



**Rules of
Department of Health and
Senior Services**

**Division 30—Division of Regulation and Licensure
Chapter 81—Certification**

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**Title 19—DEPARTMENT OF
HEALTH AND SENIOR SERVICES
Division 30—Division of Regulation and
Licensure
Chapter 81—Certification**

**19 CSR 30-81.010 General Certification
Requirements**

PURPOSE: This rule sets forth application procedures and general certification requirements for nursing facilities certified under the Title XIX (Medicaid) program and skilled nursing facilities under Title XVIII (Medicare), and procedures to be followed by nursing facilities when requesting a nurse staffing waiver.

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

(1) Definitions.

(A) Certification means the determination by the Division of Aging or the Health Care Financing Administration that a licensed skilled nursing or intermediate care facility (SNF/ICF) is in substantial compliance with all federal requirements and is approved to participate in the Medicaid or Medicare programs.

(B) Cost reporting year means the facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period that the facility uses for its federal income tax reporting.

(C) Distinct part means a portion of an institution or institutional complex that is certified to provide SNF or NF services. A distinct part must be physically distinguishable from the larger institution and must consist of all beds within the designated area. The distinct part may be a separate building, floor, wing, ward, hallway or several rooms at one end of a hall or one side of a corridor.

(D) Division means the Division of Aging (DA), Missouri Department of Social Services.

(E) HCFA means the Health Care Financing Administration section of the United States Department of Health and Human Services (HHS).

(F) ICF/MR means intermediate care facility for mentally retarded.

(G) Medicaid means Title XIX of the federal Social Security Act.

(H) Medicare means Title XVIII of the federal Social Security Act.

(I) Nursing facility (NF) means an SNF or ICF licensed under Chapter 198, RSMo which has signed an agreement with the Department of Social Services to participate in the Medicaid program and which is certified by the Division of Aging. As used within the contents of this rule, licensed SNFs, SNF/ICF and ICFs participating in the Medicaid program are subject to state and federal laws and regulations for participation as an NF.

(J) Skilled nursing facility (SNF) means an SNF licensed under Chapter 198, RSMo which has a signed agreement with the HCFA to participate in the Medicare program and which has been recommended for certification by the Division of Aging.

(K) Title XVIII means the Medicare program as provided for in the federal Social Security Act.

(L) Title XIX means the Medicaid program as provided for in the federal Social Security Act.

(2) An operator of an SNF or ICF licensed by the division electing to be certified as a provider of skilled nursing services under the Title XVIII (Medicare) or NF services under the Title XIX (Medicaid) program of the Social Security Act; or an operator of a facility electing to be certified as an ICF/MR facility under Title XIX shall submit application materials to the division as required by federal law and shall comply with standards set forth in the *Code of Federal Regulations* (CFR) of the United States Department of Health and Human Services in 42 CFR chapter IV, part 483, subpart B for nursing homes and 42 CFR chapter IV, part 483, subpart I for ICF/MR facilities, as appropriate.

(A) For Medicaid, the application shall include:

1. Form HCFA 671, Long Term Care Facility Application for Medicare and Medicaid;

2. Form HCFA 1513, Disclosure of Ownership and Control Interest Statement; and

3. Form DA-113, Bed Classification for Licensure and Certification by Category.

(B) For Medicare, the application shall include:

1. Form HCFA 671, Long Term Care Facility Application for Medicare and Medicaid;

2. Form HCFA 855, Health Care Provider/Supplier Application;

3. Expression of Intermediary Preference Form;

4. Form DA-113, Bed Classification for Licensure and Certification by Category;

5. Three (3) copies of form HCFA 1561, Health Insurance Benefit Agreement;

6. Two (2) copies of form HCFA 2572, Statement of Financial Solvency; and

7. Three (3) copies of form HHS 690, Assurance of Compliance.

(C) SNFs or NFs which are newly certified or which are undergoing a change of ownership shall submit an initial certification fee in the amount up to one thousand dollars (\$1,000) as stipulated by the division in writing to the operator following receipt of the properly completed application material referenced in subsection (2)(A) or (2)(B). The amount for the initial certification fee shall be the prorated portion of one thousand dollars (\$1,000) with prorating based on the month of receipt of the application in relation to the beginning of the next federal fiscal year. This initial certification fee shall be nonrefundable and a facility not be certified until the fee has been paid. The facility shall complete all requirements for certification prior to the end of the federal fiscal year in which application was made. If not, an additional certification fee of one thousand dollars (\$1,000) shall be submitted to the division by October 1 or the application shall be considered withdrawn.

