DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 40

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Nursing Home Care

37.40.101 LEVEL OF CARE DETERMINATIONS (1) The three basic considerations in every level of care determination are the individual patient's medical, psychological and social needs; the specific services required to fill these needs; and, the health and other personnel required to adequately provide these services.

(a) Specific level of care criteria, as well as preadmission screening procedures, are found in ARM 37.40.201 and 46.12.1303.

(2) Assessing a patient's medical condition and evaluating the appropriateness of services for that condition is primarily a nurse coordinator's function. If questions arise regarding the patient's medical condition or the propriety of some or all of the services ordered by the attending physician, physician advisor review, including peer review, may be requested by the attending physician.

(3) Assessing a patient's psychological and social condition and evaluating the appropriate services for that condition is primarily a function of the department or its designee. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, Eff. 1/3/77; AMD, 1983 MAR p. 863, Eff. 7/15/83; TRANS, from SRS, 2000 MAR p. 489.)

Rules 02 through 04 reserved

37.40.105 SKILLED CARE (1) The goal of skilled care is to provide care for patients who require general medical management and skilled nursing care on a continuing basis, but who do not require the constant availability of physician services ordinarily found only in the hospital setting.

(2) Skilled nursing care includes components which distinguish it from supportive care. Supportive care does not require professional health training. One component is the observation and assessment of the total needs of the patient. Another component is the rendering of direct services to a patient where the ability to provide the services requires specialized training, such as a registered or a licensed practical nurse.

(3) In evaluating whether the services required by the patient are the continuous skilled services which constitute skilled care, several basic principles are considered.

(a) Since skilled care represents skilled nursing care on a continuous basis, the need for a single skilled service -- for example, intramuscular injections twice a week -- would rarely justify a finding that the care constitutes skilled care.

(b) The classification of a particular service as skilled is based on the technical or professional health training required to effectively perform or supervise the service. For example, a patient, following instructions, can normally take oral medication. Consequently, the act of giving an oral medication to a patient who is too senile to take it himself would not be skilled service, even when a licensed nurse gives the medication.

(c) The importance of a particular service to an individual patient does not necessarily make it a skilled service. For example, a primary need of a non-ambulatory patient may be frequent changes of position in order to avoid development of decubiti. If changing the patient's position is the only regular and frequent service provided, it would not be a skilled service. Routine prophylactic and palliative skin care such as bathing, application of creams, etc. does not constitute skilled services. Presence of a small decubitus ulcer, rash or other relatively minor skin irritation does not generally indicate a need for skilled care. Existence of extensive decubiti or other widespread skin disorder may necessitate skilled care. Physicians' orders for treating the skin, rather than diagnosis, are the principal indication of whether skilled care is required.

(d) The possibility of adverse effects from improper performance of an otherwise unskilled service -- for example, improper transfer of patients from bed to wheelchair -- does not change it to a skilled service.

(4) Any of the following treatment services or care indicate need for skilled nursing care:

(a) oral administered medications requiring constant changes of dosage upon sudden undesirable side effects;

(b) oral medication before routine dosage established and must be watched for reactions;

(c) gastrostomy feedings;

(d) nasopharyngeal aspiration;

(e) recent postoperative colostomy and ileostomy care;

(f) repeated catheterizations during recent postoperative period;

(g) special services in application of dressings involving prescribed medications;

(h) initial phases of operation of inhalation equipment;

(i) physical therapy directed by the physician;

(j) intravenous or instramuscular injections except for the well controlled diabetic;

(k) patient on narcotics for pain;

(l) the very hostile, belligerent and demanding patient who is disruptive to other patients and staff, constantly refusing to take medication or treatment, may be destructive, may attack other patients or personnel, may have frequent periods of agitation and needs constant and close supervision; and

(m) the patient with severe impairments, or who is so withdrawn to the degree that he no longer can communicate and his needs must be anticipated.

(History: Sec. 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-402, MCA; NEW, Eff. 1/3/77; AMD, 1983 MAR p. 863, Eff. 7/15/83; TRANS, from SRS, 2000 MAR p. 489.)

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37.40.106 INTERMEDIATE NURSING CARE (1) Intermediate care services may be included in facilities licensed as a skilled nursing home or a personal care home which has a registered or a licensed practical nurse on duty eight hours a day, seven days a week, and with adequate personnel to provide the necessary nursing supervision and care to the intermediate care cases. No additional professional nurses will be required to render skilled nursing care.

(2) The intermediate nursing care patient needs some nursing service which is largely routine and whose major needs are for light personal care services. The following treatment services may indicate the need for intermediate nursing home care: oral medication after routine dosage established; routine catheter care; routine service for indwelling catheter; routine change in dressing to non-infected area; routine skin care; care of small decubitus ulcer; routine inhalation therapy; and maintenance care of colostomy or ileostomy.

(3) The following personal care services usually indicate the need for intermediate care. The incontinent patient needs to be dressed and bathed, may be a bed to chair patient, may need some restraints and constant watching for safety, needs help with toileting, needs help for ambulation or constant watching to prevent falls, needs help with eating, may be confused or senile and at times uncooperative, may have impairment, such as blindness or deafness and these impairments require some extra attention. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)

Rules 07 through 09 reserved

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37.40.110 SERVICES FURNISHED The following sections list those services commonly furnished by nursing personnel in skilled nursing homes and their usual skill classification. Any generally non-skilled service could, because of special medical complications in an individual case, require skilled performance, supervision or observation. However, the complications and special services involved should be documented by nursing notes and/or physician orders with progress notes. These records should include the observations made of physical findings, new developments in the course of the disease, the carrying out of details of treatment prescribed, and the results of the treatment.

(1) Medications given by intravenous or intramuscular injections usually require skilled services. The frequency of injections would be particularly significant in determining whether the patient needs continuous skilled nursing care. Injections which can usually be self-administered -- for example, the well-regulated diabetic who receives a daily insulin injection -- do not require skilled services. Oral medications which require immediate changes in dosages because of sudden undesirable side effects or reactions should be administered to the patient and observed by licensed nurses, e.g., anti-coagulants, quinidine. This is a skilled service. Where a prolonged regimen of oral drug therapy is instituted, the need for continued presence of skilled nursing personnel can be presumed only during the period in which the routine is being established and changes in dosage cannot be anticipated or accomplished by unskilled personnel, e.g., digitalis.

(a) Administration of eye drops and topical ointments (including those required following cataract surgery) is not a skilled service. In Montana, institutional patients must receive all medications from licensed nurses; this fact, however, would not make the administration of oral medication a skilled service where the same type of medications are frequently prescribed for home use without skilled personnel being present.

(2) Levine tube and gastrostomy feedings must be properly prepared and administered. Supervision and observation by licensed nurses are required, thus making this procedure a skilled service.

(3) The services and observation required for nasopharyngeal aspiration constitute skilled nursing care.

(4) Colostomy or ileostomy may require skilled service during the immediate postoperative period following a newly created or revised opening. The need for such care should be documented by a physician and nursing notes. General maintenance care of this condition can usually be performed by the patient himself or by a person without professional raining and would not usually require skilled services.

(5) Repeated catheterizations during the immediate post-operative period following abdominal surgery could, with a few other skilled services, constitute continuous skilled nursing care. Routine services in connection with indwelling bladder catheters do not constitute skilled care. Catheters used in other parts of the body, such as bile ducts, chest cavity, etc., require skilled care.

(6) General methods of treating incontinence, such as use of diapers and rubber sheets, are not skilled services. A catheter used for incontinence would not require skilled care. Secondary skin problems should indicate the treatment required and should be noted in the patient's record.

(7) Special service in connection with application of dressings involving prescription medications and aseptic technique constitute skilled services. Routine changes of dressings, particularly in non-infected postoperative or chronic conditions, generally do not require skilled services or supervision.

(8) Routine care in connection with braces and similar devices appliances does not constitute skilled services. Care involving training in proper use of a particular appliance should be evaluated in relation to the need for physical therapy.

(9) The use of protective restraints generally does not require services of skilled personnel. This includes such devices as bed rails, soft binders, and wheelchair patient supports.

(10) Any regimen involving regular administration of inhalation therapy can be instituted only upon specific physician order. The initial phases of instituting such a regimen would be skilled care. However, when such administration becomes a part of regular routine, it would not generally be considered a skilled service since patients can usually be taught to operate their own inhalation equipment, or non-skilled personnel can supervise its administration, as in cases of chronic asthma, emphysema, etc.

(11) Physical therapy, one aspect of restorative care, consists of the application of a complex and sophisticated group of physical modalities and therapeutic services. Physical therapy, therefore, is a skilled service. However, a provision of physical therapy only would not justify a finding that the patient requires skilled care. In some situations, however, a patient whose primary need is for physical therapy will also require sufficient skilled nursing to meet the definition of skilled care. The need for such supportive skilled nursing on a continuing basis may be presumed when all four of the following conditions are met.

(a) The therapy is directed by the physician who determines the need for therapy, the capacity and tolerance of the patient, and the treatment objectives.

(b) The physician, in consultation with the therapist, prescribes the specific modalities to be used and frequency of therapy services.

(c) The therapy is rendered by or under the supervision of a physical therapist who meets the qualifications established by regulations; when the qualified therapist is the supervisor, he is available and on the premises of the facility while the therapy is being given, he makes regular and frequent evaluations of the patient, records findings on the patient's chart, and communicates with the physician as indicated.

(d) The therapy is actively concerned with restoration of a lost or impaired function. For example, frequent physical therapy treatments in connection with a fractured back or hip or a CVA can be presumed to be directed toward restoration of lost or impaired function during the early phase --when physical therapy can be presumed to be effective. However, when the condition has stabilized, the presumption that continuing supportive skilled nursing services are required is no longer valid. Such cases must be evaluated in relation to the specific amount of skilled nursing attention required in the individual case as evidenced by physician orders and nursing notes. The routine ambulation and/or transfer of patients is not a skilled service. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)

Rules 11 through 19 reserved

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37.40.120 PROBLEM CASES (1) There are some situations in which a patient's condition requires the institutional services provided by a skilled care facility, but does not require the type of care which is defined as skilled care. Such situations often arise where a patient needs extensive personal services due to permanent handicap or general debility, and alternative living arrangements are impractical or impossible due to socio-economic, physical or emotional reasons.

(2) Certain emotional conditions, or disturbed patients may require continuous services of sufficient degree of skill as to be considered as skilled service. However, when such is the case the exact services and medications should be sufficiently documented to justify claiming this as a skilled service.

(3) When any of the following circumstances exist, there must be evidence that continuous skilled nursing service is also concurrently required and received. These are not of themselves considered skilled services, but in combination with others may be skilled services.

(a) The primary service is one or more of the following:

(i) oral medication;

(ii) skin care to prevent decubiti;

(iii) restraints;

(iv) frequent laboratory tests;

(v) routine incontinence care;

(vi) routine care for the blind;

(vii) supervision of daily living activities.

(b) The patient is capable of independent ambulation, dressing, feeding, and hygiene.

(c) The patient has outside privileges.

(d) The diagnosis shown is not of a type which is sufficiently specific to indicate skilled treatment regimen; i.e., the diagnosis is chronic brain syndrome, senility, arteriosclerosis, "old" CVA, etc. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-113, MCA; NEW, Eff. 1/3/77; TRANS, from SRS, 2000 MAR p. 489.)

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Subchapter 2

Screening for Skilled Nursing and
Intermediate Care Services

37.40.201 PREADMISSION SCREENING, DEFINITIONS

(1) "Active treatment" means:

(a) for persons with mental retardation or a related condition, a continuous program which includes aggressive consistent implementation of a program of specialized and generic training, treatment, health services and related services that is directed toward:

(i) the acquisition of the behaviors necessary for the person to function with as much self-determination and independence as possible; and

(ii) the prevention or deceleration of regression or loss of current optimal functional status. Active treatment does not include services to maintain a generally independent client who is able to function with little supervision or in the absence of a continuous treatment program.

(b) for persons with mental illness, the implementation of an individualized plan of care developed under and supervised by a physician and provided by physicians and other qualified mental health professionals, that prescribes specific therapies and activities under the supervision of trained mental health personnel for the treatment of a person who is experiencing an acute episode of severe mental illness.

(2) "Home and community services program" means the provision of services described in ARM 46.12.1401 through 46.12.1482 to a person in a community setting, who meets the nursing facility level of care requirements.

(3) "Level I screening" means a review of a nursing facility applicant to identify whether the applicant has a primary or secondary diagnosis or indications of mental retardation or of mental illness.

(4) "Level II screening" means an assessment applied to persons identified as having a primary or secondary diagnosis of mental retardation or mental illness which determines whether the person as a nursing facility applicant has need for the level of services provided by the nursing facility or by another type of facility and, if so, whether the individual requires active treatment.

(5) "Medicaid recipient" means a person who is currently medicaid eligible or who has applied for medicaid.

(6) "Mental illness" means an applicant has or has had a primary or secondary diagnosis of a major mental disorder, as defined in the Diagnostic and Statistical Manual of Mental Disorders, third edition (DSMIIIR), limited to schizophrenic, paranoid, major affective, schizoaffective disorders and atypical psychosis, and does not have a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, which is based on a neurological assessment.

(7) "Mental retardation" means:

(a) An applicant has or has had a primary or secondary diagnosis of mild, moderate, severe or profound retardation as described in the American Association on Mental Deficiency's Manual on Classification in Mental Retardation (1983); or

(b) An applicant has, or has had a primary or secondary diagnosis of a condition related to mental retardation, which is a severe, chronic disability that:

(i) is attributable to:

(A) autism, cerebral palsy or epilepsy; or

(B) any other condition, other than mental illness found to be closely related to mental retardation due to an impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons requiring treatment or services similar to those required for these persons;

(ii) is manifested before the person reaches age 22;

(iii) is likely to continue indefinitely; and

(iv) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction or;

(F) capacity for independent living.

(8) "Nursing facility" means an institution or a distinct part of an institution which is not primarily for the care and treatment of mental diseases, and is primarily engaged in providing either:

(a) skilled nursing care and related services for residents who require medical or nursing care;

(b) rehabilitation services for the rehabilitation of injured, disabled or sick persons, or

(c) on a regular basis, health-related care and services to persons who because of their mental or physical condition require care and services above the level of room and board which can be made available to them only through institutional
facilities.

(9) "Nursing facility applicant" means any person who has been referred for or is applying for admission to a nursing facility or the home and community services program.

(10) "Preadmission screening" means a medical, psychological and social evaluation of a nursing facility applicant which:

(a) is performed prior to entry to a nursing facility or the home and community services program and includes;

(i) a level I screening to determine if an applicant has a diagnosis or indication of mental illness or mental retardation;

(ii) a level II screening if an applicant is found by the level I screening to need further assessment; and

(iii) a nursing facility screening which determines an applicant's need for nursing facility services.

(11) "Preadmission screening team" means:

(a) for a nursing facility services determination, a licensed registered nurse and a department long term care specialist;

(b) for a level I screening, a long term care specialist or other professional approved by the department; and

(c) for a level II screening, employees or contractors of the state mental retardation authority or the state mental health authority.

(12) "Problems" means functional impairments, including those involving walking, bathing, grooming, dressing, toileting, transferring, feeding, bladder incontinence, bowel incontinence, special sense impairments (such as speech or hearing), mental and behavioral dysfunctions.

(13) "State mental health authority" means the Montana department of corrections.

(14) "State mental retardation authority" means the developmental disabilities division of the Montana department of public health and human services. (History: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-111, 53-6-131, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; EMERG, AMD, 1989 MAR p. 439, Eff. 4/14/89; TRANS, from SRS, 2000 MAR p. 489.)

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 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 schlerosis, 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.)

Rules 03 and 04 reserved

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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.

(b) The services of an intermediate care facility (ICF) are needed when a person:

(i) does not qualify for skilled nursing facility care; and

(ii) is determined by the department or its designee to need care at a level higher than personal care;

(c) In order to receive home and community services, an applicant must be determined to be at risk of or require care at the intermediate level as determined by the department or its designee through a functional rating of the person. The need for such care is indicated when the person:

(i) is able to ambulate (walk or wheel) to a dining room or equivalent;

(ii) is capable of self care with minimal assistance;

(iii) has four or fewer problems determined to be low level by the department or its designee; and

(iv) requires no more than one-hour of nursing care per 24 hours.

(d) A candidate for discharge is a person who has two or less problems. This criteria does not apply to persons with a diagnosis of mental illness or mental retardation.

(2) For mentally retarded persons applying for the home and community services program, the appropriate nursing facility services will be determined based upon the following criteria:

(a) The services of an intermediate care facility for the mentally retarded (ICF/MR) are needed when a mentally retarded person:

(i) has severe medical problems requiring substantial care, but not to the extent that habilitation is impossible;

(ii) has extreme deficits in self-care and daily living skills which require intensive training; or

(iii) has significant maladaptive social and/or interpersonal behavior patterns which require an on-going, supervised program of intervention.

(b) Skilled nursing facility (SNF) level of care is needed when a person with mental retardation meets the requirements for SNF services as found in (1)(a) of this rule. (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.)

37.40.206 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.

(2) For a person who is identified as in need of nursing facility services in an intermediate care facility for the mentally retarded (ICF/MR) and is enrolled in the home and community services program, a redetermination will be conducted annually. (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.)

37.40.207 PREADMISSION SCREENING, QUALIFIED MENTAL RETARDATION PROFESSIONAL (1) The department will approve persons as qualified mental retardation professionals for purposes of providing preadmission screening and medicaid related case management services.

(2) Qualified mental retardation professional means a person who has specialized training or one year of work experience in habilitation or related services with mentally retarded or other developmentally disabled individuals.

(3) The department will accept as evidence of specialized training the following factors:

(a) licensure or certification in a profession which involves direct care to developmentally disabled persons;

(b) documentation of training, such as certification as a developmental disabilities client programming technician; or

(c) certification as a developmental disabilities professional person.

(4) The department will accept as evidence of work experience documentation of supervised employment in direct care to developmentally disabled persons. (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.)

Subchapter 3

Reimbursement for Skilled Nursing
and Intermediate Care Services

37.40.301 SCOPE, APPLICABILITY, AND PURPOSE (1) This subchapter specifies requirements applicable to provision of and reimbursement for Medicaid nursing facility services, including intermediate care facility services for the mentally retarded. These rules are in addition to requirements generally applicable to Medicaid providers as otherwise provided in state and federal statute, rules, regulations and policies.

(2) These rules are subject to the provisions of any conflicting federal statute, regulation or policy, whether now in existence or hereafter enacted or adopted.

(3) Reimbursement and other substantive nursing facility requirements are subject to the laws, regulations, rules, and policies then in effect. Procedural and other nonsubstantive provisions of these rules are effective upon adoption. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.302 DEFINITIONS Unless the context requires otherwise in this subchapter, the following definitions apply:

(1) "Administrator" means the person licensed by the state, including an owner, salaried employee, or other provider, with daily responsibility for operation of the facility. In the case of a facility with a central management group, the administrator, for the purpose of these rules, may be a person other than the titled administrator of the facility if such person has daily responsibility for operation of the nursing facility and is currently licensed by the state as a nursing home administrator.

(2) "Case mix index (CMI)" means an assigned weight or numeric score assigned to each RUG-III grouping which reflects the relative resources predicted to provide care to nursing facility residents.

(3) "Department" means the Montana Department of Public Health and Human Services or its agents, including but not limited to parties under contract to perform audit services, claim processing and utilization review.

(4) "Department audit staff" and "audit staff" mean personnel directly employed by the department or any of the department's contracted audit personnel or organizations.

(5) "Estimated economic life" means the estimated remaining period during which property is expected to be economically usable by one or more users, with normal repairs and maintenance, for the purpose for which it was intended when built.

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

(7) "Maintenance therapy and rehabilitation services" mean repetitive services required to maintain functions which do not involve complex and sophisticated therapy procedures or the judgment and skill of a qualified therapist and without the expectation of significant progress.

(8) "Medicaid recipient" means a person who is eligible and receiving assistance under Title XIX of the Social Security Act for nursing facility services.

(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.

(10) "Minimum data set RUG-III quarterly assessment form" means the three page quarterly, optional version for RUG-III 1997 update.

(11) "Nonemergency routine transportation" means transportation for routine activities, such as outings scheduled by the facility, nonemergency visits to physicians, dentists, optometrists, or other medical providers. This definition includes such transportation when it is provided within 20 miles of the facility.

(12) "Nursing facility fee schedule" means the list of separately billable ancillary services provided in ARM 37.40.330.

(13) "Nursing facility services" means nursing facility services as provided in ARM 37.40.304 and 37.40.305.

(14) "Patient contribution" means the total of all of a resident's income from any source available to pay the cost of care, less the resident's personal needs allowance. The patient contribution includes a resident's incurment determined in accordance with applicable eligibility rules.

(15) "Patient day" means a whole 24-hour period that a person is present and receiving nursing facility services, regardless of the payment source. Even though a person may not be present for a whole 24-hour period on the day of admission or day of death, such day will be considered a patient day. When department rules provide for the reservation of a bed for a resident who takes a temporary leave from a provider to be hospitalized or make a home visit, such whole 24-hour periods of absence will be considered patient days.

(16) "Provider" means any person, agency, corporation, partnership or other entity that, under a written agreement with the department, furnishes nursing facility services to Medicaid recipients.

(17) "Rate year" means a 12-month period beginning July 1. For example, rate year 2006 means a period corresponding to the state fiscal year July 1, 2005 through June 30, 2006.

(18) "Resident" means a person admitted to a nursing facility who has been present in the facility for at least one 24-hour period.

(19) "RUG-III" means resource utilization group, version III.

(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. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93, (14)(e) Eff. 10/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1046, Eff. 7/1/05.)

