

907 KAR 1:022  
Material Incorporated by Reference

Medicaid Nursing Facility Services Manual  
April 2006 Edition

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**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
NURSING FACILITY SERVICES MANUAL**

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**TABLE OF CONTENTS**

---

Section	Page No.
I. INTRODUCTION	
A. Introduction	1.1
B. Fiscal Agent	1.1
C. General Information	1.1
II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM	
A. Policy	2.1
B. Appeal Process for Refund Requests	2.3
C. Timely Submission of Claims	2.4
D. KenPAC	2.4
E. Lock-in Program	2.5
F. EPSDT	2.6
H. EMPOWER Kentucky Initiative	2.6
III. CONDITIONS OF PARTICIPATION	
A. Participation Overview	3.1
B. Provider Freedom of Choice	3.1
C. Medicaid Participation	3.2
D. Resource Assessment	3.2
E. Out-of-Country Nursing Facilities	3.2
F. Out-of-State Nursing Facilities	3.2
G. Disclosure of Information	3.3
H. Termination of Participation and Provider Appeals Rights	3.3
I. Preadmission Screening and Resident Review (PASRR)	3.4
J. Deposits	3.4
K. Utilization Review	3.4
L. Placement	3.7
M. Nurse Aid Training and Competency Evaluation	3.7

**CABINET FOR HEALTH AND FAMILY SERVICES**  
**DEPARTMENT FOR MEDICAID SERVICES**  
**NURSING FACILITY SERVICES MANUAL**  

---

**TABLE OF CONTENTS**

---

Section	Page No.
IV. PROGRAM COVERAGE	
A. Recipient Eligibility	4.1
B. Medical Assistance Identification (MAID) Card	4.1
C. Authorization	4.1
D. Determining Patient Status	4.2
E. Hospice	4.7
IV-A. NURSING FACILITY BRAIN INJURY PROGRAM	
A. Scope of Benefits	4A.1
B. Admission and Continued Stay Reviews	4A.2
C. Provider Participation Requirements	4A.4
D. Additional Requirements	4A.6
IV-B. DISTINCT PART VENTILATOR NURSING FACILITIES	
A. Facility Participation Criteria	4B.1
B. Patient Criteria and Service Characteristics	4B.1
C. Nursing Facility Level of Care	4B.2
D. Ventilator Dependent Criteria	4B.3
V. SCOPE OF SERVICES	
A. Payments	5.1
B. Initiation	5.1
C. Duration	5.1
D. Case-Mix	5.1
E. Medical Prior Authorization Procedure for Medicaid	5.2
F. Covered Services	5.2

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
NURSING FACILITY SERVICES MANUAL**

---

**TABLE OF CONTENTS**

---

Section	Page No.
G. Pharmacy Services	5.8
H. Transportation Services	5.8
I. Vision Services	5.8
J. Benefits Available to Residents Under Title XVIII	5.9
K. Notice of Availability of Income for LTC Waiver/Agency/Hospice (MAP-552)	5.9
L. "Memorandum to Local DSI Office" (MAP-24)	5.11
M. Days	5.11
N. Bed Reservation Policy	5.12

**NURSING FACILITY SERVICES – APPENDIX – FORMS**

- MAP-4105 Application for Transfer Trauma Exemption
- MAP-811 Provider Application
- MAP-726A Nursing Facility Request for Admission
- MAP-524 Medicaid Nursing Facility Services
- MAP-812 Medicaid Provider Enrollment Licensing and Accreditation Checklist
- Provider Agreement Addendum I
- MAP-730 Provider Agreement Addendum II
- MAP-24 Memorandum to Local DCBS
- MAP-552 Notice of Availability of Income for Long-Term Care/Waiver Agency/Hospice
- MAP-350 Instructions and Certification Form
- MAP-573 Program Request Form for Drugs Prior-Authorized for Nursing Facility Residents
- MAP-409 PASRR NF Identification Screen (Level I)
- MAP-4092 Exempted Hospital Discharge Physician Certification of Need for NF Services
- MAP-4093 Provisional Admission to a NF
- MAP-4094 Notification of Intent Refer Level II PASRR
- MAP-4095 Significant Change in Condition Referral
- Contact Regions for PASRR Referrals

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION I- INTRODUCTION**

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**I. INTRODUCTION**

**A. Introduction**

The Kentucky Medicaid Program Nursing Facility Services Manual provides Medicaid providers with a tool to be used when providing services to qualified Medicaid recipients. This manual provides basic information concerning coverage and policy. Precise adherence to policy shall be imperative.

**B. Fiscal Agent**

The Department for Medicaid Services contracts with a fiscal agent for the operation of the Kentucky Medicaid Management Information System (MMIS). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

**C. General Information**

The Department for Medicaid Services shall be bound by both Federal and State statutes and regulations governing the administration of the State Plan. The state shall not be reimbursed by the federal government for monies improperly paid to providers for non-covered, unallowable medical services. Therefore, Kentucky Medicaid may request a return of any monies improperly paid to providers for noncovered services.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

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II. COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM

A. Policy

The basic objective of the Kentucky Medicaid Program shall be to ensure the availability and accessibility of quality medical care to eligible program recipients.

The Medicaid Program shall be the payor of last resort. If the recipient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party shall be primarily liable for the patient's medical expenses. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services provided prior to billing Medicaid. If a provider receives payment from a recipient, payment shall not be made by Medicaid. If a payment is made by a third party, Medicaid shall not be responsible for any further payment above the Medicaid maximum allowable charge.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide medical treatment according to standard medical practice accepted by their professional organization and to provide Medicaid-covered services in compliance with federal and state statutes regardless of age, color, creed, disability, ethnicity, gender, marital status, national origin, race, religion, or sexual orientation.

Providers shall comply with the Americans with Disabilities Act and any amendments, rules, and regulations of this Act.

Each eligible medical professional shall be given the choice of whether or not to participate in the Kentucky Medicaid Program in accordance with 907 KAR 1:672. From those professionals who have chosen to participate, recipients may select the provider from whom they wish to receive their medical care.

If the Department makes payment for a covered service and the provider accepts this payment in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; a bill for the same service shall not be tendered to the recipient, and a payment for the same service shall not be accepted from the recipient. The provider may bill the recipient for

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

---

services not covered by Kentucky Medicaid.

Providers of medical service or authorized representatives attest by their signatures, that the presented claims are valid and in good faith. Fraudulent claims shall be punishable by fine, imprisonment or both. Facsimiles, stamped or computer generated signatures shall not be acceptable.

The recipient's Kentucky Medical Assistance Identification Card should be carefully checked to see that the recipient's name appears on the card and that the card is valid for the period of time in which the services are to be rendered. If there is any doubt about the identity of the recipient, you may request a second form of identification. A provider can not be paid for services rendered to an ineligible person. Failure to validate the identity of a Medicaid recipient prior to a service being rendered may result in failure to comply with 907 KAR 1:671. Any claims paid by the Department for Medicaid Services on behalf of an ineligible person may be recouped from the provider.

The provider's adherence to the application of policies in this manual shall be monitored through either on-site audits, postpayment review of claims by the Department, or computer audits or edits of claims. When computer audits or edits fail to function properly, the application of policies in this manual shall remain in effect. Therefore, claims shall be subject to postpayment review by the Department.

All providers shall be subject to rules, laws, and regulations issued by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services provided to eligible Medicaid recipients shall be on a level of care that is equal to that extended private pay individuals or others, and on a level normally expected of a person serving the public in a professional capacity.

All recipients shall be entitled to the same level of confidentiality afforded persons NOT eligible for Medicaid benefits.

Claims shall not be allowed for services outside the scope of allowable benefits within a particular program specialty. Likewise, claims shall not be paid for services that required and were not granted prior authorization by the Kentucky Medicaid Program. In

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

---

addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.

Claims shall not be paid for medically unnecessary items, services, or supplies. The recipient may be billed for non-covered items and services. Providers shall notify recipients in advance of their liability for the charges for non-medically necessary and non-covered services.

If a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, responsibility for reimbursement shall not be attached to the Department and a bill for the same service shall not be paid by the Department. However, a recipient with spend down coverage may be responsible for a portion of the medical expenses they have incurred.

**B. Appeal Process for Refund Requests**

Inappropriate overpayments to providers that are identified in the postpayment review of claims shall result in a refund request.

If a refund request occurs subsequent to a postpayment review by the Department for Medicaid Services or its agent, the provider may submit a refund to the Kentucky State Treasurer or appeal the Medicaid request for refund in writing by providing clarification and documentation that may alter the agency findings. This information relating to clarification shall be sent to:

DIVISION OF LONG TERM CARE AND COMMUNITY  
ALTERNATIVES  
DEPARTMENT FOR MEDICAID SERVICES  
CABINET FOR HEALTH AND FAMILY SERVICES  
275 EAST MAIN STREET  
FRANKFORT KY 40621

If no response (refund or appeal) has been filed with Medicaid by the provider within thirty (30) days of the refund request, assent to the findings shall be assumed. If a refund check or request for a payment plan is not received within sixty (60) days, Medicaid shall deduct the refund amount from future payments.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

---

C. Timely Submission of Claims

According to Federal regulations, claims shall be billed to Medicaid within twelve (12) months of the date of service or six (6) months from the adjudication date of the Medicare payment date or other insurance. Federal regulations define "Timely submission of claims" as received by Medicaid "no later than twelve (12) months from the date of service." Received is defined in 42 CFR 447.45 (d)(5) as follows: "The date of receipt is the date the agency receives the claim, as indicated by its date stamp on the claim." To consider those claims twelve (12) months past the service date for processing, the provider shall attach documentation showing RECEIPT by Medicaid, the fiscal agent and documentation showing subsequent billing efforts. Claim copies alone shall not be acceptable documentation of timely billing. Claims shall not be considered for payment if more than twelve (12) months have elapsed between EACH RECEIPT of the aged claim by the Program.

Claims should be submitted to:

Unisys Corporation  
P.O. Box 2101  
Provider Services  
Frankfort, KY 40602-2101  
1-877-838-5085 – Provider Enrollment  
1-800-807-1232 – Provider Relations

D. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which provides Medicaid recipients with a primary care provider. The primary care provider shall be responsible for providing or arranging for the recipient's primary care and for referral of other medical services.

KenPAC recipients shall be identified by a green Medical Assistance Identification (MAID) card.

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in KenPAC.

E. Lock-In Program

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

---

The Department shall monitor and review utilization patterns of Medicaid recipients to ensure that benefits received are at an appropriate frequency and are medically necessary given the condition presented by the recipient. The Department shall investigate all complaints concerning recipients who are believed to be over-utilizing the Medicaid Program.

The Department shall assign one (1) physician to serve as a case manager and one (1) pharmacy. The recipient shall be required to utilize only the services of these providers, except in cases of emergency services and appropriate referrals by the case manager. In addition, providers and recipients shall comply with the provisions set forth in 907 KAR 1:677, Medicaid Recipient Lock-In.

Providers who are not designated as lock-in case managers or pharmacies shall not receive payment for services provided to a recipient assigned to the lock-in program, unless the case manager has pre-approved a referral or for emergency services. Recipients assigned to the lock-in program shall have a pink MAID card and the name of the case manager shall appear on the face of the card.

**F. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program**

Under the EPSDT program, Medicaid eligible children, from birth through the end of the child's birth month of his twenty-first (21) year, may receive preventative, diagnostic and treatment services by participating providers. The goal of the program is to provide quality preventative health care by performing prescribed screenings at specified time intervals according to age (termed a periodicity schedule) to identify potential physical and mental health problems. These screenings shall include a history and physical examination, developmental assessment, laboratory tests, immunizations, health education and other tests or procedures medically necessary to determine potential problems. Another goal of the program is to reimburse for medically necessary services and treatments, even if the service or treatment is not normally covered by Kentucky Medicaid. However, the service or treatment must be listed in 42 USC Section 1396 d(a) which defines those services that may be covered by state Medicaid programs. More information regarding

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION II – COMMONWEALTH OF KENTUCKY MEDICAID PROGRAM**

---

the EPSDT program may be obtained by calling the EPSDT program within the Department for Medicaid Services.

**G. Kentucky Health Care Partnership Program**

In accordance with 907 KAR 1:705, the Department shall implement, within the Medicaid Program, a capitated managed care system for physical health service for persons residing in Region 3 (Shelby, Spencer, Trimble, Wayne, Marion, Meade, Nelson, Oldham, Hardin, Henry, Jefferson, LaRue, Breckinridge, Bullitt, Carroll, and Grayson counties).

Medicaid recipients receiving waiver services, as well as nursing facility and Long Term Care services, are exempt from participation in a capitated managed care system. These recipients receive services through the traditional Medicaid program.

**H. EMPOWER Kentucky Transportation Initiative**

In accordance with 907 KAR 3:065, the Department shall implement, within the Medicaid Program, as an EMPOWER Kentucky Initiative, a capitated non-emergency medical transportation delivery system excluding ambulatory stretcher services. The Department has entered into a contract with the Transportation Cabinet, along with three other Cabinets, to implement this program incrementally statewide beginning in June 1998. This new system is designed to extend service to areas of the state currently under-served, provide transportation alternatives to more people, encourage efficiency and discourage fraud and abuse.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

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**III. CONDITIONS OF PARTICIPATION**

**A. Participation Overview**

Any facility licensed or requesting licensure as a nursing facility by the CABINET FOR HEALTH AND FAMILY SERVICES, Office of Inspector General, Division of Long Term Care, is eligible to submit a Provider Agreement with Addenda I and II, a Disclosure of Ownership and Control, Interest form, and Provider Information form. A facility survey shall then be required to determine that licensure requirements and Kentucky Medicaid Program requirements are being met.

Hospital swing bed facilities providing services in accordance with 42 USC 1395tt and 42 USC 13961 shall also be considered nursing facilities if the swing beds are certified to the Medicaid Program as meeting nursing facility standards. Hospital swing bed facilities are currently exempt from the Preadmission Screening and Resident Review (PASRR) requirement.

Surveys shall take place as often as necessary but at least within fifteen (15) months of the date of the last survey. The MAP 811 shall be submitted annually by a participating facility.

Submission of the required form shall not ensure participation in the Medicaid Program. Participation as a provider shall only be ensured after the agreement is signed by both parties (the provider and the Department for Medicaid Services), proof of the facility's certification to participate in the Medicare Program (Title XVIII) if required is received from the certifying agency, a provider number is issued, and all paperwork involved in the certification process is completed by both parties.

All participating providers shall comply with the requirements specified in 907 KAR 1:671; 907 KAR 1:672; and 907 KAR 1:673.

**B. Provider Freedom of Choice**

The freedom of choice concept has always been a fundamental principle governing the Kentucky Medicaid Program. Providers shall have the freedom to decide whether or not to accept eligible Medicaid recipients and to bill the Program for the medical care provided.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

C. Medicare Participation

All nursing facilities shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare unless they have obtained a Medicaid waiver of the nurse-staffing requirement. If the nursing facility has less than ten (10) beds certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare. If a nursing facility which has obtained a Medicaid waiver of the nurse staffing requirement CHOOSES to participate in Medicare, they shall have at least twenty (20) percent of all Medicaid certified beds, but not less than ten (10) beds, also certified to participate in Medicare; if less than ten (10) beds are certified for Medicaid, all Medicaid certified beds shall also be certified to participate in Medicare.

All nursing facilities shall participate in the Medicare Program (Title XVII) in order to participate in the Medicaid Program unless they have obtained a Medicaid waiver of the nurse-staffing requirement.

D. Resource Assessment

If a community spouse exists, nursing facilities shall advise each admission, regardless of payer source, of the availability of the resource assessment. The assessment is conducted by the local office of the Department for Community Based Services without cost to the individual. Resource assessments are only completed if a community spouse exists. In order to verify that compliance with this condition has been met, appropriate sections of the MAP-350 form shall be completed by the appropriate parties and a copy retained by the nursing facility in the active clinical record.

E. Out-of-Country Nursing Facilities

Nursing facilities located outside the United States and its territories shall not participate in the Kentucky Medicaid Program except for the purpose of billing Medicare co-insurance amounts for which payment shall be the responsibility of the Kentucky Medicaid Program until the resident is discharged or termination of the resident's QMB and Kentucky Medicaid eligibility.

F. Out-of-State Nursing Facilities

The Kentucky Medicaid Program does not routinely enroll out-of-state nursing facilities except for the purpose of paying Medicare co-insurance amounts for which payment in accordance with

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

Kentucky Medicaid reimbursement procedures shall be the responsibility of the Kentucky Medicaid Program until the resident is discharged or termination of the resident's QMB and Kentucky Medicaid eligibility.]

- G. Disclosure of Information (42 CFR 405,420, 431, and 455 and 907 KAR 1:672).

There are requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid. The federal and state regulations which relate to disclosure of information are significant and we suggest your attention to them.

OF PARTICULAR IMPACT ON MEDICAID PROVIDERS ARE THE FOLLOWING:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents or managing employees have been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX or XX.
2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.
3. The Secretary shall have access to Medicaid provider records.
4. Providers shall be required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these requirements, the federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements and not information which can be requested concerning certain business transactions.

The data shall be collected during each provider's certification process by the Division of Long Term Care, Office of the Inspector General.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

H. Termination of Participation and Provider Appeals Rights

Termination of a provider participating in the Medicaid Program and the provider's appeal process shall be in accordance with 907 KAR 1:671.

I. Preadmission Screening and Resident Review PASRR

Public Law 100-203, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) requires that preadmission screening be performed to prevent inappropriate nursing facility admissions of individuals who are mentally ill, mentally retarded, or who have a related condition.

PASRR shall be required for all admissions regardless of payor source in accordance with 907 KAR 1:755.

J. Deposits

In accordance with federal regulations, deposits shall not be required of those persons eligible for Medicaid. Presentation of a current Medical Assistance Identification Card and meeting patient status criteria shall constitute long-term care Medicaid eligibility for services. Any deposits obtained prior to Medicaid eligibility shall be returned to the resident or responsible party when eligibility is determined. Deposits shall be refunded PRIOR TO BILLING the Medicaid Program.

K. Utilization Review

A Peer Review Organization (PRO) shall have Title XIX review responsibility for nursing facility services provided in Kentucky.

The PRO is operational Monday through Friday from 8:00 a.m. to 6:00 p.m. (Eastern Time), except for holidays.

Professional staff of the Cabinet for Health and Family Services or a PRO operating under its lawful authority pursuant to the terms of its agreement with the Cabinet shall review and evaluate the health status and care needs of an individual in need of inpatient care, giving consideration to the medical diagnosis, age-related dependencies, care needs, services and health personnel required to meet these needs and the feasibility of meeting the needs through alternative institutional or non-institutional services.

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

Prior to admission of an individual to a nursing facility, the facility must request certification from the PRO. Certification for a new admission of an individual must be requested by the facility within seven (7) working days of the admission. (This seven (7) day time frame is a maximum limit. PRO certification should be requested prior to admission.) If an individual is discharged prior to a request for certification, a certification shall not be approved).

If an individual is admitted after normal business hours or on a weekend, request for certification by the PRO may be obtained through use of the MAP-726A. The MAP-726A may be faxed to the PRO at 502-429-5233, 1-800-807-7840, or 1-800-807-8843. A provider shall keep a copy of the transmission form generated that indicates the transmission was successful. The nursing facility provider will need this documentation if problems arise concerning the faxed transmission. The MAP-726A may also be used during normal business hours. (A copy of the MAP-726A is located in the Appendix of this manual).

Should a provider admit an individual who does not meet nursing facility level of care certification requirements, DMS will not be responsible for costs associated with individual's care while in the facility. If a provider fails to obtain certification for a resident as outlined above, DMS shall not be responsible for costs associated with that individual's care while in the facility.

In addition, no provision is made in the regulations or manuals for granting retroactive certifications or exceptions. As an entity of state government, the Department for Medicaid Services is obligated to comply with governing regulations. In addition, providers are subject to provisions in 907 KAR 1:671, 907 KAR 1:672, and 907 KAR 1:673.]

1. PRO Process for Nursing Facilities: Prior to admission of an individual to a nursing facility, the facility shall request certification of the admission by the PRO. The PRO shall approve the admission and transmit to the facility and the local Department for Community Based Services office a "Confirmation Notice", or deny the admission and issue a "Denial Letter." The PRO shall submit the Denial Letter to the patient or their responsible party, the physician of

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

record, the facility, and the local Department for Community Based Services office.

If the admission is approved, within thirty (30) days of the admission the PRO shall perform an on site continuing stay review. The PRO shall approve a continued stay if the resident continues to meet the nursing facility level of care criteria in accordance with 907 KAR 1:022. If the resident no longer meets the nursing facility level of care criteria in accordance with 907 KAR 1:022, the PRO shall issue a "Denial Letter".

Specific lengths of stay shall not be assigned for continued stays. The PRO nurse reviewer shall re-certify each resident in the facility every six (6) months, for a continued stay or deny the continued stay. It is the responsibility of the facility to indicate those residents which are to be reviewed by the PRO for continued stay.

It is incumbent upon nursing facilities with a Medicaid waiver of the nurse staffing requirement to discharge the resident when the resident's status changes from nursing facility level of care services to skilled nursing care services during the periods between PRO reviews.

b. PRO Process for Licensed Swing-Bed Nursing Facilities:

Prior to admission of an individual to a swing bed nursing facility, or prior to changing the bed from acute care status, if the resident was admitted to the swing bed as an acute care patient, the facility shall request certification by the PRO. The PRO shall approve or deny the admission using the same Department for Medicaid Services criteria as for nursing facilities.

If the admission is approved, the PRO shall perform an on-site continuing stay review at the end of the initial length of stay (up to thirty (30) days and at least every ninety (90) days thereafter.) The PRO shall approve or deny the continued stay using the same Department for Medicaid Services criteria as for nursing facilities.

If the bed swings to acute for three (3) or more days, the facility shall contact the PRO for review prior to swinging the bed back to nursing facility. When counting the three

**CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES**

**NURSING FACILITY SERVICES MANUAL**

---

**SECTION III - CONDITIONS OF PARTICIPATION**

---

(3) days, do not count the day the bed will swing back to nursing facility.

Facilities SHALL NOT contact the Medicaid PRO to certify the admission of a Medicaid recipient for whom Medicare Part A shall be the primary payor. Medicare procedures shall be followed for these residents. When Medicare Part A benefits are exhausted or when the resident no longer meets the level of care criteria for which Medicare shall make reimbursement, whichever comes first, the facility shall request Medicaid certification by contacting the Medicaid PRO.

