19 CSR 30-81.015 RESIDENT ASSESSMENT INSTRUMENT

PURPOSE: This rule designates the resident assessment instrument to be used by nursing facilities certified under the Title XIX (Medicaid) program and Title XVIII (Medicare) program for all residents in certified beds.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. Therefore, the material which is so incorporated is on file with the agency who filed this rule, and with the Office of the Secretary of State. Any interested person may view this material at either agency's headquarters or the same will be made available at the Office of the Secretary of State at a cost not to exceed actual cost of copy reproduction. The entire text of the rule is printed here. This note refers only to the incorporated by reference material.

(1) Effective January 1, 1991 a resident assessment instrument (RAI) shall be utilized by all nursing facilities (NFs) certified under Title XIX (Medicaid) and Title XVIII (Medicare) to perform uniform resident assessments for all residents in certified beds, regardless of payment source, as required by Title 42 U.S.C. Section 1396(r)(3)(A) of the Social Security Act.

(2) The RAI utilized shall be the one designated by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services (HHS). It is comprised of three (3) parts—

(A) The utilization guidelines, which are instructions concerning when and how to use the RAI;

(B) The minimum data set (MDS) of core elements and definitions, which is a minimum set of screening and assessment elements, including common definitions and coding categories, needed to comprehensively assess an individual nursing home resident. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies; and

(C) The resident assessment protocols (RAPs), which are structured frameworks for organizing MDS elements and additional clinically relevant information about an individual that contributes to care planning.

(3) Resident assessments shall be documented on the MDS and the RAPs shall be utilized.
(4) Frequency of Assessments.

(A) A newly admitted resident to a certified bed shall have an assessment within fourteen (14) days of admission to the facility.

(B) Each resident in a certified bed shall have an updated assessment within fourteen (14) days after a significant change in the resident’s physical or mental condition.

(C) Each resident shall be examined quarterly and the MDS core elements specified in the utilization guidelines shall be reviewed and any changes documented.

(D) Each resident in a certified bed shall have a full annual assessment no later than twelve (12) months following the last full assessment. Residents in certified beds on October 1, 1990 shall have a full assessment completed by October 1, 1991.

(5) The division shall provide each certified facility with a copy of the RAI, including guidelines for completion. Facilities may then duplicate the RAI or purchase the instrument either in paper or computerized form from a private supplier for use when performing assessments.

(6) A paper copy of all MDSs and RAP summary sheets completed for each resident shall be in the resident’s record. A facility may document on the MDS form additional information regarding a resident which is not included in the standard MDS, or may use a version of the MDS which has special codes or notations, but if information is added, the additional information shall be either in an appendix or the facility shall provide a copy of the MDS in its standard form without the additional information for use in review. All MDSs and RAP summary sheets completed within the last two (2) years must be easily retrievable from the resident’s record if requested by a representative of the Division of Aging or the federal survey and certification agency.

(7) All resident assessments shall be performed and the MDSs and RAPs shall be completed in accordance with the utilization guidelines, the definitions and all other directions as given on the forms.

(8) Whenever a resident assessment is completed on any resident in a Medicaid- or Medicare-certified bed, a legible copy of the fully completed MDS portion of the RAI shall be sent to the division within thirty (30) calendar days of completion. Forms shall be sent to: Missouri Division of Aging, Attention: MDS Unit, P.O. Box 1337, Jefferson City, MO 65102. The forms shall be submitted by each facility as a group once per month for all residents assessed in the last thirty (30) days and submitted in paper form unless the facility has requested in writing and has received written permission from the division to submit the MDS information on a properly formatted computer disk by mail or electronically.