Rule 37.40.303 reserved

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37.40.304 NURSING FACILITY SERVICES (1) Nursing facility services are provided in accordance with 42 CFR, part 483, subpart B, or intermediate care facility services for the mentally retarded provided in accordance with 42 CFR, part 483, subpart I. The department adopts and incorporates by reference 42 CFR, part 483, subparts B and I, that define the participation requirements for nursing facility and intermediate care facility for the mentally retarded (ICF/MR) providers, copies of which may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) The term "nursing facility services" includes the term "long term care facility services".

(3) Nursing facility services include, but are not limited to:

(a) a medically necessary room;

(b) dietary services including dietary supplements used for tube feeding or oral feeding such as high nitrogen diet;

(c) nursing services;

(d) minor medical and surgical supplies; and

(e) the use of equipment and facilities.

(4) Payment for the services listed in ARM 37.40.304 and 37.40.305 are included in the per diem rate determined by the department under ARM 37.40.307 or 37.40.336 and no additional reimbursement is provided for such services. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2005 MAR p. 1046, Eff. 7/1/05.)

37.40.305 NURSING FACILITY SERVICES: REIMBURSABLE SERVICES

(1) Nursing facility services include but are not limited to the following or any similar items:

(a) all general nursing services, including but not limited to administration of oxygen and medications, handfeeding, incontinence care, tray service, nursing rehabilitation services, enemas, and routine pressure sore/decubitis treatment;

(b) services necessary to provide for residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life;

(c) services required to attain or maintain the highest practicable physical, mental, and psychosocial well being of each Medicaid recipient who is a resident in the facility;

(d) items furnished routinely to all residents without charge, such as resident gowns, water pitchers, basins, and bed pans;

(e) items routinely provided to residents including but not limited to:

(i) antibacterial/bacteriostatic solutions, including betadine, hydrogen peroxide, 70% alcohol, merthiolate, zepherin solution;

(ii) cotton;

(iii) denture cups;

(iv) deodorizers (room-type);

(v) distilled water;

(vi) enema equipment and/or solutions;

(vii) facial tissues and paper toweling;

(viii) finger cots;

(ix) first aid supplies;

(x) foot soaks;

(xi) gloves (sterile and unsterile);

(xii) hot water bottles;

(xiii) hypodermic needles (disposable and nondisposable);

(xiv) ice bags;

(xv) incontinence pads;

(xvi) linens for bed and bathing;

(xvii) lotions (for general skin care);

(xviii) medication-dispensing cups and envelopes;

(xix) ointments for general protective skin care;

(xx) ointments (antibacterial);

(xxi) personal hygiene items and services, including but not limited to:

(A) bathing items and services, including but not limited to towels, washcloths, and soap;

(B) hair care and hygiene items, including but not limited to shampoo, brush, and comb;

(C) incontinence care and supplies appropriate for the resident's individual medical needs;

(D) miscellaneous items and services, including but not limited to cotton balls and swabs, deodorant, hospital gowns, sanitary napkins and related supplies, and tissues;

(E) nail care and hygiene items;

(F) shaving items, including but not limited to razors and shaving creme;

(G) skin care and hygiene items, including but not limited to bath soap, moisturizing lotion, and disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection; and

(H) tooth and denture care items and services, including but not limited to toothpaste, toothbrush, floss, denture cleaner and adhesive;

(xxii) safety pins;

(xxiii) sterile water and normal saline for irrigating;

(xxiv) sheepskins and other fleece-type pads;

(xxv) soaps (hand or bacteriostatic);

(xxvi) supplies necessary to maintain infection control, including those required for isolation-type services;

(xxvii) surgical dressings;

(xxviii) surgical tape;

(xxix) over-the-counter drugs (or their equivalents), including but not limited to:

(A) acetaminophen (regular and extra-strength);

(B) aspirin (regular and extra-strength);

(C) cough syrups;

(D) specific therapeutic classes D4B (antacids), D6S (laxatives and cathartics) and Q3S (laxatives, local/rectal) including but not limited to:

(I) Milk of Magnesia;

(II) mineral oil;

(III) suppositories for evacuation (Dulcolax and glycerine);

(IV) Maalox; and

(V) Mylanta;

(E) nasal decongestants and antihistamines;
(xxx) straw/tubes for drinking;
(xxxi) suture removal kits;
(xxxii) swabs (including alcohol swab);
(xxxiii) syringes (disposable or nondisposable hypodermic; insulin; irrigating);
(xxxiv) thermometers, clinical;
(xxxv) tongue blades;
(xxxvi) water pitchers;
(xxxvii) waste bags;
(xxxviii) wound-cleansing beads or paste;

(f) items used by individual residents which are reusable and expected to be available, including but not limited to:

(i) bathtub accessories (seat, stool, rail);
(ii) beds, mattresses, and bedside furniture;
(iii) bedboards, foot boards, cradles;
(iv) bedside equipment, including bedpans, urinals, emesis basins, water pitchers, serving trays;
(v) bedside safety rails;
(vi) blood-glucose testing equipment;
(vii) blood pressure equipment, including stethoscope;
(viii) canes, crutches;
(ix) cervical collars;
(x) commode chairs;
(xi) enteral feeding pumps;
(xii) geriatric chairs;
(xiii) heat lamps, including infrared lamps;
(xiv) humidifiers;
(xv) isolation cart;
(xvi) IV poles;
(xvii) mattress (foam-type and water);
(xviii) patient lift apparatus;
(xix) physical examination equipment;
(xx) postural drainage board;
(xxi) room (private or double occupancy as provided in ARM 37.40.331);
(xxii) raised toilet seat;

(xxiii) sitz baths;
(xxiv) suction machines;
(xxv) tourniquets;
(xxvi) traction equipment;
(xxvii) trapeze bars;
(xxviii) vaporizers, steam-type;
(xxix) walkers (regular and wheeled);
(xxx) wheelchairs (standard); and
(xxxi) whirlpool bath;

(g) laundry services whether provided by the facility or by a hired firm, except for residents' personal clothing which is dry cleaned outside of the facility; and

(h) nonemergency routine transportation as defined in ARM 37.40.302(11).

(History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2005 MAR p. 1046, Eff. 7/1/05.)

37.40.306 PROVIDER PARTICIPATION AND TERMINATION REQUIREMENTS (1) Nursing facility service providers, as a condition of participation in the Montana Medicaid program must meet the following requirements:

(a) comply with and agree to be bound by all laws, rules, regulations and policies generally applicable to Medicaid providers, including but not limited to the provisions of ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410, 37.85.414, and 37.85.415;

(b) maintain a current license issued by the department of public health and human services under Montana law for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain a current license under the laws of the state in which the facility is located for the category and level of nursing facility care being provided;

(c) maintain a current certification for Montana Medicaid issued by the Department of Public Health and Human Services under applicable state and federal laws, rules, regulations and policies for the category and level of care being provided, or, if the facility is located outside the state of Montana, maintain current Medicaid certification in the state in which the facility is located for the category and level of nursing facility care being provided;

(d) maintain a current agreement with the department to provide the level of care for which payment is being made, or, if the facility is located outside the state of Montana, comply with the provisions of ARM 37.40.337;

(e) operate under the direction of a licensed nursing home administrator, or other qualified supervisor for the facility, as applicable laws, regulations, rules, or policies may require;

(f) for providers maintaining resident trust accounts, insure that any funds maintained in such accounts are used only for those purposes for which the resident, legal guardian, or personal representative of the resident has given written authorization. The provider must maintain personal funds in excess of $50 in an interest bearing account and must credit all interest earned to the resident's account. Resident's personal funds in amounts up to $50 must be maintained in such a manner that the resident has convenient access to such funds within a reasonable time upon request. A provider may not borrow funds from such accounts or commingle resident and facility funds for any purpose;

(g) A provider holding personal funds of a deceased nursing facility resident who received Medicaid benefits at any time shall, within 30 days following the resident's death, pay those funds as provided by law and regulation.

(h) maintain admission policies which do not discriminate on the basis of diagnosis or handicap, and which meet the requirements of all federal and state laws prohibiting discrimination against the handicapped, including persons infected with acquired immunity deficiency syndrome/human immunodeficiency virus (AIDS/HIV);

(i) comply with ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201 through 37.40.207, regarding screening for nursing facility services;

(j) comply with all applicable federal and state laws, rules, regulations, and policies regarding nursing facilities at the times and in the manner required therein, including but not limited to 42 USC 1396r(b)(5) and 1396r(c) (1994 supp.) and implementing regulations, which contain federal requirements relating to nursing home reform. The department hereby adopts and incorporates herein by reference 42 USC 1396r(b)(5) and 1396r(c). A copy of these statutes may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(2) A provider which fails to meet any of the requirements of this rule may be denied Medicaid payments, refused further participation in the Medicaid program or otherwise sanctioned or made subject to appropriate department action, according to applicable laws, rules, regulations, or policies.

(a) Subject to applicable federal law and regulations, the department may impose a sanction or take other action against a provider that is not in compliance with federal Medicaid participation requirements. Department sanctions or actions may include imposition of any remedy or combination of remedies provided by state or federal law and regulations, including but not limited to federal regulations at 42 CFR 488, subpart F.

(3) A provider must provide the department with 30 days advance written notice of termination of participation in the Medicaid program. Notice will not be effective prior to 30 calendar days following actual receipt of the notice by the department. Notice must be mailed or delivered to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(a) For purposes of (3), termination includes a cessation of provision of services to Medicaid residents, termination of the provider's business, a change in the entity administering or managing the facility or a change in provider as defined in ARM 37.40.325.

(b) In the event that discharge or transfer planning is necessary, the provider remains responsible to provide for such planning in an orderly fashion and to care for its residents until appropriate transfers or discharges are effected, even though transfer or discharge may not have been completed prior to the facility's planned date of termination from the Medicaid program.

(c) Providers terminating participation in the Medicaid program must prepare and file, in accordance with applicable cost reporting rules, a close out cost report covering the period from the end of the provider's previous fiscal year through the date of termination from the program. New providers assuming operation of a facility from a terminating provider must enroll in the Medicaid program in accordance with applicable rules.

(4) A provider must notify a resident or the resident's representative of a transfer or discharge as required by 42 CFR 483.12(a)(4), (5), and (6). The notice must be provided using the form prescribed by the department. In addition to the notice contents required by 42 CFR 483.12, the notice must inform the recipient of the recipient's right to a hearing, the method by which the recipient may obtain a hearing and that the recipient may represent herself or himself or may be represented by legal counsel, a relative, a friend, or other spokesperson. Notice forms are available upon request from the department. Requests for notice forms may be made to the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: 53-6-108, 53-6-111, 53-6-113, 53-6-189, MCA; IMP, 53-2-201, 53-6-101, 53-6-106, 53-6-107, 53-6-111, 53-6-113, 53-6-168, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

37.40.307 NURSING FACILITY REIMBURSEMENT (1) For nursing facility services, other than ICF/MR services, provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider, for each Medicaid patient day, a per diem rate determined in accordance with this rule, minus the amount of the Medicaid recipient's patient contribution.

(2) Effective July 1, 2001, and in subsequent rate years, nursing facilities will be reimbursed using a price based reimbursement methodology. The rate for each facility will be determined using the operating component defined in (2)(a) and the direct resident care component defined in (2)(b):

(a) The operating component is the same per diem for each nursing facility. It is set at 80% of the statewide price for nursing facility services.

(b) The direct resident care component of each facility's rate is 20% of the overall statewide price for nursing facility services. It is adjusted for the acuity of the Medicaid residents served in each facility. The acuity adjustment increases or decreases the direct resident care component in proportion to the relationship between each facility's Medicaid average case mix index and the statewide average Medicaid case mix index.

(i) The Medicaid average case mix index for each facility to be used in rate setting will be the simple average of each facility's four Medicaid case mix indices calculated for the periods of February 1 of the current year and November 1, August 1 and May 1 of the year immediately preceding the current year. The statewide average Medicaid case mix index will be the weighted average of each facility's four quarter average Medicaid case mix index to be used in rate setting.

(c) The statewide price for nursing facility services will be determined each year through a public process. Factors that could be considered in the establishment of this price include the cost of providing nursing facility services, Medicaid recipients access to nursing facility services, and the quality of nursing facility care.

(d) The total payment rate available for the period July 1, 2009 through June 30, 2010 will be the rate as computed in (2), plus any additional amount computed in ARM 37.40.311 and 37.40.361.

(3) Providers who, as of July 1 of the rate year, have not filed with the department a cost report covering a period of at least six months participation in the Medicaid program in a newly constructed facility shall have a rate set at the statewide median price as computed on July 1, 2009. Following a change in provider as defined in ARM 37.40.325, the per diem rate for the new provider shall be set at the previous provider's rate, as if no change in provider had occurred.

(4) For ICF/MR services provided by nursing facilities located within the state of Montana, the Montana Medicaid program will pay a provider as provided in ARM 37.40.336.

(5) In addition to the per diem rate provided under (2) or the reimbursement allowed to an ICF/MR provider under (4), the Montana Medicaid program will pay providers located within the state of Montana for separately billable items, in accordance with ARM 37.40.330.

(6) For nursing facility services, including ICF/MR services, provided by nursing facilities located outside the state of Montana, the Montana Medicaid program will pay a provider only as provided in ARM 37.40.337.

(7) The Montana Medicaid program will not pay any provider for items billable to residents under the provisions of ARM 37.40.331.

(8) Reimbursement for Medicare coinsurance days will be as follows:

(a) for dually eligible Medicaid and Medicare individuals, reimbursement is limited to the per diem rate, as determined under (1) or ARM 37.40.336, or the Medicare co-insurance rate, whichever is lower, minus the Medicaid recipient's patient contribution; and

(b) for individuals whose Medicare buy-in premium is being paid under the qualified Medicare beneficiary (QMB) program under ARM 37.83.201 but are not otherwise Medicaid eligible, payment will be made only under the QMB program at the Medicare coinsurance rate.

(9) The department will not make any nursing facility per diem or other reimbursement payments for any patient day for which a resident is not admitted to a facility bed which is licensed and certified as provided in ARM 37.40.306 as a nursing facility or skilled nursing facility bed.

(10) The department will not reimburse a nursing facility for any patient day for which another nursing facility is holding a bed under the provisions of ARM 37.40.338(1), unless the nursing facility seeking such payment has, prior to admission, notified the facility holding a bed that the resident has been admitted to another nursing facility. The nursing facility seeking such payment must maintain written documentation of such notification.

(11) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of nursing facility services provided to authorized Medicaid recipients during the billing period.

(a) Authorized Medicaid recipients are those residents determined eligible for Medicaid and authorized for nursing facility services as a result of the screening process described in ARM 37.40.101, 37.40.105, 37.40.106, 37.40.110, 37.40.120, and 37.40.201, et seq.

(12) Payments provided under this rule are subject to all limitations and cost settlement provisions specified in applicable laws, regulations, rules and policies. All payments or rights to payments under this rule are subject to recovery or nonpayment, as specifically provided in these rules. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2006 MAR p. 1638, Eff. 7/1/06; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2008 MAR p. 1320, Eff. 7/1/08; AMD, 2009 MAR p. 1411, Eff. 8/14/09.)

37.40.308 RATE EFFECTIVE DATES (1) A provider's per diem rate effective for the rate period July 1, 2001 through June 30, 2002 and in subsequent rate years, shall be determined in accordance with ARM 37.40.307.

(2) Except as specifically provided in these rules, per diem rates and interim rates are set no more than once a year, effective July 1, and remain in effect at least through June 30 of the following year.

(a) Nothing in this subchapter shall be construed to require that the department apply any inflation adjustment, recalculate the medicaid case mix index or the statewide price, or otherwise adjust or recalculate per diem rates or interim rates on July 1 of a rate year, unless the department adopts further rules or rule amendments providing specifically for a rate methodology for the rate year.

(3) A provider's rate established July 1 of the rate year shall remain in effect throughout the rate year and throughout subsequent rate years, regardless of any other provision in this subchapter, until the effective date of a new rate established in accordance with a new rule or amendment to these rules, adopted after the establishment of the current rate, which specifically provides a rate methodology for the new or subsequent rate year. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 37.40.309 and 37.40.310 reserved

37.40.311 RATE ADJUSTMENT FOR COUNTY FUNDED RURAL NURSING FACILITIES (1) For each state fiscal year, the department will provide a mechanism for a one time, lump sum payment to nonstate government owned or operated facilities for Medicaid services according to the methodology specified in this rule. These payments will be for the purpose of maintaining access and viability for a class of "at risk" county affiliated facilities who are predominately rural and are the only nursing facility in their community or county or who provide a significant share of nursing facility services in their community or county.

(2) A nursing facility is eligible to participate in this lump sum payment distribution if it is a nonstate government owned or operated facility.

(a) The department will calculate the amount of lump sum distribution that will be allowed for each county affiliated provider so that the total per day amount does not exceed the computed Medicare upper payment limit for these providers. Distribution of these lump sum payments will be based on the Medicaid utilization at each participating facility for the period July 1 of the previous year through June 30 of the current year.

(b) In order to qualify for this lump sum adjustment, each county on behalf of its non-state government owned or operated facility must enter into a written agreement to transfer local county funds to be used as matching funds by the department. This transfer option is voluntary, but those counties that agree to participate must abide by the terms of the written agreement.

(3) On or after July 1 of each year, the department will provide for a one time, lump sum distribution of funding to nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services.

(4) The department will calculate the maximum amount of the lump sum payments that will be allowed for each participating non-state government owned or operated facility, as well as the additional payments for other nursing facilities not participating in the funding for "at risk" facilities for the provision of Medicaid services in accordance with state and federal laws, as well as applicable Medicare upper payment limit thresholds. This payment will be computed as a per day add-on based upon the funding available. Distribution will be in the form of lump sum payments and will be based on the Medicaid utilization at each participating facility for the period July 1 of the preceding year through June 30 of the current year.

(5) There may be no prearranged formal or informal agreements with the nursing facility to return or redirect any portion of the lump sum nursing facility payment to the county in order to fund other Medicaid services or non-Medicaid services.

(a) Payments or credits for normal operating expenses and costs are not considered a return or redirection of a Medicaid payment.

(6) "Normal operating expenses" and "costs" include, but are not limited to:

(a) taxes, including health care provider related taxes;

(b) mill levies;

(c) fees;

(d) payment of facility construction bonds or loans;

(e) health insurance costs, unemployment insurance, workers compensation, and other employee benefits;

(f) payments in lieu of rent based on depreciation cost of county buildings occupied by nursing facility;

(g) mortgage or rent payments;

(h) payment of building insurance;

(i) other business relationships with county governments unrelated to Medicaid in which there is no connection to Medicaid payments; and

(j) legitimate services provided by the county to the nursing facility such as building maintenance, legal services, accounting, and advertising.

(7) Charges for services must be reasonable and the services must be documented.

(a) Documentation supporting charges are subject to the audit and record retention provisions in ARM 37.85.414. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1401, Eff. 7/1/05; AMD, 2006 MAR p. 1638, Eff. 7/1/06.)

Rule 37.40.312 reserved

37.40.313 OPERATING COST COMPONENT (REPEALED) (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 685, Eff. 4/30/93; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.314 DIRECT NURSING PERSONNEL COST COMPONENT (REPEALED) (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.315 STAFFING AND REPORTING REQUIREMENTS

(1) Providers must provide staffing at levels which are adequate to meet federal law, regulations, and requirements.

(a) Each provider must submit to the department within ten days following the end of each calendar month a complete and accurate form DPHHS-SLTC-015, "Monthly Nursing Home Staffing Report" prepared in accordance with all applicable department rules and instructions. Copies of form DPHHS-SLTC-015 may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210.

(b) If complete and accurate copies of form DPHHS-SLTC-015 are not received by the department within ten days following the end of each calendar month, the department may withhold all payments for nursing facility services until the provider complies with the reporting requirements in (1)(a). (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-108, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 37.40.316 through 37.40.319 reserved

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.

(6) For purposes of calculating rates, the department will use the RUG-III, 34 category, index maximizer model, version 5.12. The department may update the classification methodology to reflect advances in resident assessment or classification subject to federal requirements.

(7) For purposes of calculating rates, case mix weights will be developed for each of the 34 RUG-III groupings. The department will compute a Montana specific Medicaid case mix utilizing average nursing times from the 1995 and the 1997 CMS case mix time study. The average minutes per day per resident will be adjusted by Montana specific salary ratios determined by utilizing the licensed to non-licensed ratio spreadsheet information.

(8) For purposes of calculating rates, the department shall assign each resident a RUG-III group calculated on the most current non-delinquent assessment available on the first day of the second month of each quarter as amended during the correction period. The RUG-III group will be translated to the appropriate case mix index or weight. From the individual case mix weights for the applicable quarter, the department shall determine a simple facility average case mix index, carried to four decimal places, based on all resident case mix indices. For each quarter, the department shall calculate a Medicaid average case mix index, carried to four decimal places, based on all residents for whom Medicaid is reported as the per diem payor source any time during the 30 days prior to their current assessment.

(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. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.321 CORRECTION OF ERRONEOUS OR MISSING DATA

(1) The department will prepare and distribute resident listings to facilities by the 15th day of the third month of each quarter (cut off date). The listings will identify current assessments for residents in the nursing facility on the first day of the second month of each quarter as reflected in the database maintained by the department. The listings will identify resident social security numbers, names, assessment reference date, the calculated RUG-III category and the payor source. Resident listings shall be signed and returned to the department by the 15th day of the first month of the following calendar quarter. Facilities who do not return this corrected resident listing by the due date will use the database information on file in their case mix calculation.

(2) If data reported on the resident listings is in error or if there is missing data, facilities will have until the 15th day of the first month of each calendar quarter to correct data submissions.

(a) Errors or missing data on the resident listings due to untimely submissions to the CMS database maintained by the Department of Public Health and Human Services (DPHHS) are corrected by transmitting the appropriate assessments or tracking documents to DPHHS in accordance with CMS requirements.