The Medicaid Program is monitoring the PRO determinations on a sample basis. Monitoring shall be for performance assessment only and shall have no bearing on the individual determinations, as all PRO determinations are binding on the Medicaid Program.

- L. Placement: Assistance with placement problems may be obtained by contacting the local office of the Department for Community Based Services whose staff are knowledgeable regarding potential for placement in Kentucky facilities.
- M. Nurse Aid Training and Competency Evaluation Program: Nurse Aide Training and Competency Evaluation Program shall be in accordance with regulation 907 KAR 1:450.

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**SECTION IV – PROGRAM COVERAGE**

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IV. PROGRAM COVERAGE

A. Recipient Eligibility

QMB and Medicaid eligibility are determined by the local offices of the Department for Community Based Services. Any individual determined to be eligible for Medicaid benefits by the Department for Community Based Services may receive nursing facility benefits if the services have been certified in accordance with Medicaid Program policy.

1. Section 301 of the Medicare Catastrophic Coverage Act of 1988 (MCCA) requires states to provide Medicaid coverage to certain Medicare beneficiaries in order to pay Medicare cost-sharing expenses (premium, deductible and coinsurance amounts). Individuals who are entitled to Medicare Part A and who do not exceed federally-established income and resources standards shall be known as Qualified Medicare Beneficiaries (QMBs).
2. The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) further provides that some individuals shall have dual eligibility for QMB benefits and regular Medicaid benefits.
3. Reimbursement by the Kentucky Medicaid Program for QMB Only and dually eligible individuals and the Medicare-Medicaid (non-QMB) resident includes deductible and coinsurance amounts for all Medicare Part A and Part B covered services.

B. Medical Assistance Identification (MAID) Card

Any individual determined eligible for Medicaid benefits shall be issued a MAID card each month by the Department for Community Based Services. Individuals who have been determined eligible for both Medicaid and QMB benefits shall receive a regular MAID card with a notation on the face of the card that identifies the recipient as being dually eligible, individuals who have been determined to be eligible for QMB benefits only receive a unique tri-colored (red, white, blue) card.]

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**SECTION IV – PROGRAM COVERAGE**

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Each card shall indicate the resident's Medicaid number, the month of eligibility, and third party resources (Medicare Part A and Part B, private insurance, etc.) that may be responsible for all or a portion of the resident's cost of care. Acceptance of an outdated card may jeopardize reimbursement to a facility for services provided during the period in question.

C. Authorization

The Medicaid Program shall assume responsibility for provision of financial benefits to nursing facilities on behalf of eligible residents only when specifically authorized by the PRO and the Department for Medicaid Services, as appropriate. The fact that an eligible resident is admitted to a Medicaid certified nursing facility in no way obligates or assures that the Medicaid Program shall make reimbursement for the services or items provided to the resident. This policy shall not dictate the admission policies and procedures for a facility; rather, it merely defines those admissions for which reimbursement shall be made by the Medicaid Program.

D. Determining Patient Status

Professional staff of the Cabinet for Health and Family Services or a Peer Review Organization operating under its lawful authority pursuant to the terms of its agreement with the Cabinet shall review and evaluate the health status and care needs of the resident in need of institutional care, giving consideration to the medical diagnosis, care needs, services and health personnel required to meet those needs and the feasibility of meeting the needs through alternative institutional or non-institutional services. With the exception of those Individuals admitted to hospital swing-bed facilities. An individual shall not qualify for Medicaid patient status unless the individual is qualified for admission and continued stay as appropriate, under the PASRR criteria.

Residents meeting high intensity patient status criteria shall be admitted to beds which are participating in both Medicare and Medicaid. Residents which possess high intensity care needs shall also remain in beds participating in both Medicare and Medicaid after exhaustion of any Medicare benefits.

Insulin-dependent diabetic residents who require at least daily injections which cannot be self-administered may be determined

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**SECTION IV – PROGRAM COVERAGE**

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to be either high intensity or low intensity based in part on the attending physician's evaluation. This policy shall not, however, apply to insulin-dependent diabetic residents who have other high intensity conditions.

1. High Intensity Nursing Care (criteria equivalent to skilled nursing care standards under Medicare). Medicaid eligible individuals qualify for high intensity nursing care when their care needs mandate high intensity nursing or high intensity rehabilitation services on a daily basis and when, as a practical matter, the care can only be provided on an inpatient basis. Where the inherent complexity of a service prescribed for a resident exists to the extent that it can be safely or effectively performed only by or under the supervision of technical or professional personnel, the resident would qualify for high intensity nursing care.

A resident with an unstable medical condition manifesting a combination (two (2) or more) of care needs in the following areas shall qualify for: high intensity nursing care:

- (a) Intravenous, intramuscular, or subcutaneous injections and hypodermoclysis or intravenous feeding;
- (b) Naso-gastric or gastrostomy tube feedings;
- (c) Nasopharyngeal and tracheotomy aspirations;
- (d) Recent or complicated ostomy requiring extensive care and self-help training;
- (e) In-dwelling catheter for therapeutic management of a urinary tract condition
- (f) Bladder irrigations in relation to previously indicated] stipulation;
- (g) Special vital signs evaluation necessary in the management of related conditions;
- (h) Sterile dressings;
- (i) Changes in bed position to maintain proper body alignment;
- (j) Treatment of extensive decubitus ulcers or other widespread skin disorders;
- (k) Receiving medication recently initiated, which requires high intensity observation to determine desired or adverse effects or frequent adjustment of dosage;

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**SECTION IV – PROGRAM COVERAGE**

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- (l) Initial phases of a regimen involving administration of medical gases;
  - (m) Receiving services which would qualify as high intensity rehabilitation services when provided by or under the supervision of a qualified therapist(s), for example: on-going assessment of rehabilitation needs and potential; therapeutic exercises which must be performed by or under the supervision of a qualified physical therapist; gait evaluation and training; range of motion exercises which are part of the active treatment of a specific disease state which has result in a loss of, or restriction of mobility; maintenance therapy when the specialized knowledge and judgment of a qualified therapist are required to design and establish a maintenance program based on an initial [evaluation and periodic reassessment of the resident's needs, and consistent with the resident's capacity and tolerance; ultra-sound, short-wave and microwave therapy treatments; hot pack, hydrocollator, infra-red treatment, paraffin baths, and whirlpools (in cases where the resident's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, fractures or other complications, and the skills, knowledge and judgment of a qualified physical therapist are required); and services by or under the supervision of a speech pathologist or audiologist when necessary for the restoration of function in speech or hearing;
2. Low Intensity Nursing Care (criteria equivalent to the former intermediate care patient status standards). Medicaid eligible individuals shall qualify for low intensity patient status when the individual requires, unrelated to age-appropriate dependencies with respect to a minor, intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting. In making the decision as to patient status, the following criteria shall be applicable:
- (a) An individual with a stable medical condition requiring intermittent high intensity services not provided in a personal care home shall be considered to meet patient status.

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**SECTION IV – PROGRAM COVERAGE**

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- (b) An individual with a stable medical condition, who has a complicating problem which prevents the individual from caring for himself in an ordinary manner outside the institution shall be considered to meet patient status. For example, ambulatory cardiac and hypertensive patients may be reasonably stable on appropriate medication, but have intellectual deficiencies preventing safe use of self-medication, or other problems requiring frequent nursing appraisal, and thus be considered to meet patient status.
- (c) An individual with a stable medical condition manifesting a significant combination (two (2) or more) of the following care needs shall be determined to meet low intensity patient status when professional staff determines that such combination of needs can be met satisfactorily only by the provision of intermittent high intensity nursing care, continuous personal care or supervision in an institutional setting:
  - (1) Assistance with wheelchair;
  - (2) Physical or environmental management for confusion and mild agitation;
  - (3) Must be fed;
  - (4) Assistance with going to bathroom or using bedpan for elimination;
  - (5) Old colostomy care;
  - (6) In-dwelling catheter for dry care;
  - (7) Changes in bed position;
  - (8) Administration of stabilized dosages of medication;
  - (9) Restorative and supportive nursing care to maintain the resident and prevent deterioration of his condition;
  - (10) Administration of injections during time licensed personnel is available;
  - (11) Services that could ordinarily be provided or administered by the individual but due to physical or mental condition is not capable of self-care;
  - (12) Routine administration of medical gases after a regimen of therapy has been established.
- (d) An individual shall not generally be considered to meet patient status criteria when care needs are

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**SECTION IV – PROGRAM COVERAGE**

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limited to the following:

1. Minimal assistance with activities of daily living;
2. Independent use of mechanical devices, for example, assistance in mobility by means of a wheelchair, walker, crutch(es) or cane;
3. Limited diets such as low salt, low residue, reducing and other minor restrictive diets;
4. Medications that can be self-administered or the individual requires minimal supervision.]

3. Evaluation of Patient Status for Persons with Mental Disorders or Mental Retardation

Medicaid eligible individuals with a mental disorder or mental retardation meeting high or low intensity care needs as previously defined shall generally be considered to meet patient status. However, these individuals shall be specifically excluded from coverage in the following situations:

- (a) If the Cabinet determines that in the individual case the] [combination of care needs are beyond the capability of the facility, and that placement in the facility is inappropriate due to potential danger to the health and welfare of the resident, other patients in the facility, or staff of the facility; and
- (b) If the resident does not meet the preadmission screening and resident review criteria specified in 42 USC 1396r for entering or remaining in a facility.

4. Transfer trauma criteria. A Medicaid recipient in an NF who does not meet the low intensity or high intensity nursing care patient status criteria established in Section 4 of 907 KAR 1:022 shall not be discharged from an NF if:

- (a) The recipient has resided in an NF for at least eighteen (18) consecutive months;
- (b) The recipient's attending physician determines that the recipient would suffer transfer trauma in that his or her physical, emotional or mental well being

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**SECTION IV – PROGRAM COVERAGE**

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- would be compromised by a discharge action as a result of not meeting patient status criteria; and
- (c) The department confirms the recipient's attending physician's assessment regarding the trauma caused by possible discharge from the NF.
5. A Medicaid recipient who meets transfer trauma criteria in accordance with this Section 4(9) of 907 KAR 1:022 and this section of the manual:
- (a) Shall remain in an NF and continue to be covered by the department for provider reimbursement at least until his or her subsequent transfer trauma assessment; and
  - b) Be reassessed for transfer trauma every six (6) months.
6. The recipient transfer trauma criteria established in this Section 4(9) of 907 KAR 1:022 and this section of the manual shall not apply to an individual who resides in a facility which experiences closure or a license or certificate revocation.
- E. Home- and Community-Based Waiver Program

The Department for Medicaid Services (DMS) requested that the Secretary of the United States Department of Health and Human Services (HHS) exercise his authority under Section 1915(c) of the Social Security Act to grant a waiver of certain federal requirements that would permit Medicaid coverage under the State Plan for a broad array of home and community based services that may be required by the Medicaid recipient who would otherwise require Nursing Facility (NF) level of care. Among the services available under the Home and Community Based Waiver are:

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**SECTION IV – PROGRAM COVERAGE**

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**HOME AND COMMUNITY BASED WAIVER**

The Home and Community Based (HCB) waiver program was developed to serve Kentucky residents who are aged or disabled as an alternative to placement in a nursing facility (NF). These individuals must meet the level of care criteria for placement in a NF and whose services in a NF would qualify for payment under the State Plan for Medical Assistance. An individual who is an inpatient of a hospital, NF, or Intermediate Care Facility for the Mental Retarded (ICF/MR) or enrolled in another Medicaid waiver or Medicaid-covered Hospice Program shall be excluded from eligibility.

**MODEL WAIVER II**

The Model II waiver program was developed to serve Kentucky residents as an alternative to hospital-based nursing facility care for an individual who is ventilator dependent. These individuals must meet the level of care criteria for placement in a nursing facility (NF) and whose services in an NF would qualify for payment under the State Plan for Medical Assistance. Model II waiver services are available to individuals of any age in their homes.

**HEMOCARE WAIVER**

The Homecare waiver program was developed to provide services to aged and disabled Kentucky residents aged sixty (60) and older, who, but for the provision of such services, would require nursing facility care. These individuals must meet nursing facility level of care requirements and technical and financial requirements for Kentucky's Medical Assistance Program. The Homecare waiver program allows adults who are unable to perform some activities of daily living and are at risk of institutional care to remain in their own homes by providing supportive services and coordinating the help of family, friends, and provider agencies. Homecare services are not available to individuals who are inpatients of a hospital, nursing facility or ICF/MR.

**SUPPORTS FOR COMMUNITY LIVING**

The Supports for Community Living (SCL) waiver program was

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**SECTION IV – PROGRAM COVERAGE**

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developed to serve Kentucky residents as an alternative to institutional care for an individual with mental retardation or developmental disability. These individuals must meet the level of care criteria for placement in an Intermediate Care Facility for the Mentally Retarded (ICF/MR) and whose services in an ICF/MR would qualify for payment under the State Plan for Medical Assistance. This program is designed to allow an individual to remain in or return to the community in the least restrictive setting. SCL services are not available to an individual while an inpatient of a hospital, nursing facility or ICF/MR.

**ACQUIRED BRAIN INJURY WAIVER**

The Acquired Brain Injury (ABI) waiver was developed to serve Kentucky residents age twenty-one (21) to sixty-five (65) who have an acquired brain injury. These individuals shall be receiving inpatient services in a nursing facility (NF), or a nursing facility/brain injury (NF/BI) program, or who are in the community and have the potential for inpatient services in a NF or NF/BI program. These individuals shall meet the level of care criteria for placement in a NF and whose services in an NF would qualify for payment under the State Plan for Medical Assistance. The goal of the ABI waiver program is to rehabilitate and reintegrate individuals with an acquired brain injury into the community with the availability of existing community resources when discharged from the ABI waiver program. These services are not available to individuals who have congenital brain injuries.

F. Hospice

For those residents enrolled in the Medicaid Hospice Program, charges for all services provided in a nursing facility shall be billed directly to the hospice agency responsible for the resident's care. Questions regarding hospice benefits shall be directed to the Department for Medicaid Services, Division of Long Term Care and Community Alternatives, 275 East Main Street, Frankfort, Kentucky 40621.

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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**IV-A. NURSING FACILITY BRAIN INJURY PROGRAM**

**A. Scope of Benefits**

Medicaid reimbursement for specialized physical rehabilitation services shall be available to nursing facilities that meet the requirements, and participate in the nursing facility brain injury aspect of the nursing facility element of the Medicaid Program. Nursing facilities with a Medicaid waiver for the nurse-staffing requirement are not eligible to participate in the Brain Injury Program.

A brain injury program provides categorical and goal directed services to persons principally with a primary diagnosis of traumatically acquired brain damage that results in residual deficits and disability. Inclusion of other cerebral disorders shall be based on age, disability profiles and rehabilitation potential and service needs.

The brain injury program is not intended to function as a stroke rehabilitation program, although some persons with a cerebral vascular accident may be served.

1. Injuries within the Scope of Benefits

Following is a list of injuries that may be included in the Medicaid brain injury program scope of benefits.

- (a) Central Nervous System (CNS) injury from physical trauma;
- (b) CNS damage from anoxia/hypoxic episodes; and
- (c) CNS damage from allergic conditions, toxic substances and other acute medical/clinical incidents.

2. Exclusions from Scope of Benefits

Excluded from scope of benefits shall be:

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (a) Strokes; (NOTE: Nursing facilities provide rehabilitation services expected to meet the needs of most stroke patients.)
- (b) Spinal cord injuries in which there are no known or obvious injuries to the intracranial CNS;
- (c) Progressive dementia's and other mentally impairing conditions;
- (d) Depression and psychiatric disorders in which there is not known or obvious CNS damage;
- (e) Mental retardation, developmental disabilities and birth defect related disorders of long standing; and
- (f) Neurological degenerative, metabolic and other medical conditions of a chronic, degenerative nature.

**B. Admission and Continued-Stay Reviews to Authorize Medicaid Reimbursement.**

The admission and continued stay reviews to authorize Medicaid reimbursement for the Nursing Facility Brain Injury Program shall consist of a two step process.

The first step involves the Kentucky Medicaid approved PRO and the nursing facility level of care determination. The Kentucky Medicaid approved PRO shall have responsibility for the skilled nursing facility level of care determination aspect of the admission and continued stay reviews. This determination is made for persons requesting Nursing Facility Brain Injury Program services as determined by the Medicaid Program using the skilled level of care criteria and in the same manner as it is done for persons requesting placement in a non-special-purpose Medicare and Medicaid nursing facility bed. If it appears that the individual requires rehabilitation services over and above those which are available in a non-special-purpose Medicare and Medicaid certified nursing facility, and Nursing Facility Brain Injury Program services are requested, the admission review shall be coordinated with the Department for Medicaid Services (DMS).

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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The second step is for the purpose of determining if the individual requires specialized rehabilitation over and above that which is available in a Medicare and Medicaid certified nursing facility. The authorization of Medicaid reimbursement for Nursing facility brain injury program services shall be made by the Department for Medicaid Services in conjunction with the admission and continued stay reviews that are conducted by the

PRO. This authorization of Medicaid reimbursement for nursing facility brain injury program services by Medicaid shall be granted prior to admission to the brain injury unit, or if the individual was already admitted to the unit with other third party coverage, the Medicaid authorization shall be granted prior to the exhaustion of those benefits.

The authorization shall be granted by Medicaid based upon the comprehensive evaluation and proposed plan of care performed and developed by the Nursing facility brain injury program. The following is taken into consideration.

1. Indications for Brain Injury Program

Indications for admission and continued stay are as follows:

- (a) The individual sustained a traumatic brain injury with structural, non-degenerative brain damage and is medically stable;
- (b) The individual is not in a persistent vegetative state; (Persistent vegetative state is defined as a condition in which the individual opens his or her eyes but does not focus on anything, utters no intelligible sound and makes no meaningful responses to any kind of stimulus. Many patients go through this state when emerging from a coma but do not necessarily remain permanently in this condition.);
- (c) The individual demonstrates physical, behavioral and cognitive rehabilitation potential;
- (d) The individual requires coma management; and

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (e) The individual has sustained diffuse brain damage caused by:
  - (1) Anoxia;
  - (2) Toxic poisoning; or
  - (3) CVA (condition necessitates specialized
  - (4) rehabilitation and the individual has rehabilitation potential; or encephalitis).

2. Basis of Brain Injury Program Level of Care Determination  
The determination by Medicaid shall be based upon the following:

- (a) The presenting problem(s);
- (b) The goals and expected benefits of the admission;
- (c) The initial estimated time frames for goal accomplishment; and
- (d) The services needed.

The continued stay review by the PRO shall be conducted in the same manner and at the same frequency as it is conducted for Medicaid residents occupying non-special-purpose Medicare and Medicaid certified facility beds (i.e., at the end of the initial length of stay which can be up to thirty (30) days, and at least every ninety (90) days thereafter). The initial authorization by Medicaid for Nursing facility brain injury program benefits may be made for a period of three (3) to six (6) months (subject to continued review); however, should the individual's health status and care needs, at some point during the authorized period, not be within the scope of skilled NF benefits, as determined by the Medicaid Program, he or she would no longer be eligible for Nursing facility brain injury program benefits. The Nursing facility brain injury program shall forward to Medicaid a monthly progress report for each resident for on-going review and monitoring and consideration for continued eligibility for Nursing facility brain injury program benefits. Coverage shall be discontinued when it is determined that the individual no longer requires specialized rehabilitation services over and above those which are available in a non-special-purpose Medicare and Medicaid certified nursing facility.

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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**C. Provider Participation Requirements**

1. Designation of Beds

Medicare certified nursing facilities that wish to participate as a provider of specialized rehabilitation services for brain-injured individuals in the Kentucky Medicaid program shall designate at least ten (10) Medicare certified, physically identifiable, contiguous beds, for the delivery of inpatient specialized physical rehabilitation services. The designated unit shall be organized, staffed and equipped for the specific purpose of providing a rehabilitation program. Medicaid reimbursement for services provided to residents occupying these beds shall only be made for brain injury program services. Further, the continued certification of these beds for the brain injury program shall be contingent upon the use of the beds solely for the brain injury program regardless of source of payment.

The nursing facility shall comply with the Conditions for Participation in the Federal Medicare Program and Kentucky's Medicaid Program for all certified beds including the beds designated and Medicaid-certified for the provision of inpatient specialized physical rehabilitation services. Furthermore, in order to be eligible for certification to participate in the Medicaid Nursing Facility Brain Injury Program, the facility shall meet additional requirements.

If the Nursing facility brain injury unit is physically located in the plant of a licensed comprehensive physical rehabilitation hospital or a licensed acute care hospital for rehabilitation services, the Nursing Facility Brain Injury Program shall not be required to duplicate the following requirements in order to meet the additional requirements herein outlined; however, the Nursing facility brain injury unit shall be clearly included.

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (a) Administration and Operation Policies
- (b) Governing Authority
- (c) Quality Assurance and Program Evaluation

2. Accreditation

To continue participation in the Kentucky Medicaid Nursing Facility Brain Injury Program after the first year of Kentucky Medicaid participation, the facility or unit shall be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

**D. Additional Requirements**

The additional requirements for participation in the Medicaid Nursing facility brain injury program are as follows:

1. Administration and Operation Policies

The facility shall have written policies and procedures governing all aspects of the operation and provision of specialized inpatient physical rehabilitation services which include as written:

- (a) Admission statement of the specialized inpatient physical rehabilitation services it shall offer and it shall be made available to the general public upon request;
- (b) Program narrative which describes in detail the rehabilitation problems and conditions for which the facility provides services, the delivery of the services and the goals of treatment;
- (c) Description of the organizational structure of the physical rehabilitation unit including lines of authority, responsibility and communication and department or unit organization;
- (d) Description of its program design;
- (e) Admission policies that assure the admission of

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- persons whose conditions and rehabilitation needs necessitate specialized rehabilitation services over and above that provided in a non-special-purpose Medicare and Medicaid certified nursing facility unit;
- (f) Policies that provide for the maintenance of records of persons ineligible for admission at least two (2) years, including the reason and referral action;
  - (g) Policy that requires that all patients shall have a history and assessment interview within seventy-two (72) hours after admission for rehabilitation entered into the patient record which includes:
    - (1) A determination of behavioral and cognitive functioning;
    - (2) Vocational history;
    - (3) Familial relationships;
    - (4) Educational background;
    - (5) Social support system; and
    - (6) A determination that the patient can benefit from a rehabilitation program through the use of therapies provided by the institution.