(9) Effective June 1, 1993, all facilities shall send to the Missouri Division of Aging, to either the Attention of the MDS Unit, P.O. Box 1337, Jefferson City, MO 65102 or the appropriate regional Division of Aging office, at the same time the monthly MDS form or MDS data are being mailed, a list of names of all residents who have died or who have been discharged
from the facility (and not readmitted) during the preceding month. In addition, included with the mailing at the end of June, the facility shall submit a list of those residents who have died or who were discharged from the facility since August 1, 1992. This listings shall include the complete name of the resident, as well as some specific identifying information for each, such as the Social Security number, the birthdate or the department client number (DCN).


19 CSR 30-81.030 EVALUATION AND ASSESSMENT MEASURES FOR TITLE XIX RECIPIENTS AND APPLICANTS IN LONG-TERM CARE FACILITIES

PURPOSE: This rule sets the requirements for the periodic evaluation and assessments of residents in long-term care facilities in relationship to evaluation and assessment processes, level-of-care needed by individuals, and appropriate placement of individuals in order to receive this care.

PUBLISHER’S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) For purposes of this rule only, the following definitions shall apply:

(A) Applicant—any resident or prospective resident of a certified long-term care facility who is seeking to receive inpatient Title XIX assistance;

(B) Certified long-term care facility—any long-term care facility which has been approved to participate in the inpatient program and receives Title XIX funding for eligible recipients;

(C) Initial assessment forms—the forms utilized to collect information necessary for a determination of level-of-care need pursuant to 19 CSR 30-81.030 and designated Forms DA-124 A/B (dated 6-05) and DA-124 C (dated 4-05) and Notice To Applicant Form, DA-124C ATT. (attachment) (dated 12-01), incorporated by reference in this rule and available through the Department of Health and Senior Services website: www.dhss.mo.gov or by mail at: Department of Health and Senior Services Warehouse, Attention General Services
Warehouse, PO Box 570, Jefferson City, Missouri 651020570; telephone: (573) 526-3861; fax: (573) 751-1574, shall be considered the approved Initial Assessment Forms. This rule does not incorporate any subsequent amendments or additions.

(D) Inpatient Title XIX assistance—Title XIX payments for intermediate or skilled nursing care in a certified long-term care facility;

(E) Level-of-care assessment—the determination of level-of-care need based on an assessed point count value for each category cited in subsection (4)(B) of this rule;

(F) Level-of-care need—the decision whether an individual qualifies for long-term care facility care;

(G) Long-term care facility—a skilled nursing facility (SNF), an intermediate care facility (ICF), or a hospital which provides skilled nursing care or intermediate nursing care in a distinct part or swing bed under Chapter 197, RSMo;

(H) Pro re nata (PRN)—medication or treatment ordered by a physician to be administered as needed, but not regularly scheduled;

(I) Recipient—any resident in a certified long-term care facility who is receiving inpatient Title XIX assistance;

(J) Redetermination of level-of-care—the periodic assessment of the recipients’ continued eligibility and need for continuation at the previously assigned level-of-care. Periodic assessment includes but it not limited to the following:

1. Assessment of new admissions to a long-term care facility;

2. Assessment of a change in mental and or physical status for a resident who is being readmitted to a long-term care facility after transfer to an acute care facility, and the previous DA-124 A/B or C forms do not reflect the resident’s current care needs; and

3. Assessment of DA-124 forms as requested by Department of Social Services, Family Support Division;

(K) Resident—a person seventeen (17) years or older who by reason of aging, illness, disease, or physical or mental infirmity receives or requires care and services furnished by a long-term care facility and who resides in, is cared for, treated or accommodated in such long-term care facility for a period exceeding twenty-four (24) consecutive hours; and

(L) The department—Department of Health and Senior Services.

(2) Initial Determination of Level-of-Care Needs Requirements.

(A) For the purpose of making a determination of level-of-care need and in accordance with 42 CFR sections 456.370 and 483.104, the department or its designated agents, or both, will conduct a review and assessment of the evaluations made by the attending physician for an
applicant in or seeking admission to a long-term care facility. The review and assessment shall be conducted using the criteria in section (5) of this rule.