(b) Errors in key field items are corrected following the CMS key field specifications through DPHHS.

(c) Errors on the current payor source should be noted on the resident listings prior to signing and returning to DPHHS.

(3) The department may also use Medicaid paid claim data to determine the Medicaid residents in each facility when determining the Medicaid average case mix index for each facility. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.322 OBRA NURSE AIDE TESTING AND TRAINING COST REPORTING (1) Omnibus Budget Reconciliation Act of 1987 (OBRA) costs will be reimbursed under the per diem rate determined under ARM 37.40.307. No further reimbursement will be provided outside the per diem rate.

(2) Each provider must document and submit to the department on a quarterly basis information on the nurse aide certification training and competency evaluation (testing) costs, including but not limited to the costs of training for nurse aides and the costs of actual testing required for nurse aides, incurred at the facility and, in the case of competency evaluation (testing) costs for providers that are not testing entities, incurred in payment of a qualified testing entity's fee for competency evaluation (testing). The required information must be submitted quarterly on the nurse aide certification/training and competency evaluation (testing) survey reporting form provided by the department and must include the total dollars incurred in each of the categories of facility personnel, supplies and equipment, subcontracted services and testing fees. The reporting form must include a brief description of the items included in each of the four categories.

(a) Acceptable documentation will be any documentation that adequately supports the costs claimed on the reporting form and includes all records and documentation as defined in ARM 37.40.346, such as invoices, contracts, canceled checks and time cards. This documentation is subject to desk review and audit in accordance with ARM 37.40.346. This documentation must be maintained by the facility for six years, three months from the date the form is filed with the department or until any dispute or litigation regarding the costs supported by such documentation is finally resolved, whichever is later.

(b) If a provider fails to submit the quarterly reporting form within 30 calendar days following the end of the quarter, the department may withhold reimbursement payments in accordance with ARM 37.40.346(4)(c). All amounts so withheld will be payable to the provider upon submission of a complete and accurate nurse aide certification/training survey reporting form.

(3) Medicaid nursing facility reimbursement for the costs associated with training and competency evaluation programs for nurse aides employed in Medicare and Medicaid nursing facilities, as required under OBRA, shall be as follows:

(a) Nurse aide certification training and competency evaluation (testing) costs documented in accordance with (2) and allowable under ARM 37.40.345 will be reimbursed to the extent provided under the per diem rate determined under ARM 37.40.307. No additional reimbursement will be provided for such costs.

(4) For purposes of reporting under (2), nurse aide tests are those tests which:

(a) demonstrate competency through testing methods which address each course requirement and include successful completion of both a written or oral examination and a demonstration of the skills required to perform the tasks required of a nurse aide;

(b) are performed at either a nursing facility which is currently in compliance with Medicaid nursing facility participation requirements or at a regional testing site at regularly scheduled testing times;

(c) are administered to nurse aides actually employed by the facility; and

(d) do not exceed a third attempt by the individual nurse aide to successfully complete the portion of the test for which costs are reported. The written/oral examination and the skills demonstration may be taken separately if the nurse aide passed only one portion of the test in a previous exam.

(5) Competency evaluation (testing) costs reported by a provider shall include the testing entity's basic fee charged to the facility and other costs associated with competency testing, to the extent allowable under ARM 37.40.345. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.323 CALCULATED PROPERTY COST COMPONENT (REPEALED) (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1997 MAR p. 1044, Eff. 6/24/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.324 GRANDFATHERED PROPERTY COST COMPONENT (REPEALED) (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; TRANS, from SRS, 2000 MAR p. 489; REP, 2002 MAR p. 1767, Eff. 6/28/02.)

37.40.325 CHANGE IN PROVIDER DEFINED (1) Except as provided in (2), a change in provider will be deemed to have occurred if the events described in any one of the following (1)(a) through (d) occurs:

(a) For sole proprietorship providers, a change in provider occurs where the entire sole proprietorship is sold to an unrelated party and a selling proprietor does not retain a right of control over the business.

(b) For partnership providers, a change in provider occurs where:

(i) a new partner acquires an interest in the partnership greater than 50%;

(ii) the new partner is not a related party to either a current partner or a former partner from whom the new partner acquired all or any portion of the new partner's interest; and

(iii) the current or former partners from whom the new partner acquires an interest do not retain a right of control over the partnership arising from the transferred interest.

(c) For corporation providers, a change in provider occurs where stock and the associated stockholder rights representing an interest of more than 50% in the provider's corporation is acquired by an unrelated party.

(d) For all providers, a change in provider occurs where an unrelated party acquires:

(i) the provider's title or interest in the nursing facility or a leasehold interest in the nursing facility; and

(ii) the right to control and manage the business of the nursing facility.

(2) Regardless of the provisions of (1) through (1)(d), a change in provider will not be deemed to have occurred if the circumstances indicate that:

(a) a related party will acquire, retain or actually exercise substantial influence over the new entity; or

(b) the occurrence or transaction is undertaken primarily for the purpose of triggering a change in provider under this rule.

(3) For purposes of this rule:

(a) "Provider" means the business entity having the right to control and manage the business of the nursing facility.

(b) "Related party" means:

(i) a person, including a natural person and a corporation, who is an owner, partner or stockholder in the current provider and who has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity;

(ii) A spouse, ancestor, descendant, sibling, uncle, aunt, niece, or nephew of a person described in (3)(b)(i) or a spouse of an ancestor, descendant, sibling, uncle, aunt, niece or nephew of a person described in (3)(b)(i); or

(iii) a sole proprietorship, partnership corporation or other entity in which a person described in (3)(b)(i) or (ii) has a direct or indirect interest of 5% or more or a power, whether or not legally enforceable to directly or indirectly influence or direct the actions or policies of the entity.

(c) "Unrelated party" means a person or entity that is not a related party.

(4) In determining whether a change in provider has occurred within the meaning of this rule, the provisions of federal Medicare law, regulation or policy or related caselaw regarding changes in ownership under the Medicare program are not applicable.

(5) As required in ARM 37.40.306, a provider must provide the department with 30 days advance written notice of a change in provider and must file a close out cost report, and new providers must enroll in the Medicaid program in accordance with applicable requirements.

(6) Any change in provider, corporate or other business ownership structure or operation of the facility that results in a change in federal tax identification number will require a provider to seek a new Medicaid provider enrollment. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 76, Eff. 1/17/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01.)

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37.40.326 INTERIM PER DIEM RATES FOR NEWLY CONSTRUCTED FACILITIES AND NEW PROVIDERS (1) This rule specifies the methodology the department will use to determine the interim per diem rate for in-state providers, other than ICF/MR providers, which as of July 1 of the rate year have not filed with the department a cost report covering a period of at least six months participation in the Medicaid program in a newly constructed facility or following a change in provider as defined in ARM 37.40.325.

(a) Effective July 1, 2001, and thereafter, the rate paid to new providers that acquire or otherwise assume the operations of an existing nursing facility, that was participating in the Medicaid program prior to the transaction, will be paid the price-based reimbursement rate in effect for the prior owner/operator of the facility before the transaction as if no change in provider had occurred. These rates will be adjusted at the start of each state fiscal year in accordance with (1)(b).

(b) Effective July 1, 2001, and thereafter, the rate paid to newly constructed facilities or to facilities participating in the Medicaid program for the first time will be the statewide average nursing facility rate under the price-based reimbursement system. The direct care component of the rate will not be adjusted for acuity, until such time as there are three or more quarters of Medicaid CMI information available at the start of a state fiscal year. Once the CMI information is available the price-based rate will include the acuity adjustment as provided for in ARM 37.40.307(5)(b). (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02.)

Rules 37.40.327 through 37.40.329 reserved

37.40.330 SEPARATELY BILLABLE ITEMS (1) In addition to the amount payable under the provisions of ARM 37.40.307(1) or (4), the department will reimburse nursing facilities located in the state of Montana for the following separately billable items. Refer to the department's nursing facility fee schedule for specific codes and refer to healthcare common procedure coding system (HCPCS) coding manuals for complete descriptions of codes:

(a) ostomy surgical tray;
(b) ostomy face plate;
(c) ostomy skin barriers;
(d) ostomy filter;
(e) ostomy bags (pouches);
(f) ostomy belt;
(g) adhesive;
(h) adhesive remover;
(i) ostomy irrigation set and supplies;
(j) ostomy lubricant;
(k) ostomy rings;
(l) ostomy irrigation supply, cone/catheter, including brush;
(m) catheter care kit;
(n) urine test or reagent strips or tablets;
(o) blood tubing, arterial or venous;
(p) blood glucose test strips for dialysis;
(q) blood glucose test or reagent strips for home blood glucose monitor;
(r) implantable access catheter (venous, arterial, epidural, subarachnoid, peritoneal, etc.) external access;
(s) gastrostomy/jejunostomy tube, any material, any type;
(t) oropharyngeal suction catheter;
(u) implanted pleural catheter;
(v) external urethral clamp or compression device;
(w) urinary catheters;
(x) urinary insertion trays (sets);
(y) urinary collection bags;
(z) tracheostomy care kit for established tracheostomy;

(aa) tracheostomy, inner cannula (replacement only);
(ab) oxygen contents, portable, liquid;
(ac) oxygen contents, portable, gas;
(ad) oxygen contents, stationary, liquid;
(ae) oxygen contents, stationary, gas;
(af) cannula, nasal;
(ag) oxygen tubing;
(ah) regulator;
(ai) mouth piece;
(aj) stand/rack;
(ak) face tent;
(al) humidifier;
(am) breathing circuits;
(an) respiratory suction pump, home model, portable, or stationary;
(ao) nebulizer, with compressor;
(ap) feeding syringe;
(aq) nasal interface (mask or cannula type) used with positive airway device;
(ar) stomach tube - levine type;
(as) nasogastric tubing (with or without stylet);
(at) nutrition administration kits;
(au) feeding supply kits;
(av) nutrient solutions for parenteral and enteral nutrition therapy when such solutions are the only source of nutrition for residents who, because of chronic illness or trauma, cannot be sustained through oral feeding. Payment for these solutions will be allowed only where the department determines they are medically necessary and appropriate, and authorizes payment before the items are provided to the resident;
(aw) routine nursing supplies used in extraordinary amounts and prior authorized by the department;

(ax) oxygen concentrators and portable oxygen units (cart, E tank and regulators), if prior authorized by the department.

(i) The department will prior authorize oxygen concentrators and portable oxygen units (cart, E tank and regulators) only if:

(A) The provider submits to the department documentation of the cost and useful life of the concentrator or portable oxygen unit, and a copy of the purchase invoice.

(B) The provider maintains a certificate of medical necessity indicating the PO2 level or oxygen saturation level. This certificate of medical necessity must meet or exceed Medicare criteria and must be signed and dated by the patient's physician. If this certificate is not available on request of the department or during audit, the department may collect the corresponding payment from the provider as an overpayment in accordance with ARM 37.40.347.

(ii) The provider must attach to its billing claim a copy of the prior authorization form.

(iii) The department's maximum monthly payment rate for oxygen concentrators and portable oxygen units (cart, E tank and regulators) will be the invoice cost of the unit divided by its estimated useful life as determined by the department. The provider is responsible for maintenance costs and operation of the equipment and will not be reimbursed for such costs by the department. Such costs are considered to be covered by the provider's per diem rate.

(2) The department may, in its discretion, pay as a separately billable item, a per diem nursing services increment for services provided to a ventilator dependent resident if the department determines that extraordinary staffing by the facility is medically necessary based upon the resident's needs.

(a) Payment of a per diem nursing services increment under (2) for services provided to a ventilator dependent resident shall be available only if, prior to the provision of services, the increment has been authorized in writing by the department's senior and long term care division. Approvals will be effective for one month intervals and reapproval must be obtained monthly.

(b) The department may require the provider to submit any appropriate medical and other documentation to support a request for authorization of the increment. Each calendar month, the provider must submit to the department, together with reporting forms and according to instructions supplied by the department, time records of nursing services provided to the resident during a period of five consecutive days. The submitted time records must identify the amount of time care is provided by each type of nursing staff, i.e., licensed and nonlicensed.

(c) The increment amount shall be determined by the department as follows. The department shall subtract the facility's current average Medicaid case mix index (CMI) used for rate setting determined in accordance with ARM 37.40.320 from the CMI computed for the ventilator dependent resident, determined based upon the current minimum data set (MDS) information for the resident in order to determine the difference in case mix for this resident from the average case mix for all Medicaid residents in the facility. The increment shall be determined by the department by multiplying the provider's direct resident care component by the ratio of the resident's CMI to the facility's average Medicaid CMI to compute the adjusted rate for the resident. The department will determine the increment for each resident monthly after review of case mix information and five consecutive day nursing time documentation review.

(3) The department will reimburse for separately billable items at direct cost, with no indirect charges or mark-up added. For purposes of combined facilities providing these items through the hospital portion of the facility, direct cost will mean invoice price to the hospital with no indirect cost added.

(a) If the items listed in (1)(a) through (1)(de) are also covered by the Medicare program and provided to a Medicaid recipient who is also a Medicare recipient, reimbursement will be limited to the lower of the Medicare prevailing charge or the amount allowed under (3). Such items may not be billed to the Medicaid program for days of service for which Medicare Part A coverage is in effect.

(b) The department will reimburse for separately billable items only for a particular resident, where such items are medically necessary for the resident and have been prescribed by a physician.

(4) Physical, occupational, and speech therapies which are not nursing facility services may be billed separately by the licensed therapist providing the service, subject to department rules applicable to physical therapy, occupational therapy, and speech therapy services.

(a) Maintenance therapy and rehabilitation services within the definition of nursing facility services in ARM 37.40.302 are reimbursed under the per diem rate and may not be billed separately by either the therapist or the provider.

(b) If the therapist is employed by or under contract with the provider, the provider must bill for services which are not nursing facility services under a separate therapy provider number.

(5) Durable medical equipment and medical supplies which are not nursing facility services and which are intended to treat a unique condition of the recipient which cannot be met by routine nursing care, may be billed separately by the medical supplier in accordance with department rules applicable to such services.

(6) All prescribed medication may be billed separately by the pharmacy providing the medication, subject to department rules applicable to outpatient drugs. The nursing facility will bill Medicare directly for reimbursement of Medicare Part B covered drugs and vaccines and their administration when they are provided to an eligible Medicare Part B recipient. Medicaid reimbursement is not available for Medicare Part B covered drugs and vaccines and related administration costs for residents that are eligible for Medicare Part B.

(7) Nonemergency routine transportation for activities other than those described in ARM 37.40.302(11), may be billed separately in accordance with department rules applicable to such services. Emergency transportation may be billed separately by an ambulance service in accordance with department rules applicable to such services.

(8) The provider of any other medical services or supplies, which are not nursing facility services, provided to a nursing facility resident may be billed by the provider of such services or supplies to the extent allowed under and subject to the provisions of applicable department rules.

(9) The provisions of (3) through (7) apply to all nursing facilities, including intermediate care facilities for the mentally retarded, whether or not located in the state of Montana.

(10) Providers may contract with any qualified person or agency, including home health agencies, to provide nursing facility services. However, except as specifically allowed in these rules, the department will not reimburse the provider for such contracted services in addition to the amounts payable under ARM 37.40.307. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2003 MAR p. 1294, Eff. 7/1/03; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2007 MAR p. 1100, Eff. 8/10/07.)

37.40.331 ITEMS BILLABLE TO RESIDENTS (1) The department will not pay a provider for any of the following items or services provided by a nursing facility to a resident. The provider may charge these items or services to the nursing facility resident:

(a) gifts purchased by residents;

(b) social events and entertainment outside the scope of the provider's activities program;

(c) cosmetics and grooming items and services in excess of those for which payment is made by Medicare or Medicaid;

(d) personal comfort items, including tobacco products and accessories, notions, novelties, and confections;

(e) personal dry cleaning;

(f) beauty shop services;

(g) television, radio and private telephone rental;

(h) less-than-effective drugs (exclusive of stock items);

(i) vitamins, multivitamins, vitamin supplements and calcium supplements;

(j) personal reading materials;

(k) personal clothing;

(l) flowers and plants;

(m) privately hired nurses or aides;

(n) specially prepared or alternative food requested instead of food generally prepared by facility; and

(o) the difference between the cost of items usually reimbursed under the per diem rate and the cost of specific items or brands requested by the resident which are different from that which the facility routinely stocks or provides (e.g., special lotion, powder, diapers);

(2) Services provided in private rooms will be reimbursed by the department at the same rate as services provided in a double occupancy room.

(a) A provider must provide a medically necessary private room at no additional charge and may not bill the recipient any additional charge for the medically necessary private room.

(b) A provider may bill a resident for the extra cost of a private room if the private room is not medically necessary and is requested by the resident. The provider must clearly inform the resident that additional payment is strictly voluntary. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 10/1/93; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 37.40.332 through 37.40.335 reserved

37.40.336 REIMBURSEMENT FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (1) For intermediate care facility services for the mentally retarded provided in facilities located in the state of Montana, the Montana medicaid program will pay a provider a per diem rate equal to the actual allowable cost incurred by the provider during the fiscal year, determined retrospectively in accordance with ARM 37.40.345 and 37.40.346, divided by the total patient days of service during the rate year, minus the amount of the Medicaid recipient's patient contribution, subject to the limits specified in (2)(a) and (b).

(2) Payments under (1) may not exceed the following limits:

(a) Final per diem payment rates for base years shall be as specified in (1), without application of any further limit. Base years are even-numbered state fiscal years, i.e., state fiscal years 1994, 1996, and subsequent even-numbered years.

(b) Final per diem rates in non-base years are limited to the final per diem rate for the immediately preceding base year indexed from June 30 of the base year to June 30 of the rate year. The index is the final Medicare market basket index applicable to the non-base year. Non-base years are odd-numbered state fiscal years, i.e., state fiscal years 1993, 1995 and subsequent odd-numbered years.

(3) All ICF/MR providers must use a July 1 through June 30 fiscal year for accounting and cost reporting purposes.

(4) Prior to the billing of July services each rate year, the department will determine an interim payment rate for each provider. The provider's interim payment rate shall be determined based upon the department's estimate of actual allowable cost under ARM 37.40.345, divided by estimated patient days for the rate year. The department may consider, but shall not be bound by, the provider's cost estimates in estimating actual allowable costs. The provider's interim payment rate is an estimate only and shall not bind the department in any way in the final rate determination under (1) and (5).

(5) The provider's final rate as provided in (1) shall be determined based upon the provider's cost report for the rate year filed in accordance with ARM 37.40.346, after desk review or audit by the department's audit staff. The difference between actual includable cost allocable to services to Medicaid residents, as limited in (2), and the total amount paid through the interim payment rate will be settled through the overpayment and underpayment procedures specified in ARM 37.40.347.

(6) Following the sale of an intermediate care facility for the mentally retarded after April 5, 1989, the new provider's property costs will be the lesser of historical costs or the rate used for all other intermediate care facilities, subject to the limitations in 42 USC 1396a(a)(13)(C). (History: 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1995 MAR p. 1227, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.337 REIMBURSEMENT TO OUT-OF-STATE FACILITIES

(1) The department will reimburse nursing facilities located outside the state of Montana for nursing facility services and any other reimbursable services or supplies provided to eligible Montana Medicaid individuals at the Medicaid rate and upon the basis established by the Medicaid agency in the state in which the facility is located.

(2) The Montana Medicaid program will pay for nursing facility services or related supplies provided to eligible Montana Medicaid individuals in nursing facilities located outside the state of Montana only when one of the following conditions is met:

(a) because of a documented medical emergency, the resident's health would be endangered if he or she was to return to Montana for medical services;

(b) the services required are not provided in Montana;

(c) the required services and all related expenses are less costly than if the required services were provided in Montana;

(d) the recipient is a child in another state for whom Montana makes adoption assistance or foster care assistance payments; or

(e) the department determines that it is general practice for recipients in the resident's particular locality to use medical resources located in another state.

(3) To receive payments, the out-of-state provider must enroll in the Montana Medicaid program. Enrollment information and instructions may be obtained from the department's fiscal intermediary, ACS, at P.O. Box 4286, Helena, MT 59604-4286.

(4) The department will reimburse a nursing facility located outside the state of Montana under the Montana Medicaid program only if, in addition to meeting other applicable requirements, the facility has submitted to the department the following information:

(a) a physician's order identifying the Montana resident and specifically describing the purpose, cause and expected duration of the stay;

(b) for nursing facility services, copies of documents from the facility's state Medicaid agency establishing or stating the facility's Medicaid per diem rate for the period the services were provided;

(c) for separately billable items, copies of documents from the facility's state Medicaid agency establishing or stating the Medicaid reimbursement payable for such items for the period the items were provided;

(d) a properly completed level I screening form for the resident, as required by ARM 37.40.201, et seq.;

(i) To the extent required by ARM 37.40.201, et seq., a level I screening must be performed prior to entry into the nursing facility to determine if there is a diagnosis of mental illness or mental retardation and if so, to conduct assessments which determine the resident's need for active treatment. A level I screening form may be obtained from the department.

(e) a copy of the preadmission-screening determination for the resident completed by the department or its designee;

(i) Payment will be made for services no earlier than the date of referral for screening or the date of screening, whichever is earlier.

(f) the resident's full name, Medicaid ID number and dates of service;

(g) a copy of the certification notice from the facility's state survey agency showing certification for Medicaid during the period services were provided; and

(h) assurances that, during the period the billed services were provided, the facility was not operating under sanctions imposed by Medicare or Medicaid which would preclude payment.

(5) Reimbursement to nursing facilities located outside the state of Montana for Medicare coinsurance days for dually eligible Medicaid and Medicare individuals shall be limited to the per diem rate established by the facility's state Medicaid agency, less the Medicaid recipient's patient contribution. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1994 MAR p. 1881, Eff. 7/8/94; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2003 MAR p. 1294, Eff. 7/1/03.)