(D) All SNFs or NFs certified to participate in the Medicaid or Medicare program(s) shall submit to the division an annual certification fee of one thousand dollars (\$1,000) prior to October 1 of each year. If the fee is not received by that date each year a late fee of fifty dollars (\$50) per month shall be payable to the division. If payment of any fees due is not received by the division by the time the facility license expires or by December 31 of that year, whichever is earlier, the division shall notify the Division of Medical Services and the Health Care Financing Administration recommending termination of the Medicaid or Medicare agreement as denial of license will occur as provided in 13 CSR 15-10.010 and section 198.022, RSMo.

(3) Application material shall be signed and dated and submitted to the division's central office at least fourteen (14) working days prior to the date the facility is ready to be surveyed for compliance with federal regulations. The operator or authorized representative shall notify the appropriate division



regional office by letter or by phone as to the date the facility will be ready to be surveyed. There shall be at least two (2) residents in the facility before a survey can be conducted. The facility shall already be licensed or with licensure in process shall be in compliance with all state rules.

(4) Any facility certified for participation as an NF in the Title XIX Medicaid program electing to participate in the Title XVIII Medicare program shall submit an application signed and dated to the division's central office. The division will recommend Medicare certification to the HCFA effective the date the application material is received by the division or a subsequent date if requested by the provider, provided the facility was in compliance with all federal and state regulations for SNFs at the last survey conducted by the division and provided the facility's application is complete and has been approved by the Medicare fiscal intermediary.

(5) Any facility certified for participation in the Medicare program wishing to participate in the Medicaid program shall submit a signed and dated application to the division's central office. The division will certify the facility for Medicaid participation effective the date the application is received by the division or a subsequent date requested by the provider, provided the facility was in compliance with all federal regulations at the last survey conducted by the division and the application is complete.

(6) For newly certified facilities, the facility will be certified for either Medicare or Medicaid participation effective the date the facility receives a license at the proper level or the date the facility achieves substantial compliance with the federal participation requirements, whichever is the later date. The application shall be completed. For certification in the Title XVIII (Medicare) program, the Medicare fiscal intermediary must approve the application and the HCFA must concur with the division's recommendation.

(7) The division shall conduct federal surveys in SNFs, NFs and ICF/MR facilities, utilizing regulations and procedures contained in—

(A) *The State Operations Manual (SOM)* (HCFA Publication 7);

(B) The Survey and Certification Regional letters received by the division from the HCFA regional office in Kansas City;

(C) For SNFs and NFs, federal regulation 42 CFR chapter IV, part 483, subpart B; and

(D) For ICF/MR facilities, federal regulation 42 CFR chapter IV, part 483, subpart I.

(8) A facility, in its application, shall designate the number of beds to be certified and the location in their facility. A facility can be wholly or partially certified. If partially certified, the beds shall be in a distinct part of the facility and all beds shall be contiguous.

(9) If a facility certified to participate in the Title XIX (Medicaid) or Title XVIII (Medicare) program elects to change the size of its distinct part, it must submit a written request to the Licensure/Certification Unit or the ICF/MR Unit of the division, as applicable. The request shall specify the room numbers involved, the number of beds in each room and the facility cost reporting year end date. The request must include a floor diagram of the facility and a signed DA-113 form, Bed Classification for Licensure and Certification by Category. A facility is allowed two (2) changes in the size of its distinct part during the facility cost reporting year. This may be two (2) increases or one (1) increase and one (1) decrease. It may not be two (2) decreases. The first change can be done only at the beginning of the facility cost reporting year and the second change can be done effective at the beginning of a facility cost reporting quarter within that facility cost reporting year. All requests must be submitted to the Licensure/Certification Unit or the ICF/MR Unit of the division at least forty-five (45) days in advance. Any facility wishing to eliminate its distinct part to go to full certification may do so effective at the beginning of the next facility cost reporting year with forty-five (45) days notice. The distinct part may be reestablished only at the beginning of the next facility cost reporting year. A facility may change the location of the distinct part with thirty (30) days notice to the Licensure/Certification Unit or the ICF/MR Unit of the division.