(B) The department shall complete the assessment within ten (10) working days of receipt of all documentation required by section (5) of this rule unless further evaluation by the State Mental Health Authority is required by 42 CFR 483.100 to 483.138.

(3) Redetermination of Level-of-Care Requirements.

(A) Redetermination of level-of-care of individual recipients who are eligible for placement in long-term care facilities shall be conducted by the department through a review and assessment of the DA-124 A/B and C forms and any documentation provided by the resident's attending physician.

(B) Required documentation on the DA124 C form shall include the resident’s physician’s signature and his or her Physician Identification Number.

(4) Level-of-Care Criteria for Long-Term Care Facility Care—Qualified Title XIX Recipients and Applicants.

(A) Individuals will be assessed with the ultimate goal to achieve placement for these individuals in the least restrictive environment possible, yet enable them to receive all services required by their physical/mental condition.

(B) The specific areas which will be considered when determining an individual's ability or inability to function in the least restrictive environment are—mobility, dietary, restorative services, monitoring, medication, behavioral, treatments, personal care and rehabilitative services.

(C) To qualify for intermediate or skilled nursing care, an applicant or recipient shall exhibit physical impairment, which may be complicated by mental impairment or mental impairment which may be complicated by physical impairment, severe enough to require intermediate or skilled nursing care.

(5) Assessed Needs Point Designations Requirements.

(A) Applicants or recipients will be assessed for level-of-care by the assignment of a point count value for each category cited in subsection (4)(B) of this rule.

(B) Points will be assessed for the amount of assistance required, the complexity of the care and the professional level of assistance necessary, based on the level-of-care criteria. If the applicant's or recipient's records show that the applicant's or recipient's attending physician has ordered certain care, medication or treatments for an applicant or recipient, the department will assess points for a PRN order if the applicant or recipient has actually received or required that care, medication or treatment within the thirty (30) days prior to review and evaluation by the department.

(C) For individuals seeking admission to a long-term care facility on or after July 1, 2005, the applicant or recipient will be determined to be qualified for long-term care facility care
if he or she is determined to need care with an assessed point level of twenty-one (21) points or above, using the assessment procedure as required in this rule.

(D) For individuals seeking admission to a long-term care facility on or after July 1, 2005, an applicant with eighteen (18) points or lower will be assessed as ineligible for Title XIX-funded long-term care in a long-term care facility, unless the applicant qualifies as otherwise provided in subsections, (5)(E) and/or (F) of the rule.

(E) Applicants or recipients may occasionally require care or services, or both, which could qualify as long-term care facility services. In these instances, a single nursing service requirement may be used as the qualifying factor, making the individual eligible for long-term care facility care regardless of the total point count. The determining factor will be the availability of professional personnel to perform or supervise the qualifying care services. Qualifying care services may include, but are not limited to:

1. Administration of Levine tube or gastrostomy tube feedings;
2. Nasopharyngeal and tracheotomy aspiration;
3. Insertion of medicated or sterile irrigation and replacement catheters;
4. Administration of parenteral fluids;
5. Inhalation therapy treatments;
6. Administration of injectable medications other than insulin, if required other than on the day shift; and
7. Requirement of intensive rehabilitation services by a professional therapist at least five (5) days per week.

(F) An applicant or recipient will be considered eligible for inpatient Title XIX assistance regardless of the total point count if the applicant or recipient is unable to meet physical/mental requirements for residential care facility (RCF) residency as specified by section 198.073, RSMo. In order to meet this requirement, an applicant or recipient must be able to reach and go through a required exit door on the floor where the resident is located by—

1. Responding to verbal direction or the sound of an alarm;
2. Moving at a reasonable speed; and
3. If using a wheelchair or other assistive device, such as a walker or cane, being able to transfer into the wheelchair or reach the assistive device without staff assistance.
(G) Points will be assigned to each category, as required by subsection (4)(B) of this rule, in multiples of three (3) according to the following requirements:

1. Mobility is defined as the individual’s ability to move from place-to-place. The applicant or recipient will receive—

A. Zero (0) points if assessed as independently mobile, in that the applicant or recipient requires no assistance for transfers or mobility. The applicant or recipient may use assistive devices (cane, walker, wheelchair) but is consistently capable of negotiating without assistance of another individual;

B. Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient is independently mobile once the applicant or recipient receives assistance with transfers, braces or prosthesis application or other assistive devices, or a combination of these (example, independent use of wheelchair after assistance with transfer). This category includes individuals who are not consistently independent and need assistance periodically;

C. Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient is mobile only with direct staff assistance. The applicant or recipient must be assisted even when using canes, walker or other assistive devices; and

D. Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient is totally dependent upon staff for mobility. The applicant or recipient is unable to ambulate or participate in the ambulation process, requires positioning, supportive device, application, prevention of contractures or pressure sores and active or passive range of motion exercises;

2. Dietary is defined as the applicant’s or recipient’s nutritional requirements and need for assistance or supervision with meals. The applicant or recipient will receive—

A. Zero (0) points if assessed as independent in dietary needs, in that the applicant or recipient requires no assistance to eat. The applicant or recipient has physician’s orders for a regular diet, mechanically altered diet or requires only minor modifications (example, limited desserts, no salt or sugar on tray);

B. Three (3) points if assessed as requiring minimum assistance, in that the applicant or recipient requires meal supervision or minimal help, such as cutting food or verbal encouragement. Calculated diets for stabilized conditions shall be included;

C. Six (6) points if assessed as requiring moderate assistance, in that the applicant or recipient requires help, including constant supervision during meals, or actual feeding. Calculated diets for unstable conditions are included; and

D. Nine (9) points if assessed as requiring maximum assistance, in that the applicant or recipient requires extensive assistance for special dietary needs or with eating, which could include enteral feedings or parenteral fluids;

3. Restorative services are defined as specialized services provided by trained and supervised individuals to help applicants or recipients obtain and/or maintain their optimal
highest practicable functioning potential. Each applicant or recipient must have an
individual overall plan of care developed by the provider with written goals and
response/progress documented. Restorative services may include, but are not limited to:
applicant or recipient teaching program (selftransfer, self-administration of medications,
self-care), range of motion, bowel and bladder program, remotivational therapy, validation
therapy, patient/family program and individualized activity program. The applicant or
recipient will receive—

A. Zero (0) points if restorative services are not required;
B. Three (3) points if assessed as requiring minimum services in order to maintain level of
functioning;
C. Six (6) points if assessed as requiring moderate services in order to restore the individual
to a higher level of functioning; and
D. Nine (9) points if assessed as requiring maximum services in order to restore to a higher
level of functioning. These are intensive services, usually requiring professional supervision
or direct services;

4. Monitoring is defined as observation and assessment of the applicant’s or recipient’s
physical and/or mental condition. This monitoring could include assessment of— routine
laboratory work, including but not limited to, evaluating digoxin and coumadin levels,
measurement and evaluation of blood glucose levels, measurement and evaluation of intake
and output of fluids the individual has received and/or excreted, weights and other routine
monitoring procedures. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring only routine monitoring, such as monthly weights,
temperatures, blood pressures and other routine vital signs and routine supervision;
B. Three (3) points if assessed as requiring minimal monitoring, in that the applicant or
recipient requires periodic assessment due to mental impairment, monitoring of mild
confusion, or both, or periodic assessment of routine procedures when the recipient’s
condition is stable;
C. Six (6) points if assessed as requiring moderate monitoring, in that the applicant or
recipient requires recurring assessment of routine procedures due to the applicant’s or
recipient’s unstable physical or mental condition; and
D. Nine (9) points if assessed as requiring maximum monitoring, which is intensive
monitoring usually by professional personnel due to applicant’s or recipient’s unstable
physical or mental condition;