37.40.338 BED HOLD PAYMENTS (1) Except as provided in (6) through (9) for therapeutic home visits, payment will be made to a provider for holding a bed for a resident only if:

(a) the provider's facility is full and has a current waiting list of potential residents during each such bed day claimed for reimbursement;

(b) the resident for whom the bed is held is temporarily receiving medical services outside the facility, except in another nursing facility, and is expected to return to the provider;

(c) the cost of holding the bed will evidently be less costly than the possible cost of extending the hospital stay until an appropriate long term care bed would otherwise become available; and

(d) the provider has received written approval from the department's senior and long term care division as provided in (4).

(2) For purposes of (1), a provider will be considered full if:

(a) all Medicaid certified beds are occupied or being held for a recipient who is either temporarily receiving medical services outside the provider's facility or outside the facility on a therapeutic home visit; or

(b) as to gender, if all appropriate, available beds are occupied or being held. For example, if all beds are occupied or held except for one semi-private bed in a female room, the provider is full for purposes of hold days for male recipients.

(3) For purposes of (1), the provider must maintain and, upon request, provide to the department or its agents documentation that the absence is expected to be temporary and of the anticipated duration of the absence. Temporary absences which are of indefinite duration must be documented at least weekly by the provider to assure that the absence is indeed temporary.

(4) A provider's request for the department's written approval of bed hold days as required in (1) must be submitted to the department's senior and long term care division on the form provided by the department within 90 days after the first day of the requested bed hold period. The request must include a copy of the waiting list applicable to each bed hold day claimed for reimbursement.

(5) Where the conditions of (1) through (4) are met, providers are required to hold a bed and may not fill the bed until these conditions are no longer met. The bed may not be filled unless prior approval is obtained from the department's senior and long term care division. In situations where conditions of billing for holding a bed are not met, providers must hold the bed and may not bill Medicaid for the bed hold day until all conditions of billing are met and may not bill the resident under any circumstances.

(6) Payment will be made to a provider for holding a bed for a resident during a therapeutic home visit only if:

(a) the recipient's plan of care provides for therapeutic home visits;

(b) the recipient is temporarily absent on a therapeutic home visit; and

(c) the resident is absent from the provider's facility for no more than 72 consecutive hours per absence, unless the department determines that a longer absence is medically appropriate and has authorized the longer absence in advance of the absence. If a resident leaves the facility unexpectedly, on a weekend or a non business day for a visit longer than 72 hours, a provider must call in to the department on the next business day to receive prior authorization for the visit. If a resident is unexpectedly delayed while out on a therapeutic home visit, a provider must call the department and receive prior authorization if that delay will result in the visit exceeding 72 hours or obtain an extension for a visit that was previously approved by the department in excess of 72 hours.

(7) The department may allow therapeutic home visits for trial placement in the Home and Community Services (Medicaid Waiver) program.

(8) No more than 24 days per resident in each rate year (July 1 through June 30) will be allowed for therapeutic home visits.

(9) The provider must submit to the department's Senior and Long Term Care Division a request for a therapeutic home visit bed hold, on the appropriate form provided by the department, within 90 days of the first day a resident leaves the facility for a therapeutic home visit. Reimbursement for therapeutic home visits will not be allowed unless the properly completed form is filed timely with the department's Senior and Long Term Care Division.

(10) Approvals or authorizations of bed hold days obtained from county offices will not be valid or effective for purposes of this rule. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1996 MAR p. 1698, Eff. 6/21/96; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.339 MEDICARE HOSPICE BENEFIT - REIMBURSEMENT

(1) In accordance with section 9435(b) of the Omnibus Budget Reconciliation Act of 1986, Public Law 99-509, the department may not pay a nursing facility provider for services provided to an eligible Medicaid/Medicare individual who has elected the Medicare hospice benefit.

(a) This rule applies where the hospice provider and the nursing facility provider have made a written agreement under which the hospice provider agrees to provide professional management of the individual's hospice care and the nursing facility provider agrees to provide room and board to the individual.

(b) When this rule applies, the department will pay the hospice provider in accordance with the department's rules governing Medicaid reimbursement to hospice providers. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

Rules 37.40.340 through 37.40.344 reserved

37.40.345 ALLOWABLE COSTS (1) This rule applies for purposes of determining allowable costs for cost reporting periods beginning on or after July 1, 1991. Allowable costs for cost reporting periods beginning prior to July 1, 1991 will be determined in accordance with rules for allowable costs then in effect.

(2) For purposes of reporting and determining allowable costs, the department hereby adopts and incorporates herein by reference the Provider Reimbursement Manual (PRM-15), published by the United States Department of Health and Human Services, Social Security Administration, which provides guidelines and policies to implement Medicare regulations and principles for determining the reasonable cost of provider services furnished under the Health Insurance for Aged Act of 1965, as amended. A copy of the PRM-15 may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 N. Sanders, Helena, MT 59604-4210. Applicability of the PRM-15 is subject to the exceptions and limitations specified in this rule.

(a) The term "allowable costs" means costs which are allowable under the provisions of this subchapter and which are considered in determining the costs of providing Medicaid nursing facility services. The determination that a cost is an allowable cost does not require the department to reimburse the provider for that cost. Providers will be reimbursed only as specifically provided in these rules.

(3) For purposes of reporting costs as required in ARM 37.40.346, allowable costs will be determined in accordance with the PRM-15, subject to the exceptions and limitations provided in these rules, including but not limited to the following:

(a) Return on net invested equity is an allowable cost only for providers of intermediate care facility services for the mentally retarded which provide services on a for-profit basis.

(b) Allowable property costs are limited as follows:

(i) The capitalized costs of movable equipment are not allowable in excess of the fair market value of the asset at the time of acquisition.

(ii) Property-related interest, whether actual interest or imputed interest for capitalized leases, is not allowable in excess of the interest rates available to commercial borrowers from established lending institutions at the date of asset acquisition or at the inception of the lease.

(iii) Leases must be capitalized according to generally accepted accounting principles.

(iv) Depreciation of real property and movable equipment must be in accordance with American hospital association guidelines. Depreciation of real property and movable equipment based upon accelerated cost recovery guidelines is not an allowable cost.

(v) In accordance with sections 1861(v)(1)(O) and 1902(a)(13) of the Social Security Act, allowable property costs shall not be increased on the basis of a change in ownership which takes place on or after July 18, 1984. Section 1861(v)(1)(O) and section 1902(a)(13) of the Social Security Act are hereby adopted and incorporated herein by reference. The cited statutes are federal statutes governing allowability of certain facility property costs for purposes of Medicare and Medicaid program reimbursement. Copies of these sections may be obtained through the Department of Public Health and Human Services, Senior and Long Term Care Division, P.O. Box 4210, 111 N. Sanders, Helena, MT 59604-4210.

(c) Administrator compensation is allowable only as determined according to the PRM-15 provisions relating to owner compensation, and as specifically limited in this rule.

(i) For purposes of reporting and determining allowable administrator compensation, administrator compensation includes:

(A) all salary paid to the administrator for managerial, administrative, professional or other services;

(B) all employee benefits except employer contributions required by state or federal law for FICA, workers' compensation insurance (WCI), federal unemployment insurance (FUI), and state unemployment insurance (SUI);

(C) all deferred compensation either accrued or paid;

(D) the value of all supplies, services, special merchandise, and other valuable items paid or provided for the personal use or benefit of the administrator;

(E) wages of any provider employee to the extent such employee works in the home of the administrator;

(F) the value of use of an automobile owned by the provider business to the extent used by the administrator for uses not related to patient care;

(G) personal life, health, or disability insurance premiums paid by the provider on the administrator's behalf;

(H) the rental value of any portion of the facility occupied by the administrator as a personal residence;

(i) the value of any other remuneration, compensation, fringe, or other benefits whether paid, accrued, or contingent.

(d) Allowable costs include employee benefits as follows:

(i) Employee benefits are defined as amounts accrued on behalf of an employee, in addition to direct salary or wages, and from which the employee or his beneficiary derives a personal benefit before or after the employee's retirement or death, if uniformly applicable to all employees. An item is an employee benefit only if it directly benefits an individual employee and does not directly benefit the owner, provider, or related parties.

(ii) Employee benefits include all employer contributions which are required by state or federal law, including FICA, WCI, FUI, SUI.

(iii) Costs of recreational activities or facilities available to employees as a group, including but not limited to condominiums, swimming pools, weight rooms and gymnasiums, are not allowable.

(iv) For purposes of this rule, an employee is one from whose salary or wages the employer is required to withhold FICA. Stockholders who are related parties to the corporate providers, officers of a corporate provider, and sole proprietors and partners owning or operating a facility are not employees even if FICA is withheld for them.

(v) Accrued vacation and sick leave are employee benefits if the facility has in effect a written policy uniformly applicable to all employees within a given class of employees, and are allowable to the extent they are reasonable in amount.

(e) Bad debts, charitable contributions and courtesy allowances are deductions from revenue and are not allowable costs.

(f) Revenues received for services or items provided to employees and guests are recoveries of cost and must be deducted from the allowable cost of the related items.

(g) Dues, membership fees, and subscriptions to organizations unrelated to the provider's provision of nursing facility services are not allowable costs.

(h) Charges for services of a chaplain are not an allowable cost.

(i) Subject to (4), fees for management or professional services (e.g., management, legal, accounting or consulting services) are allowable to the extent they are identified to specific services and the hourly rate charged is reasonable in amount. In lieu of compensation on the basis of an hourly rate, allowable costs may include compensation for professional services on the basis of a reasonable retainer agreement which specifies in detail the services to be performed. Documentation that such services were in fact performed must be maintained by the provider. If the provider elects compensation under a retainer agreement, allowable costs for services specified under the agreement are limited to the agreed retainer fee.

(j) Travel costs and vehicle operating expenses related to resident care are allowable to the extent such costs are reasonable and adequately documented.

(i) Vehicle operating costs will be allocated between business and personal use based on actual mileage logs, a percentage derived from a sample mileage log and pre-approved by the department, or any other method pre-approved by the department.

(ii) For vehicles used primarily by an administrator, any portion of vehicle costs allocated to personal use shall be included as administrator compensation and subject to the limits specified in (3)(c).

(iii) Allowable costs include automobile depreciation calculated on a straight-line basis, subject to salvage value, with a minimum of a three-year useful life. The total of automobile depreciation and interest, or comparable lease costs will not be allowable in excess of $7,500 per year.

(iv) Public transportation costs will be allowable only at tourist or other available commercial rate (not first class).

(k) Allowable costs for purchases, leases or other transactions between related parties are subject to the following limitation:

(i) Allowable cost of services, facilities and supplies furnished to a provider by a related party or parties shall not exceed the lower of costs to the related party or the price of comparable services, facilities or supplies obtained from an unrelated party. A provider must identify such related parties and costs in the annual cost report.

(4) Costs, including attorney's fees, in connection with court or administrative proceedings are allowable only to the extent that the provider prevails in the proceeding. Where such proceedings are related to specific reimbursement amounts, the proportion of costs which are allowable shall be the percentage of costs incurred which equals the percentage derived by dividing the total cost or reimbursement on which the provider prevails by the total cost or reimbursement at issue. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1992 MAR p. 1617, Eff. 7/31/92; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00; AMD, 2003 MAR p. 1294, Eff. 7/1/03.)

37.40.346 COST REPORTING, DESK REVIEW AND AUDIT

(1) Providers must use generally accepted accounting principles to record and report costs. The provider must, in preparing the cost report required under this rule, adjust such costs in accordance with ARM 37.40.345 to determine allowable costs.

(2) Providers must use the accrual method of accounting, except that, for governmental institutions that operate on a cash method or a modified accrual method, such methods of accounting will be acceptable.

(3) Cost finding means the process of allocating and prorating the data derived from the accounts ordinarily kept by a provider to ascertain the provider's costs of the various services provided. In preparing cost reports, all providers must use the methods of cost finding described at 42 CFR 413.24 (1997), which the department hereby adopts and incorporates herein by reference. 42 CFR 413.24 is a federal regulation setting forth methods for allocating costs. A copy of the regulation may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. Notwithstanding the above, distinctions between skilled nursing and nursing facility care need not be made in cost finding.

(4) All providers must report allowable costs based upon the provider's fiscal year and using the financial and statistical report forms designated and/or provided by the department. Reports must be complete and accurate. Incomplete reports or reports containing inconsistent data will be returned to the provider for correction.

(a) A provider must file its cost report:

(i) within 150 days after the end of its designated fiscal year;

(ii) within 150 days after the effective date of a change in provider as defined in ARM 37.40.325; or

(iii) for changes in providers occurring on or after July 1, 1993, within 150 days after six months participation in the Medicaid program for providers with an interim rate established under ARM 37.40.326. Subsequent cost reports are to be filed in accordance with (4)(a)(i) above and subsequent cost reports shall not duplicate previous cost reporting periods.

(b) The report forms required by the department include certain Medicare cost report forms and related instructions, including but not limited to certain portions of the most recent version of the CMS-2540 or CMS-2552 cost report forms, as more specifically identified in the department's cost report instructions. The department also requires providers to complete and submit certain Medicaid forms, including but not limited to the most recent version of the Medicaid expense statement, form DPHHS-MA-008A.

(i) In preparing worksheet A on the CMS-2540 or CMS-2552 cost report form, providers must report costs in the worksheet A category that correspond to the category in which the cost is reportable on the Medicaid expense statement, as designated in the department's cost report instructions.

(ii) For purposes of the Medicaid cost report required under this rule, all Medicare and Medicaid cost report forms must be prepared in accordance with applicable cost report instructions. Medicare cost report instructions shall apply to Medicare cost report forms to the extent consistent with Medicaid requirements, but the Medicaid requirements specified in these rules and the department's Medicaid cost reporting instructions shall control in the event of a conflict with Medicare instructions.

(c) If a provider files an incomplete cost report or reported costs are inconsistent, the department may return the cost report to the facility for completion or correction, and may withhold payment as provided in (4)(d).

(d) If a provider does not file its cost report within 150 days of the end of its fiscal year, or if a provider files an incomplete cost report, the department may withhold from payment to the provider an amount equal to 10% of the provider's total reimbursement for the month following the due date of the report or the filing of the incomplete report. If the report is overdue or incomplete a second month, the department may withhold 20% of the provider's total reimbursement for the following month. For each succeeding month for which the report is overdue or incomplete, the department may withhold the provider's entire Medicaid payment for the following month. If the provider fails to file a complete and accurate cost report within six months after the due date, the department may recover all amounts paid to the provider by the department for the fiscal period covered by the cost report. All amounts so withheld will be payable to the provider upon submission of a complete and accurate cost report.

(e) The department may grant a provider one 30-day extension for filing the cost report if the provider's written request for the extension is received by the department prior to expiration of the filing deadline and if, based upon the explanation in the request, the department determines that the delay is unavoidable.

(f) Cost reports must be executed by the individual provider, a partner of a partnership provider, the trustee of a trust provider, or an authorized officer of a corporate provider. The person executing the reports must sign, under penalties of false swearing, upon an affirmation that he has examined the report, including accompanying schedules and statements, and that to the best of his knowledge and belief, the report is true, correct, and complete, and prepared in accordance with applicable laws, regulations, rules, policies, and departmental instructions.

(5) A provider must maintain records of financial and statistical information which support cost reports for six years, three months after the date a cost report is filed, the date the cost report is due, or the date upon which a disputed cost report is finally settled, whichever is later.

(a) Each provider must maintain, as a minimum, a chart of accounts, a general ledger and the following supporting ledgers and journals: revenue, accounts receivable, cash receipts, accounts payable, cash disbursements, payroll, general journal, resident census records identifying the level of care of all residents individually, all records pertaining to private pay residents and resident trust funds.

(b) To support allowable costs, the provider must make available for audit at the facility all business records of any related party, including any parent or subsidiary firm, which relate to the provider under audit. To support allowable costs, the provider must make available at the facility for audit any owner's or related party's personal financial records relating to the facility. Any costs not so supported will not be allowable.

(c) Cost information and documentation developed by the provider must be complete, accurate and in sufficient detail to support payments made for services rendered to recipients and recorded in such a manner to provide a record which is auditable through the application of reasonable audit procedure. This includes all ledgers, books, records and original evidence of cost (purchase requisitions, purchase orders, vouchers, checks, invoices, requisitions for materials, inventories, labor time cards, payrolls, bases for apportioning costs, etc.) which pertain to the determination of reasonable cost. The provider must make and maintain contemporaneous records to support labor costs incurred. Documentation created after the fact will not be sufficient to support such costs.

(d) The provider must make all of the above records and documents available at the facility at all reasonable times after reasonable notice for inspection, review or audit by the department or its agents, the federal department of health and human services, the Montana legislative auditor, and other appropriate governmental agencies. Upon refusal of the provider to make available and allow access to the above records and documents, the department may recover, as provided in ARM 37.40.347, all payments made by the department during the provider's fiscal year to which such records relate.

(6) Department audit staff may perform a desk review of cost statements or reports and may conduct on site audits of provider records. Such audits will be conducted in accordance with audit procedures developed by the department.

(a) Department audit staff may determine adjustments to cost reports or reported costs through desk review or audit of cost reports. Department audit staff may conduct a desk review of a cost report to verify, to the extent possible, that the provider has provided a complete and accurate report.

(b) Department audit staff may conduct on site audits of a provider's records, information and documentation to assure validity of reports, costs and statistical information. Audits will meet generally accepted auditing standards.

(c) The department shall notify the provider of any adverse determination resulting from a desk review or audit of a cost report and the basis for such determination. Failure of the department to complete a desk review or audit within any particular time shall not entitle the provider to retain any overpayment discovered at any time.

(d) The department, in accordance with the provisions of ARM 37.40.347, may collect any overpayment and will reimburse a provider for any underpayment identified through desk review or audit.

(7) A provider aggrieved by an adverse department action may request administrative review and a fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1993 MAR p. 1385, Eff. 7/1/93; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1997 MAR p. 474, Eff. 3/11/97; AMD, 1998 MAR p. 1749, Eff. 6/26/98; AMD, 2000 MAR p. 492, Eff. 2/11/00; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.347 COST SETTLEMENT PROCEDURES (1) The department will notify the provider of any overpayment discovered. The provider may contact the department to seek an agreement providing for repayment of the full overpayment within 60 days of mailing of the overpayment notice.

(2) Unless, within 30 days of mailing of overpayment notice to the provider, the provider enters into an agreement with the department which provides for full repayment within 60 days of mailing of the overpayment notice, the department will immediately commence offsetting from rate payments so as to complete full recovery as soon as possible.

(3) The department may recover the full overpayment amount regardless of whether the provider disputes the department's determination of the overpayment in whole or in part. A request for administrative review or fair hearing does not entitle a provider to delay repayment of any overpayment determined by the department.

(4) The department will notify the provider of any underpayment discovered. In the event an underpayment has occurred, the department will reimburse the provider promptly following the department's determination of the amount of the underpayment.

(5) Court or administrative proceedings for collection of overpayment or underpayment must be commenced within five years following the due date of the original cost report or the date of receipt of a complete cost report whichever is later. In the case of a reimbursement or payment based on fraudulent information, recovery of overpayment may be undertaken at any time.

(6) The amount of any overpayment constitutes a debt due the department as of the date the department mails notice of overpayment to the provider. The department may recover the overpayment from any person, party, transferee, or fiduciary who has benefited from either the payment or from a transfer of assets. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489.)

Rules 37.40.348 through 37.40.350 reserved

37.40.351 THIRD PARTY PAYMENTS AND PAYMENT IN FULL

(1) Regardless of any other provision of these rules, a provider may not bill the Medicaid program for any patient day, item, service or other amount which could have been or could be paid by any other payer, including but not limited to a private or governmental insurer, or Medicare, regardless of whether the facility participates in such coverage or program. If the department finds that Medicaid has made payments in such an instance, retroactive collections may be made from the provider in accordance with ARM 37.40.347.

(a) This rule does not apply to payment sources which by law are made secondary to Medicaid.

(2) The payments allowed under ARM 37.40.307 constitute full payment for nursing facility services and separately billable items provided to a resident. A provider may not charge, bill, or collect any amount from a Medicaid recipient, other than the resident's patient contribution and any items billable to residents under ARM 37.40.331.

(3) This rule applies in addition to ARM 37.85.415. (History: 53-2-201, 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 492, Eff. 2/11/00.)

37.40.352 UTILIZATION REVIEW AND QUALITY OF CARE

(1) Upon admission and as frequently thereafter as the department may deem necessary, the department or its agents, in accordance with 42 CFR 456 subpart F (1997), may evaluate the necessity of nursing facility care for each Medicaid resident in an intermediate care facility for the mentally retarded. 42 CFR 456 subpart F contains federal regulations which specify utilization review criteria for intermediate care facilities. The department hereby adopts and incorporates herein by reference 42 CFR 456 (1997). A copy of these regulations may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 111 N. Sanders, P.O. Box 4210, Helena, MT 59604-4210. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-142, MCA; NEW, 1991 MAR p. 2050, Eff. 11/1/91; AMD, 1995 MAR p. 1227, Eff. 7/1/95; AMD, 1998 MAR p. 1749, Eff. 6/26/98; TRANS, from SRS, 2000 MAR p. 489.)

Rules 37.40.353 through 37.40.359 reserved

37.40.360 LIEN AND ESTATE RECOVERY FUNDS FOR ONE-TIME EXPENDITURES (REPEALED) (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1108, Eff. 6/22/01; REP, 2003 MAR p. 1294, Eff. 7/1/03.)