(10) If a facility certified to participate in the Title XIX (Medicaid) or Title XVIII (Medicare) program undergoes a change of operator, the new operator shall submit an application as specified in section (2) of this rule. The application shall be submitted within five (5) working days of the change of operator. For applications made for the Title XIX (Medicaid) program, the division shall provide the application to the Division of Medical Services of the Department of Social Services so that a provider agreement can be negotiated and signed. For applications made for the Title XVIII (Medicare) program, the division shall provide the application to the HCFA. Certification status will be retained unless or until formally denied.

(11) If it is determined by the division that a facility certified to participate in Medicaid or Medicare does not comply with federal regulations at the time of a federal survey, complaint investigation or state licensure inspection, the division shall take enforcement action using the regulations and procedures contained in the following sources:

(A) 42 CFR chapter IV, part 431, subparts D, E and F;

(B) 42 CFR chapter IV, part 442;

(C) Sections 1819(h) and 1919(h) of the Social Security Act;

(D) 42 U.S.C. 1396(r);

(E) Sections 198.026 and 198.067, RSMo; and

(F) 13 CSR 70-10.015 and 13 CSR 70-10.030.

(12) If a facility certified to participate in the Medicaid Title XIX program has been decertified as a result of noncompliance with the federal requirements, the facility can be readmitted to the Medicaid program by submitting an application for initial participation in the Medicaid program. After having received the application, the division shall conduct a survey at the earliest possible date to determine if the facility is in substantial compliance with all federal participation requirements. The effective date of participation will be the date the facility is found to substantially comply with all federal requirements.

(13) If a change in the administrator or the director of nursing of a facility occurs, the facility shall provide written notice to the division's central office at the time of the change. The notice shall indicate the effective date of the change, the identity of the new director of nursing or administrator and a copy of his/her license or the license number. A change of administrator is also part of the licensure application process; therefore, the information shall be submitted as a notarized statement by the operator in accordance with section 198.018, RSMo.

(14) An NF may request a waiver of nurse staffing requirements to the extent the facility is unable to meet the requirements including the areas of twenty-four (24)-hour licensed nurse coverage, the use of a registered nurse for eight (8) consecutive hours seven (7) days per week and the use of a registered nurse as director of nursing.

(A) Requests for waivers shall be made in writing to the deputy director, Division of Aging.

(B) Requests for waivers will be considered only from facilities licensed under



Chapter 198, RSMo as ICFs which do not have a nursing pool agency that is within fifty (50) miles, within state boundaries, and which can supply the needed nursing personnel.

(C) The division shall consider each request for a waiver and shall approve or disapprove the request in writing within thirty (30) working days of receipt or, if additional information is needed, shall request from the facility the additional information or documentation within ten (10) working days.

(D) Approval of a nurse waiver request shall be based on an evaluation of whether the facility has been unable, despite diligent efforts—including offering wages at the community prevailing rate for nursing facilities—to recruit the necessary personnel. Diligent effort shall mean prominently advertising for the necessary nursing personnel in a variety of local and out-of-the-area publications, including newspapers and journals within a fifty (50)-mile radius, and which are within state boundaries; contacts with nursing schools in the area; and participation in job fairs. The operator shall submit evidence of the diligent effort including:

1. Copies of newspapers and journal advertisements, correspondence with nursing schools and vocational programs, and any other relevant material;

2. If there is a nursing pool agency within fifty (50) miles which is within state boundaries and the agency cannot consistently supply the necessary personnel on a per-diem basis to the facility, the operator shall submit a letter from the agency so stating;

3. Copies of current staffing patterns including the number and type of nursing staff on each shift and the qualifications of licensed nurses;

4. A current form HCFA 672, Resident Census and Conditions of Residents;

5. Evidence that the facility has a registered nurse consultant required under 13 CSR 15-14.042(36)(B) and evidence that the facility has made arrangements to assure registered nurse involvement in the coordination of the assessment process as required under 42 CFR 20(c)(1)(ii);

6. Location of the nurses' stations and any other pertinent physical feature information the facility chooses to provide;

7. Any other information deemed important by the facility including personnel procedures, promotions, staff orientation and evaluation, scheduling practices, benefit programs, utilization of supplemental agency personnel, physician-nurse collaboration, support services to nursing personnel and the like; and

8. For renewal requests, the information supplied shall show diligent efforts to recruit appropriate personnel throughout the prior waiver period. Updates of prior submitted information in other areas are acceptable.