5. Medication is defined as the drug regimen of all physician-ordered legend medications,
and any physician-ordered nonlegend medication for which the physician has ordered
monitoring due to the complexity of the medication or the condition of the applicant or
recipient. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no medication, or has not required PRN
medication within the thirty (30) days prior to review and evaluation by the department;
B. Three (3) points if assessed as requiring any regularly scheduled medication and the applicant or recipient exhibits a stable condition;

C. Six (6) points if assessed as requiring moderate supervision of regularly scheduled medications, requiring daily monitoring by licensed personnel; and

D. Nine (9) points if assessed as requiring maximum supervision of regularly scheduled medications, a complex medication regimen, unstable physical or mental status or use of medications requiring professional observation and assessment, or a combination of these;

6. Behavioral is defined as an individual’s social or mental activities. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring little or no behavioral assistance. Applicant or recipient is oriented and memory intact;

B. Three (3) points if assessed as requiring minimal behavioral assistance in the form of supervision or guidance on a periodic basis. Applicant or recipient may display some memory lapses or occasional forgetfulness due to mental or developmental disabilities, or both. Applicant or recipient generally relates well with others (positive or neutral) but needs occasional emotional support;

C. Six (6) points if assessed as requiring moderate behavioral assistance in the form of supervision due to disorientation, mental or developmental disabilities or uncooperative behavior; and

D. Nine (9) points if assessed as requiring maximum behavioral assistance in the form of extensive supervision due to psychological, developmental disabilities or traumatic brain injuries with resultant confusion, incompetency, hyperactivity, hostility, severe depression, or other behavioral characteristics. This category includes residents who frequently exhibit bizarre behavior, are verbally or physically abusive, or both, or are incapable of self-direction. Applicants or recipients who exhibit uncontrolled behavior that is dangerous to themselves or others must be transferred immediately to an appropriate facility;

7. Treatments are defined as a systematized course of nursing procedures ordered by the attending physician. The applicant or recipient will receive—

A. Zero (0) points if no treatments are ordered by the physician;

B. Three (3) points if assessed as requiring minimal type-ordered treatments, including nonroutine and preventative treatments, such as whirlpool baths and other services;

C. Six (6) points if assessed as requiring moderate type-ordered treatments requiring daily attention by licensed personnel. These treatments could include: daily dressings, PRN oxygen, oral suctioning, catheter maintenance care, treatment of stasis or pressure sore ulcers, wet/moist packs, maximist and other such services; and

D. Nine (9) points if assessed as requiring maximum type-ordered treatments of an extensive nature requiring provision, direct supervision, or both, by professional personnel. These treatments could include: intratrachial suctioning; insertion or maintenance of
suprapubic catheter; continuous oxygen; new or unregulated ostomy care; dressings of deep draining lesions more than once daily; care of extensive skin disorders, such as advanced pressure sore or necrotic lesions; infrared heat and other services;

8. Personal care is defined as activities of daily living, including hygiene; personal grooming, such as dressing, bathing, oral and personal hygiene, hair and nail care, shaving; and bowel and bladder functions. Points will be determined based on the amount of assistance required and degree of assistance involved in the activity. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no assistance with personal care in that the applicant or recipient is an independent, self-care individual. No assistance is required with personal grooming; the applicant or recipient has complete bowel and bladder control;

B. Three (3) points if assessed as requiring minimal assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, and/or exhibits infrequent incontinency (once a week or less);

C. Six (6) points if assessed as requiring moderate assistance with personal care, in that the applicant or recipient requires assistance with personal grooming, requiring close supervision or exhibits frequent incontinency (incontinent of bladder daily but has some control or incontinent of bowel two (2) or three (3) times per week), or a combination of these; and

D. Nine (9) points if assessed as requiring maximum assistance with personal care, in that the applicant or recipient requires total personal care to be performed by another individual, and/or exhibits continuous incontinency all or most of the time; and