37.40.361 DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE REPORTING/ADDITIONAL PAYMENTS INCLUDING LUMP SUM PAYMENTS FOR DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE AND BENEFIT INCREASES (1) Effective for the period July 1, 2009 and for the six months thereafter, nursing facilities must report to the department actual hourly wage and benefit rates paid for all direct care and ancillary services workers or the lump sum payment amounts for all direct care and ancillary services workers that will receive the benefit of the increased funds. The reported data shall be used by the department for the purpose of comparing types and rates of payment for comparable services and tracking distribution of direct care wage funds to designated workers.

(2) The department will pay Medicaid certified nursing care facilities located in Montana that submit an approved request to the department a lump sum payment in addition to the amount paid as provided in ARM 37.40.307 and 37.40.311 to their computed Medicaid payment rate to be used only for wage and benefit increases or lump sum payments for direct care or ancillary services workers in nursing facilities.

(a) The department will determine the lump sum payments, twice a year commencing July 1, 2009, and again in six months from that date as a pro rata share of appropriated funds allocated for increases in direct care and ancillary services workers' wages and benefits or lump sum payments to direct care and ancillary services workers.

(b) To receive the direct care and/or ancillary services workers' lump sum payment, a nursing facility shall submit for approval a request form to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility to comply with all statutory requirements. The facility shall submit all of the information required on a form to be developed by the department in order to continue to receive subsequent lump sum payment amounts for the entire rate year. The form for wage and benefit increases will request information including but not limited to:

(i) the number by category of each direct care and ancillary services workers that will receive the benefit of the increased funds, if these funds will be distributed in the form of a wage increase;

(ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the increased funds;

(iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;

(iv) the number of staff receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and

(v) the number of projected hours to be worked in the budget period.

(c) If these funds will be used for the purpose of providing lump sum payments (i.e. bonus, stipend or other payment types) to direct care and ancillary services workers in nursing care facilities the form will request information including, but not limited to:

(i) the number by category of each direct care and ancillary services worker that will receive the benefit of the increased funds;

(ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;

(iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and

(iv) the effective date of implementation of the lump sum benefit.

(d) A facility that does not submit a qualifying request for use of the funds distributed under (2), that includes all of the information requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care and ancillary services workers.

(3) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including but not limited to the provisions of ARM 37.40.345, 37.40.346 and 37.85.414. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, MCA; NEW, 1999 MAR p. 1393, Eff. 6/18/99; TRANS, from SRS, 2000 MAR p. 489; AMD, 2000 MAR p. 1754, Eff. 7/14/00; AMD, 2001 MAR p. 1108, Eff. 6/22/01; AMD, 2002 MAR p. 1767, Eff. 6/28/02; AMD, 2005 MAR p. 1046, Eff. 7/1/05; AMD, 2006 MAR p. 1638, Eff. 7/1/06; AMD, 2007 MAR p. 1100, Eff. 8/10/07; AMD, 2009 MAR p. 1411, Eff. 8/14/09.)

Subchapter 4

Swing-beds

37.40.401 SWING-BED HOSPITALS, DEFINITIONS (1) A swing-bed hospital is a licensed hospital, critical access hospital (CAH) with swing-bed approval or licensed medical assistance facility which is Medicare-certified to provide post-hospital SNF care as defined in 42 CFR 409.20.

(2) Swing-bed hospital services are services provided in accordance with these rules by a swing-bed hospital which meets the swing-bed hospital participation requirements specified in these rules.

(3) "Swing-bed" means a bed approved pursuant to 42 USC 1395tt to be used to provide either acute care or extended skilled nursing care to a patient. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1984 MAR p. 996, Eff. 6/29/84; AMD, 1993 MAR p. 3069, Eff. 1/1/94; TRANS, from SRS, 2000 MAR p. 489; AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.402 SWING-BED HOSPITALS, PROVIDER PARTICIPATION REQUIREMENTS (1) To participate and be reimbursed as a swing-bed hospital service provider in the Montana Medicaid program, a hospital must meet all of the following requirements:

(a) The hospital is a swing-bed hospital as defined in ARM 37.40.401.

(b) The hospital has fewer than 50 hospital beds and has provided written assurance to the health care financing administration that the hospital will not operate over 49 hospital beds, including swing-beds, except in connection with a catastrophic event.

(i) The hospital bed count is determined by excluding from the total licensed hospital beds:

(A) beds which because of their special nature would not be available for swing-bed use, such as newborn and intensive care beds;

(B) beds included in a separately certified skilled nursing facility or nursing facility;

(C) beds included in a distinct part psychiatric or rehabilitation unit; and

(D) beds which the department determines are not consistently staffed and utilized by the hospital, as demonstrated by the hospital's staffing schedules and census records for the 12 months immediately preceding application for enrollment as a Medicaid swing-bed hospital services provider.

(c) The critical access hospital (CAH) with swing-bed approval has no more than 25 acute care inpatient beds, of which no more than 15 are used for acute care at any one time for providing inpatient care.

(d) The hospital is located in a rural area of the state. A rural area is an area which is not designated as "urbanized" by the most recent official census. A copy of the bureau of the census listing of urbanized areas is available upon request from the Department of Public Health and Human Services, Senior and Long Term Care Division, 2030 11th Avenue, P.O. Box 4210, Helena, MT 59604-4210.

(e) The hospital has a certificate of need from the state Department of Public Health and Human Services to provide swing-bed hospital services.

(f) The hospital does not have in effect a 24 hour nursing waiver under the provisions of 42 CFR 488.54(c).

(g) The hospital's Medicare or Medicaid swing-bed certification or approval has not been terminated within two years prior to the application for enrollment as a Medicaid swing-bed hospital services provider.

(h) The hospital meets the requirements of (2).

(i) The hospital has applied for and the department has approved enrollment in the Medicaid program as a Medicaid swing-bed hospital services provider.

(i) As a condition of granting enrollment approval or of allowing continuing enrollment, the department may require a hospital to submit documentation or information relating to participation requirements.

(ii) The department may terminate a provider's swing-bed hospital services provider enrollment if it determines that the hospital is not in compliance with any of the requirements of this rule. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1984 MAR p. 996, Eff. 6/29/84; AMD, 1989 MAR p. 670, Eff. 5/26/89; AMD, 1993 MAR p. 3069, Eff. 1/1/94; TRANS, from SRS, 2000 MAR p. 489; AMD, 2004 MAR p. 1479, Eff. 7/2/04.)

Rules 37.40.403 and 37.40.404 reserved

37.40.405 SWING-BED HOSPITALS, SPECIAL SERVICE REQUIREMENTS (1) Before admitting a Medicaid recipient to a swing-bed, the swing-bed hospital must meet all of the following requirements:

(a) the hospital must obtain a preadmission screening to determine the level of care required by the patient's medical condition. Medicaid will not reimburse a provider for swing-bed hospital services provided to a Medicaid recipient admitted to a swing-bed unless the recipient meets the nursing facility level of care requirements specified in ARM 37.40.202 and 37.40.205. The swing-bed hospital must ensure that form DPHHS-SLTC-61, "screening notification", is completed by the department preadmission screening team to document the level of care determination.

(b) Except when a waiver is obtained under (4), the hospital must determine that no appropriate nursing facility bed is available to the Medicaid patient within a 25 mile radius of the swing-bed hospital. The hospital is required to maintain written documentation of inquiries to nursing facilities about the availability of a nursing facility bed and indicating that if a bed is not available, the hospital will provide swing-bed services to the patient. The swing-bed hospital is encouraged to enter into availability agreements with Medicaid-participating nursing facilities in its geographic region that require the nursing facility to notify the hospital of the availability of nursing facility beds and dates when beds will be available.

(i) For purposes of this rule, an "appropriate" nursing facility bed is a bed in a Medicaid-participating nursing facility which provides the level of care required by the recipient's medical condition.

(2) A Medicaid patient admitted to a swing-bed must be discharged to an appropriate nursing home bed within a 25 mile radius of the swing-bed hospital within 72 hours of an appropriate nursing home bed becoming available.

(3) The requirements of (1)(b) and (2) apply regardless of the 30-day notice requirement generally applicable to transfers and discharges under ARM 37.40.420(1). When an appropriate nursing facility bed is or becomes available, the provider must provide notice as required by ARM 37.40.420(5)(f) and must otherwise comply with the requirements of ARM 37.40.420(1) to the extent practicable in the time available before transfer to the nursing facility bed.

(4) A provider may request a waiver of the determination requirement of (1)(b) for an acute care patient of the swing-bed hospital or may request for a swing-bed patient a waiver of the transfer requirement of (2) when the recipient's attending physician verifies in writing that either the recipient's condition would be endangered by transfer to an appropriate nursing facility bed within a 25 mile radius of the swing-bed hospital or that the individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

(a) The waiver request and physician's written verification must be submitted to the Department of Public Health and Human Services, Senior and Long Term Care Division, 2030 11th Avenue, P.O. Box 4210, Helena, MT 59640-4210. Waiver approvals granted by county offices will not be valid or effective for purposes of this rule.

(b) The waiver request and physician's written verification must be received by the nursing facility services bureau within five working days of admission to the swing-bed or within five days of availability of an appropriate nursing facility bed and the provider must obtain written approval from the Medicaid services bureau prior to billing for services provided after the date of admission to the swing-bed or the date of availability of an appropriate nursing facility bed.

(5) The department may retrospectively review the use of swing-bed services provided to Medicaid patients and may deny payments when it is determined that the requirements of this rule were not met. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1984 MAR p. 996, Eff. 6/29/84; AMD, 1989 MAR p. 670, Eff. 5/26/89; AMD, 1993 MAR p. 3069, Eff. 1/1/94; TRANS, from SRS, 2000 MAR p. 489; AMD, 2004 MAR p. 1479, Eff. 7/2/04; AMD, 2009 MAR p. 2166, Eff. 1/1/10.)

37.40.406 SWING-BED HOSPITALS, REIMBURSEMENT (1) Montana Medicaid will reimburse swing-bed hospitals as provided in this rule for swing-bed hospital services provided in accordance with all applicable swing-bed hospital service requirements specified in ARM 37.40.401, 37.40.402, 37.40.405 and this rule and subject to all other applicable laws and regulations.

(2) For swing-bed hospital services, the Montana Medicaid program will pay a provider a per diem rate as specified in (2)(a) for each Medicaid patient day, plus additional reimbursement for separately billable items as provided in (2)(b).

(a) The swing-bed hospital services per diem rate is the average Medicaid per diem rate paid to nursing facilities under ARM 37.40.307 for routine services furnished during the calendar year immediately previous to the year in which the swing-bed hospital services are provided. Nursing facility routine services are those services included in the definition of "nursing facility services" specified at ARM 37.40.302.

(b) Separately billable items are those items specified in ARM 37.40.330. Swing-bed hospital service providers will be reimbursed for separately billable items at the rates specified in ARM 37.40.330 and subject to the requirements of ARM 37.40.330.

(c) The Montana Medicaid program will not reimburse swing-bed hospital service providers for items billable to residents as specified in ARM 37.40.331.

(3) For purposes of reporting costs under ARM 37.86.2803, inpatient hospital services providers which also provide swing-bed hospital services shall allocate hospital inpatient general routine service costs associated with swing-bed hospital services on the Medicare "carve out" method as specified in 42 CFR 413.53(a)(2). The department adopts and incorporates by reference 42 CFR 413.53(a)(2)(2004). A copy of 42 CFR 413.53(a)(2) may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 2030 11th Avenue, P.O. Box 4210, Helena, MT 59604-4210.

(4) Providers must bill for all services and supplies in accordance with the provisions of ARM 37.85.406. The department's fiscal agent will pay a provider on a monthly basis the amount determined under these rules upon receipt of an appropriate billing which reports the number of patient days of swing-bed hospital services provided to authorized Medicaid recipients during the billing period.

(5) Swing-bed hospital service providers aggrieved by adverse determinations by the department may request administrative review and fair hearing as provided in ARM 37.5.304, 37.5.305, 37.5.307, 37.5.310, 37.5.311, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337. (History: 2-4-201, 53-2-201, 53-6-113, MCA; IMP, 2-4-201, 53-2-201, 53-6-101, 53-6-111, 53-6-113, 53-6-141, MCA; NEW, 1984 MAR p. 996, Eff. 6/29/84; AMD, 1984 MAR p. 2047, Eff. 12/28/84; AMD, 1989 MAR p. 670, Eff. 5/26/89; AMD, 1993 MAR p. 3069, Eff. 1/1/94; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00; AMD, 2004 MAR p. 482, Eff. 2/27/04.)

Rule 37.40.407 reserved

37.40.408 FACILITY POLICY REQUIREMENTS (1) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(2) The policies must provide that the facility will:

(a) not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(b) not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property;

(c) report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the nurse aide registry maintained by the Department of Public Health and Human Services;

(d) ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility, the long term care ombudsman, and the Department of Public Health and Human Services in accordance with 52-3-811, MCA;

(e) have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress;

(f) ensure that the results of all investigations must be reported to the administrator of the facility and to the Department of Public Health and Human Services in accordance with 52-3-811, MCA, within five working days of the incident; and

(g) if the alleged violation is verified, take appropriate corrective action. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.409 SPECIALIZED REHABILITATIVE SERVICES (1) If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation are required in the resident's comprehensive plan of care, the facility must provide the required services, or obtain the required services from an outside resource from a provider of specialized rehabilitative services.

(a) Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

(2) The facility must assist residents in obtaining routine and 24-hour emergency dental care.

(a) The facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the dentist's office.

(b) The facility must promptly refer residents with lost or damaged dentures to a dentist. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

Rules 37.40.410 and 37.40.411 reserved

37.40.412 RESIDENT ACTIVITIES PROGRAM (1) The facility must provide for an ongoing program of activities designed to meet the interests and the physical, mental, and psychosocial well being of each resident.

(2) The activities program must be directed by a qualified professional who:

(a) is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990;

(b) has two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program in a health care setting;

(c) is a qualified occupational therapist or occupational therapy assistant; or

(d) has completed a training course approved by the state.

(3) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

Rules 37.40.413 through 37.40.415 reserved

37.40.416 RESIDENT RIGHTS (1) The swing-bed hospital must be in substantial compliance with the requirements set forth in this rule pertaining to resident rights.

(2) A provider must protect and promote the rights of each resident, including each of the following rights:

(a) The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the provider's facility.

(b) The resident has the right to be fully informed of the resident's total health status, including but not limited to medical condition, in language that the resident can understand.

(c) The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in 42 CFR 483.10(b)(8). The department adopts and incorporates by reference 42 CFR 483.10(b)(8). A copy of 42 CFR 483.10(b)(8) may be obtained from the Department of Public Health and Human Services, Senior and Long Term Care Division, 2030 11th Avenue, PO Box 4210, Helena, MT 59604-4210.

(3) Each resident who is entitled to Medicaid benefits has a right to be informed by the provider in writing, at the time of admission to the swing-bed or, when the resident becomes eligible for Medicaid of:

(a) the items and services that are included in the swing-bed per diem rate for which the resident may not be charged, i.e., those items included in nursing facility services under ARM 37.40.302(14) or ancillary services under ARM 37.40.330(1); and

(b) those other items and services that the provider offers and for which the resident may be charged, and the amount of charges for those services; and

(c) changes made to the items and services specified in (3)(a) and (b).

(4) The resident has the right to:

(a) choose a personal attending physician;

(b) be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well being; and

(c) unless adjudged incompetent or otherwise found to be incapacitated under state law, participate in planning care and treatment or changes in care and treatment.

(5) The resident has the right to personal privacy and confidentiality of personal and clinical records.

(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. The right of personal privacy does not require the provider to provide a private room for each resident.

(b) The resident may approve or refuse the release of personal and clinical records to any individual outside the facility, except when the resident is transferred to another health care institution or record release is required by law.

(6) The resident has the right to:

(a) refuse to perform services for the facility;

(b) perform services for the facility, if the resident chooses, when:

(i) the facility has documented in the plan of care the need or desire for work;

(ii) the plan specifies the nature of the services performed and whether the services are voluntary or paid;

(iii) compensation for paid services is at or above prevailing rates; and

(iv) the resident agrees to the work arrangement described in the plan of care.

(7) The resident has the right to privacy in written communications, including the right to:

(a) send and promptly receive mail that is unopened; and

(b) have access to stationery, postage, and writing implements at the resident's own expense.

(8) The resident has the right to see, and the facility must provide immediate access to any resident by, the following:

(a) subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and

(b) subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.

(9) The resident has the right to retain and use personal possessions, including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(10) The resident has the right to share a room with a spouse when married residents live in the same facility and both spouses consent to the arrangement.

(11) The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(12) The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(13) The resident has the right to be informed in writing of the policies and procedures developed by the facility pursuant to ARM 37.40.408. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

Rules 37.40.417 through 37.40.419 reserved

37.40.420 RESIDENT TRANSFER AND DISCHARGE RIGHTS (1) The resident has the following transfer and discharge rights. Transfer and discharge includes movement of a resident to a bed outside of the swing-bed hospital facility whether or not that bed is in the same physical plant. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

(2) The facility must permit each resident to remain in the facility and may not transfer or discharge the resident from the facility unless any one or more of the following apply:

(a) the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(b) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(c) the safety of individuals in the facility is endangered;

(d) the health of individuals in the facility would otherwise be endangered;

(e) the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;

(f) the facility ceases to operate; or

(g) an appropriate nursing facility bed is available within a 25 mile radius of the swing-bed hospital, as provided in ARM 37.40.405.

(3) When the facility transfers or discharges a resident, the facility must document the reason for transfer or discharge in the resident's clinical record. The documentation must be made by the resident's physician when transfer or discharge is necessary under (2)(a) and (b), or a physician when transfer or discharge is necessary under (2)(d).

(4) Before a facility transfers or discharges a resident, the facility must:

(a) notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand;

(b) record the reasons in the resident's clinical record; and

(c) include in the notice the items described in (6) through (6)(f).

(5) Notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged except when:

(a) the safety of individuals in the facility would be endangered;

(b) the health of the individuals in the facility would be endangered;

(c) the resident's health improves sufficiently to allow a more immediate transfer or discharge;

(d) an immediate transfer or discharge is required by the resident's urgent medical needs;

(e) a resident has not resided in the facility for 30 days; or

(f) transfer is required within 72 hours because an appropriate nursing facility bed is available within a 25 mile radius of the swing-bed hospital. In such cases, the facility must provide notice within 24 hours of determining that the nursing facility bed is available.

(6) The written notice of transfer or discharge must include the following:

(a) the reason for transfer or discharge;

(b) the effective date of transfer or discharge;

(c) the location to which the resident is transferred or discharged;

(d) a statement that the resident has the right to appeal the action to the Fair Hearings Office at the Department of Public Health and Human Services;

(e) the name, address and telephone number of the long term care ombudsman in the Governor's Office on Aging; and

(f) for nursing facility residents with developmental disabilities and nursing facility residents who are mentally ill, the mailing address and telephone number of the Montana Advocacy Program, Inc.

(7) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.421 RESIDENT POST DISCHARGE RIGHTS (1) When the facility anticipates discharge, a resident must have a discharge summary that includes:

(a) a recapitulation of the resident's stay;

(b) a final summary of the resident's status which includes:

(i) medically defined conditions and prior medical history;

(ii) medical status measurement;

(iii) physical and mental functional status;

(iv) sensory and physical impairments;

(v) nutritional status and requirements;

(vi) special treatments or procedures;

(vii) mental and psychosocial status;

(viii) discharge potential;

(ix) dental condition;

(x) activities potential;

(xi) cognitive status;

(xii) drug therapy; and

(c) a post discharge plan of care that is developed with the participation of the resident and family, which will assist the resident to adjust to the new living environment. (History: 53-6-113, MCA; IMP, 53-6-101, 53-6-113, MCA; NEW, 2004 MAR p. 1479, Eff. 7/2/04.)

37.40.422 DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE REPORTING/ADDITIONAL PAYMENTS INCLUDING LUMP SUM PAYMENTS FOR DIRECT CARE AND ANCILLARY SERVICES WORKERS' WAGE AND BENEFIT INCREASES (1) Effective for the period January 1, 2010 through December 31, 2010, swing-bed hospitals must report to the department actual hourly wage and benefit rates paid for all direct care and ancillary services workers or the lump sum amounts paid for all direct care and ancillary services workers that will receive the benefit of a direct care and ancillary workers' wage and benefit increase.

(2) The department will use the reported data for the purpose of comparing types and rates of payment for comparable services and for tracking distribution of direct care wage funds to designated workers.

(3) The department will pay Medicaid certified swing-bed hospitals located in Montana, in accordance with this rule, lump sum payments in addition to the reimbursement rate to be used only for wage and benefit increases or lump sum payments for direct care or ancillary services workers in swing-bed hospitals.

(a) The department will determine lump sum payments commencing January 1, 2010, and again six months from that date as a pro rata share of appropriated funds allocated for increases in direct care and ancillary services workers' wages and benefits or lump sum payments to direct care and ancillary services workers.

(b) To receive the direct care or ancillary services workers' lump sum payment, a swing-bed hospital must submit:

(i) a request to the department stating how the direct care and ancillary services workers' lump sum payment will be spent in the facility in compliance with all statutory requirements; and

(ii) all of the information required on a form developed by the department in order to continue to receive subsequent lump sum payment amounts for the entire rate year.

(c) The form for wage and benefit increases will request information including but not limited to:

(i) the number by category of each direct care and ancillary services workers that will receive the benefit of the increased funds, if these funds will be distributed in the form of a wage increase;

(ii) the actual per hour rate of pay before benefits and before the direct care wage increase has been implemented for each worker that will receive the benefit of the increased funds;

(iii) the projected per hour rate of pay with benefits after the direct wage increase has been implemented;

(iv) the number of workers receiving a wage or benefit increase by category of worker, effective date of implementation of the increase in wage and benefit; and

(v) the number of projected hours to be worked in the budget period.