(E) In order to meet the conditions specified in federal regulation 42 CFR 483.30, the following shall be considered in granting approval:

1. There is assurance that a registered nurse or physician is available to respond immediately to telephone calls from the facility for periods of time in which licensed nursing services are not available;

2. There is assurance that if a facility requesting a waiver has or admits after receiving a waiver any acutely ill or unstable residents requiring skilled nursing care, the skilled care shall be provided in accordance with state licensure rule 13 CSR 15-14.042(6); and

3. The facility has not received a Class I notice of noncompliance in resident care within one hundred twenty (120) days of the waiver request or the division has not conducted an extended survey in the facility within one (1) year of the waiver request. Any facility which receives a Class I notice of noncompliance in resident care or an extended survey while under waiver status will not have the waiver renewed unless the problem has been corrected and steps have been taken to prevent recurrence. If a facility received more than one (1) Class I notice of noncompliance in resident care during a waiver period, the Division of Aging will consider revocation of the waiver.

(F) The facility shall cooperate with the Division of Aging in providing the proper documentation. For renewal requests, the request and proper documentation shall be submitted to the Division of Aging at least forty-five (45) days prior to the ending date of the current waiver period. If any changes occur during a waiver period that affect the status of the waiver, a letter shall be submitted to the deputy director of institutional services within ten (10) days of the changes. The request for a waiver or renewal of a waiver shall be denied if the facility fails to abide by these previously mentioned time frames.

(G) If a waiver request is denied, the division shall notify the facility in writing and within twenty (20) days, the facility shall submit to the division a written plan for how the facility will recruit the required personnel. If appropriate personnel are not hired within two (2) months, the division shall initiate enforcement proceedings.

*AUTHORITY: sections 208.151 and 536.021, RSMo 2000. * This rule originally filed as 13*

CSR 15-9.010. Emergency rule filed Sept. 18, 1990, effective Oct. 1, 1990, expired Jan. 25, 1991. Original rule filed Nov. 2, 1990, effective June 10, 1991. Amended: Filed June 3, 1993, effective Dec. 9, 1993. Amended: Filed Feb. 1, 1995, effective Sept. 30, 1995. Amended: Filed May 11, 1998, effective Nov. 30, 1998. Amended: Filed Nov. 27, 2000, effective July 30, 2001. Emergency amendment filed July 13, 2001, effective July 30, 2001, expired Feb. 28, 2002. Moved to 19 CSR 30-81.010, effective Aug. 28, 2001. Amended: Filed July 13, 2001, effective Feb. 28, 2002.

**Original authority: 208.151, RSMo 1967, amended 1973, 1981, 1982, 1987, 1988, 1989, 1990, 1991, 1993, 1995, 2001 and 536.021, RSMo 1975, amended 1976, 1989, 1992, 1993, 1994, 1997.*

19 CSR 30-81.015 Resident Assessment Instrument

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

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

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

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



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

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

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

(3) Resident assessments shall be documented on the MDS and the RAPs shall be utilized.

(4) Frequency of Assessments.

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

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

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

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

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

(6) A paper copy of all MDSs and RAP summary sheets completed for each resident shall be in the resident's record. A facility may document on the MDS form additional information regarding a resident which is not included in the standard MDS, or may use a version of the MDS which has special codes or notations, but if information is added, the additional information shall be either in an appendix or the facility shall provide a copy of the MDS in its standard form without the

additional information for use in review. All MDSs and RAP summary sheets completed within the last two (2) years must be easily retrievable from the resident's record if requested by a representative of the Division of Aging or the federal survey and certification agency.