2. Governing Authority

The governing authority means the individual, agency, partnership or corporation, in which the ultimate responsibility and authority for the conduct of the facility are vested.

The governing authority shall

- (a) Provide effective and ethical leadership;
- (b) Have the responsibility for the maintenance of high standards for the brain injury program; and
- (c) Conduct a periodic, systematic assessment of its brain injury program.

If the brain injury unit is located in a free-standing or a general hospital-based nursing facility (i.e., is not attached

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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to an acute care hospital that is licensed specifically for rehabilitation services or a licensed comprehensive physical rehabilitation hospital) the governing authority shall have a written contractual arrangement for the provision of active and regular consultation in the provision of high quality specialized physical rehabilitation for persons with brain injuries. This consultation shall be at a frequency sufficient to ensure the provision of high quality specialized services and be documented in writing at least every thirty (30) days.

3. Quality Assurance and Program Evaluation

There shall be a planned and systematic process for monitoring and evaluating the quality and appropriateness of patient care and services and for resolving identified problems. This process shall include input from both professional and administrative staffs regarding the character of the head injury caseload and program effectiveness.

(a) The quality and appropriateness of patient care shall be monitored and evaluated in all major clinical functions of the comprehensive physical rehabilitation program. Monitoring and evaluating shall be accomplished through the following means:

- (1) Routine collection of information about important aspects of rehabilitation care; and
- (2) Periodic assessments of the collected information in order to identify important problems in patient care and opportunities to improve care. Objective criteria shall be established and applied that reflect current knowledge and clinic experience concerning the services offered by the institution.

(b) The program evaluation shall involve at least a sampling of persons served, including persons

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- discharged and shall be conducted quarterly.
- (c) When important problems in patient care or opportunities to improve care are identified;
  - (d) The findings from the conclusions of monitoring, evaluating, and problem-solving activities and the actions taken to resolve problems and improve patient care, and information about the impact of the actions taken, shall be documented and shall be reported to the governing authority and appropriate committees, and made available to the Cabinet for Health and Family Services upon request.
  - (e) If an outside source(s) provides rehabilitation services, the quality and appropriateness of patient care provided shall be monitored and evaluated, and identified problems resolved.

4. Service Requirements

The nursing facility shall offer a planned combination of comprehensive, specialized inpatient rehabilitation services. A planned program of comprehensive rehabilitation services is a program of coordinated and integrated services which include evaluation and treatment and emphasizes education and training of those served and their families.

The program is composed of medical, nursing, therapeutic, restorative, psychosocial, vocational and educational services which enable an individual with an injury to function at his maximum potential. While vocational and educational services are essential components to the individual's overall rehabilitation, Medicaid does not provide reimbursement for these services. The Kentucky Department of Education is a possible resource for funding some of these services.

Comprehensive physical rehabilitation programs offer a wide range of therapeutic services provided by registered, certified, licensed or degreed professionals, who utilize an

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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interdisciplinary, goal oriented, team approach with treatment plans designed for the individual patient needs.

5. Program Design

The program shall target medically stable, traumatic brain injured individuals with an expected length of stay of three (3) to twelve (12) months. The goal oriented program shall provide an individualized planned and coordinated program for specialized physical rehabilitation services in accordance with the plan of treatment developed by an interdisciplinary team. The plan shall be directed at restoring the individual to his optimal level of physical, cognitive and behavioral functioning.

- (a) There shall be an individual designated with the administrative responsibility and qualifications for the head injury program as follows:
  - (1) The program director shall have two (2) years clinical or administrative experience in traumatic brain injury programs;
  - (2) Provide direction and oversight of the program;
  - (3) Provide ongoing review and implement changes as needed; and
  - (4) Assure the development and implement of educational programs for staff on an ongoing basis.
- (b) There shall be an individual designated with the responsibility for the service delivery of the head injury program.
- (c) Designated treatment space shall be provided, including distraction-free areas for all treating disciplines.
- (d) There shall be sufficient space, equipment, and facilities to support clinical, education and administrative functions of the program.

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (e) There shall be provisions for ensuring a safe and secure environment consistent with the behavioral and cognitive limitations of brain-injured individuals. This includes trained staff to deal with crisis and physical intervention procedures to secure patient and good staff safety and alarm systems such as those used on beds, rooms, wheelchairs, and on exit doors. Mechanical restraints may at times be necessary to maintain patient safety and shall be used in accordance with state and federal regulations and facility policy.
- (f) The facility shall not admit or retain individuals who are dangerous to themselves or others to the extent that the health, welfare and safety of the individual, other patients and staff cannot be insured.
- (g) The formally organized program shall provide for support and the offering of counseling to families and patients.
- (h) The program shall have a formalized mechanism for ongoing evaluation of alternative service settings appropriate to the neurological and psychological needs of individuals served and their families and the frequency and intensity of services needed.
- (i) The program shall have an established process for coordination with relevant public and community agencies including, but not limited to, vocational rehabilitation, education, mental health, developmental disabilities, Social Security, Department for Social Insurance, etc.
- (j) The brain injury program shall have appropriate services to manage the functional, psychosocial, and medical needs of those served.
- (k) There shall be appropriate psychosocial intervention from admission through discharge in order to meet the needs of those served.
- (l) The scope and intensity of medical services shall relate to the persons' medical care needs in order to safely provide a comprehensive rehabilitation program. There shall be ready availability of these

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- medical services, either within the facility or by linkages with other agencies and individuals.
- (m) The scope and intensity of rehabilitation services shall relate to the disability and to the individual's response to treatment.
  - (n) Services shall be provided by a coordinated, interdisciplinary team.
    - (1) The team shall be the major decision-making body in determining the goals, process and time frames for accomplishment of each person's rehabilitation program.
    - (2) The team shall be composed of the treating members of each discipline essential to the person's accomplishment of the goals and expected benefits of the admission.
    - (3) The team shall meet on a formalized basis at a frequency necessary to carry out their decision-making responsibilities. A team conference shall occur for each person served no less than every other week. There should be an interim informal conference among the members of the team.
  - (o) There shall be a written plan of follow-up care. The brain injury program shall provide for follow-up care when this is appropriate for those people who remain in its service area. Arrangements to facilitate follow-up care shall be made for those who will leave the program's geographic service area. The follow-up plan shall provide for:
    - (1) Referral and forwarding of clinical information to a designated physician and service program.
    - (2) Provisions for reevaluation of status as appropriate and feasible.
    - (3) Specific recommendations for medical, neurological, physical, cognitive, behavioral,

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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vocational, educational, psychological, and family management.

- (4) Designation of an individual responsible for case management after discharge to assure continuity and coordination of post discharge services.
- (5) Identification of an individual within the receiving community who will be responsible for case management after discharge to assure continuity and coordination of post discharge services.

6. Rehabilitation Treatment Plan

- (a) The treatment plan shall have been developed by the interdisciplinary team and based on an integrated assessment. The initial plan shall be developed within fourteen (14) days of admission and reviewed and revised at least every fourteen (14) days thereafter. The following shall be assessed during the initial and on-going assessments:
  - (1) Medical and neurological issues;
  - (2) Health and nutrition;
  - (3) Sensorimotor capacity including gross and fine motor strength and control, sensation, balance, joint range of motion, mobility and function;
  - (4) Cognitive capacity;
  - (5) Perceptual capacity;
  - (6) Communicative capacity;
  - (7) Affect and mood;
  - (8) Interpersonal and social skills;
  - (9) Behavior;
  - (10) Activities of daily living including self-care, home and community skills;
  - (11) Recreation and leisure time skills;
  - (12) Educational and vocational capacities;
  - (13) Sexuality;

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (14) Family;
  - (15) Legal competency of the person;
  - (16) Community reintegration, including appropriate post-discharge services;
  - (17) Environmental modification;
  - (18) Adjustment to disability, and
  - (19) All other areas deemed relevant for the person;
- (b) The treatment plan shall include:
- (1) Identification of the patient's rehabilitation goals stated in functional and behavioral objectives relative to the performance of life tasks and capabilities, with criteria for termination of treatment or discharge from the program;
  - (2) Participation of the patient and his family, to the extent possible;
  - (3) Physician input relative to both the general medical and rehabilitation medical needs of the patient;
  - (4) Discharge planning addressed as part of goal setting as early as possible in the rehabilitation process;
  - (5) Time intervals at which treatment or service outcomes will be reviewed;
  - (6) Anticipated time frame(s) for the accomplishment of individual's specified goals;
  - (7) The measures to be used to assess the effects of treatment or services; and
  - (8) The person(s) responsible for implementation of the plan.

7. Staff Requirements

The program shall have adequate personnel to meet the needs of patients on a twenty-four (24) hour basis. The number and classification of personnel required shall be

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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based on the number of patients and the individual treatment plans. The following staffing requirements shall be considered separate from any remaining beds in the facility.

(a) Medical Staff Services

- (1) Medical management shall be provided under the direction of a physician who has advanced training and experience in traumatic brain injury rehabilitation.
- (2) Physician services shall be available twenty-four (24) hours a day on at least an on-call basis.
- (3) There shall be sufficient medical staff coverage for services provided in the institution in keeping with the size of the institution, the scope of services provided and the types of patients admitted to the facility.
- (4) An individual rehabilitation program plan shall be developed for each patient under the supervision of a physician. The attending physician shall attend and actively participate in conferences concerning those served.
- (5) The attending physician shall complete the discharge summary and sign the records within fifteen (15) days of discharge.
- (6) The physician responsible for the patient's rehabilitation program shall have specialized training or experience in rehabilitation.
- (7) There shall be direct individual contact by a physician at least three (3) times per week; however, more frequent physician visits shall be made if the individual's medical condition warrants.

(b) Nursing Services

These services provide prevention of complications

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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of disability, restoration of optimal functioning, and adaptation to an altered lifestyle through the use of the nursing process (assessment, planning, intervention, and evaluation).

- (1) The facility or unit shall have a nursing department and nursing staff organized to provide basic nursing services as well as rehabilitation nursing services.
- (2) A registered nurse with training and experience in rehabilitative nursing shall serve as charge nurse of the unit and director of the nursing department.
- (3) There shall be a registered nurse on duty on the Nursing facility brain injury program unit at all times.
  - a) There shall be registered nurse supervision of nursing staff personnel on a twenty-four (24) hour basis to ensure immediate availability of a registered nurse with rehabilitation experience for all patients.
  - b) There shall be other nursing personnel on the unit in sufficient numbers to provide nursing care not requiring the services of a registered nurse.
  - c) Nursing care shall be documented on each shift by persons providing care to patients. This documentation shall describe the nursing care provided and include information and observations of significance which contribute to the continuity of patient care.
- (4) Rehabilitation of nursing services shall include physical and psychosocial assessment of function of the following:

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- a) All body systems related to the patient's physical rehabilitation nursing needs, with special emphasis on skin integrity, bowel and bladder function, and respiratory and circulatory systems function;
  - b) Self-care skills development;
  - c) Interpersonal relationships;
  - d) Adaptation mechanisms and patterns used to manage stress, and
  - e) Sleep and rest patterns.
- 5) Nursing services shall also include the following interventions:
- a) Health maintenance and discharge teaching;
  - b) Prevention of the complications of immobility;
  - c) Physical care including hygiene, skin care, physical transfer from one place to another, positioning and bowel and bladder care;
  - d) Psychosocial services including socialization, adaptation to an altered lifestyle; and
  - e) Reinforcement of the interdisciplinary treatment plan.
- (6) As appropriate, nurses collaborate with the patient, family, other disciplines and agencies in discharge planning and teaching.
- (7) Rehabilitation nursing shall monitor the degree of achievement of individualized nursing patient care goals.
- (c) Interdisciplinary Team

There shall be an interdisciplinary team responsible

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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for developing the individual treatment plans, discharge plans and conducting the quality assurance reviews. The interdisciplinary team shall include a physician, rehabilitation nurse, social workers, or psychologist, and those therapists involved in the patient's care. At a minimum, a team shall include a physician, rehabilitation nurse and two (2) therapists.

(d) Program Manager

(1) A single program manager shall be designated for each patient served. The provision of services to each patient shall be organized through the patient's program manager. The program manager shall:

- a) Assume responsibility for the patient during the course of treatment;
- b) Coordinate the treatment plan; and
- c) Cultivate the patient's participation in the program.

(2) The patient's program manager shall evaluate regularly the appropriateness of the treatment plan in relation to the progress of the patient toward the attainment of stated goals. The program manager shall assure that:

- a) The person is adequately oriented;
- b) The plan proceeds in an orderly, purposeful, and timely manner; and
- c) The discharge decision and arrangement for follow-up are properly made.

(e) Therapeutic Services

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- (1) In addition to physician and nursing services, the facility shall provide the following allied services directly or under contract. These services shall be provided at an intensity appropriate to the disability and to the patient's response to treatment with a minimum average level for three (3) to five (5) hours of therapeutic service per person per day at least five (5) days per week. Therapeutic services consist of treatment and rehabilitation services that involve the patient's participation and do not include services that are performed on behalf of the patient. Services shall be delivered by the appropriate registered, certified, licensed and degreed personnel or be performed substantially in their presence.
  
- (2) Occupational therapy services shall be provided by or under the supervision of an individual certified by the American Occupational Therapy Association as an occupational therapist. Services shall include:
  - a) Assessment and treatment of functional performance; independent living skills; prevocational and work adjustment skills; educational, play and leisure and social skills.
  - b) Assessment and treatment of performance components and neuromuscular, sensor integrative, cognitive and psycho-social skills.
  - c) Therapeutic interventions, adaptations, and prevention.
  - d) Individualized evaluations of past and current performance shall be achieved through observation of individual or

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- group tasks, standardized test, record review, interviews, or activity histories.
- e) Assess architectural barriers in home and workplace, and recommend equipment, adaptations, and different arrangements.
  - f) Treatment goals shall be achieved through use of selected modalities and techniques which include:
    - 1.) Tasks oriented activities; simulation or actual practice or work, self-care, home management, leisure and social skills and their components, creative media, games, computers and other equipment.
    - 2.) Pre-vocational training;
    - 3.) Sensor motor activities;
    - 4.) Patient and family education and counseling;
    - 5.) Design, fabrication and application of orthotic devices;
    - 6.) Guidance in use of adaptive equipment and prosthetic devices;
    - 7.) Adaptation to physical and social environment, and use of therapeutic milieu;
    - 8.) Joint protection and body mechanics;
    - 9.) Positioning;
    - 10.) Work simplification and energy conservation;
    - 11.) Cognitive remediation; and
    - 12.) Dysphasia evaluation and retraining.



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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- functioning.
- b) Interventions include individual and group psycho-therapy, family consultation and therapy; and design of such specialized psychological intervention programs as behavior modification, behavioral treatment regimens' patients, and the use of biofeedback and relaxation procedures.
  - c) The psychologist shall monitor the cognitive and emotional adaptation of the patient and family to the patient's disability.
- (5) Speech-language services shall be provided by or under the supervision of a licensed speech- language pathologist who meets the standards for the Certificate of Clinical Competency by the American Speech-Language, and Hearing Association. Services shall include:
- a) Screening to identify individuals who require further evaluation to determine the presence or absence of a communicative disorder and the presence of a swallowing disorder.
  - b) When the speech and language competencies of individuals are evaluated, the pathologist plans, directs, and conducts habilitative, rehabilitative, and counseling programs to improve language, voice, cognitive linguistic skills, articulation, fluency, and adjustment to hearing loss, and assesses and provides alternative and augmentative communicative devices.
  - c) Plans for discharge and provides for the patient's understanding of

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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communication abilities and prognosis.

- d) Services are monitored for effectiveness of actions taken to improve communication skills of patients.

(f) Other Services

The following services shall be provided directly or through a contractual arrangement with other providers as needed in accordance with the facility's brain injury program narrative:

- (1) Social work services shall be provided by an individual with a master's degree in social work from a curriculum accredited by the Council for Social Work Education.

- a) The scope of rehabilitation social services shall include the following areas related to work assessment and interventions to facilitate rehabilitation:

- 1.) Assessment of the personal history and current psychosocial adaptation to the disability;
- 2.) Assessment of immediate and extended family and other support persons relative to increasing support networks;
- 3.) Assessment of housing, living arrangements, and stability and source of income relative to facilitating discharge plans; and

- b) Intervention strategies, aimed at increasing effectiveness of coping, strengthening informal support systems, and facilitating continuity of care, shall include at least the following:

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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- 1.) Discharge planning activities;
  - 2.) Casework with individual patients;
  - 3.) Family counseling and therapy;
  - 4.) Group work focused on both education and therapy; and
  - 5.) Community service linkage and referrals.
- c) The person responsible for social services shall monitor the achievement of goals relative to discharge planning activities designed to meet the basic sustenance, shelter, and comfort needs of patients and their families.
- (2) Audiology services provided by or under the supervision of a licensed audiologist, and certified by the American Speech-Language, and Health Association. When the range, nature, and degree of the patient's auditory and vestibular function using instrumentation such as audiometers, electroacoustic equipment and electro-nystagmographic equipment are determined, the professional plan directs and conducts aural habilitation and rehabilitation programs. These shall include:
- a) Hearing aid and assistive listening device selection and orientation;
  - b) Counseling, guidance and auditory training; and
  - c) Speech reading
- (3) Vocational and vocational rehabilitation services. These services provide assessment and evaluation to the individual's need for services to enable to return to productive activity through the use of testing, counseling, and other service related activities. These identified needs are met either directly or

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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through appropriate referrals. Services shall include:

- a) Evaluation and assessment focusing on maximizing the independent productive functioning of the individual; and
  - b) Comprehensive services shall include, at a minimum, the following areas:
    - 1.) Physical and intellectual capacity evaluation;
    - 2.) Interest and attitudes;
    - 3.) Emotional and social adjustment;
    - 4.) Work skills and capabilities;
    - 5.) Vocational potential and objectives; and
    - 6.) Job analysis.
  - c) Appropriate instruments, equipment and methods, under supervision of a qualified therapist shall be used.
  - d) A written report with interpretation and recommendations shall be prepared and shared with the individual and referral source.
  - e) Services shall monitor the degree to which appropriate work skills are achieved, the improvement in independent functioning relative to work skill capability; and, the achievement or vocational objectives.
- (4) Prosthetic and orthotic services shall be provided by authorized specialists who are qualified to manage the orthotic (prosthetic) needs of disabled persons by performing an examination; by participating in the prescribing of needed specialized equipment; by designing and fitting the equipment; and by following up to ensure that the equipment is properly functioning and fitting.

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**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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Monitoring of prosthetics and orthotic services shall include:

- a) Documented evidence or communication with the prosthetist relative to function and fit of the equipment.
  - b) Patient satisfaction with the orthosis or prosthesis relative to function and fit of the equipment.
- (5) Therapeutic recreation services shall be provided by or under the supervision of a therapeutic recreation specialist, or under the supervision of an occupational therapist. These services may be provided in conjunction with occupational therapy services. Services shall include the following:
- a) Assessment of the patient's leisure, social and recreational abilities, deficiencies, interests, barriers, life experiences, needs, and potential;
  - b) Treatment services designed to improve social, emotional, cognitive, and physical functional behaviors as a necessary prerequisite to future leisure and social involvement;
  - c) Leisure education designed to help the patient acquire knowledge, skills and attitudes needed for independent leisure and social involvement, community adjustment, responsible decision-making, and use of free time; and
  - d) Monitoring which measures the extent to which goals are achieved relative to the use of leisure time and socialization skills.
- (6) Respiratory therapy services shall be provided as medically indicated in accordance with written physician orders.

**SECTION IV-A – NURSING FACILITY BRAIN INJURY PROGRAM**

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8. In-service Training

The facility shall have a planned program for ongoing in-service training at least quarterly for all staff with emphasis on the service and rehabilitation needs unique to individuals who have sustained brain injuries. The training shall also include topics such as infection control, medical and other emergencies, mobility training, etc.

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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**IV-B. DISTINCT PART VENTILATOR NURSING FACILITIES**

Individuals who are ventilator dependent and meet usual skilled nursing facility level of care criteria may be provided care in a certified distinct part ventilator nursing facility unit providing specialized ventilator services if the care is preauthorized using criteria specified in this Section of the Nursing Facilities Services Manual.

**A. Facility Participation Criteria shall be:**

1. The nursing facility shall operate a program of ventilator care within a certified distinct part nursing facility which meets the needs of all ventilator patients admitted to the unit.
2. The unit shall have not less than twenty (20) beds certified for the provision of ventilator care.
3. The unit shall be required to have an average patient census of not less than fifteen (15) patients during the calendar quarter preceding the beginning of the facility's rate year or the quarter for which certification is being granted in order to qualify for distinct part ventilator nursing facility certification.
4. The unit shall have a ventilator machine owned by the facility for each certified bed with an additional back up ventilator machine required for every ten (10) beds.
5. The facility shall have an appropriate program for discharge planning and weaning from the ventilator.

**B. Patient Criteria and Service Characteristics**

The following describe general patient criteria and treatment characteristics for distinct part ventilator nursing facilities:

1. The individual shall be ventilator (or respiration stimulating mechanism) dependent for twenty-four (24) hours per day and requiring twenty-four (24) hours per day skilled specialty nursing care;
2. The individual shall be ventilator (or respiration stimulating

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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mechanism) dependent for twelve (12) hours or more per day during a weaning program with the goal to attain the least mechanical support in the least invasive manner that is consistent with maximal function of the individual and requiring twenty-four (24) hours per day skilled specialty nursing care;

3. Admissions from hospitalization or other locations should demonstrate two (2) weeks clinical and physiologic stability including applicable weaning attempts prior to transfer; and
4. As a practical matter, the services cannot be provided in an appropriate alternative setting to meet the medical stability and safety needs of the individual.

**C. Nursing Facility Level of Care determinations shall be made taking into consideration the following factors:**

1. Alternative care possibilities;
2. Goals for patient care;
3. Primary hypoventilation, restrictive lung, ventilatory muscle dysfunction, and obstructive airway disorder needs which may necessitate ventilator and related care;
4. Non-hospital management factors and needs;
5. Patient treatment characteristics;
6. Home care potential;
7. Suitability of transfer to the ventilator care unit;
8. Provision of an appropriate place of care; and
9. Other facility admission indicators as shown in this manual.