(d) If these funds will be used for the purpose of providing lump sum payments such as bonuses, stipends, or other payment types to direct care and ancillary services workers in swing-bed hospitals, the form will request information including, but not limited to:

(i) the number by category of each direct care and ancillary services worker that will receive the benefit of the increased funds;

(ii) the type and actual amount of lump sum payment to be provided for each worker that will receive the benefit of the lump sum funding;

(iii) the breakdown of the lump sum payment by the amount that represents benefits and the direct payment to workers by category of worker; and

(iv) the effective date of implementation of the lump sum benefit.

(e) A facility that does not submit a qualifying request for use of the funds distributed under (2), that includes all of the information requested by the department, within the time established by the department, or a facility that does not wish to participate in this additional funding amount shall not be entitled to their share of the funds available for wage and benefit increases or lump sum payments for direct care and ancillary services workers.

(4) A facility that receives funds under this rule must maintain appropriate records documenting the expenditure of the funds. This documentation must be maintained and made available to authorized governmental entities and their agents to the same extent as other required records and documentation under applicable Medicaid record requirements, including, but not limited to the provisions of ARM 37.40.345, 37.40.346, and 37.85.414. (History: 53-2-201, 53-6-113, MCA; IMP, 53-2-201, 53-6-101, 53-6-111, MCA; NEW, 2009 MAR p. 2166, Eff. 1/1/10.)

Subchapters 5 and 6 reserved

Subchapter 7

Home Health Services

37.40.701 HOME HEALTH SERVICES DEFINITIONS (1) "Home-bound status" means that a recipients:

(a) is confined on a full time, part time or intermittent basis to the person's place of residence for medical reasons;

(b) is unable to obtain required medical services without demonstrated taxing effort; or

(c) cannot reasonably obtain medical services other than through a home health agency.

(2) "Home health aide services" means services to assist a recipient in the activities of daily living and the care of the household.

(3) "Home health services" means services provided by a licensed home health agency to a recipient considered homebound in the recipient's place of residence for the purposes of postponing or preventing institutionalization.

(a) Home health services include:

(i) skilled nursing services;

(ii) home health aide services;

(iii) physical therapy services;

(iv) occupational therapy services;

(v) speech therapy services; and

(vi) medical supplies and equipment suitable for use in the home.

(b) Home health services do not include:

(i) personal care services as provided at ARM 37.40.1101 et seq.;

(ii) visits made by a registered nurse for evaluating the home health needs of a recipient or to review the provision of home health services by a home health aide or a licensed practical nurse; and

(iii) maintenance therapy as provided at ARM 37.86.601, et seq.

(4) "Home health service visit" means a personal contact in the place of residence of a recipient made for the purpose of providing a covered home health service.

(5) "Place of residence" means the residential setting in which the recipient generally resides.

(a) Place of residence includes a recipient's own home, a personal care facility, a foster home, a community home or other residential setting for persons who have a developmental disability or a physical disability, a rooming house or a retirement home.

(b) Place of residence does not include a hospital, a nursing facility, an adult day care center, or a day habilitation facility providing developmental disabilities services.

(6) "Skilled nursing services" means nursing services, as defined in the Montana Nurse Practice Act, provided on an intermittent or part time basis to meet the medical needs of a recipient who needs nursing procedures. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1761, Eff. 6/27/80; AMD, 1981 MAR p. 690, Eff. 7/17/81; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

37.40.702 HOME HEALTH SERVICES, REQUIREMENTS (1) These requirements are in addition to those rule provisions generally applicable to medicaid providers.

(2) A home health agency must be:

(a) licensed by the Montana department of public health and human services;

(b) medicare certified; and

(c) an enrolled medicaid provider.

(3) Home health services may be provided by providers located outside of the borders of the state of Montana only if the service meets the requirements of ARM 37.85.207(3) and the service is prior authorized by the department or the department's designee.

(4) Home health services must be:

(a) ordered by the recipient's attending physician;

(b) part of a written plan of care; and

(c) reviewed and renewed by the recipient's attending physician at a minimum of 60 day intervals.

(5) The provider must maintain documentation that the recipient meets the homebound definition.

(6) Written physician orders, care plans and other recipient records must be current and available upon request of the department or its designated representative.

(7) Home health services, except skilled nursing services, are limited to a combined maximum of 100 visits per recipient per fiscal year. Skilled nursing services are limited to 75 visits per recipient per fiscal year.

(a) The department may, within its discretion, authorize additional visits in excess of this limit. Any services exceeding this limit must be prior authorized by the department or the department's designee.

(8) Home health aide services are subject to the following limitations:

(a) Home health aide services must be prior authorized by the department or the department's designee.

(b) Home health aide services must be provided under the supervision of a registered professional nurse and in accordance with a written plan of treatment established by a physician.

(c) A person receiving personal care attendant services may not receive home health aide services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1761, Eff. 6/27/80; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

Rules 03 and 04 reserved

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37.40.705 HOME HEALTH SERVICES, REIMBURSEMENT

(1) Reimbursement fees for home health services are as provided for in this rule.

(2) The interim reimbursement for a category of service submitted for reimbursement as provided in (4) or (5) is the most current medicare percent of billed charges for each provider.

(3) The provider's final reimbursement as provided for in (4) and (5) is calculated when the actual reimbursement fees based on the medicare cost settlements are determined for the period. The medicare cost settlements are derived from an audit of allowable costs conducted for medicare purposes.

(4) For home health agencies located within the borders of the state that began providing services before July 1, 1989, the reimbursement fee for a category of service after January 1, 1990 and prior to July 1, 1995 is the lowest of:

(a) the provider's billed charges;

(b) the average medicare cost for the category of service;

(c) the upper medicare limit for the category of service; or

(d) the adjusted indexed fee for the category of service for state fiscal year ending June 30, 1990.

(i) The state fiscal year 1990 adjusted indexed fee for a category of service is the sum of:

(A) the lowest fee for the category of service reported in the provider's medicaid cost settlement report ending calendar year 1989, indexed to a common fiscal year ending December 30, 1989 by the most recent home health DRI market basket index percentage of the health care financing administration of the department of health and human services (HCFA); and

(B) 2% of the indexed lowest fee. The department hereby adopts and incorporates by reference the HCFA home health DRI market basket rate which is a forecast model of market basket increase factors. The rate and a description of the general methodology and variables used in formulating this model is available from HCFA, Office of the Actuary, 6325 Security Blvd., Baltimore, MD 21209.

(ii) The state fiscal year 1991 indexed fee for a category of service is the 1990 indexed fee for a category of service increased by 2%.

(5) For home health agencies which are located within the borders of the state that began providing services on or after July 1, 1989, the medicaid reimbursement fee for a category of service delivered prior to July 1, 1995 is the lowest of:

(a) the provider's billed charges;

(b) the average medicare cost for the category of service;

(c) the upper medicare cost limit for the category of service; or

(d) the adjusted averaged medicaid fee for the category of service for that state fiscal year.

(i) The adjusted averaged medicaid fee for a category of service is the sum of:

(A) costs for the category derived from the most recent medicaid cost settlements finalized before June 30, of that state fiscal year from all participating in-state home health providers divided by the total number of delivered services; and

(B) 2% of the averaged medicaid fee.

(6) For home health agencies located within the borders of the state for services provided on or after July 1, 1995 and prior to July 1, 1997, the reimbursement fee for a home health service, except for a home health aide service, is 60% of the average of the provider's medicare cost limits for skilled nursing, physical therapy, speech therapy and occupational therapy services.

(a) The reimbursement fee for home health aide services is 60% of the provider's medicare cost limit for that service.

(7) For home health services provided on or after July 1, 1997, the reimbursement is the following:

(a) for a nursing or therapy service - $59.54 per visit;

(b) for a home health aide visit - $26.60;

(c) for medical supplies and equipment suitable for use in the home - 90% of the amount allowable for the specific item under medicare. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1762, Eff. 6/27/80; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2017, Eff. 1/1/87; AMD, 1989 MAR p. 1285, Eff. 9/1/89; AMD, 1990 MAR p. 1042, Eff. 6/1/90; AMD, 1991 MAR p. 1856, Eff. 9/27/91; AMD, 1995 MAR p. 1182, Eff. 7/1/95; AMD, 1997 MAR p. 1042, Eff. 6/24/97; TRANS, from SRS, 2000 MAR p. 489.)

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Subchapter 8

Hospice

37.40.801 HOSPICE, DEFINITIONS (1) "Department" means the Montana department of public health and human services.

(2) Except for the definition of "physician", the department hereby adopts and incorporates by reference 42 CFR 418.3, as amended through October 1, 1988, which sets forth definitions of terms related to services covered as hospice care. Copies of 42 CFR 418.3, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) "Physician" means an individual licensed under the state medical practice act to practice medicine or osteopathy. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

Rules 02 through 04 reserved

37.40.805 HOSPICE, CONDITIONS OF PARTICIPATION (1) The hospice must be licensed under state law and must meet medicare's conditions of participation for hospice programs and have a valid provider agreement with medicare as conditions of enrollment in medicaid.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.50 through 418.100, as amended through October 1, 1988, which set forth medicare's conditions of participation for hospice providers. Copies of 42 CFR 418.50 through 418.100, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) The above requirements are in addition to those contained in ARM 37.82.102 and 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410 and 37.85.414.

(4) The hospice must submit a physician listing with their provider application and update changes in the listing of the physicians which are hospice employees, including physician volunteers.

(5) The designated hospice must notify the department when the designated attending physician of a recipient in their care is not a hospice employee. (History: Sec. 53-6-113, MCA; IMP, 53-6-101, MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

37.40.806 HOSPICE, COVERED SERVICES (1) To be covered, hospice services must meet the following requirements:

(a) they must be reasonable and necessary for the palliation or management of the terminal illness as well as related conditions;

(b) the individual must elect hospice care in accordance with ARM 37.40.815;

(c) a plan of care must be established as set forth in ARM 37.40.805 and 37.40.807 before services are provided. The services must be consistent with the plan of care; and

(d) a certification that the individual is terminally ill must be completed as set forth in ARM 37.40.808.

(2) For covered hospice services, medicaid will generally pay for the services covered by medicare. The department hereby adopts and incorporates by reference 42 CFR 418.202 through 418.204, as amended through October 1, 1988, except for those provisions of 42 CFR 418.202 which apply to physicians' services. The incorporated material sets forth requirements for medicare coverage of hospice services. Copies of 42 CFR 418.202 through 418.204, as amended through October 1, 1988, except for those provisions of 42 CFR 418.202 which apply to physicians' services, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(a) Physicians' services is a covered hospice service and must be performed by a doctor of medicine or osteopathy.

(b) Outpatient drugs and biologicals not related to the terminal conditions will be reimbursed separately under the provisions of ARM 37.86.1101, 37.86.1102, 37.86.1105 and 46.12.701. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; AMD, 1990 MAR p. 539, Eff. 3/16/90; TRANS, from SRS, 2000 MAR p. 489.)

37.40.807 HOSPICE REQUIREMENTS, PLAN OF CARE (1) The plan of care must be maintained by the hospice and available for department review. To be eligible for coverage, services must be consistent with the plan of care. In order to establish a plan of care:

(a) one member of the basic interdisciplinary assessment group must assess the individual's needs;

(b) prior to writing the initial plan that member must discuss his assessment with at least one other group member;

(i) one of those two members must be either a physician or nurse.

(c) the initial plan must be completed on the same day as the assessment if that day is to be a covered day; and

(d) the entire group must approve the initial plan within two calendar days following the assessment. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

37.40.808 HOSPICE, CERTIFICATION OF TERMINAL ILLNESS

(1) In order to be eligible to elect hospice care under medicaid, an individual must be certified as being terminally ill in accordance with medicare certification requirements.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.22, as amended through October 1, 1988, which sets forth medicare conditions for certification of terminal illness to qualify an individual to be eligible to elect hospice care. Copies of 42 CFR 418.22, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

Rules 09 through 14 reserved

37.40.815 HOSPICE, ELECTION AND WAIVER OF OTHER BENEFITS

(1) An individual eligible for hospice care or his representative must file an election statement with a particular hospice in order to receive that care. The department will follow medicare guidelines in administering this provision.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.24(a) through 418.24(d), as amended through October 1, 1988, which set forth requirements for individual election of hospice care and 42 CFR 418.26, as amended through October 1, 1988, which sets forth elements of the election statement. Copies of 42 CFR 418.24(a) through 418.24(d) and 418.26, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) An individual waives all rights to medicaid payments for the duration of the election of hospice care for the following services:

(a) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

(b) Any medicaid services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for:

(i) services provided by the designated hospice;

(ii) services provided by another hospice under arrangements made by the designated hospice; and

(iii) services provided by the individual's attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; AMD, 1990 MAR p. 539, Eff. 3/16/90; TRANS, from, SRS, 2000 MAR p. 489.)

37.40.816 HOSPICE, REVOCATION OF ELECTION (1) An individual or representative may revoke the individual election of hospice care at any time during an election period. The department will follow medicare guidelines in administering this provision.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.28, as amended through October 1, 1988, which sets forth the medicare requirements for revoking the election of hospice care. Copies of 42 CFR 418.28, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

Rules 17 through 24 reserved

37.40.825 HOSPICE, CHANGE OF HOSPICE (1) An individual or representative may change once in each election period the designation of the particular hospice from which hospice care will be received. The department will follow medicare guidelines in administering this provision.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.30, as amended through October 1, 1988, which sets forth the medicare requirements that must be met when another hospice is chosen in an election period. Copies of 42 CFR 418.30, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

Rules 26 through 29 reserved

37.40.830 HOSPICE, REIMBURSEMENT (1) Medicaid payment for covered hospice care will be made in accordance with the specific categories of covered hospice care (routine home care day, continuous home care day, inpatient respite care day, and general inpatient care day) and the payment amounts and procedures established by medicare.

(2) The department hereby adopts and incorporates by reference 42 CFR 418.302, as amended through October 1, 1988, which sets forth the medicare payment procedures. Copies of 42 CFR 418.302, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(3) The board and room rate to be paid a hospice for a medicaid recipient who resides in a nursing facility (SNF/ICF) will be the medicaid rate established by the department for the individual facility minus the amount the recipient pays toward his own cost of care. Payment for board and room will be made to the hospice and, in turn, the hospice will reimburse the nursing facility. General inpatient care or hospice respite care in a nursing facility will not be reimbursed directly by the medicaid program when a medicaid recipient elects the hospice benefit payment. Under such circumstances payment will be made to the hospice in accordance with this rule.

(a) In this context, the term "room and board" includes performance of personal care services, including assistance in the activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room, and supervision and assisting in the use of durable medical equipment and prescribed therapies.

(4) The following services performed by hospice physicians are included in the rates described in (1) and (2) of this rule:

(a) general supervisory services of the medical director; and

(b) participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician member of the interdisciplinary group.

(5) For services not described in (4), medicaid will pay the hospice for those physician services furnished by hospice employees or under arrangements with the hospice in accordance with ARM 37.86.101, 37.86.104 and 37.86.105. Reimbursement for these physician services is included in the amount subject to the hospice limit described below. Services furnished voluntarily by physicians are not reimbursable.

(6) Services of the patient's attending physician, if he or she is not an employee of the hospice or providing services under arrangements with the hospice, are not considered hospice services and are not included in the amount subject to the hospice payment limit.

(7) Medicaid reimbursement to a hospice in a cap period is limited to a cap amount established using medicare principles.

(8) The department hereby adopts and incorporates by reference 42 CFR 418.309, as amended through October 1, 1988, which sets forth medicare's methodology for calculating the hospice cap amount. Copies of 42 CFR 418.309, as amended through October 1, 1988, are available from the Department of Public Health and Human Services, Health Policy and Services Division, 1400 Broadway, P.O. Box 202951, Helena, MT 59620-2951.

(9) The department will notify the hospice of the determination of program reimbursement at the end of the cap year.

(10) Payments made to a hospice during a cap period that exceed the cap amount are overpayments and must be refunded. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101, MCA; NEW, 1989 MAR p. 842, Eff. 7/1/89; TRANS, from SRS, 2000 MAR p. 489.)

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Subchapter 9

Home Dialysis for
End Stage Renal Disease

37.40.901 HOME DIALYSIS FOR END STAGE RENAL DISEASE, DEFINITION (1) Home dialysis service for end stage renal disease is the provision of equipment required for the renal dialysis of a recipient in his home.

(a) Related services includes training at a certified home dialysis training center for a recipient and a "back-up" person, if necessary, in dialysing a patient at home. (History: Sec. 53-6-113 MCA; IMP, Sec. 53-6-101 and 53-6-141 MCA; NEW, 1980 MAR p. 1789, Eff. 6/27/80; TRANS, from SRS, 2000 MAR p. 489.)

37.40.902 HOME DIALYSIS FOR END STAGE RENAL DISEASE, REQUIREMENTS These requirements are in addition to those contained in ARM 37.85.401, 37.85.402, 37.85.406, 37.85.407, 37.85.410 and 37.85.414.

(1) The provision of home dialysis and related services by the medicaid program shall be coordinated with the Title XVIII medicare renal disease program and any other program providing the same or similar service. Application for medicare benefit is required if medicaid coverage is to be allowed.

(2) Any interest in equipment accrued by means of lease or purchase by the department shall be retained by the department. In no case will a recipient have or be entitled to any property interest in the equipment leased or purchased.

(3) Home dialysis and related services shall be provided only to a person who has been diagnosed as suffering from chronic end stage renal disease by a physician.

(4) Medical necessity and appropriateness of the services shall be subject to review by the designated professional review organization.

(5) In all cases where feasible and necessary, a member of the recipient's household shall be trained as the "back-up" person. (History: Sec. 53-6-113 MCA; Sec. 53-6-101 and 53-6-141 MCA; NEW, 1980 MAR p. 1789, Eff. 6/27/80; TRANS, from SRS, 2000 MAR p. 489.)

Rules 03 and 04 reserved

37.40.905 HOME DIALYSIS FOR END STAGE RENAL DISEASE, REIMBURSEMENT (1) Reimbursement for equipment shall be the lesser of the following:

(a) the provider's usual and customary charges which are reasonable; or

(b) the medicaid established fee for that service.

(2) Payment to a nonrelated individual for "back-up" services shall be negotiated between the department and the provider on a case-by-case basis. Members of a recipient's family shall not be reimbursed for providing this service. Reimbursement shall only be allowed in those cases where a family member is not available to provide "back-up" services. (History: Sec. 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1789, Eff. 6/27/80; TRANS, from SRS, 2000 MAR p. 489; AMD, 2001 MAR p. 1476, Eff. 8/10/01; AMD, 2001 MAR p. 2156, Eff. 10/26/01.)

Subchapter 10 reserved

Subchapter 11

Personal Care

37.40.1101 PERSONAL CARE, SERVICES, SERVICES PROVIDED AND LIMITATIONS (1) Personal care services are medically necessary in-home services provided to medicaid recipients whose health conditions cause them to be functionally limited in performing activities of daily living. Personal care services are intended to prevent or delay institutionalization by providing medically necessary, long-term maintenance or supportive care in the home.

(2) Personal care includes assistance with the following activities:

(a) activities of daily living;

(b) household tasks; and

(c) escort services.

(3) Activities of daily living are limited to bathing, grooming, transferring, walking, eating, dressing, toileting, self-administered medication and meal preparation.

(4) Household tasks are limited to housekeeping activities, provided in accordance with the personal care plan and furnished in conjunction with activities of daily living, that are directly related to the recipient's medical needs. Household tasks include only:

(a) cleaning the area used by the recipient;

(b) changing the recipient's bed linens;

(c) doing the recipient's laundry; and

(d) shopping for groceries and household items essential to the health care, nutritional needs, and maintenance of the recipient.

(5) Escort services are provided by a personal care attendant who accompanies the recipient to a medical examination, treatment or for shopping to meet the recipient's essential health care or nutritional needs. Escort services are available to a recipient who requires personal care services enroute or at the destination, when a family member or caregiver is unable to accompany them.

(6) Personal care services may not include any skilled services that require professional medical training unless otherwise permitted under 37-8-103, MCA.

(7) Personal care services may not include services which maintain an entire household or family or which are not medically necessary. Personal care services do not include:

(a) cleaning floors and furniture in areas recipients do not use or occupy;

(b) laundering clothing or bedding recipients do not use;

(c) supervision, respite care, babysitting or visiting;

(d) maintenance of animals unless the animal is a certified service animal specifically trained to meet the safety needs of the recipient; and

(e) home and outside maintenance.

(8) Personal care provided by a member of the recipient's immediate family is not personal care services for the purposes of the medicaid program, and is not eligible for reimbursement.

(a) Immediate family member includes the following:

(i) husband or wife;

(ii) natural parent;

(iii) natural child;

(iv) natural sibling;

(v) adopted child;

(vi) adoptive parent;

(vii) stepparent;

(viii) stepchild;

(ix) step-brother or step-sister;

(x) father-in-law or mother-in-law;

(xi) son-in-law or daughter-in-law;

(xii) brother-in-law or sister-in-law;

(xiii) grandparent;

(xiv) grandchild;

(xv) foster parents; or

(xvi) foster child. (History: Sec. 53-6-113 and 53-6-201, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1102 PERSONAL CARE SERVICES, REQUIREMENTS (1) To qualify for personal care, a person must be medicaid eligible and demonstrate a medical need for personal care.

(2) Personal care services, except for escort services and household tasks, may be provided only in the recipient's home.

(3) Personal care services provided in licensed foster or group homes must be prior authorized by the department. Personal care services may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in foster or group home settings. For example, a person requiring additional assistance because of an acute medical episode or post-hospitalization period may receive personal care services in a foster or group home setting.

(4) Personal care services may not be provided to persons who reside in a hospital or long-term care facility as defined in 50-5-101, MCA, and licensed under 50-5-201, MCA.

(5) The recipient, in order to receive personal care services, must be capable of making choices about activities of daily living, understand the impact of these choices and assume responsibility for the choices or have someone residing within or outside the household willing to assist the recipient in decision making and to direct their activities.