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

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

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

AUTHORITY: section 536.021, RSMo Supp. 1993. This rule originally filed as 13 CSR 15-9.015. Emergency rule filed Dec. 18, 1990, effective Dec. 31, 1990, expired April 29, 1991. Emergency rule filed May 7, 1991, effective May 17, 1991, expired Sept. 13, 1991. Original rule filed Dec. 18, 1990, effective June 10, 1991. Emergency amendment filed June 16, 1992, effective Aug. 1, 1992, expired Nov. 28, 1992. Amended: Filed*

June 16, 1992, effective Feb. 26, 1993. Emergency amendment filed May 14, 1993, effective June 1, 1993, expired Sept. 28, 1993. Emergency amendment filed July 14, 1993, effective July 25, 1993, expired Nov. 21, 1993. Amended: Filed May 14, 1993, effective Dec. 9, 1993. Moved to 19 CSR 30-81.015, effective Aug. 28, 2001.

**Original authority: 536.021, RSMo 1975, amended 1976, 1989, 1992, 1993.*

19 CSR 30-81.020 Prolong-Term Care Screening

PURPOSE: This rule establishes the requirement and procedure for screening by the Division of Aging of Medicaid-eligible and potentially Medicaid-eligible individuals considering long-term care, in order to acquaint them at the earliest possible time with all services available to them, to determine on a preliminary basis their level-of-care need and to permit an effective evaluation by a Division of Aging worker of the resources available in the home, family and community, as required by 42 CFR 456.370(c)(7).

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

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

(A) Initial Assessment Form means the Division of Aging form utilized to collect information necessary for a determination of level-of-care need pursuant to 13 CSR 15-9.030, designated Form DA-124;

(B) Intermediate care facility (ICF) as defined in section 198.006, RSMo;

(C) Long-term care facility means an ICF, a skilled nursing facility (SNF), as defined in section 198.006, RSMo, or a hospital providing skilled or intermediate nursing care in a distinct part under Chapter 197, RSMo;

(D) Make a referral means a contact by telephone, referring the name and address of the potential Medicaid recipient and any



other available pertinent information about the potential Medicaid recipient;

(E) Medicaid agency means the single state agency administering or supervising the administration of the Missouri State Medicaid plan;

(F) Medical assistance means benefits provided under section 208.152, RSMo;

(G) Participation in the Medicaid program means the ability and authority to provide services to eligible Medicaid recipients and to receive payment from the Medicaid program for the services;

(H) Potential Medicaid resident means any individual who—*a*) has already been determined by the Division of Family Services to be eligible for Medical Assistance benefits, *b*) has applied to the Division of Family Services for Medical Assistance benefits or *c*) has less than one thousand dollars (\$1000) in cash and liquid assets if single or less than two thousand dollars (\$2000) in cash and liquid assets if married;

(I) Provider means an SNF, an ICF or a hospital providing skilled or intermediate nursing care in a distinct part under Chapter 197, RSMo which has been certified to participate in the Medicaid program;

(J) Resident as defined in section 198.006, RSMo; and

(K) Skilled nursing facility, or SNF, as defined in section 198.006, RSMo.

(2) All providers shall make a referral to the toll-free Division of Aging hotline (1-800-392-0210) within one (1) working day after the facility is initially contacted by or on behalf of a potential Medicaid resident unless the potential Medicaid resident is, at the time of the initial contact—

(A) Residing in another long-term care facility as a Medicaid resident;

(B) In a hospital and had been in a long-term care facility as a Medicaid resident immediately prior to the hospitalization;

(C) In a hospital and hospital staff can document they have made a referral to the Division of Aging;

(D) Residing in a state hospital for the mentally ill operated under Chapter 630, RSMo or a state habilitation center operated under Chapter 630, RSMo; and

(E) A child (seventeen (17) years of age or under).

(3) In order to document that referrals to the Division of Aging have been made as required by this rule, providers shall provide the following information, with regard to each resident applying for Medicaid benefits, on the Initial Assessment Form:

(A) The date the provider was initially contacted by or on behalf of the resident concerning admission to an long-term care facility;

(B) The date the resident was initially admitted to the provider's facility;

(C) The date a referral was made to the Division of Aging and the screening referral number assigned by the Division of Aging hotline when the referral was made; and

(D) If the provider did not make a referral to the Division of Aging, an explanation of why no referral was made.