**D. The following criteria shall be considered in determining Nursing Facility Level of Care for ventilator dependent individuals.**

1. Alternative care considerations shall include:
  - (a) Disease and benefits of ventilator care on a continuing basis;
  - (b) Patient and family desire;
  - (c) Ability to manage at home; and
  - (d) Available resources and required technologies.

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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2. Goals for patient care shall include:
  - (a) Extended and enhanced quality of life;
  - (b) Enhancement of individual potential;
  - (c) Minimal morbidity;
  - (d) Improved physical and physiologic function; and
  - (e) Cost-benefit factor.
  
3. Patient conditions which may benefit from long term mechanical ventilation (LTMV):
  - (a) Central hypoventilation
    - (1) Congenital-idiopathic, anatomic Arnold-Chiori with myelomeningocele
    - (2) Acquired-traumatic, infectious, surgical procedure, cerebrovascular accident (CVA).
  
  - (b) Ventilator muscle dysfunction:
    - (1) Central nervous system (CNS) disease;
    - (2) Polyneuropathy;
    - (3) Muscular dystrophy, myopathies; and
    - (4) Kyphoscoliosis.
  
  - (c) Restrictive lung disease: Less benefit achieved, trial to be done in the hospital before commitment to LTMV.
  
  - (d) Chronic obstructive airway disease (COPD) (emphysema, chronic obstructive bronchitis, bronchopulmonary dysplasia (BPD) and cystic fibrosis.:
  
4. Nonhospital management factors shall include:
  - (a) Physiologic and clinical stability prior to commitment;

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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- (b) Coexistent diseases shall be addressed; and
  - (c) Patients with intermittent or frequent changes may be suitable candidates for care in a regular nursing facility bed when home care is not clinically suitable.
  - (d) Alternative methods of treatment to be considered shall include:
    - (1) Phrenic nerve stimulation (pacer); and
    - (2) Rocking bed pneumobelt.
5. Characteristics of candidate for LTMV shall include:
- (a) Central hypoventilation - cervical trauma;
  - (b) Multiple failed wean attempts;
  - (c) Repeated frequent ventilation failure and admission for ventilator support;
  - (d) Progressive muscular dystrophy (MD) or amyotrophic lateral sclerosis (ALS); and
  - (e) Documented ventilation is needed to sustain life or to enhance the life quality.
6. Home care candidacy may be appropriate under the following conditions:
- (a) Patient desires placement: Decision made when acute problem is stable and patient participates in decision-making process.
  - (b) Family desires placement of member:
    - (1) Psychosocial assistance and support is available;
    - (2) Structured education; and
    - (3) Safety issues.
  - (c) Resources available for alternate placement.
    - (1) Psychosocial:
      - a) Established psychosocial support

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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- system in the home;
    - b) Depression and fear addressed;
    - c) Safety and back-up procedures; and
    - d) Rehabilitation for mobility when feasible.
  - (2) Family care needs:
    - a) Respite; and
    - b) Training in patient care needs.
  - (3) Environment:
    - a) Care setting, mobility and safe exiting;
    - b) Electrical outlets for ventilator, humidification, and suction;
    - c) Battery rechargeability or generators; and
    - d) Alarms systems and accessibility.
  - (d) Necessary medical support and access available for alternate placement.
  - (e) Necessary technical support available for alternate placement.
- 7. The criteria for transfer from a hospital or alternate location setting to a distinct part ventilator nursing facility shall be:
  - (a) Clinical stability;
  - (b) Physiologic stability;
  - (c) Comprehensive program for transfer to a distinct part ventilator nursing facility shall include:
    - (1) Discharge team;
    - (2) Educational program; and
    - (3) Rehabilitation program.
  - (d) Prescription shall include:

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**SECTION IV-B – DISTINCT PART VENTILATOR NURSING FACILITIES**

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- (1) Respiratory care plan; and
    - (2) Management plan.
  
  - (e) Focus on optimizing functional ability; and
  - (f) Prior to discharge to home or other community placement, training in use of equipment to be used in the home.
8. The plan of care shall include:
- (a) Medical condition stabilization;
  - (b) Development and evaluation of realistic goals to include self-care techniques;
  - (c) Training rehabilitation plan;
  - (d) Rehabilitation training for strength and endurance;
  - (e) Discharge planning and equipment maintenance; and
  - (f) Home care, follow-up and emergency measures.
9. Facility admission indicators shall include:
- (a) Respiratory infections;
  - (b) Assessment of the “free time” off the ventilator;
  - (c) Absence of adequate caregivers;
  - (d) Evaluation of hemoptysis or respiratory failure; and
  - (e) Backup failure.

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**SECTION V – SCOPE OF SERVICES**

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V. SCOPE OF SERVICES

A. Nature

Benefits shall be financial reimbursement for authorized services that were provided. Reimbursement shall be made directly to participating providers. All payments shall be made to the nursing facility for services provided to Medicaid residents with the exception of reimbursement for Medicaid covered drugs and insulin syringes which shall be made to the Medicaid participating pharmacy under contract to the nursing facility to provide drugs for the facility's residents.

Payment of a zero ("0") amount is considered as a payment by the Medicaid Program. A zero payment is not to be interpreted as a non-payment.

B. Initiation

Provider payments shall begin upon admission of an eligible resident to a participating nursing facility provided such benefit provision has been authorized by the PRO and admission is to a nursing facility participating in the Medicaid Program, authorized by the Department for Medicaid Services.

C. Duration

Provider payments shall continue until the resident is discharged, expires, or until authorization for benefit provision is withdrawn by the PRO and if residency is in a nursing facility participating in the Medicaid Program authorization is withdrawn by the Department of Medicaid Services, on the basis of medical data indicating an alleviation of needs for nursing facility services as defined by the Medicaid Program.

D. Case-Mix

Medicaid makes reimbursement to nursing facilities for routine services they provide plus ancillaries (other than brain injury programs and specially certified ventilator facilities which have all-inclusive rates). A nursing facility's Medicaid routine per diem rate, unless otherwise specified, is established by Medicaid based on a prospective case-mix assessment reimbursement system which is fully described in the regulation 907 KAR 1:065.

The prospective Case Mix Assessment Reimbursement system is designed to achieve three major objectives:

1. To assure that needed nursing facility care is available for

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**SECTION V – SCOPE OF SERVICES**

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2. all eligible residents including those with higher care needs. To provide an equitable basis for both urban and rural facilities to participate in the Program, and
3. To assure Program control and cost containment consistent with the public interest and the required level of care.

E. Medical Prior-Authorization Procedure for Medicaid

The PRO shall be responsible for determining if nursing facility level of care is met for all nursing facility services for Medicaid residents as described in Section IV of this manual. PRO staff shall review prospective admissions when contacted by telephone at 1-800-292-2392. Nursing facility level of care shall be reevaluated by PRO staff during on-site visits.

When a Medicaid applicant or resident has been certified by the PRO as meeting the criteria for nursing facility care, a copy of the Confirmation Notice shall be sent by the PRO to the local office of the Department for Community Based Services.

F. Covered Services

Reimbursement by Medicaid represents payment-in-full for Medicaid covered services provided to Medicaid residents who have been determined by the PRO to meet the criteria for nursing facility placement. Any item covered by Medicaid for a nursing facility shall be prescribed by a physician and necessary for the habilitation or rehabilitation of the Medicaid resident so that he can function at his maximum level. Medicare (Title XVIII) has first liability for coverage of items for residents who are QMB only, dually eligible and Medicare and Medicaid non-QMB eligibles. The Medicaid Program shall only be responsible for any applicable Medicare deductible or coinsurance amounts in these instances.

The Medicaid Program shall only make reimbursement for services that are medically necessary and ordered by the attending physician.

If the facility receives payment from an eligible Medicaid resident for a covered service, Medicaid Program regulations require that the payment be refunded PRIOR TO BILLING the Medicaid Program. A covered service or item shall be reimbursed only (1) one time. Any duplication of payment by the Medicaid Program, whether due to erroneous billing or payment system faults, shall be refunded to the Medicaid Program. Failure to refund a duplicate or inappropriate payment may be interpreted as fraud and abuse, and prosecuted as such. This policy shall not apply to payments made by residents for non-covered items or services.

All items and services considered by the Medicaid Program to be

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**SECTION V – SCOPE OF SERVICES**

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non-covered, that were provided to Medicaid residents during any period of a covered stay, may be billed to the resident or another payer. The amounts covering these items shall not be listed as an amount received from other sources when billing the Medicaid Program. The charge made to the Medicaid Program shall be the same charge made for comparable services and items provided to any party or payer.

1. Routine Services

Covered routine services include room, dietary services, social services, nursing services, the use of equipment and facilities, and medical and surgical supplies.

2. Private Room

(a) If the attending physician orders a private room for the resident, the facility shall not charge the family or responsible party any difference in private and semi-private room charges. The facility enters their charges for a private room when billing the Medicaid Program.

(b) If the only available Kentucky Medicaid certified bed in the facility is in a private room, and the attending physician did not order a private room, the facility may:

[a) Make arrangements with the family or responsible party (but not the resident) to pay the difference between the facility's CHARGES for a private room and their CHARGES for a semi-private room,]

[OR]

b) Decline to charge the family or responsible party for any difference in private and semi-private room charges. If the facility elects the first option, the facility shall submit their charges to the Kentucky Medicaid Program for a semi-private room. If the facility elects the second option, the

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**SECTION V – SCOPE OF SERVICES**

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facility shall submit their charges for a private room.

(c) If the family or responsible party requests the private room, and the attending physician did not order a private room, the facility shall make arrangements with the family or responsible party (but not the resident) to pay the difference in the facility's private and semi-private room CHARGES. Under these circumstances, the facility shall only enter their charges for a semi-private room when billing the Medicaid Program. This is regardless of whether or not the family or responsible party paid the difference in private and semi-private room charges.

(d) If the recipient chooses a private room, and the attending physician did not order a private room, the facility may make arrangements with the resident to pay the difference in the facility's private and semi-private room charges. THIS IS THE ONLY CIRCUMSTANCE UNDER WHICH THE RESIDENT SHALL BE CHARGED.THE DIFFERENCE IN PRIVATE AND SEMI-PRIVATE ROOM CHARGES.

The facility may only enter their charges for a semi-private room when billing the Medicaid Program. This is regardless of whether the resident paid the difference in the facility's private and semi-private room charges.

3. Podiatry Services

The cost of podiatry services, when ordered by the attending physician, shall be allowable under the routine aspect of the case-mix reimbursement system for Medicaid-only residents. Podiatrists shall not independently bill the Medicaid Program for services provided to Medicaid-only residents in provider payment status in a nursing facility. Payment to the podiatrist for the Medicaid-only resident shall be through a contractual arrangement between the facility and the podiatrist. For the QMB only, dual eligible and Medicare and Medicaid (non-QMB) residents, Medicare has first liability. The podiatrist, if enrolled in the Medicaid Program, may bill the Medicaid Program for Medicare deductible and coinsurance amounts. If the podiatrist is not enrolled in the Medicaid Program or does not choose to bill the Medicaid Program, the nursing facility may bill Medicare deductible and

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**SECTION V – SCOPE OF SERVICES**

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coinsurance amounts to Medicaid on the UB-04 billing form.

4. Prosthetic Devices

Prosthetic devices which are necessary for the rehabilitation of the Medicaid resident so that he or she can function at a maximum level should be provided to the Medicaid recipient residing in a nursing facility, if it has been ordered by a physician and is medically and functionally necessary for the treatment of an illness or injury. Prosthetic devices, such as artificial limbs and braces, is allowable under the routine aspect of the case-mix reimbursement system. Medicare (Title XVIII) Part B has first liability for coverage of such items for the QMB only resident, the dual eligible resident, and the resident eligible for both Medicare and Medicaid non-QMB.

The procurement and provision of these devices is included in the calculated nursing facility's routine reimbursement rate. Some prosthetic devices may be reimbursed by other sections of the Medicaid program. For example, dentures, lenses and frames, hearing aids, pacemakers, etc.

The purchase of orthopedic shoes shall be allowable under routine reimbursement ONLY if the shoe is affixed to and is an essential part of the orthotic device.

5. Durable Medical Equipment

The Medicaid Program shall not make reimbursement to durable medical equipment (DME) providers for services and items provided to the nursing facility resident other than Medicare deductible and coinsurance amounts.

6. Laundry

Nursing facilities shall launder institutional gowns, robes and personal clothing which are the normal wearing apparel in the facility without charge to the resident or his family or responsible party. If the family or responsible party CHOOSES, they (family or responsible party) can pay for laundry charges or accept responsibility for the laundry. It shall clearly be the choice of the family or responsible party and not a condition of admission or continued stay. If the family or responsible party does not choose to pay for laundry charges or to launder the

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**SECTION V – SCOPE OF SERVICES**

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clothing, the facility shall provide the service as a part of routine cost.

The facility shall advise the family or responsible party of all options regarding laundering of personal clothing including the fact that if they (family or responsible party) chooses not to pay for laundry charges or launder the clothing, the facility shall provide the service without charge to them (family or responsible party) or the resident.

The facility shall separate personal laundry from the facility's soiled linens and diapers to achieve cleanliness and to ensure that the clothing is not damaged. Reasonable efforts shall be taken to assure that resident's laundry is done properly, even if that requires special handling.

7. Ancillary Services

Ancillary services are those for which a separate charge is customarily made. Ancillary services include physical therapy, occupational therapy, speech therapy, laboratory procedures, x-ray, and oxygen therapy.

(a) Therapy

907 KAR 1:023, Review and Approval of selected therapies as ancillary services in Nursing Facilities, provides for the conditions under which oxygen and therapies meet the criteria for payment as ancillary services.

(b) Dietary Supplements

Enteral food supplements used for tube feeding or oral feeding, even if written as a prescription item by a physician, and the supplies related to their administration shall be considered allowable routine costs. If covered by Medicare, Medicaid shall make reimbursement for any Medicare deductible and coinsurance amounts when appropriately billed to Medicaid by the actual provider of the service or item, if that provider is enrolled in Kentucky Medicaid, or to the nursing facility but not by both. Hyperalimentation is considered a drug and therefore billable to Medicaid by the pharmacy.

(c) Laboratory Services

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**SECTION V – SCOPE OF SERVICES**

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Coverage of laboratory procedures for Kentucky Medicaid participating independent laboratories include procedures for which the laboratory is certified by Medicare.

G. Pharmacy Services

General Pharmacy services shall be provided through a contractual arrangement between the nursing facility and a pharmacy that is enrolled, or will enroll, in the Medicaid Program. Payment for Medicaid covered drugs and insulin syringes shall be made to the Medicaid participating pharmacy.

Payment shall not be made for those drugs determined to be less than effective by the Food and Drug Administration (FDA). This includes all drugs listed on the Drug Efficacy Implementation Study (DESSI) and Identical, Related and Similar (IRS) drug lists. Notification of these drugs is periodically distributed to Medicaid participating pharmacies and nursing facilities. Also, for drugs provided on or after May 1, 1991. A payment shall not be made for those labelers who have not signed a rebate agreement with the federal government.

H. Transportation Services

Medicaid shall cover transportation to and from Medicaid Program covered medical services by ambulance or other approved vehicle if the resident's condition requires special transportation. Also covered shall be prior authorized non-emergency medical transportation to physicians and other non-emergency, Medicaid-covered medical services when provided by a participating medical transportation provider. Travel to pharmacies shall not be covered.

I. Vision Services

Examinations and certain diagnostic procedures performed by ophthalmologists and optometrists shall be covered for recipients of all ages. Professional dispensing services, lenses, frames and repairs shall be covered for eligible recipients under age twenty-one (21).

J. Benefits Available to Residents Under Title XVIII

Dually eligible residents and residents eligible for both Medicare and Medicaid (non-QMB) shall be required to EXHAUST any applicable benefits under Title XVIII (Part A and Part B) prior to

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**SECTION V – SCOPE OF SERVICES**

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coverage under the Medicaid Program.

1. Part A Benefits

Medicare Part A coinsurance amounts shall be billed to Medicaid by the nursing facility.

2. Part B Benefits

Medicare Part B deductible and coinsurance amounts may be billed to Medicaid by the nursing facility or the actual provider of the Part B service if that provider is enrolled in the Medicaid Program, but not by both. Examples of services that might be covered under Medicare Part B are x-ray, laboratory, physical therapy and occupational therapy.

K. The Notice of Availability of Income for Long Term Care/Waiver Agency/Hospice (MAP-552)

The MAP-552 advises the nursing facility of the monthly amount of income the resident is responsible for paying the facility toward his cost of care. The facility shall not collect a patient liability amount from the resident who is QMB only.

For dually eligible residents who are admitted to a nursing facility under Title XVIII (Part A) and for whom Medicare coinsurance will be billed to the Medicaid Program, the local Department for Community Based Services (DCBS) initiates action on the MAP-552 when they have received a Memorandum (MAP-24) from the nursing facility, Medicaid or other insurance, notifying DCBS of the admission.

For Medicaid only applicants or residents, DCBS initiates action on the MAP-552 when they have received a Confirmation Notice from the PRO.

When there is a change in the amount of the continuing income received by the resident (either an increase or a decrease), a MAP-552 shall be prepared by the DCBS worker. Income data entered on the MAP-552 for that admission shall remain in effect until a new MAP-552 is issued.

The resident's income shall be disregarded through the month of admission when initially admitted to a nursing facility. The continuing income as indicated on the MAP-552 is to be collected by the facility from the resident or responsible party, e.g., family, guardian, or conservator. A direct transfer to another nursing facility would not begin another period of income disregard. If the

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**SECTION V – SCOPE OF SERVICES**

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resident is out of provider payment status for thirty (30) days or more, DCBS shall allow a new income disregard period. The Medicaid Program disregards the income for the month of admissions (EXCEPT for individuals covered under a Veterans Administration contract, commercial health insurance or private pay) but considers it only for any other subsequent month. The Medicaid Program also disregards the income for the month of admission when the individual transfers to a nursing facility from a personal care facility or from a family care facility.

Claims processed prior to entry into the system of continuing income data will reject; therefore, it is recommended that initial claims be submitted only after the MAP-552 is received by the nursing facility.

Continuing income, if any, is to be collected when billing Medicaid for in-house days, bed reservation days, and Medicare Part A coinsurance days.

If a partial month of services is provided, the total amount of a resident's available income is not to be collected. The computer automatically prorates the resident's available income and deducts that portion of the income available for collection of a partial month of services. The following formula shall be used.

Days of service x resident's available income - days in month = amount to be collected from the resident or APPLICABLE INCOME for that portion of the month.

For example: 10 days x \$110.00 divided by 30 days in month = \$36.67

L. Memorandum to Local DCBS Office (MAP-24)

The MAP-24 shall be submitted by the nursing facility to the local DCBS office to report the following information, within ten (10) days of its occurrence:

1. Admission of a dually eligible resident for whom Medicare Part A is the primary payer. A MAP-24 shall not be submitted for the QMB-only resident.
2. Discharge or death of any Medicaid resident.
3. The date a Medicaid resident is accepted for hospice coverage. (To be reported as a discharge from the nursing facility even if the resident shall remain in the facility.)

This information allows the DCBS office to generate an MAP-552 for the dually eligible resident for whom Medicare is the primary payer. This flow of information is essential to timely payment to the nursing facility and efficient records for DCBS.

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**SECTION V – SCOPE OF SERVICES**

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M. Days

1. For Medicaid purposes, a day shall be considered in relation to the midnight census.
2. Medicaid shall pay for the date of admission but shall not pay for the date of discharge (death).
3. Ancillary charges incurred on the date of discharge (death) shall be Medicaid covered.
4. Neither the resident nor his family or responsible party shall be billed for the date of discharge.
5. Early admission fees or late discharge fees shall not be billed to Medicaid or charged to the resident or his or her family or responsible party.

N. Bed Reservation Policy

The Medicaid Program shall make payment to a nursing facility during a Medicaid resident's absence for acute care hospitalization and therapeutic home visits provided certain criteria are met. Bed reservation days shall not be available for the resident admitted to a mental hospital.

Facilities shall allow residents for whom Medicaid is paying to reserve a bed, return to that bed when they are ready for discharge from the hospital or when returning from therapeutic home visits, regardless of the day of the week (this includes holidays and weekends.)

If the facility chooses not to reserve a bed for a resident for whom bed reservation days are available, the facility shall advise the resident prior to his or her departure from the facility.

It shall be the responsibility of the nursing facility to assure that services and items ordered by a resident's physician are provided while the resident is out of the facility (other than for hospitalization) and Medicaid will be billed to reserve the bed. The nursing facility shall not be responsible if the resident was on bed reservation days for hospitalization as the hospital would be providing required services and items. If the nursing facility cannot provide the required ancillaries directly, the facility shall make arrangements with a qualified source (i.e., pharmacy, physical therapist, speech therapist, etc.) for the resident to obtain the required services and items. Pharmacies shall bill Medicaid directly; therapists, etc. shall bill the facility. As always, if the resident receives an ancillary service or item that Medicare Part B can cover, the nursing facility shall ensure that the Title XVIII carrier is billed prior to seeking reimbursement from Medicaid.

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**SECTION V – SCOPE OF SERVICES**

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1. Criteria for approved bed reservation shall be:
  - (a) The resident is in Medicaid long term care vendor payment status and has been a resident of the facility at least overnight. Persons for whom Medicaid is making Title XVIII Part A coinsurance payments shall not be considered to be in Medicaid payment status for purposes of this policy.
  - (b) The resident is reasonably expected to return to the same facility with Medicaid as the primary payer. If returning to the same facility with Medicare as the primary payer, bed reservation days shall only be available up to the day Medicare eligibility is determined, provided the bed reservation day maximums are not exceeded.
  - (c) Due to a demand for beds at the facility, there is a likelihood that the bed would be occupied by some other resident were it not reserved.
  - (d) The hospitalization shall be in an acute care hospital or a Kentucky hospital certified by Kentucky to participate in the acute care hospital program. The hospitalization shall be approved by the PRO.
  - (e) If hospitalization is approved, and the bed occupied by the resident is also a Medicaid certified acute care bed, the resident shall have been transferred to a specialty unit of a hospital.