(6) The type and amount of personal care services must be specified in a plan of care which governs delivery of services. The plan of care for a recipient must be approved by a physician and developed by a licensed nurse employed by a provider. The approval of the service plan must be renewed at least annually. The plan of care shall be developed based upon the completion of the department's recipient profile by the provider.

(7) The delivery of personal care services must be supervised by a licensed nurse.

(8) The recipient must agree to accept the provision of personal care services as specified in the plan of care.

(9) Household tasks and escort services must be provided only in conjunction with other personal care services and must be directly related to a recipient's medical needs.

(10) Household tasks may not account for more than 1/3 of the total time allocated per week for personal care services.

(11) Personal care services must be prescribed in writing at least annually by a physician and must be reviewed at least every 180 days by a licensed nurse.

(12) A recipient may receive personal care services through the medicaid home and community based services program for elderly and physically disabled persons or the medicaid home and community based services program for persons with developmental disabilities, in addition to the personal care services provided through these rules.

(13) Personal care providers must be independent contractors for purposes of federal and state wage and hour laws and workers' compensation laws. Personal care providers are limited to businesses incorporated under the laws of the state of Montana. Personal care providers must demonstrate that they are paying workers' compensation and unemployment insurance premiums.

(14) The department will enroll providers who provide the following documentation:

(a) the provider's articles of incorporation;

(b) a written contingency plan, approved by the department, addressing service delivery to clients in the event an agency is unable to deliver services in a timely manner or in the event the agency ceases operation;

(c) general liability insurance with a minimum coverage of $100,000 per person;

(d) motor vehicle liability insurance with a minimum coverage of $100,000 per person;

(e) current unemployment insurance and worker's compensation coverage;

(f) financial solvency, to include the ability to make a projected 4 month payroll; and

(g) a description of the proposed service area which must be defined to include at a minimum coverage of the entire area of at least one county or Indian reservation.

(15) The department may contract with out-of-state agencies to provide personal care services for Montana medicaid recipients living out of state.

(16) Personal care services may only be delivered by a personal care attendant employed by an enrolled medicaid provider that has met the criteria established by the department for the delivery of personal care services.

(17) Personal care services may not be provided to relieve a parent of child caring or other legal responsibilities.

(a) Personal care for disabled children may be appropriate when the parent is unqualified or otherwise unable to provide the personal care and the child is at risk of institutionalization unless the services are provided.

(18) Personal care services must be delivered in the most efficient manner available.

(19) Personal care services are not available to recipients who live in homes which are not safely accessible by normal modes of transportation.

(20) Personal care services may be terminated for any of the following reasons:

(a) the recipient or other persons in the household subjects the personal care attendant to physical or verbal abuse, sexual harassment, exposure to the use of illegal sustances or to threats of physical harm;

(b) the recipient requests termination of services or refuses to accept help;

(c) the environment of the recipient is unsafe for the provision of personal care services;

(d) the recipient's physician requests termination of services;

(e) the recipient no longer has a medical need for personal care services;

(f) the recipient refuses the services of a personal care attendant based solely or partly on the attendant's race, creed, religion, sex, marital status, color, age, handicap or national origin; or

(g) the recipient refuses to accept services in accord with the plan of care.

(21) The department may terminate or reduce personal care services when funding for services is unavailable.

(22) The provider shall give at least 10 days advance notice to a recipient when personal care services are terminated for reasons listed in (20)(d) through (20)(g).

(23) The provider may immediately but temporarily suspend services for the reasons listed in (20)(a) through (20)(c). Following the temporary suspension of services the provider may enter into an agreement with the recipient to ensure that the violations of (20)(a) through (20)(c) do not reoccur. If the recipient fails to abide by the term of the agreement services may be permanently terminated.

(24) The department shall provide written notice to an applicant when personal care services are initially denied to the applicant.

(25) A person may request a fair hearing for any adverse determination made by the department. Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.310, 37.5.313, 37.5.316, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101, 53-6-131 and 53-6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Rules 03 and 04 reserved

37.40.1105 PERSONAL CARE SERVICES, REIMBURSEMENT

(1) Personal care services may be provided up to but not more than 40 hours of attendant service per week per recipient as defined by the plan of care. The department may, within its discretion, authorize additional hours in excess of this limit. Any services exceeding this limit must be prior authorized by the department. Prior authorization for excess hours may be authorized if additional assistance is required:

(a) for a period of time not to exceed 3 months and as the result of an acute medical episode;

(b) for a period of time not to exceed 3 months and to prevent institutionalization during the absence of the normal caregiver; or

(c) for a period of time not to exceed 3 months and during a post-hospitalization period.

(2) Reimbursement for personal care services is $2.64 per 15 minute unit of service. The rate is for units of attendant and nurse supervision service.

(a) A unit of attendant service is 15 minutes and means an on-site visit specific to a recipient.

(b) A unit of nurse supervision service is 15 minutes and means an on-site recipient visit and related activity specific to that recipient.

(3) A person retained personally by a recipient to deliver personal care services is not a provider of personal care services for the purposes of this rule and therefore may not be reimbursed for personal care services by the department.

(4) Reimbursement is not available for personal care provided by immediate family members. (History: Sec. 53-2-201 and 53-6-113, MCA; IMP, Sec. 53-6-101 and 53-6-141, MCA; NEW, 1980 MAR p. 1105, Eff. 3/28/80; AMD, 1980 MAR p. 2979, Eff. 11/29/80; AMD, 1981 MAR p. 559, Eff. 6/12/81; AMD, 1981 MAR p. 1975, Eff. 1/1/82; AMD, 1982 MAR p. 1289, Eff. 7/1/82; AMD, 1987 MAR p. 372, Eff. 4/17/87; AMD, 1988 MAR p. 1259, Eff. 7/1/88; AMD, 1989 MAR p. 982, Eff. 7/28/89; AMD, 1993 MAR p. 1363, Eff. 6/25/93; AMD, 1995 MAR p. 1191, Eff. 7/1/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1106 PERSONAL CARE SERVICES, PROVIDER COMPLIANCE

(1) Providers of personal care services shall be subject to compliance reviews to provide assurance to the department that services are being provided within the rules and policy of the program.

(2) Compliance reviews shall be conducted by department staff on the provider's premises.

(3) The reviews shall take place:

(a) on an annual basis;

(b) 90 days after the enrollment of a new provider; and

(c) at other times as determined by the department.

(4) The department shall determine compliance in the following service delivery areas:

(a) response to referrals;

(b) service initiation;

(c) physician orders;

(d) recipient needs intake;

(e) service delivery;

(f) attendant orientation to recipient;

(g) supervisory visits;

(h) service breaks;

(i) prior authorization; and

(j) service termination.

(5) The department shall determine compliance in the following administrative areas:

(a) attendant basic training;

(b) attendant in service training;

(c) nurse licensure;

(d) response to complaints;

(e) maintenance of incident reports;

(f) recipient surveys;

(g) attendant pool; and

(h) development of agency manuals and handouts.

(6) The department may choose to review other areas of the program at its discretion.

(7) The department shall examine 15 cases or 5% of the provider's case load for the purpose of the compliance review.

(8) The provider must meet all standards in 90% of the cases to be considered in compliance. If 90% compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled.

(9) The provider must meet all standards in 90% of the cases in the second review or it will be subject to department sanctions as provided in ARM 37.85.401, 37.85.502, 37.85.505, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513. (History: Sec. 53-6-101, 53-6-113 and 53-2-201, MCA; IMP, Sec. 53-6-101 and 53-6-113, MCA; NEW, 1995 MAR p. 1191, Eff. 7/1/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

Subchapter 12 reserved

Subchapter 13

Self-Directed Personal Assistance Services

37.40.1301 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, DESCRIPTION AND PURPOSE (1) Self-directed personal assistance services are medically necessary in-home services provided to medicaid consumers whose disability functionally limits performing activities of daily living, and who take the responsibility or have a representative to take the responsibility of managing the services. Self-directed personal assistance services are intended to provide control of service delivery to the consumer and to allow the consumer to direct health related tasks.

(2) Consumers will provide their physician or health care professional evidence of ability to manage their personal assistance services.

(a) The scope and detail of the evidence shall be determined by the physician or health care professional.

(3) Consumers who are unable to utilize self-directed personal assistance services may receive services through the personal assistance services program managed by provider agencies under agreement with medicaid. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

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37.40.1302 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, APPLICATION OF GENERAL PERSONAL CARE RULES (1) The following ARM cites apply to the self-directed personal assistance services program:

(a) ARM 37.40.1101(2) through (5), (7) and (8), pertaining to a description of services provided;

(b) ARM 37.40.1102(2), (4), (5), (9), (10), (12), (17), (18), (21) and (25), pertaining to requirements, limitations and termination of services;

(c) ARM 37.40.1105 pertaining to reimbursement; and

(d) ARM 37.40.1106(1), (6) and (9), pertaining to compliance reviews.

(History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

Rules 03 and 04 reserved

37.40.1305 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, CONSUMER REQUIREMENTS (1) To qualify for self-directed personal assistance, the consumer must:

(a) have a medical condition which results in the need for personal assistance services;

(b) be capable of assuming the management responsibilities of assistants or have an immediately involved representative willing to assume this responsibility;

(c) have authorization from a physician or health care professional to participate in the program; and

(d) be capable of making choices about activities of daily living, understand the impact of these choices and assume the responsibility of the choices.

(2) The consumer must be capable of acting as though the personal assistant is their employee for the purposes of selection, management and supervision of the personal assistant, although the personal assistant is the employee of a self-directed personal assistance provider.

(a) The consumer has the primary responsibility in the scheduling, training and supervision of the personal assistant. The consumer has the right to require that a particular assistant discontinue providing services to the consumer.

(b) The consumer may have an immediately involved representative assume some or all of the responsibilities imposed by this rule. An immediately involved representative is a person who is directly involved in the day to day care of the consumer. An immediately involved representative must be available to assume the responsibility of managing the consumer's care, including directing the care as it occurs in the home. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

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37.40.1306 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PLAN OF CARE REQUIREMENTS (1) A consumer must develop a service plan and have it approved annually by a physician or health care professional prior to receiving self-directed personal assistance services. The plan must include:

(a) the consumer's need for personal assistance services as documented by the provider agency through completion of the department's personal assistance services consumer profile;

(b) tasks assigned to the personal assistant;

(c) an emergency back-up plan;

(d) a training plan for assistants performing health related tasks;

(e) a method for recruiting personal assistants; and

(f) a schedule to update the consumer profile by the provider agency at least once every 180 days. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1307 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, PROVIDER REQUIREMENTS (1) Self-directed personal assistance providers have the following responsibilities:

(a) assist consumers to identify resources for personal assistants;

(b) advise the consumer regarding program participation;

(c) determine the amount of services available to the consumer by completing the consumer profile;

(d) re-certify consumer needs every 180 days;

(e) review the plan of care; and

(f) act as the employer of record for personal assistants for the purposes of payroll and federal hiring practices. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

37.40.1308 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, GENERAL REQUIREMENTS (1) Health maintenance activities include urinary system management, bowel treatments, administration of medications and wound care.

(2) Self-directed personal assistance providers are limited to businesses organized under the laws of the state of Montana.

(3) Self-directed personal assistance services may only be delivered by an individual who is the employee of a medicaid enrolled provider and who is selected by the consumer or their immediately involved representative.

(4) Personal assistance services managed by provider agencies under agreement with medicaid are not available to individuals participating in the self-directed personal assistance program.

(a) The use of personal assistance services managed by provider agencies may be permissible in the event that the consumer's emergency back up plan fails.

(5) Home health skilled nursing services are not available to consumers for the completion of health maintenance activities which the consumer has been authorized to manage.

(a) The use of home health skilled nursing services may be permissible in the event that the consumer's emergency back up plan fails.

(6) Consumers who have been terminated from the self-directed program may apply for personal assistance services through the medicaid personal assistance services program managed by approved provider agencies. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS, from SRS, 2000 MAR p. 489.)

Rules 09 through 14 reserved

37.40.1315 SELF-DIRECTED PERSONAL ASSISTANCE SERVICES, COMPLIANCE REVIEWS (1) Compliance reviews shall be conducted on the provider by department staff at the provider's premises.

(a) Completion of the compliance review may require participation from the consumer.

(2) The compliance reviews shall be conducted:

(a) on an annual basis; or

(b) at other times, as determined by the department.

(3) The department shall determine compliance in the following areas:

(a) service delivery;

(b) service authorization;

(c) records maintenance;

(d) assistant surveys; and

(e) consumer surveys.

(4) Providers must achieve a 90% compliance rate as provided in ARM 37.40.1106.

(5) Providers have two opportunities to achieve a 90% compliance rate or the following may occur:

(a) providers shall be subject to department sanctions as provided in ARM 37.85.401, 37.85.502, 37.85.505, 37.85.506, 37.85.507, 37.85.511, 37.85.512 and 37.85.513. (History: Sec. 53-6-113 and 53-6-145, MCA; IMP, Sec. 53-6-101 and 53-6-145, MCA; NEW, 1995 MAR p. 2823, Eff. 12/22/95; TRANS & AMD, from SRS, 2000 MAR p. 1653, Eff. 6/30/00.)

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Subchapter 14

Home and Community-based Services

37.40.1401 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS AUTHORITY AND SCOPE OF PROGRAM

(1) The United States department of health and human services (HHS) has granted the department, through 42 CFR 441.300 through 441.310, the authority to establish a program of medicaid funded home and community-based services for persons who are elderly or who have physical disabilities and who would otherwise have to reside in and receive medicaid reimbursed care in a hospital or nursing facility.

(2) The department, in accordance with state and federal statutes and rules governing the provision of medicaid funded home and community-based services and any federal-state agreements governing the provision of medicaid funded home and community-based services and within the available funding appropriated for the program, may determine within its discretion:

(a) the types of services to be available through the program;

(b) the amount, scope and duration of the services available through the program;

(c) the categories of persons to be served through the program;

(d) the total number of persons who may receive services through the program;

(e) the total number of persons who may receive services through the program by category of eligibility, geographical area or specific case management team; and

(f) eligibility of individual persons for the program.

(3) There is no entitlement to eligibility for the program. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-131, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 02 through 05 reserved

37.40.1406 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SERVICES (1) The services available through the program are limited to those specified in this rule.

(2) The department may determine the particular services of the program to make available to a recipient based on, but not limited to, the following criteria:

(a) the recipient's need for a service generally and specifically;

(b) the availability of a specific service through the program and any ancillary service necessary to meet the recipient's needs;

(c) the availability otherwise of alternative public and private resources and services to meet the recipient's need for the service;

(d) the recipient's risk of significant harm or of death if not in receipt of the service;

(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; or

(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.

(4) Bases for denying a service to a person include, but are not limited to:

(a) the person requires more supervision than the service can provide;

(b) the person's needs, inclusive of health, can no longer be effectively or appropriately met by the service;

(c) access to the service, even with reasonable accommodation, is precluded by the person's health or other circumstances;

(d) a necessary ancillary service is no longer available; and

(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(5) The department may make program services for persons with intensive needs available to a recipient whom it determines, based on past medical history and current medical diagnosis, would otherwise require on a long term basis the level of care of an inpatient hospital or a rehabilitation service setting.

(6) The following services, as defined in these rules, may be provided through the program:

(a) case management services;
(b) homemaking;
(c) personal assistance;
(d) adult day health;
(e) habilitation;
(f) respite care;
(g) personal emergency response systems;
(h) nutrition services;
(i) environmental accessibility adaptations;
(j) nonmedical transportation;
(k) outpatient physical therapy;
(l) outpatient occupational therapy;
(m) speech pathology and audiology;
(n) respiratory therapy;
(o) nursing;
(p) psycho-social consultation; and
(q) dietetic services;
(r) adult residential care;
(s) specially trained attendant care;
(t) chemical dependency counseling;
(u) cognitive rehabilitation;
(v) comprehensive day treatment;
(w) community residential rehabilitation;
(x) supported living;
(y) specialized medical equipment and supplies;
(z) specialized child care for children with AIDS; and
(aa) behavioral programming.

(7) Monies available through the program may not be expended on the following:

(a) room and board; and
(b) special education and related services as defined at 20 USC 1401(16) and (17).

(8) A service available through the program is not available to any extent that a service of another program is otherwise available to a recipient to meet the recipient's need for that service. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1407 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: GENERAL REQUIREMENTS

(1) Services of the program may only be provided by or through a provider that is enrolled with the department as a medicaid provider or that is under contract with a provider the department is contracting with for home and community-based case management services.

(2) A facility providing services to a recipient must meet all licensing requirements including fire and safety standards.

(3) A provider of service must meet the requirements necessary for the receipt of reimbursement with medicaid monies.

(4) A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include:

(a) a spouse; and

(b) a natural or adoptive parent of a minor child.

(5) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1408 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENROLLMENT (1) A person in order to be considered by the department for enrollment in the program, must be determined by the department to qualify for enrollment in accordance with the criteria in this rule.

(2) A person is qualified to be considered for enrollment in the program if the person:

(a) meets one of the following criteria:

(i) is 65 years of age or older; or

(ii) is certified as disabled by the social security administration but does not have a primary diagnosis of mental retardation or serious mental illness.

(b) is medicaid eligible;

(c) requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, 37.40.206 and 37.40.207.

(d) does not reside in a hospital or a nursing facility; and

(e) has needs that can be met through the program.

(3) The department considers for an available opening for services those persons who, as determined by the department:

(a) are actively seeking services;

(b) are in need of the services available;

(c) are likely to benefit from the available services; and

(d) have a projected total cost of plan of care that is within the limits specified at ARM 37.40.1421.

(4) The department offers an available opening for services to the person, as determined by the department, who is most in need of the available services and most likely to benefit from the available services.

(5) Factors to be considered in the determinations of whether a person is in need of the available services and likely to benefit from those services and as to which person is most likely to benefit from the available services include, but are not limited to, the following:

(a) medical condition;

(b) degree of independent mobility;

(c) ability to be alone for extended periods of time;

(d) presence of problems with judgment;

(e) presence of a cognitive impairment;

(f) prior enrollment in the program;

(g) current institutionalization or risk of institutionalization,

(h) risk of physical or mental deterioration or death;

(i) willingness to live alone;

(j) adequacy of housing;

(k) need for adaptive aids or environmental modifications;

(l) need for 24 hour supervision;

(m) need of person's caregiver for relief;

(n) need, in order to receive services, of a waiver of the medicaid deeming financial eligibility requirement;

(o) appropriateness for the person, given the person's current needs and risks, of services available through the program;

(p) status of current services being purchased otherwise for the person; and

(q) status of support from family, friends and community.

(6) A person enrolled in the program may be removed from the program by the department. Bases for removal from the program, include, but are not limited to, the following:

(a) a determination by the case management team that the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person's needs;

(b) the failure of the person to use the services as provided for in the plan of care;

(c) the behaviors of the person place the person, caregivers or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care;

(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;

(e) a determination by the case management team that the service providers necessary to the delivery of services as provided for in the plan of care are unavailable; and

(f) a determination that the total cost of plan of care is not within the limits specified at ARM 37.40.1421. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-113, 53-6-131 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 09 through 14 reserved

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37.40.1415 HOME AND COMMUNITY BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: REIMBURSEMENT (1) Services available through the program are reimbursed as specified in this rule.

(2) The following services are reimbursed as provided in (3):

(a) environmental accessibility adaptations;

(b) homemaking;

(c) adult day health;

(d) habilitation;

(e) personal emergency response systems;

(f) nutrition;

(g) psycho-social consultation;

(h) nursing;

(i) respiratory therapy;

(j) dietetic services;

(k) specially trained attendant care;

(l) behavioral programming;

(m) chemical dependency counseling;

(n) cognitive rehabilitation;

(o) comprehensive day treatment;

(p) community residential rehabilitation;

(q) supported living;

(r) specialized child care for children with AIDS;

(s) adult residential care;

(t) respite care not provided by a nursing facility; and

(u) nonmedical transportation.

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

(a) the provider's usual and customary charge for the service; or

(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service as a service of the general medicaid program.

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general medicaid program:

(a) personal assistance as provided at ARM 37.40.1105 and 37.40.1302;

(b) outpatient occupational therapy as provided at ARM 37.86.610;

(c) outpatient physical therapy as provided at ARM 37.86.610;

(d) speech therapy as provided at ARM 37.86.610; and

(e) audiology as provided at ARM 37.86.705.

(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.

(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.

(8) Specialized medical equipment and supplies are reimbursed as follows:

(a) equipment and supplies which are reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806 and 37.86.1807 shall be reimbursed as provided in ARM 37.86.1807;

(b) equipment and supplies which are not reimbursable under ARM 37.86.1801, 37.86.1802, 37.86.1806 and 37.86.1807 shall be reimbursed at the lower of the following:

(i) 100% of the provider's usual and customary charge for the item; or

(ii) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(9) Reimbursement is not available for the provision of a service to a person that may be reimbursed through another program.

(10) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with medicaid monies.

(11) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-101, 53-6-111, 53-6-113 and 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00; AMD, 2004 MAR p. 82, Eff. 1/1/04.)

Rules 16 through 19 reserved

37.40.1420 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PLANS OF CARE (1) A plan of care is a written plan of supports and interventions based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.

(2) The services that a recipient may receive through the program and the amount, scope and duration of those services must be specifically authorized in writing through an individual plan of care for the person.

(3) The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least 6 months beginning with the date of the initial plan of care.

(4) Each plan of care is developed, reviewed and revised by the case management team.

(5) The case management team in developing the plan of care consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals and others who have knowledge of the recipient's needs.

(6) Each plan of care must include the following:

(a) diagnosis, symptoms, complaints and complications indicating the need for services;

(b) a description of the recipient's functional level;

(c) objectives;

(d) any orders for:

(i) medication;

(ii) treatments;

(iii) restorative and rehabilitative services;

(iv) activities;

(v) therapies;

(vi) social services;

(vii) diet; and

(viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care.