(4) When the provider makes a referral to the Division of Aging, the Division of Aging will contact the potential Medicaid resident or his/her guardian within five (5) working days of the date of the referral. The Division of Aging will provide the potential Medicaid resident with information regarding services available to meet the individual's needs in the home, if the services are available and with information regarding long-term care facilities. If the individual or his/her guardian wishes to receive services in a home-based setting, the Division of Aging will evaluate the individual to determine the potential availability of alternative services and advise the individual or guardian that if s/he wish to obtain financial assistance for these services, s/he will need to apply for Title XIX benefits at the respective County Division of Family Services Office. Once the application is made, services may be authorized by the Division of Aging. If the individual or his/her guardian has no objection, the individual's relatives and other significant persons, including the attending physician, may be included in discussions. If the person wants to enter an long-term care facility s/he will be given a Division of Aging DA-13 form with documentation of the screening referral number to give to the provider to verify that alternatives to long-term care facility care have been presented.

(5) The Medicaid agency may terminate or suspend the participation in the Medicaid program of a provider determined to have demonstrated a consistent pattern or practice of failing to comply with this rule. The Medicaid agency shall offer a provider the opportunity for a hearing as required by 42 CFR sections 431.151—431.154.

(6) The Medicaid agency may withhold or recoup Medicaid payments to a provider for services provided to a resident from the time of admission to a provider's facility until the recipient is determined eligible for ICF or SNF level-of-care if the provider failed to

make a referral of that resident to the Division of Aging as required by this rule. This recoupment or withholding shall be accomplished utilizing the procedures, and after providing prior notice to the provider, set out at 13 CSR 70-3.030(5) and 13 CSR 70-10.005(9). Providers from whom payments have been withheld or recouped pursuant to this section shall not charge or attempt to charge the resident or his/her responsible party for the amount withheld or recouped by the Medicaid agency.

(7) The Medicaid agency shall not impose the sanctions provided for in section (5) or withhold or recoup in accordance with section (6) of this rule as a result of any failure to make a referral where the provider made a good faith effort to determine whether the resident in question was a potential Medicaid resident but received incorrect or incomplete information.

AUTHORITY: sections 207.020 and 208.159, RSMo 1986 and 208.153, RSMo Supp. 1991. This rule was previously filed as 13 CSR 40-81.086 and 13 CSR 15-9.020. Emergency rule filed March 14, 1984, effective April 12, 1984, expired Aug. 8, 1984. Original rule filed March 14, 1984, effective Aug. 9, 1984. Amended: Filed Aug. 3, 1992, effective May 6, 1993. Moved to 19 CSR 30-81.020, effective Aug. 28, 2001.*

**Original authority: 207.020, RSMo 1945, amended 1961, 1965, 1977, 1981, 1982, 1986; 208.159, RSMo 1979; and 208.153, RSMo 1967, amended 1967, 1973, 1989, 1990, 1991.*



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF AGING
LTACS CLIENT REPORT

INITIAL	CORR	UPDATE	REASS	CLOSE	REASON

A. CLIENT INFORMATION

NAME		STREET ADDRESS			CITY		ZIP																
DCN	SSN	R	S	DOB	CO	LA	REF	INC	INC TYPE	XIX													
DEINST	MM	YY	MON	MEDS	TRTS	REST	REHB	PC	BEH	MOB	DIET	LOC	ENV	G/B	TLTG	SH/TR	HOUS	SUPS	FIN	ANE	GDN	ALZ	BLD

B. TITLE XIX SERVICES

SERV	OPEN	CLOSE	SERV	OPEN	CLOSE	DA-II EXPIRES	DATE OF PAS
REASON FOR CLOSING TXIX							

C. NON-TITLE XIX PURCHASED SERVICES

FIRST PROVIDER NAME				PROVIDER NO		SECOND PROVIDER NAME				PROVIDER NO	
FUND	SERV	UNITS	OPEN	CLOSE	PROV	FUND	SERV	UNITS	OPEN	CLOSE	PROV