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**SECTION V – SCOPE OF SERVICES**

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2. Medicaid payment for bed reservation days shall be limited as follows:
  - (a) A maximum of fourteen (14) days per calendar year due to an acute care hospital stay.
  - (b) A maximum of ten (10) days per calendar year for leaves of absence other than hospitalization.
  - (c) Reimbursement shall be seventy-five (75) percent of a facility's rate if the facility has an occupancy percentage of ninety-five (95) percent or higher.
  - (d) Reimbursement shall be fifty (50) percent of a facility's rate if the facility has an occupancy percentage lower than ninety-five (95) percent.

Maximums are applied per resident per calendar year. Accumulated bed reserve days shall follow a resident if he or she relocates to another facility rather than starting over at zero (0) due to a relocation.

**KENTUCKY MEDICAID PROGRAM  
NURSING FACILITY SERVICES MANUAL**

**APPENDIX I – MAID CARDS**

CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
NURSING FACILITIES SERVICES MANUAL

MAID CARDS

MAID CARDS

Medical Assistance Identification (MAID) cards are issued monthly to recipients with ongoing eligibility. These cards show a month-to-month eligibility period. Eligible individuals with excess income for ongoing eligibility may be eligible as a "spend down" case if incurred medical expenses exceed the excess income amount. Individuals eligible as a "spend down" case receive one MAID card indicating the specific period of eligibility. After this eligibility period ends, the person may reapply for another "spend down" eligibility period.

MAID CARDS shall show a retroactive period of eligibility. Depending on the individual circumstances of eligibility, the retroactive period shall include several months.

Duplicate MAID cards shall be issued for individuals whose original card is lost or stolen. The recipient shall report the lost or stolen card to the local Department for Community-Based Services, Division of Field Services worker responsible for the case.

VERIFYING ELIGIBILITY

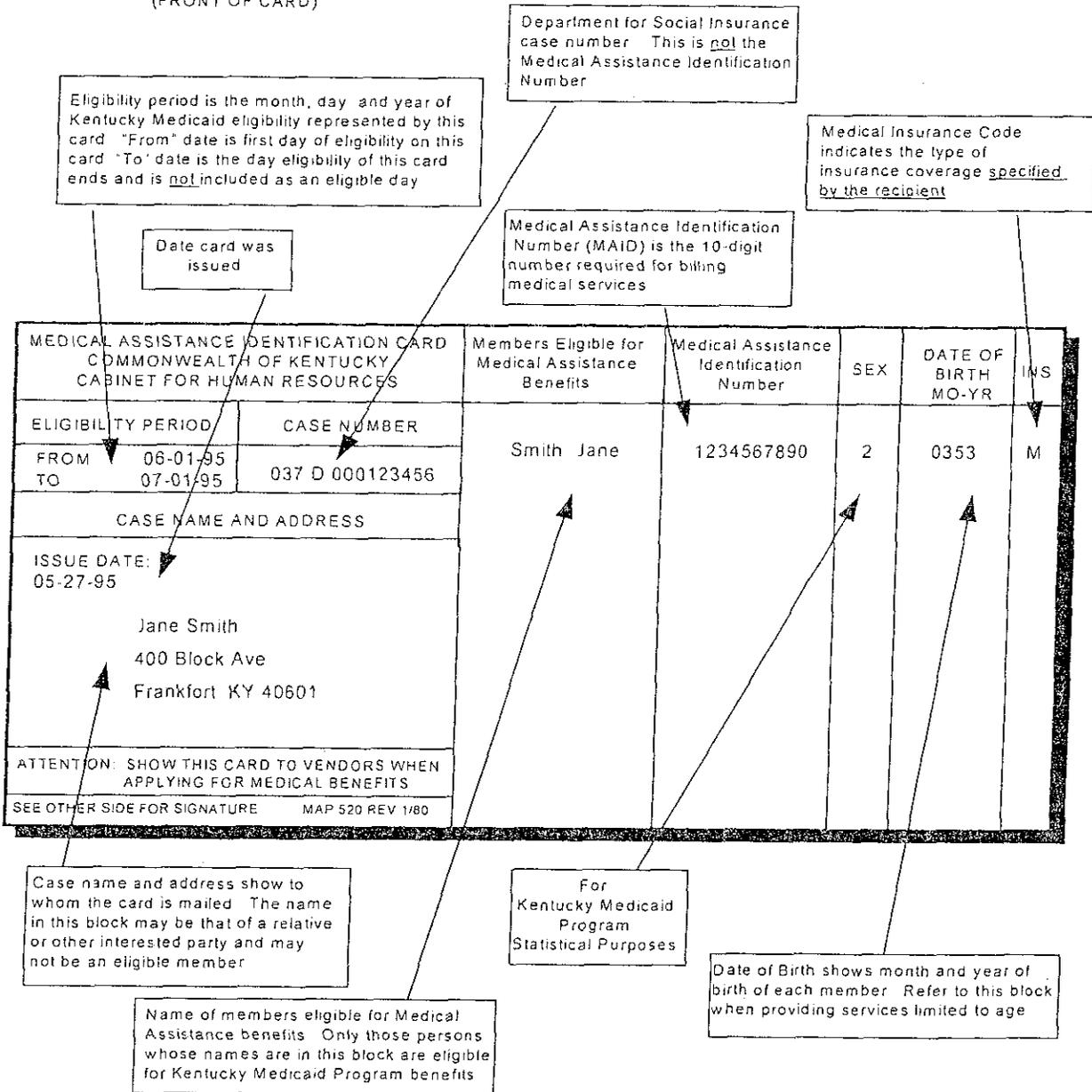
The local Department for Community-Based Services, Division of Field Services staff shall provide eligibility information to providers requesting MAID numbers and eligibility dates for active, inactive or pending cases.

The Department for Medicaid Services, Eligibility Services Section at (502) 564-6885 shall also verify eligibility for providers.

# 1.1. KENTUCKY MEDICAL ASSISTANCE IDENTIFICATION (MAID) CARDS

## 1.1.1. REGULAR MAID CARD

(FRONT OF CARD)



WHITE CARD

# BACK OF MAID CARD

Information to Providers  
Insurance Identification  
codes which indicate type  
of insurance coverage as  
shown on the front of the  
card in "Ins" block.

<p><b>PROVIDERS OF SERVICES</b></p> <p>This card certifies that the person(s) listed hereon are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>Questions regarding provider participation, type, scope and duration of benefits, billing procedures, amounts paid, or third party liability should be directed to:</p> <p>Cabinet for Human Resources Department for Medicaid Services Frankfort KY 40621 0001</p>	<p><b>RECIPIENT OF SERVICES</b></p> <ol style="list-style-type: none"> <li>This card may be used to obtain services from participating hospitals, drug stores, physicians, dentists, nursing facilities, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing vision, ambulance, non-emergency transportation, screening and family planning services.</li> <li>Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.</li> <li>You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection please sign on the line below and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.</li> <li>If you have questions, contact your eligibility worker at the county office.</li> <li>Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.</li> </ol>																		
<p><b>Insurance Identification</b></p> <table border="0"> <tr> <td>A. Part A, Medicare Only</td> <td>F. Private Medical Insurance</td> </tr> <tr> <td>R. Part A, Medicare Premium Paid</td> <td>G. Champus</td> </tr> <tr> <td>B. Part B, Medicare Only</td> <td>H. Health Maintenance Organization</td> </tr> <tr> <td>C. Both Parts A &amp; B Medicare</td> <td>J. Unknown</td> </tr> <tr> <td>S. Both Parts A &amp; B Medicare Premium Paid</td> <td>K. Other</td> </tr> <tr> <td>D. Blue Cross Blue Shield</td> <td>L. Absent Parent's Insurance</td> </tr> <tr> <td>E. Blue Cross Blue Shield Major Medical</td> <td>M. None</td> </tr> <tr> <td></td> <td>N. United Mine Workers</td> </tr> <tr> <td></td> <td>P. Black Lung</td> </tr> </table>		A. Part A, Medicare Only	F. Private Medical Insurance	R. Part A, Medicare Premium Paid	G. Champus	B. Part B, Medicare Only	H. Health Maintenance Organization	C. Both Parts A & B Medicare	J. Unknown	S. Both Parts A & B Medicare Premium Paid	K. Other	D. Blue Cross Blue Shield	L. Absent Parent's Insurance	E. Blue Cross Blue Shield Major Medical	M. None		N. United Mine Workers		P. Black Lung
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E. Blue Cross Blue Shield Major Medical	M. None																		
	N. United Mine Workers																		
	P. Black Lung																		
<p><b>RECIPIENT OF SERVICES:</b> You are hereby notified that under State Law, KRS 205.624, your right to third party payment has been assigned to the cabinet for the amount of medical assistance paid on your behalf. Federal Law provides for a \$10,000 fine or imprisonment for a year or both for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.</p> <p style="text-align: right;">_____ Signature</p>																			

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments

Recipient's signature is not required

# 1.1.2. QUALIFIED MEDICARE BENEFICIARY (QMB)/MAID CARD

(FRONT OF CARD)

MEDICAL ASSISTANCE IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		Members Eligible for Medical Assistance Benefits	Medical Assistance Identification Number	SEX	DATE OF BIRTH MO-YR	INS
ELIGIBILITY PERIOD	CASE NUMBER	THIS PERSON IS ALSO ELIGIBLE FOR QMB BENEFITS	IS ALSO QMB BENEFITS	2	0353	M
FROM: 06-01-95 TO: 07-01-95	037 D 000123456					
CASE NAME AND ADDRESS		Smith Jane				
Jane Smith 400 Block Ave Frankfort KY 40601						
ISSUE DATE: 05-27-95						
ATTENTION SHOW THIS CARD TO VENDORS WHEN APPLYING FOR MEDICAL BENEFITS						
SEE OTHER SIDE FOR SIGNATURE		MAP 520 REV 1/90				

**Department for Social Insurance case number. This is not the Medical Assistance Identification Number**

**Medical Insurance Code indicates the type of insurance coverage specified by the recipient**

**Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services**

**NOTICE QMB Info**

**Eligibility period is the month, day and year of Kentucky Medicaid eligibility represented by this card. "From" date is first day of eligibility on this card. "To" date is the day eligibility of this card ends and is not included as an eligible day**

**Date card was issued**

**Case name and address show to whom the card is mailed. The name in this block may be that of a relative or other interested party and may not be an eligible member**

**Name of members eligible for Medical Assistance benefits. Only those persons whose names are in this block are eligible for Kentucky Medicaid Program benefits**

**Date of Birth shows month and year of birth of each member. Refer to this block when providing services limited to age**

**For Kentucky Medicaid Program Statistical Purposes**

WHITE CARD (ALSO)

**BACK OF QMB/MAID CARD**

Information to Providers  
Insurance Identification  
codes which indicate type  
of insurance coverage as  
shown on the front of the  
card in "Ins." block

**PROMDERS OF SERVICES**  
This card certifies that the person(s) listed hereon are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.  
Questions regarding provider participation, type, scope, and duration of benefits, billing procedures, amounts paid, or third party liability, should be directed to

Cabinet for Human Resources  
Department for Medicaid Services  
Frankfort, KY 40621-0001  
Insurance Identification

- |  |                                   |
|--|-----------------------------------|
| A-Part A, Medicare Only                  | F-Private Medical Insurance       |
| R-Part A, Medicare Premium Paid          | G-Champus                         |
| B-Part B, Medicare Only                  | H-Health Maintenance Organization |
| C-Both Parts A & B Medicare              | J-Unknown                         |
| S-Both Parts A & B Medicare Premium Paid | K-Other                           |
| D-Blue Cross Blue Shield                 | L-Absent Parent's Insurance       |
| E-Blue Cross Blue Shield Major Medical   | M-None                            |
|  | N-United Mine Workers             |
|  | P-Black Lung                      |

**RECIPIENT OF SERVICES**  
1 This card may be used to obtain services from participating hospitals, drug stores, physicians, dentists, nursing facilities, intermediate care facilities, independent laboratories, home health agencies, community mental health centers, and participating providers of hearing, vision, ambulance, non-emergency transportation, screening and family planning services.  
2 Show this card whenever you receive medical care or have prescriptions filled, to the person who provides these services to you.  
3 You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the line below, and destroy your old card. Remember that it is against the law for anyone to use this card except the persons listed on the front of this card.  
4 If you have questions, contact your eligibility worker at the county office.  
5 Recipient temporarily out of state may receive emergency Medicaid services by having the provider contact the Kentucky Cabinet for Human Resources, Department for Medicaid Services.

\_\_\_\_\_  
Signature

**RECIPIENT OF SERVICES:** You are hereby notified that under State Law, KRS 205.624 your right to third party payment has been assigned to the cabinet for for the amount of medical assistance paid on your behalf.  
Federal Law provides for a \$10,000 fine or imprisonment for a year or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.

Notification to recipient of assignment to the Cabinet for Human Resources of third party payments.

Recipient's signature is not required

# 1.1.3. QMB IDENTIFICATION CARD

(FRONT OF CARD)

Eligibility period is the month, day, and year of QMB eligibility represented by this card  
 "From" date is first day of eligibility of this card "To" date is the day eligibility of this card ends and is not included as an eligible day

Medical Assistance Identification Number (MAID) is the 10-digit number required for billing medical services

Medical Insurance Code indicates the type of insurance coverage

Red  
 Blue

LIMITED MEDICAID FOR QUALIFIED MEDICARE BENEFICIARIES IDENTIFICATION CARD COMMONWEALTH OF KENTUCKY CABINET FOR HUMAN RESOURCES		
ELIGIBLE RECIPIENT AND ADDRESS	ELIGIBILITY PERIOD	COVERAGE IS LIMITED TO
Jane Smith. 400 Block Ave Frankfort KY 40601	FROM: 06-01-95 TO: 07-01-95	* MEDICARE PART A PREMIUMS * MEDICARE PART B PREMIUMS * MEDICARE CO-INSURANCE * MEDICARE DEDUCTIBLES  SEE REVERSE SIDE FOR ADDITIONAL INFORMATION
	MEDICAID QMB ID NO 4014567890	
	SEX CODE 2	
	INSURANCE ID C	
	DATE OF BIRTH MONTH/YEAR 09/25	
	ATTENTION: SHOW THIS CARD TO VENDORS WHEN SEEKING MEDICAL CARE	
MAP 520-C REV 3/90		

Name of member eligible to be a Qualified Medicare Beneficiary. Only the person whose name is in this block is eligible for QMB benefits

Date of Birth shows month and year of birth of eligible individual

RED, WHITE, AND BLUE CARD

# BACK OF QMB IDENTIFICATION CARD

Information to Providers  
Insurance Identification  
codes which indicate type  
of insurance coverage as  
shown on the front of the  
card in "Ins" block

Information to Recipients including  
limitations, coverage and emergency  
care through QMB.

<p align="center"><b>PROVIDERS OF SERVICES</b></p> <p>This card certifies that the person(s) listed hereon are eligible during the period indicated on the reverse side for current benefits of the Kentucky Medical Assistance Program. The Medical Assistance Identification No. must be entered on each billing statement precisely as contained on this card in order for payment to be made.</p> <p>Questions regarding provider participation, type, scope, and duration of benefits, billing procedures, amounts paid, or third party liability should be directed to:</p> <p align="center">Cabinet for Human Resources Department for Medicaid Services Frankfort, KY 40621-0001</p>	<p align="center"><b>RECIPIENT OF SERVICES</b></p> <ol style="list-style-type: none"> <li>1 Show this card whenever you receive Medical care.</li> <li>2 You will receive a new card at the first of each month as long as you are eligible for benefits. For your protection, please sign on the front of the card immediately.</li> <li>3 Remember that it is against the law for anyone to use this card except the person listed on the front of this card.</li> <li>4 If you have questions, contact your case worker at the Department for Social Insurance County office.</li> </ol>																		
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<p><b>RECIPIENT OF SERVICES:</b> You are hereby notified that under State Law KRS 205.624, your right to third party payment has been assigned to the cabinet for the amount of medical assistance paid on your behalf.</p> <p>Federal Law provides for a \$10,000 fine or imprisonment for a year, or both, for anyone who willfully gives false information in applying for medical assistance, fails to report changes relating to eligibility or permits use of the card by an ineligible person.</p>																			

09  
KENTUCKY MEDICAID PROGRAM  
NURSING FACILITY SERVICES MANUAL

APPENDIX II - FORMS

## APPLICATION FOR TRANSFER TRAUMA EXEMPTION

Printed Name of Attending Physician: \_\_\_\_\_

### PROVIDER INFORMATION

Name of Provider: \_\_\_\_\_ Provider # \_\_\_\_\_

Provider's Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### RECIPIENT INFORMATION

Name of Recipient: \_\_\_\_\_ MAID # (or SS#) \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Admission: \_\_\_\_\_ Number of Consecutive Months at Facility: \_\_\_\_\_

### JUSTIFICATION WHY THIS RECIPIENT WOULD BE HARMED UPON TRANSFERRING FROM THIS NURSING FACILITY:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I attest that this is true and accurate information.

Attending Physician's Signature: \_\_\_\_\_

CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

NURSING FACILITY SERVICES MANUAL

CONTACT REGIONS FOR PASRR REFERRALS

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<b><u>REGION 1</u></b>	Western KY MH/MR Board P.O. Box 7287 Paducah, KY 42002 Tel: 502/442-7121	<b><u>REGION 10</u></b>	Mountain MH/MR Board 150 S. Front Street Prestonburg, KY 41653 Tel: 606/886-8572
<b><u>REGION 2</u></b>	Pennyroyal MH/MR Board 735 North Drive Hopkinsville, KY 42240 Tel: 502/885-5163	<b><u>REGION 11</u></b>	KY. River Community Care P.O. Box 587 Hyden, KY 41749 Tel: 606/678-4215
<b><u>REGION 3</u></b>	River Valley Behavioral P.O. Box 1637 Owensboro, KY 42302 Tel: 502/684-0696	<b><u>REGION 12</u></b>	Area A Cumberland River MH/MR P.O. Box 568 Corbin, KY 40701 Tel: 606/528-7010
<b><u>REGION 4</u></b>	LifeSkills, Inc 523 E. 12th Street Bowling Green, KY 42101 Tel: 502/342-4887		Area B Cumberland River MH/MR Mounted Route Harlan, KY 40831 Tel: 606/337-6137
<b><u>REGION 5</u></b>	Communicare, Inc. 1311 N. Dixie Avenue Elizabethtown, KY 42701 Tel: 502/769-5301	<b><u>REGION 13</u></b>	ADANTA 193 Reed Street Columbia, KY 42748 Tel: 502/384-5351
<b><u>REGION 6</u></b>	Seven Counties Services inc. 929 S. Third Street Louisville, KY 40203 Tel: 502/585-2008	<b><u>REGION 14</u></b>	Bluegrass MH/MR Board 191 Doctors Drive Frankfort, KY 40601 Tel: 502/223-1606
<b><u>REGION 7</u></b>	Northern Kentucky MH/MR 1201 S. Ft. Thomas Avenue Fort Thomas, KY 41075 Tel: 606/781-5566		
<b><u>REGION 8</u></b>	Comprehend, Inc 611 Forest Avenue Maysville, KY 41056 Tel: 606/564-4016		
<b><u>REGION 9</u></b>	Pathways, Inc P.O. Box 790 Ashland, KY 41105-0790 Tel: 606/324-1141		

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## NURSING FACILITY LEVEL OF CARE REQUEST FOR ADMISSION

Resident Name \_\_\_\_\_ Medicaid # \_\_\_\_\_

Room # \_\_\_\_\_ Room Certified for Medicaid  Yes  No

If Pending Medicaid Social Security # \_\_\_\_\_

Medicare # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Marital Status  M  W  S  D  Male  Female

Responsible Party \_\_\_\_\_

Responsible Party Address \_\_\_\_\_

Relationship \_\_\_\_\_

Diagnoses \_\_\_\_\_

\_\_\_\_\_

Living Arrangements Prior To Admission \_\_\_\_\_

\_\_\_\_\_

**CHECK ONE ONLY:**

New Admit Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Readmit Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Pay Source Change Date \_\_\_\_/\_\_\_\_/\_\_\_\_

(Last Admit Date \_\_\_\_/\_\_\_\_/\_\_\_\_)

Admission or Readmission From:	
Acute Care Hospital	
Free-Standing Psychiatric Hospital	
Home	
ICF/MR/DD	
Nursing Facility	
Personal Care Home	
Other:	

### NURSING FACILITY LEVEL OF CARE REQUEST FOR ADMISSION

**\*PASRR LEVEL I FORM (AND IF APPLICABLE, THE LEVEL II FORM) MUST BE COMPLETED AND A COPY FAXED WITH ALL NEW ADMISSIONS AND ALL PAY SOURCE CHANGES.**

Level I PASRR Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed By \_\_\_\_\_

Level II PASRR Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Appropriate for NF Placement?  Yes  No

Completed By \_\_\_\_\_

Verbal Determination Form

(Mental Illness Only) Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Appropriate for NF Placement?  Yes  No

Completed By \_\_\_\_\_

Inappropriate Referral Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Completed By \_\_\_\_\_

NF Name	Facility ID # Phone ( )
Physician Name Address	Physician Phone ( ) Fax # ( )
Physician License #	
<b>MEDICATIONS</b>	
Describe resident's medications: Number of Oral, Tube, Topical, Inhalers, Sprays, or Patches List the name and frequency of any IV, SQ, or IM medications (include routine flushes) Routine Administration of Oxygen (i.e. new administration of oxygen or regulating oxygen how often checking pulse oximetry, etc.) and Nebulizer Treatments	

Is resident capable of self-administering medications?  Yes  No If no why \_\_\_\_\_

## NURSING FACILITY LEVEL OF CARE REQUEST FOR ADMISSION

### COGNITIVE ABILITIES

Comatose	Y	N	If Yes Proceed to Communication	
Memory Recall:				
Knows Own Name	Y	N	Comments:	
Knows Date/Time	Y	N	Comments:	
Knows Location	Y	N	Comments:	
Knows Staff	Y	N	Comments:	

### COMMUNICATION /HEARING ABILITIES

Hears Adequately	Y	N	Uses Speech to Communicate	Y	N	Comments:
Hearing Aid Use	Y	N	Understands Verbal Direction	Y	N	Comments:

### VISION PATTERNS

Vision Adequate	Y	N	Comments:
Visual Limitations	Y	N	Comments:

### MOOD AND BEHAVIOR

Wanders	Y	N	Comments:
Physically Abusive	Y	N	Comments:
Verbally Abusive	Y	N	Comments:
Socially Inappropriate	Y	N	Comments:
Resists Care	Y	N	Comments:

## NURSING FACILITY LEVEL OF CARE REQUEST FOR ADMISSION

### ACTIVITIES OF DAILY LIVING

**Bed Mobility :**

Independent  Yes  No  
Hands on assist  Yes  No  
How often requires assist? \_\_\_\_\_  
Bedbound  Yes  No

**Transfer :**

Independent  Yes  No  
Hands on assist  Yes  No  
To/From  Bed  Chair  Wheelchair  
How often requires assist? \_\_\_\_\_

**Ambulation :**

Independent  Yes  No  
Hands on assist  Yes  No  
How often requires assist? \_\_\_\_\_  
Standby assist  Yes  No  
How often requires assist? \_\_\_\_\_  
Independent with device  Yes  No  
Wheelchair per self  Yes  No  
Wheelchair assist  Yes  No  
How often requires assist? \_\_\_\_\_

**Bathing :**

Independent  Yes  No  
Hands on assist  Yes  No  
How often requires assist? \_\_\_\_\_  
Standby assist  Yes  No  
How often requires assist? \_\_\_\_\_  
 Back  Arms  
 Legs  Hands  
 Feet

**Dressing :**

Independent  Yes  No  
Hands on assist  Yes  No  
 Pulling on pants  Putting on shirt  
 Buttons Zippers  Prothesis  
How often requires assist? \_\_\_\_\_  
 Continuous Supervision/Cues

**Grooming :**

Independent  Yes  No  
Hands on assist  Yes  No  
 Hair  Nails  
 Teeth  Shaving  
 Makeup  
How often requires assist? \_\_\_\_\_  
 Continuous Supervision/Cues

**Toileting :**

Independent  Yes  No  
Hands on assist  Yes  No  
 Pericare  Adjust Clothing  On/Off Toilet  
 Changing pads/briefs  Manage ostomy/catheter  
How often requires assist? \_\_\_\_\_  
 Continuous Supervision/Cues

ADL Comments



## NURSING FACILITY LEVEL OF CARE REQUEST FOR ADMISSION

### THERAPIES

Physical Therapy	Y	N	Days Per Week:	Comments:
Occupational Therapy	Y	N	Days Per Week:	Comments:
Speech Therapy	Y	N	Days Per Week:	Comments:
Respiratory Therapy	Y	N	Days Per Week:	Comments:

### NURSING REHABILITATION/RESTORATIVE CARE

a. Range of Motion (Passive)	Y	N	Days Per Week:	Comments:
b. Range of Motion (Active)	Y	N	Days Per Week:	Comments:
c. Splint or Brace Assistance	Y	N	Days Per Week:	Comments:
d. Bed Mobility	Y	N	Days Per Week:	Comments:
e. Transfer	Y	N	Days Per Week:	Comments:
f. Walking	Y	N	Days Per Week:	Comments:
g. Dressing or Grooming	Y	N	Days Per Week:	Comments:
h. Eating or Swallowing	Y	N	Days Per Week:	Comments:
i. Amputation/Prosthesis Care	Y	N	Days Per Week:	Comments:
j. Communication	Y	N	Days Per Week:	Comments:
k. Toileting	Y	N	Days Per Week:	Comments:



## MEDICAID NURSING FACILITY SERVICES FACT SHEET

### What are Medicaid Nursing Facility Services?

Nursing facility (NF) services include room, dietary services, social services, nursing services, the use of equipment and facilities, medical and surgical supplies, laundry services, drugs ordered by the physician and personal items routinely provided by the facility. Also included, if ordered by the physician, are x-rays, physical therapy, speech therapy, occupational therapy, laboratory services and oxygen, and related oxygen supplies.

### Who is Eligible for Nursing Facility Services?

You may be eligible for NF services if:

- You reside in a facility that participates in the Kentucky Medicaid Program and are placed in a Medicaid certified bed;
- You require and meet the level of care for skilled nursing services, intermediate care services, intermediate care services for the mentally retarded and the developmentally disabled, or nursing facility services; and
- You are aged sixty-five (65) years or older, blind or disabled, or are currently Medicaid eligible.

### What are Resources?

Resources are cash money and any other personal property or real property that you own, may convert to cash; and could use for support and maintenance. Resources include checking and savings accounts, stocks or bonds, certificates of deposit, automobiles, land, buildings, burial reserves and life insurance policies, and more.

We do not use some resources in determining Medicaid eligibility. These resources include the home, household goods and personal effects, the first \$1,500 of a burial reserve or a life insurance policy, one automobile used for work, medical treatment, or by the community spouse, burial spaces and plots, life estate interests, and IRA Keoghs, retirement funds and other tax deferred assets (until accessed).

Your resources must be within Medicaid resource guidelines. The resource limits vary if you are married and we count your spouse's resources.

Marital Status	Living Arrangement	Resource Limit
Single Person	NF Resident	
Married Couple	Both NF Residents	\$ 2,000
Married Couple	NF resident with spouse who is still at home	\$ 4,000
		\$ 92,660

### What is a Resource Assessment?

You, your spouse or someone representing you may ask the Department for Community Based Services (DCBS) to make an assessment of your combined countable resources. You do not have to apply for Medicaid to get a resource assessment. The resource assessment involves documenting and verifying all countable resources owned by you and your spouse at the time of the most recent NF admission. The assessment compares the combined countable resources to the current Medicaid limits to determine if you meet Medicaid resource guidelines.

Contact DCBS in the county where you live to request a resource assessment. DCBS will give you and your spouse copies of the completed assessment.

### What are Transferred Resources?

If you or your spouse transfers resources, you may not be able to get Medicaid NF services. Transferred resources are cash, liquid assets, personal property or real property which are voluntarily transferred, sold, given away, or otherwise disposed of for less than fair market value. If you transfer resources in the 3 year period before the Medicaid application month (or 5 years for a trust) DCBS assumes that the transfer was made to qualify for Medicaid. It is up to you to prove the transfer was for another reason. If DCBS determines that there was a prohibited transfer of resources they may set up a penalty period beginning with the month the transfer was made.

### What is Income?

Income is money you get from Social Security, Veteran's pension, Black Lung benefits, Railroad Retirement benefits, pension plans, rental property, investments or wages. Your income must be within Medicaid guidelines to get Medicaid NF services. We consider your income, but do not count your spouse's income. The income limits may vary depending on the number of days you have been in the facility.

You are income eligible if your income is at or below \$1,656 or the NF private pay rate. You may be required to pay part of the cost of your care. Patient liability is subsequently determined by considering your income, allowing a deduction of \$40 for personal needs, maintenance deductions for family members (including an at home spouse deduction in an amount to bring the at home spouse's income up to \$2,267) and deductions for medical expenses and health insurance premiums. The amount left over is what you must pay to the NF for your care.

### How can I apply?

You or someone representing you may make a Medicaid application at the DCBS office in the county where you live. Bring proof of social security number, income, resources, life insurance policies or burial reserves, health insurance, and medical bills to the application interview.

## MAP-811 Provider Application Instructions

### Enrollment Block.

- If applying for a Kentucky Medicaid number for the first time, check first block
- if re-enrolling as a Kentucky Medicaid number check second block and enter your eight(8) digit provider number in number 1.
- if a change in Federal Tax Identification number (FEIN) has occurred check third block
- If applicant has been excluded from Medicare/Medicaid by Federal, State, or court sanction please declare "I am enrolling as a reinstatement" check fourth block

### Section A: Administrative Information

Field #	Description
1	If a Medicaid provider number has already been assigned to this entity please enter. Otherwise leave blank.
2	Enter License/Certificate number for the applicant.
3	Enter type of provider. EXAMPLE: physician; hospital; pharmacy; etc. Mark appropriate block for profit or non-profit.
4	Name of individual provider practice or facility enrolling- mark the appropriate block.
5	Enter the name the provider will be doing business as, if different than field 4, otherwise you may enter N/A. If you are applying for an individual provider number do not enter your employers name in this field.
6	Enter the type of service that will be provided. EXAMPLE: Acute care; diabetic supplies; etc.
7	Enter the date of your license or the date you wish your enrollment with Medicaid to be effective.
8	Only ICF/MR providers will enter the beginning and ending dates of their provider certification period; all other providers will enter N/A.
9	Name of person with signature authority.
10	Title of person with signature authority.
11	State individual Social Security number and date of birth.
12	State corporate Federal Tax Identification Number.

**NOTE:** If you are an individual who has incorporated please enter both Federal Tax Identification Number and Social Security Number.

13	Enter the name of the person to sign for a summons in case of a lawsuit (N/A is not acceptable).
14	Telephone number of person named in number 13.
15	If you have held any Medicaid numbers in the past three years list them here. If not mark N/A.
16	Physical address of applicant.
17	Physical county of applicant.
18	Physical city of applicant.
19	Physical state of applicant.
20	Physical zip code of applicant.
21	Physical telephone number of applicant.
22	Contact name and number.
23	Physical fax number of applicant.
24	Billing location telephone number.
25	Mailing address (where provider receives correspondence such as letters, newsletters, etc) if different from physical address.
26	Mailing city (follow instructions from number 25).
27	Mailing state (follow instructions from number 25).

Revised 2/2004

MAF-811 Application Instructions

- 28 Mailing zip code (follow instructions from number 25)
- 29 Enter E-mail address of applicant. (optional)
- 30 Pay-to-address (where providers will receive payment from Medicaid) if different from physical address.
- 31 Pay-to-address city (follow instructions from number 30).
- 32 Pay-to-address state (follow instructions from number 30)
- 33 Pay-to-address zip code (follow instructions from number 30).
- 34 if applicable, enter your National Provider Identification Number (NPI#) otherwise enter N/A
- 35 if you are an individual, please list individual Medicare number; if you are an entity list entity Medicare numbers. If your Medicare number is pending you must notify Unisys at the address below in writing when you receive your Medicare number

Unisys Corporation  
PO Box 2110  
Frankfort KY 40602-2110

**NOTE:** You must notify Provider Enrollment, in writing, what your Medicare number is and that you want it cross-referenced to your Medicaid provider number. Failure to do so will result in your claims not crossing over to Unisys for processing.

- 36 Enter your Unique Provider ID Number, otherwise enter N/A
- 37 Enter the Drug Enforcement Agency number (DEA #)
- 38 Enter effective date of the DEA #.
- 39 Check block if Clinical Laboratory Improvement Agreement (CLIA) is attached.
- 40 Check this block if copy of any and all specialty licenses are attached
- 41 If applying as a physician assistant please enter the supervising physician's name and Medicaid provider number.
- 42 Enter name of the software vendor (if doing own billing) or name of billing agency if someone else is submitting the claims electronically. Enter magnetic tape; 3.5-inch diskette; 5.25-inch diskette; Asynchronous PC Modem; Synchronous 3760 mainframe or Point of service
- 43 if individual skip to Section B. If Hospital/Nursing Facility or ICF/MR must complete bed breakdown of facility

**NOTE:** Chemical Dependency beds are not covered under the hospital provider type

- 44 If facility has had a change in beds within the last 2 years, indicate the current bed count and the previous bed count plus the date the change occurred
- 45 Enter the facility administrator's name with telephone and fax number
- 46 Enter Assistant Administrator's name and telephone number
- 47 Enter Controller with telephone number.
- 48 Enter Accountant with telephone number.
- 49 Enter Fiscal Year End (FYE).
- 50 This item is voluntary and used for statistics only

**Section B: Disclosure of Ownership and Control Interest**

- | Field # | Description  |
|---------|--|
| 1       | List current Medicaid provider numbers   |
| 2       | List current Medicare provider numbers   |
| 3       | If there has been a change of Federal Tax Identification number please list previous Medicaid provider numbers and effective dates for each. |
| 4       | Describe relationship or similarities between the provider disclosing information on this form and items 'A' through 'C'                     |

- 5 Do you plan to have a change in ownership management company or control within the next year? If so, when?
- 6 Do you anticipate filing bankruptcy? If so, when?
- 7 State Federal Tax Identification Number if there is an affiliation with a chain along with name, address, city, state and zip code.
- 8 List name address, SSN/FEIN of each person or organization having direct or indirect ownership or control interest in the disclosing entity. If owner by a corporation attach sheet with officers and board members names and social security numbers (N/A is not acceptable).

**NOTE:** Do not send the list of board directors unless they own 5% or more

Indirect Ownership Interest-means an ownership interest in an entity that has an ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity

Ownership Interest- means the possession of equity in the capital the stock or the profits of the disclosing entity

Person with an ownership or control interest- means a person or corporation that

- Has an ownership interest totaling 5% or more in a disclosing entity
- Has an indirect ownership interest equal to 5% or more in a disclosing entity
- Has a combination of direct and indirect ownership interests equal to 5% or more in a disclosing entity.
- Owns an interest of 5% or more in any mortgage deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5% of the value of the property or assets of the disclosing entity
- Is an officer or director of a disclosing entity that is organized as a corporation or
- is a partner in a disclosing entity that is organized as a partnership

- 9 List name address and SSN/FEIN of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more

Subcontractor- means an individual agency or organization to which a disclosing entity have contracted or delegate some of its management functions or responsibilities of providing medical care to its patients

OR an individual agency or organization with which a fiscal agent has entered into a contract, agreement purchase order, or lease (or lease of real property) to obtain space supplies equipment or services provided under the Medicaid agreement

- 10 If applicant is related to persons listed in number 9 please list relationship
- 11 List name of managing company if not applicable enter N/A.
- 12 List names of the disclosing entities in which persons have ownership of other Medicare/Medicaid facilities.

Other Disclosing Entity- means any other Medicaid disclosing entity and any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V XVIII or XX of the Act. This includes:

- Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII)
- Any Medicare intermediary or carrier.
- Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.

- 13 If entity engages with subcontractors such as physical therapist, pharmacies, etc which exceeds the lesser of \$25,000 or 5% of applicant's operating expense please list subcontractors name and address

Significant Business Transaction- means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 or 5% of applicant's operating expense

- 14 List name, Social Security Number, address of any provider who is authorized to prescribe drugs, medicine, devices, or equipment
- 15 List anyone in number 7 whom has been convicted of a criminal offense related to the involvement of such persons or organizations in any problem established under Title 19 (Medicaid) or Title 20 (Social Services Block Grants) of the Social Security Act or any criminal offense in this state or any other state
- 16 List any agent and/or managing employee who has been convicted of a criminal offense related to any program established under Title XVIII, XIX or XX of the Social Security Act or any criminal offense in this state or any other state

Agent- means any person who has been delegated the authority to obligate or act on behalf of a provider

Managing Employee- means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency

- 17 For any current or previous Medicaid provider, please list any changes in administrator, director of nursing, medical director
- 18 Please indicate where you would like monies paid to you from Medicaid reported to for 1099 purposes. *Example: If you are an individual completing this question please input your Social Security Number unless you are a sole proprietor. A 54 provider can bill under his/her individual provider number even if they are working in a group setting*
- 19 Please indicate the address you want your Medicaid 1099 mailed
- 20 W-9 OR a copy of your Social Security Card OR a notarized statement thereof must be attached

**Section C: Tax Structure**

**Field # Description**

- 1 Check block which pertains to applicant's tax structure.
- If 'B' is marked, please complete number 2 with name, address, city, state, zip code, and telephone number
  - If 'C' is marked, please complete number 3 name, address, city, state, zip code and FEIN/SSN
  - If 'E' is marked, please attach a list of Officer and Board Members.
  - If 'F' is marked, please attach list of Board Members
  - If 'G' is marked, please attach list of Board Members.
  - If 'H' is marked, please attach list of Limited Liability members

Page 10 (Signature Page)

**Signature Block**

Sign to ensure patient confidentiality and privacy

**Provider Signature:**

Revised 2/2004

MAF-811 Application Instructions

Name: enter original signature from the director, administrator, individual provider, owner, or authorized personnel

Title: must be the title of person signing. EXAMPLE: administrator, doctor, etc.

Date: enter the date the agreement was signed

Witnessed By: name of witness

**Health Care Partnership Signature:**

To be completed by Managed Care representative only

**Regional Transportation Broker Signature:**

This field to be completed by the transportation broker. All taxi, Ambulatory and non-ambulatory specialty carriers and bus-co-op must have this field completed. If field is incomplete the application will be rejected for participation with the Kentucky Medicaid program.

**Department for Medicaid Services Signature:**

To be completed by Department for Medicaid Service representative only



MAP 811 Revised 04/04 Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.

State MAILING Address (if different from physical address) in items 25 - 28

25 \_\_\_\_\_ Address \_\_\_\_\_ 26 \_\_\_\_\_ City \_\_\_\_\_

27. [ ] [ ] 28. \_\_\_\_\_  
State Zip

29 Email Address (optional) \_\_\_\_\_ Note: Your email address will not be given to any  
outside party for any reason. DMS may use provider email addresses to send provider letters/notices

State PAY-TO Address (if different from physical address) for items 30 - 33.

30. \_\_\_\_\_ Address \_\_\_\_\_ 31. \_\_\_\_\_ City \_\_\_\_\_

32. [ ] [ ] 33. \_\_\_\_\_ 34. \_\_\_\_\_  
State Zip NPI (National Provider Identifier)

35. Please list all Medicare Provider Numbers. (Attach extra sheet if necessary.)

(a) \_\_\_\_\_ (b) \_\_\_\_\_ (c) \_\_\_\_\_

36. \_\_\_\_\_ 37. \_\_\_\_\_ 38. \_\_\_\_\_  
UPIN # DEA # DEA # Effective Date

39. Attach a copy of CLIA  I have attached a copy  
40. Attach a copy of specialty certification.  I have attached a copy

41. If you are applying as a Physician Assistant please indicate supervising Physician name & provider number.

Name \_\_\_\_\_ Provider Number \_\_\_\_\_

42. If you wish to BILL ELECTRONICALLY:

Software Vendor and/or Billing Agency \_\_\_\_\_ Media \_\_\_\_\_

Facilities only complete 43 through 49.

43. Bed Breakdown

[ ] [ ] Acute [ ] [ ] ICU [ ] [ ] Surgical ICU [ ] [ ] Burn ICU  
[ ] [ ] ICU [ ] [ ] Nursery [ ] [ ] Neonatal ICU [ ] [ ] CCU  
[ ] [ ] Hosp Swing [ ] [ ] Rehab Hosp [ ] [ ] Psych Hosp. [ ] [ ] PRTF

[ ] [ ] [ ] ICF/MR/DD [ ] [ ] [ ] Ventilator Unit [ ] [ ] [ ] Brain Injury Unit

[ ] [ ] [ ] NF/Medicaid [ ] [ ] [ ] NF (Medicare/Medicaid)

[ ] [ ] [ ] Other /specify \_\_\_\_\_

44. If your bed capacity has increased by 10% OR by 10 beds, whichever is greater within the last two (2) years, give current bed and prior bed counts and the date change occurred:

[ ] [ ] [ ] [ ] [ ] [ ]  
Current Bed Count Prior Bed Count Date of Change

MAP 817 Revised 04/04 Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.

45. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Administrator Phone Number Ext.  
\_\_\_\_\_  
Fax #
46. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Assistant Administrator Phone Number Ext.
47. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Controller Phone Number Ext.
48. \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Accountant or CPA Phone Number Ext.
49. Fiscal Year Ends Date (FYE) \_\_\_\_\_

50 For statistical purposes only. Not required.

Race: \_\_\_\_\_ Sex (circle one):  M  F

The Program Integrity Division in the Department for Medicaid Services oversees the Lock-In program. Lock-In locks a recipient to one provider and one pharmacy for one year at a time, if there is reason to believe that a recipient is over-utilizing services. If you would like additional information please call (502) 564-1012



MAP 811 Revised 04/04 *Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.*

NAME (b): \_\_\_\_\_ DOB: \_\_\_\_\_  
Box or Address: \_\_\_\_\_ SSN: \_\_\_\_\_  
City: \_\_\_\_\_ -and/or-  
FEIN: \_\_\_\_\_  
State: [ ] [ ] Zip: \_\_\_\_\_

9. List name, address, SSN# FEIN# of each person with an ownership or control interest in any subcontractor in which the provider applicant has direct or indirect ownership of 5% or more. Attach extra page if necessary.

NAME (a): \_\_\_\_\_ SSN: \_\_\_\_\_  
Box or Address: \_\_\_\_\_ -and/or-  
FEIN: \_\_\_\_\_  
City: \_\_\_\_\_  
State: [ ] [ ] Zip \_\_\_\_\_

NAME (b): \_\_\_\_\_ SSN: \_\_\_\_\_  
Box or Address: \_\_\_\_\_ -and/or-  
FEIN: \_\_\_\_\_  
City: \_\_\_\_\_  
State [ ] [ ] Zip \_\_\_\_\_

10. If any individuals listed in item #8 (above) are related to each other as spouse, parent, child, or sibling (including step or adoptive relationships) provide the following information: (Attach extra page if necessary.)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
SSN: _____	SSN: _____
-and/or- FEIN: _____	-and/or- FEIN: _____

11. If this facility employs a management company, please provide following information:

Name: \_\_\_\_\_  
Box or Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State [ ] [ ] Zip: \_\_\_\_\_

12. List the names of any other disclosing entity in which person(s) listed on this update ownership of other Medicare/Medicaid facilities

NAME (a): \_\_\_\_\_ Provider #: \_\_\_\_\_  
Box or Address: \_\_\_\_\_  
City: \_\_\_\_\_  
State [ ] [ ] Zip: \_\_\_\_\_

MAP 811 Revised 04/04 *Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.*

NAME (b): \_\_\_\_\_ Provider #: \_\_\_\_\_

Box or Address: \_\_\_\_\_

City: \_\_\_\_\_

State [ ] [ ] Zip: \_\_\_\_\_

- 13 List the names and addresses of all other Kentucky Medicaid providers with which your health service and/or facility engages in a significant business transaction and/or a series of transactions that during any one (1) fiscal year exceed the lesser of \$25,000 or 5% of your total operating expense. (Attach extra page if necessary.)

