for payment purposes. All Level I and II decisions are subject to monitoring by the Department of Social Welfare.~~

~~7605.6~~ 3. Post-Admission Review

Clinical eligibility for Any any Medicaid recipient beneficiary or applicant residing in or admitted to a nursing home facility shall be reviewed determined by the Vermont Department of Health DAIL within ten (10) days of notification of admission or notification of application. If the recipient beneficiary is found medically clinically ineligible, he or she will be notified by the Vermont Department of Health. No 30 day certification will be granted DAIL.

~~7605.7~~ Determining Need for Continued Stay

~~The Vermont Department of Health shall review Medicaid recipients in accordance with the Department of Social Welfare regulations and the UR Plan. When it is determined that an eligible recipient no longer requires continuous nursing care, coverage may continue through the same day of the following month. Example: The Date of Determination (last date the DSW 282 is signed by appropriate review staff) is March 12, coverage may continue through and including April 12.~~

4. Children in Long-Term Care Facilities

Least restrictive alternate living situations shall be utilized for children under age 18. When necessary, children may be served by nursing facilities in Vermont. All out-of-state nursing facilities are only covered after obtaining prior approval from DAIL. Payment for out-of-state nursing facilities for children will be covered only if there is no less restrictive placement in Vermont, only if deemed necessary by DAIL, and only if the facility is enrolled as a Vermont Medicaid provider.

B. ICF/MRs

Decisions regarding initial admission and continued stay in an ICF/MR shall be made by DAIL in accordance with state and federal regulations.

7606 Request for Reconsideration and Appeal of Level of Care or Termination

If a recipient feels proper consideration has not been given and (s)he disagrees with the Vermont Department of Health Level of Care determination or termination decision, (s)he may file a request for Reconsideration by the Vermont Department of Health. If (s)he does not agree with the reconsideration decision, an Appeal (Review of Reconsideration) may be requested.

REQUEST FOR RECONSIDERATION: If a recipient disagrees with the Vermont Department of Health determination, either because of the Level of Care Determination or because of a termination decision, (s)he must request a reconsideration within two (2) days of receipt of the determination notice. The request for reconsideration must be in writing stating the reasons for disagreement with the determination. The request for reconsideration should be directed to: The Vermont Department of Health, Division of Medical Care Regulations, Licensing and Certification Section, P.O. Box 70, 60 Main Street, Burlington, VT 05401. The Vermont Department of Health will thoroughly review the circumstances and a decision will be rendered regarding the case. Benefits will continue at the same rate as in effect at the time of Request for Reconsideration.

7606.1 Appeal Process - Review of Reconsideration

If an individual is dissatisfied with the Reconsideration determination, the individual has a further right of appeal by filing a request within 30 days of the mailing date of the notice of decision being reconsidered. The request must be written and must state the reasons for disagreeing with the reconsidered determination. The request for an appeal should be directed to Human Services Board, State Office Building, Montpelier, VT 05602. No payment will be made during the appeal process.

7606.2 Appeal Process - Mental Health Facilities

Request for appeals because of medical ineligibility in a mental health facility shall be made in accordance with procedures established by the Department of Mental Health. Requests shall be forwarded to Central Office, Department of Mental Health.

7606.3 Appeal Process - Medicaid Financial Eligibility

Requests for fair hearing regarding financial eligibility shall be handled in accordance with Section 4151-4154 of the Welfare Assistance Manual.

~~7607~~ Appeal Process – Provider Agreement

~~Any SNF or ICF whose provider certification agreement has been denied, terminated or not renewed as a result of the Health Department survey shall, in accordance with 42 CFR Part 431 Subpart D, be given an opportunity for a full evidentiary hearing before the Human Services Board on the denial, termination or renewal. The hearing will include:~~

- ~~— Written notice of the facility of the basis for the decision and disclosure of the evidence on which the decision is taken;~~
- ~~— An opportunity for the facility to appear before the Board to refute the basis for the decision;~~
- ~~— An opportunity for the facility to be represented by counsel or another representative;~~
- ~~— An opportunity for the facility to have its representative be heard in person, to call witnesses and to present documentary evidence.~~
- ~~— An opportunity for the facility to cross-examine witnesses; and,~~
- ~~— A written decision by the Board setting forth the reasons for the decision and the evidence upon which the decision is based.~~

~~7607.1~~ Notice of Voluntary Medicaid Closure

~~Notification of voluntary closing or voluntary withdrawal of participation in the Medicaid program shall be made at least 60 days before the effective date of closing or withdrawal. Notice will be made to Department of Social Welfare and the Department of Health and to each Medicaid recipient (or his/her representative) residing in the facility.~~

~~7607.2~~ Medicaid Closure or Prohibition by the State of Vermont

~~When a facility is closed by a regulatory department of the State of Vermont or is prohibited from Medicaid participation by a regulatory department of the State, the Agency of Human Services or its designated department shall bear responsibility for discharge planning and appropriate placement of Medicaid recipients. No further admissions of Medicaid recipients or applicants shall be permitted after notification of closure or prohibition of participation. The State will not be responsible for the placement of recipients in instances of voluntary closure or withdrawal from the Medicaid program except in instances where the recipient is remanded to the care and custody of the State of Vermont or its designee.~~

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76087606 Level I and Level II Nursing Facility Care In in Vermont General Hospitals - Swing Beds

Payment may be made on behalf of a Medicaid ~~recipient~~ beneficiary who remains ~~confined to a Vermont general~~ residing in a hospital upon determination ~~that he/she no longer needs hospital care but has been found to be in need of either skilled nursing facility (Level I) or intermediate care facility (Level II) services~~ by the Department of Disabilities, Aging, and Independent Living (DAIL) that he/she no longer needs hospital care but has been found in need of nursing facility level of care (swing bed). Such payment will be made only if the following conditions are met:

- A. a. — The ~~individual~~ beneficiary is eligible for Medicaid during the period for which reimbursement is requested.
- B. b. — The ~~individual~~ beneficiary is determined by the appropriate Utilization Review authority to be in need of ~~Level I or Level II nursing facility~~ care for this period.
- C. c. — The ~~individual~~ beneficiary has ~~had~~ a qualifying inpatient hospital stay in the ~~Vermont general~~ hospital seeking ~~Level I or Level II nursing facility~~ payment under these provisions.
- D. d. — The hospital's ~~documentation shows~~ makes a concerted and continuous effort to secure appropriate alternative placement for the ~~beneficiary~~ recipient. No payment will be made in instances in which the ~~Medicaid Division~~ Office of Vermont Health Access establishes that discharge planning efforts have been inadequate; ~~and~~ where payment has already been made, recovery will be sought, ~~and~~.
- E. e. — The ~~patient~~ beneficiary or anyone acting ~~in on~~ his or her behalf has not declined an available bed in an appropriate participating ~~long long-term~~ care facility in the area.

The per diem rate, ~~established under 7602,~~ is all inclusive and ~~covers~~ includes all daily care ~~the covered~~ services as specified in Medicaid Rule 7603. For ~~persons~~ beneficiaries covered by Medicare, billing for ancillary services covered by either Part A or Part B is allowed. For ~~persons~~ beneficiaries not covered by Medicare, billing to Medicaid for ancillary services listed in Medicaid Rule 7603.5-3 is allowed.

Out-of-state pre-approved hospitals with swing bed status are regarded the same as any participating Vermont facility. The current list of approved facilities can be found on the DAIL web site (<http://dail.vermont.gov/dail-programs/dail-programs-providers/dial-providers-list-ooanf/dail-ooanf-providers-default-page>) or can be requested from the DAIL.