D. MISCELLANEOUS

SSBG CO-PAY	MM	YY	DATE OF DA-2	CASELOAD NO.	SIGNATURE	DATE

E. COMMENTS



19 CSR 30-81.030 Evaluation and Assessment Measures for Title XIX Recipients and Applicants in Long-Term Care Facilities

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

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

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

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

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

(C) Initial assessment forms—the forms utilized to collect information necessary for a determination of level-of-care need pursuant to 19 CSR 30-81.030 and designated Forms DA-124 A/B (dated 6-05) and DA-124 C (dated 4-05) and Notice To Applicant Form, DA-124C ATT. (attachment) (dated 12-01), incorporated by reference in this rule and available through the Department of Health and Senior Services website: www.dhss.mo.gov or by mail at: Department of Health and Senior Services Warehouse, Attention General Services Warehouse, PO Box 570, Jefferson City, Missouri 65102-0570; telephone: (573) 526-3861; fax: (573) 751-1574, shall be considered the approved Initial Assessment Forms. This rule does not incorporate any subsequent amendments or additions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) Required documentation on the DA-124 C form shall include the resident's physician's signature and his or her Physician Identification Number.

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

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

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

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

(5) Assessed Needs Point Designations Requirements.

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

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



actually received or required that care, medication or treatment within the thirty (30) days prior to review and evaluation by the department.

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

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

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

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

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

1. Responding to verbal direction or the sound of an alarm;
2. Moving at a reasonable speed; and
3. If using a wheelchair or other assistive device, such as a walker or cane, being

able to transfer into the wheelchair or reach the assistive device without staff assistance.

(G) Points will be assigned to each category, as required by subsection (4)(B) of this rule, in multiples of three (3) according to the following requirements:

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

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

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

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

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

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

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

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

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

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

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

A. Zero (0) points if restorative services are not required;

B. Three (3) points if assessed as requiring minimum services in order to maintain level of functioning;

C. Six (6) points if assessed as requiring moderate services in order to restore the individual to a higher level of functioning; and

D. Nine (9) points if assessed as requiring maximum services in order to restore to a higher level of functioning. These are intensive services, usually requiring professional supervision or direct services;

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

A. Zero (0) points if assessed as requiring only routine monitoring, such as monthly weights, temperatures, blood pressures and other routine vital signs and routine supervision;

B. Three (3) points if assessed as requiring minimal monitoring, in that the



applicant or recipient requires periodic assessment due to mental impairment, monitoring of mild confusion, or both, or periodic assessment of routine procedures when the recipient's condition is stable;

C. Six (6) points if assessed as requiring moderate monitoring, in that the applicant or recipient requires recurring assessment of routine procedures due to the applicant's or recipient's unstable physical or mental condition; and

D. Nine (9) points if assessed as requiring maximum monitoring, which is intensive monitoring usually by professional personnel due to applicant's or recipient's unstable physical or mental condition;

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

A. Zero (0) points if assessed as requiring no medication, or has not required PRN medication within the thirty (30) days prior to review and evaluation by the department;

B. Three (3) points if assessed as requiring any regularly scheduled medication and the applicant or recipient exhibits a stable condition;

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Zero (0) points if assessed as requiring no assistance with personal care in

that the applicant or recipient is an independent, self-care individual. No assistance is required with personal grooming; the applicant or recipient has complete bowel and bladder control;

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

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

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

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

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

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

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

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

AUTHORITY: sections 192.006 and 198.079, RSMo 2000 and 660.050, RSMo Supp. 2004. This rule was previously filed as 13 CSR 40-81.084 and 13 CSR 15-9.030. Original rule filed Aug. 9, 1982, effective Nov. 11, 1982. Emergency rescission filed Nov. 24, 1982, effective Dec. 4, 1982,*



expired March 10, 1983. Rescinded: Filed Nov. 24, 1982, effective March 11, 1983. Readopted: Filed Dec. 15, 1982, effective March 11, 1983. Emergency amendment filed Dec. 21, 1983, effective Jan. 1, 1984, expired April 11, 1984. Emergency amendment filed March 14, 1984, effective April 12, 1984, expired June 10, 1984. Amended: Filed March 14, 1984, effective June 11, 1984. Moved to 19 CSR 30-81.030, effective Aug. 28, 2001. Emergency amendment filed June 20, 2005, effective July 1, 2005, expired Dec. 27, 2005. Amended: Filed June 20, 2005, effective Dec. 30, 2005.

**Original authority: 192.006, RSMo 1993, amended 1995; 198.079, RSMo 1979; and 660.050, RSMo 1984, amended 1988, 1992, 1993, 1994, 1995, 2001.*