NAME (a): \_\_\_\_\_

Box or Address: \_\_\_\_\_

City: \_\_\_\_\_

State [ ] [ ] Zip: \_\_\_\_\_

NAME (b): \_\_\_\_\_

Box or Address: \_\_\_\_\_

City: \_\_\_\_\_

State [ ] [ ] Zip: \_\_\_\_\_

- 14 List the name, SSN and address of any immediate family member who is authorized under Kentucky Law or any other states professional boards to prescribe drugs, medicine, medical devices or medical equipment in accordance with KRS 205.3477

NAME(a): \_\_\_\_\_

Credential (MD etc): \_\_\_\_\_

Box or Address: \_\_\_\_\_

DOB: \_\_\_\_\_

City: \_\_\_\_\_

SSN: \_\_\_\_\_

State [ ] [ ] Zip: \_\_\_\_\_

NAME(b): \_\_\_\_\_

Credential (MD etc): \_\_\_\_\_

Box or Address: \_\_\_\_\_

DOB: \_\_\_\_\_

City: \_\_\_\_\_

SSN: \_\_\_\_\_

State [ ] [ ] Zip: \_\_\_\_\_



455.104 Definitions:

- 1 Indirect Ownership Interest means an ownership interest in an entity that has an ownership interest in a disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
- 2 Other Disclosing Entity Means any other Medicaid disclosing entity and any entity that does not participate in Medicaid but is required to disclose ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:
  - (a) Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, mental disease facility, dental health clinic, or health maintenance organization that participates in Medicare (title XVIII);
  - (b) Any Medicare intermediary or carrier, and
  - (c) Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under Title V or Title XX of the Act.
- 3 Person with an Ownership or Control Interest means a person or corporation that:
  - (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;
  - (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;
  - (c) Has a combination of direct or indirect ownership interests equal to 5 percent or more in a disclosing entity;
  - (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity (that interest equals at least 5 percent of the value of the property or assets of the disclosing entity);
  - (e) Is an officer or director of a disclosing entity that is organized as a corporation;
  - (f) Is a partner in a disclosing entity that is organized as a partnership.
- 4 Subcontractor means:
  - (a) An individual, agency, organization to which a disclosing entity has subcontracted or delegated some of its management functions or operations in order to provide medical care to its patients; or
  - (b) An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order or lease (or lease of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

### SECTION C: TAX STRUCTURE

1. Provider Tax Structure of Applicant: Please check only one (1)

- (A) Individual (applying for an individual number)
- (B) Sole Proprietor (applying for an individual number)
- (C) Partnership (whether applying for an individual or group number)
- (D) Estate/Trust
- (E) Corporation
- (F) Public Service Corporation
- (G) Government/Non-Profit
- (H) Limited Liability Company

2. If tax structure is (B) Sole Proprietor give name d b a (if applicable) address and telephone number of owner:

Name (and d b a, if applicable) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

[ ] [ ] \_\_\_\_\_ ( ) \_\_\_\_\_

State (2-digit) Zip Telephone # Ext

3. If tax structure is (C) Partnership list name, address, and the social security numbers of partners.

Name	Address	SSN
_____	_____	_____
_____	_____	_____

4. If tax structure is (E) Corporation, please attach a list of Officers and Board Members' names or list below.

I have attached a list

5. If tax structure is (F) Public Service Corporation, please attach a list of Board Members' names or list below.

I have attached a list

6. If tax structure is (G) Government/Non-Profit, please attach a list of Board Members' names or list below.

I have attached a list

7. If tax structure is (H) Limited Liability, please attach a list of the members.

I have attached a list

MAP 811 Revised 04/04 Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.  
**WHOEVER KNOWINGLY OR WILLFULLY MAKES, OR CAUSES TO BE MADE, A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT SHALL BE SUBJECT TO PROSECUTION UNDER APPLICABLE FEDERAL OR STATE LAWS. (42USC 1320a-7b, CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS IS PRINTED ON PAGE 13) FAILURE TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED SHALL RESULT IN A DENIAL OF A REQUEST TO PARTICIPATE IN OR TERMINATION OF THE CURRENT AGREEMENT WITH THE STATE AGENCY, AS REQUIRED BY 42 CFR 455.104 AND KRS CHAPTER 205 AS AMENDED.**

Provider Authorized Signature: I certify, under penalty of law, that the information given in this form is correct and complete to the best of my knowledge. I am aware that, should investigation at any time show any falsification, I will be considered for suspension from the Program and/or for prosecution for Medicaid fraud. I certify that I have read and understand the 'Medicaid Rules, Regulation, Policy and 42USC 1320a-7b' (pp. 11-13) to the best of my ability. I agree to abide by the Medicaid Program terms and conditions listed in this document, and I hold a license/certification to provide service corresponding to the information above and for which this agreement applies. I hereby authorize the Cabinet for Health Services, the Kentucky Health Care Partnership to make all necessary verification concerning me and/or my medical practice/facility, and further authorize each educational institute, medical/license board or organization to provide all information that may be needed in connection with my application for participation in the Kentucky Medicaid Program.

If you keep medical records on an electronic database, you must certify by signature that electronic records are confidential and patient privacy is protected (KRS 205.510).

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Witnessed By: \_\_\_\_\_

Health Care Partnership Signature:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Regional Transportation Broker Signature:

Broker Name: \_\_\_\_\_

Broker Signature: \_\_\_\_\_

Approval Date: \_\_\_\_\_

Department for Medicaid Services Signature:

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE MAKE A COPY OF COMPLETED PAGES FOR YOUR RECORDS. YOU WILL RECEIVE A DMS-SIGNED COPY OF THIS PAGE ALONG WITH NOTIFICATION OF YOUR KENTUCKY MEDICAID PROVIDER NUMBER.**

## MEDICAID RULES, REGULATION, POLICY AND 42USC 1320a-7b

1. **Scope of Agreement**

This provider agreement sets forth the rights, responsibilities, terms and conditions governing the provider's participation in the Kentucky Medicaid Program, KIRPAC, KCHIP and/or Kentucky Health Care Partnership and supplements those terms and conditions imposed by these four (4) programs.

2. **Medical Services to be Provided**

The provider agrees to provide covered services to Medicaid, KIRPAC and KCHIP recipients in accordance with all applicable federal and state laws, regulations, policies and procedures relating to the provision of medical services according to Title XIX, Title VI, the approved Waivers for Kentucky and, for those providers participating in the Partnership, all applicable provisions of the partnership contract for managed care and policies and procedures duly adopted by the governing board of the Partnership applicable to provider and recipients of Title XIX services.

3. **Administrative**

**Electronic Billing**

- (1) Agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to KCHIP and Title XIX recipients for a minimum of five (5) years or as required by state and federal laws, and for such additional time as may be necessary in the event of an audit, exception, quality of care issue, or other dispute and to furnish the state or federal agencies with any information requested regarding payments claimed for furnishing services.
- (2) Agrees to permit representatives of the state and federal government, and for those providers participating in the Partnership, staff of the Kentucky Health Care Partnership to have the unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to KCHIP and Title XIX recipients. Such examinations, inspections, copying and audits may be made without prior notice to the Provider. This right shall include the ability to interview facility staff during the course of any inspection, review, investigation or audit.
- (3) Agrees to comply with the Civil Rights requirements set forth in 45 CFR Parts 80, 84, and 90 and the Americans with Disabilities Act (ADA) 42 USC 12101. Payments shall not be made to providers who discriminate on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.
- (4) Agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for KCHIP and Title XIX recipients in order to ensure quality of care and avoid the provision of duplicate or unnecessary medical services.
- (5) Agrees awareness of the provisions of 42 USC 1320a-7b reproduced on page 12 of this agreement and of the provisions of KRS 203.8451 to KRS 203.8483 relating to Medicaid Program, Fraud and Abuse, and applicable Kentucky Administrative Regulations as specified in Title 907 relating to the Kentucky Health Care Partnership and Provider Agreements.
- (6) Agrees to inform the Cabinet for Health Services, Department for Medicaid Services of the appropriate Partnership:
  - A. within thirty (30) days of any change in the following:
    1. name,
    2. ownership,
    3. address, and
  - B. within five (5) days of information concerning the following:
    1. change in licensure/registration,
    2. regulation status,
    3. disciplinary action by the appropriate professional board/association,
    4. criminal charges.
- (7) Agrees to the following:
  - A. To assume responsibility for appropriate, accurate and timely submission of claims and associated data, whether submitted directly by the provider or by an agent;
  - B. To use EMC submittal procedures and record layouts as defined by the Cabinet in submitting electronic claims;
  - C. That the provider's signature on this agreement constitutes compliance with the following: the transmitted information is true, accurate and complete and any subsequent correction which alters the information contained therein will be transmitted promptly;
  - D. Payment and satisfaction of claims will be from federal and state funds and that any false claims, statements or documents or concealment of falsification of a material fact may be prosecuted under applicable federal and state law.
- (8) Agrees to participate in the quality assurance programs of the partnership and the Department for Medicaid Services and understands that the data will be used for analysis of medical services provided to assure quality of care according to professional standards.
- (9) A contract for the sale or change of ownership participating in the Medicaid Program shall specify whether the buyer or seller is responsible for the amounts owed to the department by the provider, regardless of whether the amounts have been identified at the time of sale. In the absence of such specification in the contract for the sale or change of ownership, the owners or the partners at the time the department paid the amounts payments have the responsibility for liabilities arising from these payments, regardless of when identified.
- (10) Agrees to notify the Department for Medicaid Services and/or the Partnership in writing of having filed for protection from creditors under the Bankruptcy code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.
- (11) Agrees to return any overpayment made by the Department for Medicaid Services to the Partnership, resulting from agency error, a clerical error of amount or review of submitted claims.
- (12) Agrees to refund the Kentucky State Treasurer, the processing agent used by the fiscal agent for the Department for Medicaid Services in the event claim submission has an error rate of 25% or greater.

MAP 817 Revised 04/04 Fill out all Applicable Sections. Write Not Applicable (N/A) where appropriate. Please print or type.

4. ITEM # 4 APPLIES ONLY TO LONG TERM CARE FACILITIES (NF, ICF/MR or Mental Hospital), AND HOME COMMUNITY BASED WAIVER SERVICES (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.)

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility providing long term care services agrees to advise all new admissions of Medicare beneficiaries to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program in accordance with 907 KAR 1:072 and is effective with new admissions on and after September 30, 1988.

Each long term care program is to comply with the preadmission screening rules as set forth in regulations codified in Section 1319 of the Social Security Act effective with long term admissions and re-admissions beginning on or after January 1, 1989.

5. Payor:

In consideration for the provision of approved Title XIX services rendered to Medicaid recipients, Title XIX services rendered to KCHIP recipients, and subject to the availability of federal and state funds:

- (1) The Cabinet for Health Services, Department for Medicaid Services, agrees to reimburse the provider according to current applicable federal and state laws, rules and regulations and policies of the Cabinet for Health Services for providers participating as direct Medicaid payment providers. Payment shall be made only upon receipt of appropriate billings and reports as prescribed by the Cabinet for Health Services, Department for Medicaid Services.
- (2) The Partnership agrees to reimburse the provider according to the provisions of the Partnership agreement with the provider. Payments shall be made only upon receipt of appropriate encounter data, claims and reports as prescribed by the Partnership governing board.
- (3) In accordance with 42 CFR 447.15, if the department makes payment for a covered service and the provider accepts this payment in accordance with the department's policies, this amount paid shall be considered payment in full, and all for the same service shall not be included in the recipient's bill. Payment for the same service shall not be included in the recipient's bill. A payment for the same service shall not be accepted from the recipient. A provider may bill Medicaid recipients for the following conditions:

- a. Services rendered by Kentucky Medicaid, and not reimbursed by the federal or state funds.
- b. Provider's not enrolled in Kentucky Medicaid.

6. Provider Certification:

- (1) If the provider is required to participate in health care services under Title XXIII of the Social Security Act to provide Title XIX services, the provider must certify participation or certification is current and active.
- (2) If the Provider is a specialty hospital providing psychiatric services to persons age twenty one (21) and under, the Provider shall be approved by the Joint Center for Home Hospitals of the Council on Accreditation of Service for Families and Children or any other accrediting body with comparable standards that are recognized by the state. In the event that the Provider is a general hospital, the Provider shall be certified for participation under Title XXIII of the Social Security Act or the Joint Commission on the Accreditation of Health Care Organizations.
- (3) Home Care Waiver Services agree to comply with the conditions for participation under 907 KAR 1:070. All staff shall meet all training requirements for providing services.
- (4) Personal Care Assistance Program agree to comply with the conditions for participation under 907 KAR 1:090. All staff shall meet all training requirements for providing services.

7. Lobbying Certification:

The undersigned certifies that he/she has no knowledge of the following lobbying activities during the period of July 1st through the end of the agreement:

- (1) No federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, or any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.
- (2) If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-L.L. Disclosure Form to Report Lobbying in accordance with its instructions.
- (3) The undersigned shall require that the language of this certification be included in the award documents for all sub-awards to all persons or organizations and contracts under grants, loans, and cooperative agreements and that all sub-awards shall comply and disclose accordingly.
- (4) This certification is a material representation of fact upon which reliance was placed when the transaction was made or entered into, in reliance of this certification a prerequisite for making or entering into this transaction imposed under Section 1352, Title 28, US Code. Any person who fails to file as required or if a violation shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each failure.

8. Termination:

- (1) The Department for Medicaid Services and/or partnership provider shall have the right to terminate this agreement for any cause on thirty (30) days written notice served upon the other party by registered mail with return receipt requested. The Partnership and/or Department for Medicaid Services may terminate this agreement immediately for cause, or in accordance with state or federal laws upon written notice served upon the Provider by registered mail with return receipt requested.
- (2) If Medicaid or Medicaid terminates the provider, the Partnership shall also terminate the provider from participation.
- (3) If there is a change of ownership of nursing facility, the Cabinet for Health Services agrees to automatically assign this agreement to the new owner according to 42 CFR 442.14.
- (4) Failure of the provider to comply with the terms of this agreement may result in the following sanctions:
  - Freezing member enrollment with the provider.
  - Withholding all or part of the provider's monthly management fee.
  - Making a referral to the Department's Division of Program Integrity for investigation of potential financial quality of care issues.
  - Terminating the provider from the KCHIP program.

The Department will allow the provider two weeks to cure a violation. If the sanction is the terminating of the provider, if the provider does not or refuses to cure the violation, the Department will proceed with action to impose sanctions on the provider. If such action is applied against the provider, the action will be reported to the appropriate professional boards and/or agencies. One or more of the above sanctions may be imposed simultaneously at the discretion of the Department based on the severity of the compliance violation. The Commission makes the determination to impose sanctions against a provider. The provider will be notified of this action in a written notification by certified mail.



# Medicaid Provider Enrollment

# Registration and Accreditation Checklist

Below is a processing and accreditation checklist for Medical Assistance providers. In addition to the checklist items, providers are required to complete the appropriate forms and return to Unisys. If you do not see your provider type listed, or if no credentials are listed, contact Unisys at (877) 838-5085. NOTE: You may apply in all areas in which you meet the requirements. A separate application is required for each provider type you wish to apply.

Type	Provider Type	IN STATE				OUT OF STATE						
		CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	JCAHO
	Acquired Brain Injury											
	Adult Day Care											
	Adult Targeted											
	Ambulatory Surg											
	Audiologist											
	(may apply as group-709)											
	Birthing Center											
	Child Sexual Abuse Clinic											
	Children Targeted											
	Chiropractor											
	(may apply as group-859)											
	Clinic Social Worker											
	(may apply as group-829)											
	Comm. for Children with Special Health Care Needs											
	Comm. Mental Health											
	CORP											
	(comprehensive outpatient rehabilitation facility)											
	Dental											
	(may apply as group-61)											
	Department Social Services											
	Dialysis & Renal Dialysis											
	DMR											
	(durable medical equip.)											
	EPSDT											
	Provider Type											

Provider Type	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	CLIA	License or Certif.	Medicare Certif.	Medicare Letter	Medicare Provider #	FCARF
Family Practice		Professional									
First Steps HANDS		Professional									
Hearing (may apply as group-509)		Professional									
Home & Community Based Waiver		Professional									
Home Care Waiver		Professional									
Home Health		Professional									
Hospice		Professional									
Hospital		Professional									
ICF/MR/DD Independent Lab		Professional									
Mental Hospital		Professional									
Model Waiver II		Professional									
Nurse Auct (CRNA) (may apply as group-749)		Professional									
Nurse Practitioner (ARNP) (may apply as group-789)		Professional									
Nursing Facility		Professional									
Occupational Therapy (may apply as group-879)		Professional									
Optician (may apply as group-528)		Professional									
Optometrist (may apply as group-779)		Professional									
Other Lab X-Ray		Professional									
Pathologist		Professional									
Physician		Professional									
Podiatrist		Professional									
Psychiatrist		Professional									
Psychologist		Professional									
Respiratory Therapist		Professional									
Speech Therapist		Professional									
Therapist		Professional									
Ultrasonographer		Professional									
X-Ray Technologist		Professional									
Yoga Instructor		Professional									

Must participate in own state's Medicare or Medicaid

Approved by DMS

Approved by DMS

	Certification by Office of Aging Servs							
	Operator Permit & Annual Renewals	Specialty License if applicable	Operator Permit & Annual Renewals	Specialty License if applicable	Operator Permit & Annual Renewals	Specialty License if applicable	Operator Permit & Annual Renewals	Specialty License if applicable
Physical Therapy	✓		✓		✓		✓	
Physician (MD-Oaeapadi) (may apply as group-65)	✓		✓		✓		✓	
Physician Assistant (may apply as group-959)	✓		✓		✓		✓	
Podiatrist	✓		✓		✓		✓	
Preventive Care	✓		✓		✓		✓	
Primary Care	✓		✓		✓		✓	
PRTE (psychiatric residential)	✓		✓		✓		✓	
Psychologist (may apply as group-899)	✓		✓		✓		✓	
Rural Health SCL	✓		✓		✓		✓	
School Based	✓		✓		✓		✓	
Transportation (emergency)	✓		✓		✓		✓	
Transportation (non-emergency)	✓		✓		✓		✓	

(Rev. 1/00)

COMMONWEALTH OF KENTUCKY  
CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES  
PROVIDER AGREEMENT ADDENDUM I

FACILITY NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_

Participation Requirement: Each nursing facility agrees to comply with the pre-admission screening and annual resident review requirement specified in Section 1919 of the Social Security Act, effective with regard to admissions and resident stays occurring on or after January 1, 1989.

PROVIDER

CABINET FOR HUMAN RESOURCES  
DEPARTMENT FOR MEDICAID SERVICES

BY: \_\_\_\_\_  
Signature of Authorized Official

BY: \_\_\_\_\_  
Signature of Authorized Official

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

MAP-730  
(Rev 6/99)

COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
PROVIDER AGREEMENT ADDENDUM II  
FOR  
LONG TERM FACILITIES  
(NF, ICF/MR/DD OR MENTAL HOSPITAL)  
HOME- AND COMMUNITY-BASED WAIVER SERVICES  
PROVIDERS FOR:  
(HCB, SCL, MODEL WAIVER II,  
ACQUIRED BRAIN INJURY ETC)

AGENCY/FACILITY NAME: (1) \_\_\_\_\_

ADDRESS (2) \_\_\_\_\_  
\_\_\_\_\_

PROVIDER NUMBER: (3) \_\_\_\_\_

PARTICIPATION REQUIREMENT

As a result of the Medicare Catastrophic Coverage Act of 1988, each facility/ agency providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Department for Community Based Services through a contractual arrangement with the Department for Medicaid Services. This requirement is a Condition of Participation in the Kentucky Medicaid Program in accordance with 907 KAR 1-672 and is effective with new admissions on and after September 30, 1989.

PROVIDER

BY: (4) \_\_\_\_\_  
SIGNATURE OF AUTHORIZED OFFICIAL

NAME: (5) \_\_\_\_\_

TITLE: (6) \_\_\_\_\_

DATE: (7) \_\_\_\_\_

CABINET FOR HEALTH SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

BY: (8) \_\_\_\_\_  
SIGNATURE OF AUTHORIZED OFFICIAL

NAME: (9) \_\_\_\_\_

TITLE: (10) \_\_\_\_\_

DATE: (11) \_\_\_\_\_



CABINET FOR HEALTH SERVICES  
COMMONWEALTH OF KENTUCKY  
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES  
An Equal Opportunity Employer M/F/D/V

\_\_\_\_\_  
(Date)

MEMORANDUM

TO: Local Office  
Department for Community Based Services  
Cabinet for Families & Children

FROM: \_\_\_\_\_ Provider #: \_\_\_\_\_  
(Facility/Waiver Agency)

SUBJECT: \_\_\_\_\_  
(Recipient Name) (Social Security/Medicaid Number)  
\_\_\_\_\_  
(Previous Address)  
\_\_\_\_\_  
(Responsible Relative's Name & Address)

This is to notify you that the above-referenced recipient

was admitted to this facility/waiver agency \_\_\_\_\_  
(Date)  
is in Title \_\_\_\_\_ Payment Status \_\_\_\_\_ and was placed in a  
(XVIII or XIX)

- NF bed       ICF/MR/DD bed       MH bed       EPSDT Bed  
 Home & Community Based Waiver Service       SCL Waiver Service and/or

was discharged from this facility/waiver agency on \_\_\_\_\_  
(Date)  
and went to \_\_\_\_\_  
(Home Address/Name & Address of New Facility/Waiver Agency)  
and/or expired on \_\_\_\_\_  
(Date)

was re-instated to Home & Community Based or SCL waiver services within 60 days of the  
NF admission \_\_\_\_\_  
(Date Re-instated)

For Home & Community Based waiver Clients only – last date service was provided \_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature)

**MAP-552 – NOTICE OF AVAILABLE INCOME FOR LONG TERM CARE**

COMMONWEALTH OF KENTUCKY  
 CABINET FOR HEALTH AND FAMILY SERVICES  
 DEPARTMENT FOR SOCIAL INSURANCE

NOTICE OF AVAILABILITY OF INCOME FOR LONG TERM CARE/WAIVER AGENCY/HOSPICE

AID NUMBER: \_\_\_\_\_

CORRECTION  
 INITIAL  
 CHANGE

PROGRAM: \_\_\_\_\_

CLIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

PROVIDER NUMBER: \_\_\_\_\_

ADMISSION DATE: \_\_\_\_\_ DISCHARGE DATE: \_\_\_\_\_ DEATH DATE: \_\_\_\_\_

LEVEL OF CARE: \_\_\_\_\_ LTC INELIGIBLE DATE: \_\_\_\_\_

FAMILY STATUS: \_\_\_\_\_ SPOUSE STATUS: \_\_\_\_\_

**INCOME COMPUTATION:**

UNEARNED INCOME SOURCE	AMOUNT
RSDI	\$ _____
SSI	\$ _____
RR	\$ _____
VA	\$ _____
STATE SUPPLEMENTATION	\$ _____
OTHER	\$ _____
SUB-TOTAL UNEARNED INC	\$ _____

EARNED INCOME	AMOUNT
WAGES	\$ _____
EARNED INC DEDUCTION	\$ _____
SUB-TOTAL EARNED INC.	\$ _____
TOTAL INCOME	\$ _____

CASE STATUS  
 ACTIVE CASE: \_\_\_\_\_  
 IF ACTIVE EFF. MA DATE: \_\_\_\_\_  
 IF DISC EFF. MA DATE: \_\_\_\_\_

NOTIF FORM \_\_\_\_\_  
 NOTIF FORM DATE \_\_\_\_\_

DEDUCTIONS	AMOUNT
PERSONAL NEEDS ALLOWANCE	\$ _____
INCREASED FNA	\$ _____
SPOUSE/FAMILY MAINT	\$ _____
SMI	\$ _____
HEALTH INS	\$ _____
INCURRED MEDICAL EXPENSES	\$ _____
TOTAL DEDUCTIONS	\$ _____
VA AID AND ATTENDANCE	\$ _____
THIRD PARTY PAYMENTS	\$ _____
AVAILABLE INCOME	\$ _____
AVAILABLE INCOME (ROUNDED)	\$ _____
AVAILABLE MONTHLY INCOME	\$ _____

EFF DATE OF CORR: \_\_\_\_\_  
 ENDING DATE OF CORR: \_\_\_\_\_

PRIVATE PAY PATIENT  
 FROM: \_\_\_\_\_ THRU \_\_\_\_\_

EFFECTIVE DATE: \_\_\_\_\_

WORKER CODE: \_\_\_\_\_ CASELOAD CODE: \_\_\_\_\_ UPDATE DATE: \_\_\_\_\_

### LONG TERM CARE FACILITIES AND HOME AND COMMUNITY BASED PROGRAM CERTIFICATION FORM

#### I. ESTATE RECOVERY

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1993 states are required to recover from an individual's estate the amount of Medicaid benefits paid on the individual's behalf during a period of institutionalization or during a period when an individual is receiving community based services as an alternative to institutionalization.