(e) the specific services to be provided, the frequency of the services, and the type of provider to provide them;

(f) the projected annualized costs of each service; and

(g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.

(7) The case management team must provide a copy of the plan to the recipient.

(8) Plan of care approval is based on:

(a) completeness of plan;

(b) consistency of plan with screening criteria; and

(c) feasibility of service provision, including cost-effectiveness of plan as provided for in ARM 37.40.1421. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1421 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COST OF PLAN OF CARE (1) In order to maintain the program cost within the appropriated monies, the cost of plans of care for recipients may be limited by the department collectively and individually.

(2) The total annual cost of services for each recipient, except as provided in (3), may not exceed a maximum amount set by the department based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature.

(3) The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:

(a) the excess service need is short term and only a one time purchase is necessary;

(b) the excess service need is intensive services of 90 days or less which are necessary to:

(i) resolve a crisis situation which threatens the health and safety of the recipient;

(ii) stabilize the recipient following hospitalization or acute medical episode; or

(iii) prevent institutionalization during the absence of the normal caregiver;

(c) the excess service need is adult residential services; or

(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.

(4) The cost of services to be provided under a plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

(5) A cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 22 through 25 reserved

37.40.1426 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NOTICE AND FAIR HEARING

(1) The department provides written notice to an applicant for and recipient of services when a determination is made by the department concerning:

(a) financial eligibility;

(b) level of care;

(c) feasibility, including cost-effectiveness of services to the recipient; and

(d) termination of recipient's eligibility for the program.

(2) The department provides a recipient of services with notice 10 working days before termination of services due to a determination of ineligibility.

(3) A person aggrieved by any adverse final determinations as listed in (1)(a) through (1)(d) or any adverse determinations regarding services in the plan of care may request a fair hearing as provided in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337.

(4) Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334 and 37.5.337. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 27 through 29 reserved

37.40.1430 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: CASE MANAGEMENT, REQUIREMENTS

(1) Case management is the planning for, arranging for, implementation of and monitoring of the delivery of services available through the program to a recipient.

(2) Case management services includes:

(a) developing a plan of care for a recipient;

(b) monitoring and managing a plan of care for a recipient;

(c) establishing relationships and contracting with service providers and community resources;

(d) maximizing a recipient's efficient use of services and community resources such as family members, church members and friends;

(e) facilitating interaction among people working with a recipient;

(f) prior authorizing the provision of all services; and

(g) managing expenditures.

(3) The case management team consists of a registered nurse and a social worker.

(4) The case management team must:

(a) function as directed by the department;

(b) assure that services provided to recipients are of appropriate quality and cost effective;

(c) provide case management services to no more than the number of persons specified by the department;

(d) manage expenditures within the allocated monies; and

(e) meet the department's reporting requirements. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 31 through 34 reserved

37.40.1435 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT RESIDENTIAL CARE, REQUIREMENTS (1) Adult residential care is the provision of supportive services to a recipient residing in an adult foster home, a residential hospice, or a personal care facility.

(2) Adult residential care may include:

(a) personal care services as specified at ARM 37.40.1101(1) through (5);

(b) homemaking as specified at ARM 37.40.1450;

(c) social activities;

(d) recreational activities;

(e) medication oversight; and

(f) assistance in arranging transportation for medical care.

(3) Adult residential care must provide for 24 hour on site response staff to meet scheduled or unpredictable needs of recipients and to provide supervision of recipients for safety and security.

(4) A recipient of adult residential care may not receive the following services through the program:

(a) personal assistance as specified at ARM 37.40.1447;

(b) homemaking services as specified at ARM 37.40.1450;

(c) environmental accessibility adaptation services as specified at ARM 37.40.1485.

(d) respite care as specified at ARM 37.40.1451;

(e) medical alert personal emergency response system as specified at ARM 37.40.1486; and

(f) nutrition as specified in ARM 37.40.1476. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rule 36 reserved

37.40.1437 HOME AND COMMUNITY-BASED SERVICES TREATMENT FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMMUNITY RESIDENTIAL REHABILITATION, REQUIREMENTS (1) Community residential rehabilitation is the provision of 24 hour care to a recipient in both a comprehensive day treatment setting as specified in ARM 37.40.1446 and in one of the following supervised residential settings: an adult foster home or a personal care facility.

(2) An entity providing community residential rehabilitation services, must provide services 24 hours a day for 7 days a week.

(3) An entity providing community residential rehabilitation must meet the requirements of ARM 37.40.1435 and 37.40.1446.

(4) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1438 COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SUPPORTED LIVING, REQUIREMENTS

(1) Supported living is the provision of supportive services to a recipient residing in an individual residence or in a group living situation. It is a comprehensive service designed to support a person with brain injury or other severe disability.

(2) Supported living services may include:

(a) independent living evaluation;

(b) service coordination;

(c) 24 hour supervision of the person;

(d) health and safety supervision;

(e) homemaking services as specifed at ARM 37.40.1450;

(f) day habilitation as specified at ARM 37.40.1448;

(g) habilitation aide as specified at ARM 37.40.1448;

(h) behavioral programming as specified at 37.40.1465;

(i) supported employment as specified at ARM 37.40.1448;

(j) prevocational training as specified at ARM 37.40.1448;

(k) nonmedical transportation as specified at ARM 37.40.1488; and

(l) specially trained attendants as specified at ARM 37.40.1449.

(3) An entity providing supported living services must meet the following criteria:

(a) be accredited by the commission on accreditation of rehabilitation facilities (CARF) or by the council on quality in the areas of integrated living, congregate living, personal, social and community services, community employment services and work services; and

(b) have 2 years experience in providing services to persons with physical disabilities.

(4) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 39 through 44 reserved

37.40.1445 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ADULT DAY HEALTH (1) Adult day health is the provision of services to meet the health, social and habilitation needs of a recipient in settings outside the recipient's place of residence. An entity providing adult day health services must be licensed as provided at ARM 16.32.1001, et seq. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1446 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COMPREHENSIVE DAY TREATMENT, REQUIREMENTS (1) Comprehensive day treatment is the provision of therapeutic intervention to a recipient with brain injury on a week day basis in a non-residential setting. Comprehensive day treatment assists in reducing the dependency of the recipient and in facilitating the integration of the recipient into the community.

(2) Comprehensive day treatment services may include:

(a) cognitive rehabilitation as specified at ARM 37.40.1467;

(b) behavioral programming as specified at ARM 37.40.1465;

(c) chemical dependency counseling as specified at ARM 37.40.1466;

(d) therapeutic recreational activities;

(e) nutrition services as specified in ARM 37.40.1476;

(f) nonmedical transportation as specified at ARM 37.40.1488; and

(g) counseling.

(3) An entity providing comprehensive day treatment services, must provide services from 8 a.m. to 5 p.m. during the 5 working days of the week.

(4) An entity providing comprehensive day treatment services must be under the direction of an interdisciplinary team consisting of a licensed psychologist, a licensed neuropsychologist, a board certified physiatrist, therapists and other appropriate support staff.

(5) An entity providing comprehensive day treatment services must be accredited or in the process of becoming accredited by the commission on accreditation of rehabilitation facilities (CARF) as a community reentry program for persons with brain injury.

(6) This service must be prior authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1447 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PERSONAL ASSISTANCE, REQUIREMENTS (1) Personal assistance is the provision of an array of personal care and other services to a recipient for the purpose of meeting personal needs in the home and the community. (2) Personal assistance services includes the provision of the following services:

(a) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308;

(b) homemaking services as specified at ARM 37.40.1450;

(c) supervision for health and safety reasons; and

(d) nonmedical transportation as specified at ARM 37.40.1488.

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308.

(4) The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308 and 37.40.1315 govern the provision of personal assistance services. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1448 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: HABILITATION, REQUIREMENTS

(1) Habilitation is the provision of intervention services designed for assisting a recipient to acquire, retain and improve the self-help, socialization and adaptive skills necessary to reside successfully at home and in the community.

(2) Habilitation services may include:

(a) residential habilitation;

(b) day habilitation;

(c) prevocational services;

(d) supported employment; and

(e) habilitation aide.

(3) Residential habilitation is habilitation provided in a community home for persons with physical disabilities.

(4) Day habilitation is habilitation provided in a day service setting.

(5) Prevocational services are habilitative activities that foster employability for a recipient who is not expected to join the general work force or participate in a transitional sheltered workshop within a year by preparing the recipient for paid or unpaid work. Prevocational services include teaching compliance, attendance, task completion, problem solving and safety.

(6) Supported employment is intensive ongoing support to assist a recipient who is unlikely to obtain competitive employment in performing work activities in a variety of settings, particularly work sites where nondisabled persons are employed. Supported employment service includes supervision, training and other activities needed to sustain paid work by a recipient.

(7) Habilitation aide is the assistance of an aide directed at fostering the recipient's ability to achieve independence in instrumental activities of daily living such as homemaking, personal hygiene, money management, transportation, housing and use of community resources. Habilitation aide services include conducting an assessment and the provision of training and teaching.

(8) An entity inclusive of its staff, providing habilitation services must be qualified generally to provide the services and specifically to meet each recipient's defined habilitation needs. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1449 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS (1) Specially trained attendant care is the provision of supportive services to a recipient residing in their own residence.

(2) Specially trained attendant care services may include:

(a) personal assistance services as specified at ARM 37.40.1447; and

(b) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307 and 37.40.1308.

(3) A person providing specially trained attendant care must be an employee of a medicaid enrolled personal assistance provider, trained in accordance with the department's training requirements by the provider and others to deliver the services that meet the specific needs of the recipient. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1450 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: HOMEMAKING, REQUIREMENTS

(1) Homemaking is the provision of general household activities or chore services to a recipient when the recipient is unable to manage the recipient's home or care for self or others in the home, or when another who is regularly responsible for these responsibilities is absent.

(2) Homemaking may include:

(a) household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing;

(b) social restorative services consisting of assistance which further a recipient's involvement with activities and other persons; and

(c) teaching services consisting of activities which improve a recipient's or family's skills in household management and social functioning.

(3) Homemaking services do not include the provision of personal care as specified at ARM 37.40.1101 and 37.40.1302.

(4) A person providing homemaking services must be:

(a) physically and mentally able to perform the duties required; and

(b) literate and able to follow written orders. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1451 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPITE CARE, REQUIREMENTS

(1) Respite care is the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility.

(2) Respite care services may be provided only on a short term basis, such as part of a day, weekends or vacation periods.

(3) Respite care services may be provided in a recipient's place of residence or through placement in another private residence or other related community setting, a hospital, a nursing facility or a therapeutic camp.

(4) A person providing respite care services must be:

(a) physically and mentally qualified to provide this service to the recipient; and

(b) aware of emergency assistance systems.

(5) A person who provides respite care services to a recipient may be required by the case management team to have the following when the recipient's needs so warrant:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of common medications and related conditions of the recipient; and

(c) capability to administer basic first aid. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1452 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALIZED CHILD CARE FOR CHILDREN WITH AIDS, REQUIREMENTS (1) Specialized child care for children with AIDS is the provision of day care, respite care, and other direct and supportive care to a recipient under 18 years of age who is HIV positive or has a diagnosis of AIDS and who, due to medical and other needs, cannot be served through traditional child care settings.

(2) A person providing specialized child care for children with AIDS services must be:

(a) physically and mentally able to perform the duties;

(b) aware of emergency assistance systems; and

(c) literate and able to follow written orders.

(3) A person providing specialized child care for children with AIDS services may be required, if appropriate to the circumstances of the recipient, to have:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of the recipient's commonly needed medications and the conditions for which they are administered; and

(c) the capability to administer basic first aid. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 53 through 59 reserved

37.40.1460 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS (1) Outpatient occupational therapy services may include:

(a) occupational therapy services as specified at ARM 37.86.601; and

(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient occupational therapy services provided at ARM 37.86.601, 37.86.605, 37.86.606 and 37.86.610, govern the provision of outpatient occupational therapy services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-5-205, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-5-205, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1461 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: OUTPATIENT PHYSICAL THERAPY, REQUIREMENTS (1) Outpatient physical therapy services may include:

(a) physical therapy services as specified at ARM 37.86.601; and

(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient physical therapy services at ARM 37.86.601, 37.86.605, 37.86.606 and 37.86.610, govern the provision of outpatient physical therapy services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1462 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPEECH PATHOLOGY AND AUDIOLOGY, REQUIREMENTS (1) Speech pathology and audiology services may include:

(a) speech therapy services as defined at ARM 37.86.601;

(b) audiology services as defined at ARM 37.86.702;

(c) services for habilitative or maintenance purposes;

(d) screening and evaluation with respect to speech and hearing functions;

(e) comprehensive audiological assessment, as indicated by screening results, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;

(f) assessments of the use of amplification;

(g) provision for procurement, maintenance and replacement of hearing aids, as specified by a qualified audiologist;

(h) comprehensive speech and language evaluation, as indicated by screening results, including appraisal of articulation, voice, rhythm and language;

(i) participation in the continuing interdisciplinary evaluation for purposes of beginning, monitoring and following up on individualized habilitation programs; and

(j) treatment services as an extension of the evaluation process, that include:

(i) direct counseling with a recipient;

(ii) consultation with appropriate persons involved with a recipient for speech improvement and speech education activities; and

(iii) work with an appropriate recipient to develop specialized programs for developing communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization and skills in expression, including improvement in articulation, voice, rhythm and language.

(2) The requirements for the delivery of speech therapy services at ARM 37.86.605 and 37.86.606 and for audiology services at ARM 37.86.701 and 37.86.702 govern the provision of speech pathology and audiology services.

(3) No visit limitation exists for maintenance therapy. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1997 MAR p. 1269, Eff. 7/22/97; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1463 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: RESPIRATORY THERAPY, REQUIREMENTS (1) Respiratory therapy is the provision of direct respiratory treatment, ongoing assessment of respiratory and medical conditions, equipment monitoring and upkeep, pulmonary education and respiratory rehabilitation.

(2) A certified respiratory therapy technician, as defined by the national board for respiratory care, may assist under the direct supervision of a registered respiratory therapist or physician who is responsible for and participates in the recipient's treatment program. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1464 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PSYCHO-SOCIAL CONSULTATION, REQUIREMENTS (1) Psycho-social consultation is consultation with providers and caregivers directly involved with a recipient and the development and monitoring of behavior programs.

(2) Psycho-social consultation services may include those services as specified at ARM 37.88.601 and 37.88.605.

(3) Requirements for the delivery of psychological services as specified at ARM 37.88.601 and 37.88.605 govern the provision of psycho-social consultation. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1990 MAR p. 2184, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1465 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: BEHAVIORAL PROGRAMMING, REQUIREMENTS (1) Behavioral programming is the continuous in-depth assessment on a short term basis of a recipient with brain injury.

(2) Behavioral programming services includes assessment, if appropriate, of the abilities and effectiveness of caregivers.

(3) A person providing behavioral programming services, must:

(a) have a bachelor's degree;

(b) be employed by a rehabilitation agency; and

(c) be under the direct supervision of a licensed neurologist, board certified psychiatrist, or board certified physiatrist who has experience in working with persons with brain injury.

(4) This service is limited to 80 hours per plan of care year unless otherwise authorized by the department. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1466 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: CHEMICAL DEPENDENCY COUNSELING, REQUIREMENTS (1) Chemical dependency counseling is the provision of counseling to a recipient with a substance abuse problem by a certified chemical dependency counselor.

(2) Chemical dependency counseling services may be provided on an individual or group basis.

(3) A person providing chemical dependency counseling services for a recipient with brain injury must be a state certified chemical dependency counselor who has received training in the needs of persons with brain injury and the provision of brain injury services. The counselor must provide proof of such training in the form of a training certificate or diploma. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1467 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: COGNITIVE REHABILITATION, REQUIREMENTS (1) Cognitive rehabilitation is the provision of therapeutic cognitive activities to meet the functional needs of a recipient with brain injury.

(2) Cognitive rehabilitation services may include:

(a) the reinforcement, strengthening, or reestablishment of previously learned patterns of behavior;

(b) the establishment of new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems; and

(c) training significant others to assist in meeting the functional needs of the recipient.

(3) A person providing cognitive rehabilitation services, must be:

(a) employed by a rehabilitation agency; and

(b) under the direct supervision of a licensed psychologist, licenced neuropsychologist, board certified neurologist, or board certified physiatrist who has experience in working with persons with brain injury. (History: 53-2-201, 53-6-113, 53-6-402, MCA; IMP, 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 68 through 74 reserved

37.40.1475 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: DIETETIC SERVICES, REQUIREMENTS (1) Dietetic services are the management of a person's nutritional needs.

(2) Dietetic services may include evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education and dietetic research necessary for the management of a recipient's nutritional needs.

(3) Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1476 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NUTRITION, REQUIREMENTS

(1) Nutrition services are meals, congregate meals and home delivered meals as specified at ARM 37.41.302 including the meals on wheels program.

(2) The requirements for the delivery of nutrition services as specified at ARM 37.41.306 through 37.41.315 govern the provision of nutrition services.

(3) A full nutritional regimen of three meals a day may not be provided through this service. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1477 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NURSING, REQUIREMENTS

(1) Nursing is the provision of individual and continuous nursing care.

(History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

Rules 78 through 84 reserved

37.40.1485 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: ENVIRONMENTAL ACCESSIBILITY ADAPTATION, REQUIREMENTS (1) Environmental accessibility adaptations are modifications to a recipient's home designed to maintain or improve the recipient's ability to remain at home.

(2) Environmental accessibility adaptation services may include:

(a) modifications to a personal vehicle that allow the recipient to be more independent;

(b) the installation of specialized electrical and plumbing systems to accommodate necessary medical equipment and supplies;

(c) consultation regarding the appropriateness of an adaptation; and

(d) facilitation of the ability of a caregiver or service provider to maintain a recipient at home.

(3) An environmental accessibility adaptation must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) provide for the recipient's access to the home environment and increased independence and safety in the home;

(c) be reasonably expected to promote the recipient's functional ability or the ability of the caregiver to maintain the recipient at home;

(d) be the most cost effective adaptation among the adaptations that are available to meet the recipient's needs; and

(e) meet the 1980 specifications set by the American national standards institute.

(4) Environmental accessibility adaptation services do not include:

(a) general housing maintenance, including but not limited to plumbing, heating systems, or appliance repair; or

(b) measures to facilitate leisure time activities.

(5) The department may require review and approval by a consultant for certain types of environmental accessibility adaptations.

(6) A recipient may only receive any one environmental accessibility adaptation once unless the department specifically authorizes the repurchase of an adaptation. (History: Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101 and 53-6-402, MCA; NEW, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1486 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: PERSONAL EMERGENCY RESPONSE SYSTEMS, REQUIREMENTS (1) A personal emergency response system is an electronic device or mechanical system used to summon assistance in an emergency situation.

(2) A personal emergency response system must be connected to a local emergency response unit with the capacity to activate emergency medical personnel.

(3) The provision of a personal emergency response system as a service does not include the purchase, installation or routine monthly charges of a telephone. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1487 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a recipient for the purpose of maintaining and improving the recipient's ability to reside at home and to function in the community.

(2) The provision of medical equipment and supplies services may include:

(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and

(b) the provision of supplies and care necessary to maintain a service animal.

(3) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) substantively meet the recipient's needs for accessibility, independence, health, or safety;

(c) be likely to improve the recipient's functional ability or the ability of a caregiver or service provider to maintain the recipient in the recipient's home; and

(d) be the most cost effective item that can meet the needs of the recipient.

(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.

(5) Specialized medical equipment and supplies services do not include:

(a) items used for leisure and recreational purposes only;

(b) items of clothing;

(c) basic household furniture; or

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit.

(6) A service animal is an animal trained to undertake particular tasks on behalf of a recipient that the recipient can not perform and that are necessary to meet the recipient's needs for accessibility, independence, health, or safety.

(7) A service animal does not include any of the following:

(a) pets, companion animals, and social therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

(8) Supplies necessary for the performance of a service animal may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal to meet the specific needs of the recipient. Supplies do not include food to maintain the service animals.

(9) Care necessary to the health and maintenance of a service animal may include, but is not limited to, veterinarian care, transportation for veterinarian care, license, registration, and where the recipient or recipient's primary care giver is unable to perform it, grooming.

(10) Certain items of medical equipment or supplies for short term use, as specified by the department, may be leased or rented instead of purchased.

(11) The department may require a consultation prior to the purchase of certain equipment and supplies. (History: Sec. 53-2-201, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-6-402, MCA; NEW, 2000 MAR p. 2023, Eff. 7/28/00.)

37.40.1488 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY AND PHYSICALLY DISABLED PERSONS: NONMEDICAL TRANSPORTATION, REQUIREMENTS (1) Nonmedical transportation is the provision to a recipient of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

(3) Nonmedical transportation providers must provide proof of:

(a) a valid Montana driver's license;

(b) adequate automobile insurance; and

(c) assurance of vehicle compliance with all applicable federal, state and local laws and regulations.

(4) Nonmedical transportation services must be provided by the most cost effective mode.

(5) Nonmedical transportation services are available only for the transport of recipients to and from activities that are included in the individual plan of care. (History: Sec. 53-2-201, 53-6-101, 53-6-113 and 53-6-402, MCA; IMP, Sec. 53-2-201, 53-6-101, 53-6-141 and 53-6-402, MCA; NEW, 1983 MAR p. 863, Eff. 7/15/83; AMD, 1986 MAR p. 2094, Eff. 1/1/87; AMD, 1988 MAR p. 1268, Eff. 7/1/88; AMD, 1991 MAR p. 470, Eff. 12/14/90; TRANS & AMD, from SRS, 2000 MAR p. 2023, Eff. 7/28/00.)

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