9. Rehabilitation is defined as the restoration of a former or normal state of health through medically-ordered therapeutic services either directly provided by or under the supervision of a qualified professional. Rehabilitation services include, but are not limited to: physical therapy, occupational therapy, speech therapy and audiology. If ordered by the physician, each resident must have an individually planned and implemented program with written goals and response/progress documented. Points will be determined by intensity of required services and the applicant’s or recipient’s potential for rehabilitation as determined by the rehabilitation evaluation. The applicant or recipient will receive—

A. Zero (0) points if assessed as requiring no ordered rehabilitation services;

B. Three (3) points, if assessed as requiring minimal-ordered rehabilitation services of one (1) time per week;

C. Six (6) points if assessed as requiring moderate-ordered rehabilitative services of two (2) or three (3) times per week; and

D. Nine (9) points if assessed as requiring maximum-ordered rehabilitative services of four (4) times per week or more.

This rule was previously filed as 13 CSR 40-81.084 and 13 CSR 15-9.030. Original rule filed
37.40.202 PREADMISSION SCREENING, GENERAL REQUIREMENTS

(1) This rule provides the preadmission screening requirements of the Montana Medicaid program for applicants to nursing facilities participating in the Montana Medicaid program.

(2) Nursing facility applicants must undergo a level I screening prior to admission to a nursing facility.

(a) A level I screening may result in the following determinations which will apply as indicated:

(i) a nursing facility applicant who has no diagnosis or any indications of mental retardation or mental illness will:

(A) if not a medicaid recipient, receive a copy of the level I screen. No further action will be taken by the department; and

(B) if a medicaid recipient, undergo a level of care determination for nursing facility services.

(ii) a nursing facility applicant who has a diagnosis or indications of mental retardation or mental illness will be referred to either the state mental health authority or the mental health authorit

retardation authority for a level II screening unless determined by the level I screening to be within one of the exceptions provided for in (3)(a) of this rule.

(3) A nursing facility applicant who has a diagnosis or indications of mental retardation or mental illness may enter a nursing facility only if the applicant is determined to be in need of nursing facility services and is allowed to enter as provided for in (3)(a) or (b) of this rule;

(a) A person with a diagnosis or indications of mental retardation or mental illness who is in need of nursing facility services may enter a nursing facility without a level II screening or a determination of appropriate active treatment, if either:

(i) the person is being discharged from an acute care facility and admitted to a nursing facility for recovery from an illness or surgery for a period not to exceed 120 days and is not a danger to self or others;

(ii) the person is certified by a physician to be terminally ill (prognosis of a life expectancy of six months or less) and is not a danger to self or others;

(iii) the person is comatose, ventilator dependent, functioning at the brain stem level or diagnosed as having chronic obstructive pulmonary disease, severe Parkinson's disease, Huntington's Chorea, amyotrophic lateral sclerosis, congestive heart failure or other similar diagnosis which prohibits the person from participating in active treatment; or

(iv) the person has a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, based on a neurological examination.

(b) A level II screening may result in the following determinations which will apply as indicated:

(i) Any person with mental retardation or mental illness determined not to be in need of nursing facility services, whether or not active treatment services are required, shall be considered inappropriate for placement or continued residence in a nursing facility;

(ii) Any person with mental retardation or mental illness determined to be in need of active treatment services shall be considered inappropriate for placement or continued residence in a nursing facility;

(iii) Any person with mental retardation or mental illness determined to be in need of nursing facility services but not to be in need of active treatment services shall be considered appropriate for placement or continued residence in a nursing facility;

(iv) Any person with mental retardation or mental illness determined to be in need of both nursing facility services and active treatment, who is of advanced years, competent to make an independent decision and who is not a danger to self or others shall be considered appropriate for placement or continued residence in a nursing facility if the person so chooses.
(4) Medicaid recipients must be determined by a preadmission screening team to require nursing facility services before Medicaid payment for services in a nursing facility or the home and community services program will be authorized.