In compliance with Section 1917 (b) of the Social Security Act, estate recovery will apply to nursing facility long term care services (NF, NF/Bf, ICF/MR/DD) home and community based services that are an alternative to long term care facility services and related hospital and prescription drug services

Recovery will only be made from an estate if there is no surviving spouse or children under age 21 or children of any age who are blind or disabled

I certify that I have read and understand the above information

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### II. HOME AND COMMUNITY BASED WAIVER SERVICES FOR THE AGED AND DISABLED, PEOPLE WITH MENTAL RETARDATION OR DEVELOPMENTAL DISABILITIES, MODEL WAIVER II, BRAIN INJURY WAIVER

A. HCBS - This is to certify that I/legal representative have been informed of the HCBS waiver for the aged and disabled. Consideration for the HCBS program as an alternative to NF placement is requested \_\_\_\_\_; is not requested \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

B. This is to certify that I/legal representative have been informed of the home and community based waiver program for people with mental retardation/ developmental disabilities. Consideration for the waiver program as an alternative to ICF/MR/DD is requested \_\_\_\_\_; is not requested \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

C. MODEL WAIVER II - This is to certify that I/legal representative have been informed of the Model Waiver II program. Consideration for the Model Waiver II program as an alternative to NF placement is requested \_\_\_\_\_; is not requested \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

D. BRAIN INJURY (BI) WAIVER - This is to certify that I/legal representative have been informed of the BI Waiver Program. Consideration for the BI Waiver Program as an alternative to NF or NF/BI placement is requested \_\_\_\_\_; is not requested \_\_\_\_\_.

Signature \_\_\_\_\_

Date \_\_\_\_\_

III. FREEDOM OF CHOICE OF PROVIDER

I understand that under the waiver programs I may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services

Signature \_\_\_\_\_

Date \_\_\_\_\_

IV. RESOURCE ASSESSMENT CERTIFICATION

This is to certify that I/legal representative have been informed of the availability, without cost of resource assessments to assist with financial planning provided by the Department for Community Based Services

Signature \_\_\_\_\_

Date \_\_\_\_\_

V. RECIPIENT INFORMATION

Medicaid Recipient's Name: \_\_\_\_\_

Address of Recipient: \_\_\_\_\_

Phone: \_\_\_\_\_

Medicaid Number: \_\_\_\_\_

Responsible Party/Legal Representative: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature and Title of Person Assisting with Completion of Form:

Agency/Facility: \_\_\_\_\_

Address: \_\_\_\_\_

**KENTUCKY MEDICAID PROGRAM REQUEST FORM  
 FOR DRUGS PRIOR-AUTHORIZED FOR NURSING FACILITY RESIDENTS**

MAID Number	Recipient Name
Facility Name	Facility Address
Facility Provider Number	

Admission Date \_\_\_\_\_ Effective Date \_\_\_\_\_

This certifies that the above recipient is (is expected to be) in Kentucky Medicaid vendor payment status in a Medicaid certified nursing facility. Prior authorization is requested for the additional drugs that can be prior authorized as a group

Authorized Representative of Facility \_\_\_\_\_

This certifies my request that the above named resident be authorized to receive drugs prior authorized for nursing facility residents

Name of Physician \_\_\_\_\_ License Number \_\_\_\_\_

Signature of Physician \_\_\_\_\_ Date \_\_\_\_\_

The facility completes the form and obtains the signature of the physician, retains one (1) copy in the resident's records and provides the pharmacy with the remaining two (2) copies. The pharmacy sends the original copy to Unisys. After processing Unisys will notify the Pharmacy by letter

Pharmacy Name	Pharmacy Provider Number
Pharmacy Address	
City/State/Zip	

**THIS FORM MUST BE COMPLETED FOR EACH ADMISSION**

**CAUTION: THE ABOVE RESIDENT MUST BE KENTUCKY MEDICAID ELIGIBLE ON THE DATE OF SERVICE VERIFY BY CHECKING THE RESIDENT'S MEDICAID CARD. THIS PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT**

Mailroom use
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\_\_\_\_ MAP-552 Continuing Income Information not on file

Date: \_\_\_\_\_

**COMMONWEALTH OF KENTUCKY  
DEPARTMENT FOR MEDICAID SERVICES  
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)  
NURSING FACILITY IDENTIFICATION SCREEN (LEVEL 1)**

Applicant Name – Last First

Social Security Number

Date of Birth

Applicant's Address

City

State

Zip Code

1. An individual is considered to have mental illness (MI) if he/she meets all of the following requirements regarding diagnosis, level of impairment and duration of illness.

**A. DIAGNOSIS:**

The individual has a major mental disorder [as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3<sup>rd</sup> Edition (DMS—III)] which includes: a schizophrenic, mood paranoid, panic, or other severe anxiety disorder; somatoform disorder; other psychotic disorders; or another mental disorder that may lead to a chronic disability. This does not include a primary diagnosis of dementia, including Alzheimers' disease or a related disorder, or a non-primary diagnosis is a major mental disorder as defined above.      Yes      No

**B. LEVEL OF IMPAIRMENT:**

The mental disorder resulted in functional limitations in major life activities within the past three (3) to six (6) months that would be appropriate for the individual's developmental stage. An individual typically has at least one (1) of the following characteristics on a continuing or intermittent basis (check the appropriate boxes):

**1. Interpersonal functioning.** The individual has serious difficulty interacting appropriately and communicating effectively with other individuals has a possible history of altercations, evictions, firing, fear of strangers avoidance of interpersonal relationships, and social isolation;

**2. Concentration, persistence, and pace.** The individual has serious difficulty in sustaining focused attention for a long enough period to permit the completion of tasks commonly found in work settings or in work-like structured activities occurring in school or home settings manifests difficulties in concentration, inability to complete simple tasks with an established time period makes frequent errors or requires assistance in the completion of these tasks;

**3. Adaptation to change.** The individual has serious difficulty in adapting to typical changes in circumstances associated with work, school, family, or social interaction, manifests agitation, exacerbated signs and symptoms associated with the illness, or withdrawal from the situation, or requires intervention by the mental health or judicial system.

**C. RECENT TREATMENT:**

The treatment history indicates that the individual has experienced at least one of the following (check the appropriate box(es)):

1. Psychiatric treatment more intensive than outpatient psychiatric care more than once in the past two (2) years (e.g. partial hospitalization or inpatient hospitalization); or

\_\_\_\_\_  
**Name of inpatient facility, partial program, or other mental health treatment**

2. Within the last two (2) years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment or which resulted in intervention by housing, or law enforcement officials.

**D** Does the applicant meet all of the requirements of having a mental illness listed in Section I. A-C? \_\_\_\_\_Yes \_\_\_\_\_No

**II. Mental Retardation and Related Conditions**

An individual is considered to have mental retardation if he/she has a level of retardation (mild, moderate, severe, or profound) as described in the American Association of Mental Retardation Manual on Classification in Mental Retardation (1983)

**A.** The individual has significantly sub-average general intellectual functioning (I.Q. of approximately 70 or below) resulting in, or associated with, concurrent impairments in adaptive behavior and manifested during the development period before the age of 18. \_\_\_\_\_Yes \_\_\_\_\_No

**B.** Is there a history of mental retardation or developmental disability in the identified past? \_\_\_\_\_Yes \_\_\_\_\_No

**C.** Is there any presenting evidence (cognitive or behavior functions) that may indicate the person has mental retardation or a developmental disability?  
\_\_\_\_\_Yes \_\_\_\_\_No

Please List: \_\_\_\_\_  
\_\_\_\_\_

**D** Has the person been referred by an agency that serves persons with mental retardation or developmental disabilities and been deemed eligible for that agency services? \_\_\_\_\_Yes \_\_\_\_\_No

Please List Agency: \_\_\_\_\_

E. 'Persons with related conditions' means individuals who have a severe, chronic disability that meets all of the following conditions:

1. It is attributable to:
  - a. Cerebral palsy or epilepsy; or
  - b. Any other condition, other than mental illness, found to be closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation, and requires treatment or services similar to those required for those persons.
2. it is manifested before the person reaches age 22.
3. It is likely to continue indefinitely
4. It results in substantial functional limitations in three (3) or more of the following:
  - a. Self care;
  - b. Understanding and the use of language;
  - c. Learning;
  - d. Mobility;
  - e. Self-direction; or
  - f. Capacity for independent living.

Examples of diagnoses that may indicate that the individual has a related condition if all of the above criteria are met include:

Autism, Blind/Severe Visual Impairment, Cerebral Palsy, Cystic Fibrosis, Deaf/Severe Hearing Impairment, Head Injury, Epilepsy/Seizure Disorder, Multiple Sclerosis, Spina Bifida Muscular Dystrophy, Orthopedic Impairment, Speech Impairment Spinal Cord Injury or Deafness/Blindness.

Does this applicant meet all of the conditions in Section E?  Yes  No

- iii. If responses to the applicable Section I and/or Section II were answered 'Yes', do not admit the applicant to the nursing facility. The nursing facility staff shall refer the applicant to the Community Mental Health Center for a Level II PASRR. The Level II PASRR determination shall be completed prior to the nursing facility admitting the applicant.

IF RESPONSES TO THE APPLICABLE SECTION I AND/OR SECTION II WERE ANSWERED 'NO' AND THERE IS NO FURTHER EVIDENCE TO INDICATE THE POSSIBILITY OF MENTAL ILLNESS, MENTAL RETARDATION, OR OTHER RELATED CONDITION, THE NURSING FACILITY MUST DECIDE WHETHER OR NOT TO ADMIT THE APPLICANT. ADMISSION TO THE FACILITY DOES NOT CONSTITUTE APPROVAL FOR TITLE XIX LEVEL OF CARE.

IV. Does the applicant meet the Criteria for Exceptional Admission to a Nursing Facility without a Level II PASRR. The applicant may be admitted if one of the following conditions exists (PLEASE NOTE TIME LIMITS):

A. Person Is An Exempted Hospital Discharge

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self and/or others may be directly admitted for nursing facility services from an acute care hospital for a period up to thirty (30) days without a Level II PASRR if such admission is based on a written medically prescribed period of recovery for the conditions requiring hospitalization. An Exempted Hospital Discharge Physician Certification form shall be completed and in the resident's clinical record at the nursing facility  
 Yes  No

B. Person Requires Respite Care

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self or others may be admitted for Respite Care for a period up to fourteen (14) days without a Level II PASRR. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility.  Yes  No

C. Person Has A Diagnosis of Delirium

Although identified as an individual with mental illness, mental retardation, or other related condition, an applicant who is not dangerous to self and/or others may receive nursing facility services for a period up to fourteen (14) days without a Level II PASRR, if certified by the referring or attending physician to have a diagnosis of delirium. A Provisional Admission Form shall be completed and in the resident's clinical record at the nursing facility.  Yes  No

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**ROUTING OF FORM**

This form shall be completed by nursing facility personnel prior to admission of the applicant to the nursing facility.

If the individual wishes to apply for Medicaid, application shall be made to the local county DSI office in the usual manner.

The facility is required to call the PRO for the Medicaid level of care determination prior to admission, and a copy of the Level I and, if appropriate, Level II PASRR, shall be faxed to the PRO. Except for the pre-admission screening process, the procedure of approval of nursing facility applicants remains the same.

A COPY OF THIS FORM, AS WELL AS A COPY OF THE LEVEL II PASRR DETERMINATION, IF REQUIRED, SHALL BE PLACED IN EACH RESIDENT'S CLINICAL RECORD AT THE FACILITY.

If someone other than the person signing the form provided any of the above history please list name and telephone number:

\_\_\_\_\_  
Name Telephone

\_\_\_\_\_  
Name Telephone

I understand that this report may be relied upon for payment of claims from Federal and State funds. Any willful falsification or concealment of a material fact may result in prosecution under Federal and State Laws. I certify that to the best of my knowledge, the foregoing information is true, accurate, and complete.

\_\_\_\_\_  
Signature Title Date Telephone Number

Facility Name \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_

\*\*\*\*\*

**COPY TO:** Original - Community Mental Health Center  
Second - Medical Records

COMMONWEALTH OF KENTUCKY  
DEPARTMENT FOR MEDICAID SERVICES  
PRE-ADMISSION SCREENING (PAS)

EXEMPTED HOSPITAL DISCHARGE  
PHYSICIAN CERTIFICATION OF NEED  
FOR NURSING FACILITY SERVICES

Applicant's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Nursing Facility Requested \_\_\_\_\_ Date Admitted to NF \_\_\_\_\_

Nursing Facility Medicaid Provider Number \_\_\_\_\_

Hospital Discharged From \_\_\_\_\_ Date of Discharge \_\_\_\_\_

Hospital's Medicaid Provider Number \_\_\_\_\_

Level I screen triggered mental illness  Yes

Level I screen triggered mental retardation or related condition  Yes

Exempted Hospital Discharge: An exempted hospital discharge means:

1. The applicant is being admitted to a nursing facility after receiving acute inpatient care at the hospital; and  Yes
2. The applicant requires nursing facility care for the condition for which he received care in the hospital; and  Yes
3. The attending physician, upon signing this document, has certified to the nursing facility that applicant is likely to require less than thirty (30) days nursing facility services.  Yes

Attending Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Attending Physician Name \_\_\_\_\_

**Note:** If an individual enters the nursing facility as an exempted hospital discharge and is later found to require more than thirty (30) days of nursing facility care, a Level II PASRR shall be completed within forty (40) calendar days of admission. The nursing facility staff shall refer persons with mental illness, mental retardation, or related condition for a Level II PASRR evaluation prior to the end of the exempt thirty (30) days by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. (This allows ten (10) calendar days for the Level II PASRR to be completed.)

Date Transmitted \_\_\_\_\_

Signature and Title \_\_\_\_\_

Print Name and Title \_\_\_\_\_

Original to Community Mental Health/Mental Retardation Center  
Second Copy - Medical Records

**COMMONWEALTH OF KENTUCKY  
DEPARTMENT FOR MEDICAID SERVICES  
PRE-ADMISSION SCREENING (PAS)**

**PROVISIONAL ADMISSION  
TO A NURSING FACILITY**

Applicant's Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Name of Nursing Facility \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_ Fax Number \_\_\_\_\_

Date Admitted to NF \_\_\_\_\_

Level I screen triggered mental illness  Yes

Level I screen triggered mental retardation or related condition  Yes

"Provisional Admission" means an individual who is admitted to a nursing facility for fourteen (14) days or less before a PASRR Level II is required; and

- 1. The applicant is expected to stay in NF for fourteen (14) days or less; and  Yes
- 2. The applicant has been diagnosed with delirium; or  Yes
- 3. The applicant is in need of respite for the in-home caregiver, and the applicant is expected to return to that in-home caregiver upon discharge from the nursing facility.  Yes

Authorized Nursing Facility Staff \_\_\_\_\_ Date \_\_\_\_\_

NF Applicant Responsible Party \_\_\_\_\_

**Note:** If an individual who is admitted to a NF under the provisional admission is later found to require more than fourteen (14) days of nursing facility services, a Level II PASRR shall be completed within the fourteen (14) day provisional admission. Therefore, nursing facility staff shall refer the individual for a Level II PASRR as soon as it is indicated that the resident requires more than fourteen (14) days of nursing facility services by transmitting a copy of this form to the Community Mental Health/Mental Retardation Center. PASRR evaluators shall complete the Level II PASRR written evaluation report within nine (9) working days from the referral date.

Date Transmitted \_\_\_\_\_

Signature and Title \_\_\_\_\_

Print Name and Title \_\_\_\_\_

Original to Community Mental Health/Mental Retardation Center

Second Copy - Medical Records

COMMONWEALTH OF KENTUCKY  
DEPARTMENT FOR MEDICAID SERVICES  
PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

NOTIFICATION OF INTENT TO REFER  
FOR LEVEL II PASRR

Individual/Resident Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address (if not in facility) \_\_\_\_\_

Name of Nursing Facility \_\_\_\_\_

Medicaid Provider Number \_\_\_\_\_

Facility Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Date Admitted to Nursing Facility \_\_\_\_\_

Responsible Party \_\_\_\_\_

Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Date Level I PASRR Completed \_\_\_\_\_

This is the written notification to inform the individual and the responsible party that the Level I PASRR indicates:

(Please check appropriate box)

a diagnosis of mental illness,   
or mental retardation,   
or a related condition.

The individual is being referred to the Community Mental Health/Mental Retardation Center for a Level II PASRR. The Level II PASRR is an evaluation and determination of the need for nursing facility services, and if so, whether specialized services are needed.

Authorized Nursing Facility Staff \_\_\_\_\_ Date \_\_\_\_\_

Print Authorized Nursing Facility Staff Name \_\_\_\_\_

Original Copy to Individual or Responsible Party

Second Copy - Medical Records

Third Copy - Community Mental Health/Mental Retardation Center

**PASRR SIGNIFICANT CHANGE/DISCHARGE DATA**

Resident Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

Facility: \_\_\_\_\_ ID#: \_\_\_\_\_

**"Significant change"** means that the individual's mental or physical condition has changed significantly in a manner that affects his/her need for specialized services or might no longer meet Medicaid criteria for nursing facility level of care. If any of the following events have occurred, please check the appropriate choice and forward this form to your local Community Mental Health/Mental Retardation within twenty-one (21) days. The Level II PASRR shall be completed within nine (9) working days upon receipt of this form.

**Type of Change:**

- Resident has a mental illness with active symptoms.
- Resident has a mental illness and the medical condition for which he/she was admitted has significantly improved
- Resident has mental retardation or developmental disability and the medical condition for which he/she was admitted has significantly improved.
- Resident has mental retardation or developmental disability and now requires more intensive services than a nursing facility setting can provide.
- Resident has mental retardation or developmental disability and receives specialized services and medical condition has significantly declined.
- None of the above. No referral required.

**Type of Discharge:**

- Deceased
- Discharged: (Please check the appropriate discharge location)
  - 1.  NF Setting:                       KY                       Out of State
  - 2.  PC Setting                      3.  Supports for Community Living
  - 4.  Group Home                      5.  Foster Care Home
  - 6.  Other Community Setting (specify, if possible) \_\_\_\_\_

\_\_\_\_\_  
Signature of Facility Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

**\*Mail completed form to your Regional PASRR office.**

CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES

NURSING FACILITY SERVICES MANUAL

CONTACT REGIONS FOR PASRR REFERRALS

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<u>REGION 1</u>	Western KY MH/MR Board P.O. Box 7287 Paducah, KY 42302 Tel: 502/442-7121	<u>REGION 10</u>	Mountain MH/MR Board 150 S. Front Street Prestonburg, KY 41653 Tel: 606/866-8572
<u>REGION 2</u>	Pennyroyal MH/MR Board 735 North Drive Hopkinsville, KY 42240 Tel: 502/886-5163	<u>REGION 11</u>	KY. River Community Care P.O. Box 587 Hyden, KY 41749 Tel: 606/678-4215
<u>REGION 3</u>	River Valley Behavioral P.O. Box 1637 Cwensboro, KY 42302 Tel: 502/684-0696	<u>REGION 12</u>	Area A Cumberland River MH/MR P.O. Box 568 Corbin, KY 40701 Tel: 606/528-7010
<u>REGION 4</u>	LifeSkills, Inc. 523 E. 12th Street Bowling Green, KY 42101 Tel: 502/842-4887		Area B Cumberland River MH/MR Mounted Route Harlan, KY 40631 Tel: 606/337-6137
<u>REGION 5</u>	Communcare, inc. 1311 N. Dixie Avenue Elizabethtown, KY 42701 Tel: 502/769-5301	<u>REGION 13</u>	ADANTA 103 Reed Street Columbia, KY 42748 Tel: 502/384-5351
<u>REGION 6</u>	Seven Counties Services, Inc. 929 S. Third Street Louisville, KY 40203 Tel: 502/585-2068	<u>REGION 14</u>	Bluegrass MH/MR Board 191 Doctors Drive Frankfort, KY 40601 Tel: 502/223-1606
<u>REGION 7</u>	Northern Kentucky MH/MR 1201 S. Ft. Thomas Avenue Fort Thomas, KY 41075 Tel: 606/781-5586		
<u>REGION 8</u>	Comprehend, Inc. 611 Forest Avenue Maysville, KY 41056 Tel: 606/364-4016		
<u>REGION 9</u>	Pathways, Inc. P.O. Box 790 Ashland, KY 41105-0790 Tel: 606/324-1141		

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