(a) If a person is Medicaid eligible prior to admission to a nursing facility, a nursing facility screening must be requested prior to admission. Payment for nursing facility care shall be effective on the date of entry to the nursing facility if the applicant meets all eligibility requirements.

(b) If the person applies for Medicaid while a resident of a nursing facility, the nursing facility screening must be done prior to initial Medicaid payment. Payment shall be effective on the date of the nursing facility screening or the date of referral to the preadmission screening team, whichever is earlier.

(5) Retroactive approval for nursing facility services is available only if:

(a) the applicant is determined to be financially eligible for Medicaid during the retroactive period; and

(b) the applicant had undergone a determination of need for nursing facility services either by the preadmission screening team or for purposes of Medicare payment; and

(c) the applicant was determined to be in need of nursing facility services as a result of the screenings.

(6) A nursing facility applicant who is not a Medicaid recipient may request that a nursing facility screening be conducted. This screening will be performed by the preadmission screening team.

(7) Preadmission screening will be performed by persons the department determines are qualified to conduct the various elements of the screening.

(8) A nursing facility admitting a nursing facility applicant for whom a level I screening or a nursing facility screening has not been conducted may be subject to the sanctions provided at ARM 37.85.502 and to any other measures that federal or state authorities deem appropriate and necessary for the purposes of the federal Social Security Act. (History: Sec. 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; EMERG, NEW, 1989 MAR p. 439, Eff.

4/14/89; TRANS, from SRS, 2000 MAR p. 489.)

37.40.205 PREADMISSION SCREENING, NURSING FACILITY SERVICES

(1) For elderly persons and physically disabled persons, the need for nursing facility service will be determined based upon the following criteria:

(a) The services of a skilled nursing facility (SNF) are needed when a person meets the criteria for skilled care as defined by Title XVIII of the Social Security Act.
37.40.206 PREADMISSION SCREENING, REDETERMINATION OF NEED
FOR NURSING FACILITY SERVICES

(1) For a person who is identified as in need of nursing facility services, and is enrolled in
the home and community services program, a redetermination of the need for nursing
facility services will take place 90 days after enrollment and every 180 days thereafter.

(History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-
111 and 53-6-402, MCA; EMERG, NEW, 1989 MAR p. 439, Eff. 4/14/89; TRANS, from SRS,
2000 MAR p. 489.)
37.40.320 Minimum Data Set Submission, Treatment of Delays
In Submission, Incomplete Assessments, and Case Mix Index Calculation

(1) Nursing facilities shall submit all minimum data set assessments and tracking documents to the centers for Medicare and Medicaid services (CMS) database as required by federal participation requirements, laws and regulations.

(2) Submitted assessment data shall conform to federal data specifications and meet minimum editing and validation requirements.

(3) Retention of assessments on the database will follow the records retention policy of the department of public health and human services. Back up tapes of each rate setting period will be maintained for a period of five years.

(4) Assessments not containing sufficient in-range data to perform a resource utilization group-III (RUG-III) algorithm will not be included in the case mix calculation during the transition period.

(5) All current assessments in the database older than six months will be excluded from the case mix index calculation.

(9) Facilities will be required to comply with the data submission requirements specified in this rule and ARM 37.40.321. The department will utilize medicaid case mix data in the computation of rates for the period July 1, 2001 through June 30, 2002 and for rate years thereafter.

(6) "Fiscal year" and "fiscal reporting period" both mean the provider's internal revenue tax year.

(9) "Minimum data set (MDS)" means the assessment form approved by the centers for Medicare and Medicaid services (CMS), and designated by the department to satisfy conditions of participation in the Medicaid and Medicare programs.


(18) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.
(20) "RUG-III grouper version" means the resource utilization group version III algorithm that classifies residents based upon diagnosis, services provided and functional status using MDS assessment information for each resident.