

Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

Provider Manual



**Iowa Department
of Human Services**



Iowa
Department
of Human
Services

Provider

**Intermediate Care Facilities for the
Intellectually Disabled (ICF/ID)**

Page

1

Date

May 1, 2014

TABLE OF CONTENTS

Chapter I. General Program Policies

Chapter II. Member Eligibility

Chapter III. Provider-Specific Policies

Chapter IV. Billing Iowa Medicaid

Appendix

III. Provider-Specific Policies





TABLE OF CONTENTS

	<u>Page</u>
CHAPTER III. PROVIDER-SPECIFIC POLICIES.....	1
A. INTERMEDIATE CARE FACILITIES ELIGIBLE TO PARTICIPATE	1
B. ADMINISTRATION	1
1. Governing Body.....	1
2. Records.....	2
a. Personal Needs Accounts	3
b. Resident Records.....	4
3. Services Provided Under Agreements with Outside Sources.....	5
C. APPEALS OF ADVERSE ACTIONS	5
D. ARRANGEMENTS MADE WITH THE RESIDENT.....	6
1. Financial Participation.....	6
2. Personal Needs Allowance	8
3. Medicare, Veterans, and Similar Benefits.....	9
4. Resident Care Agreement	10
E. AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS.....	11
F. CERTIFICATION PROCESS	12
1. Certification of Need.....	12
a. Inclusion in the Community.....	12
b. Family-Scale Size	12
c. Location in Community Residential Neighborhood.....	12
2. License.....	13
3. Provider Agreements.....	14
4. Survey and Certification.....	15
G. MEDICAID ELIGIBILITY.....	17
1. Application Procedure	17
2. Continued Stay Reviews	18
3. Eligibility for Services	18
a. Placement Approved	19
b. Placement Not Approved.....	20



	<u>Page</u>
H. PHYSICAL ENVIRONMENT.....	20
1. Bedrooms.....	20
2. Disaster Plans and Drills	21
3. Resident Bathrooms.....	22
4. Safety.....	22
I. PROTECTION OF RESIDENTS' RIGHTS.....	24
1. Communication with Residents, Parents, and Guardians	25
2. Health Care Services	26
a. Dental Services	26
b. Dietetic Services.....	27
c. Laboratory Services	28
d. Pharmacy Services.....	29
e. Physician Services	31
f. Nursing Services.....	32
3. Management of Inappropriate Resident Behavior.....	33
a. Drug Usage.....	34
b. Oversight Committee	34
c. Physical Restraints.....	35
d. Time-Out Rooms	36
4. Safeguarding Personal Property	36
5. Staff Treatment of Residents	37
J. PROVISION OF SERVICES	38
1. Individual Program Plan.....	38
a. Program Implementation	40
b. Program Monitoring and Change	40
2. Resident Assessment.....	41
3. Staff Conduct Toward Residents.....	41
K. RESIDENT ADMISSIONS	42
L. STAFF	44
1. Direct Care Staff.....	44
2. Nursing Staff.....	45
3. Professional Program Staff	45
4. Qualified Intellectual Disability Professional	47
5. Staff Training Program	47



	<u>Page</u>
M. TRANSFER AND DISCHARGE.....	48
1. Administrative Procedures.....	49
2. Closing of Facility.....	50
3. Department Procedures	51
4. Reasons for Discharge or Transfer	51
5. Transfer of Residents by Ambulance	52
N. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS	52
1. ICF/ID Provider Assessment Fee	52
2. Method of Reimbursement	53
3. Time Frames for Submitting Claims	53
4. Periods of Service for Which Payment Will Be Authorized	54
a. Absence for Hospitalization	55
b. Absence for Visits	55
c. Payment Rate for Reserved Beds	56
d. Payment After Medical Eligibility Denial	56
5. Supplementation	57



CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. INTERMEDIATE CARE FACILITIES ELIGIBLE TO PARTICIPATE

This manual contains the policies and procedures governing care in intermediate care facilities for the intellectually disabled (ICFs/ID), when provided under the Medicaid program. The Medicaid program is administered by the states under regulations established by the United States Department of Health and Human Services. Facilities may become certified as Medicaid providers by meeting program, administrative, and facility conditions of participation.

The policies in this manual are from rules promulgated for the Medicaid ICF/ID program by the Department of Human Services at 441 Iowa Administrative Code (IAC) Chapter 82. These are based on Code of Federal Regulations sections entitled "Conditions of Participation for Intermediate Care Facilities for the Intellectually Disabled," found at 42 CFR 483, Subpart I.

The Department of Health and Human Services has provided further clarification through interpretive guidelines prepared to assist survey agencies, program participants, and certifying agencies to identify program intent. These guidelines are published as an addendum to the ICF/ID licensing rules at 481 CFR 64.

In this manual, Medicaid members who receive care in an ICF/ID are referred to as "residents." The Department of Human Services is referred to as "the Department."

B. ADMINISTRATION

1. Governing Body

The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- ◆ Exercise general policy, budget, and operating direction over the facility;
- ◆ Set the qualifications for the administrator of the facility (in addition to those already set by state law); and
- ◆ Appoint the administrator.



2. Records

The facility shall, at a minimum, maintain the following records:

- ◆ All records required by the Department of Public Health and Department of Inspections and Appeals.
- ◆ Residents' medical records.
- ◆ Records of all treatments, drugs, and services for which vendor payments have been made, or are to be made under the Medicaid program, including the authority for and the date of administration of the treatment, drugs, or services.
- ◆ Documentation in each resident's record which enables the Department to verify that each charge is due and proper before payment.
- ◆ Financial records maintained in the standard, specified form including the facility's most recent audited cost report *Financial and Statistical Report for Purchase of Service Contracts*, form 470-0664. Click [here](#) to view a sample of the form online.
- ◆ Census records, to include:
 - The date,
 - Number of residents at the beginning of each day,
 - Names of residents admitted, and
 - Names of residents discharged.
- ◆ Resident accounts.
- ◆ In-service education records.
- ◆ Inspection reports pertaining to conformity with federal, state, and local laws.
- ◆ Disaster-preparedness reports.
- ◆ All other records as may be found necessary by the Department in determining compliance with any state or federal regulations.

Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer. All records shall be retained within the facility upon change of ownership.



a. Personal Needs Accounts

When the facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. This accounting system is subject to audit by state representatives and must meet the following criteria.

- ◆ Upon a resident's admission to the facility, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger must be kept current on a monthly basis. The facility may combine this accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger sheet must be maintained for each resident.
- ◆ When something is purchased for the resident and is not a direct cash disbursement to the resident, the expenditure item in the ledger must be supported by a dated receipt signed by the resident or the resident's legal representative. The receipt must indicate the article furnished for the resident's benefit.
- ◆ Personal funds must not be turned over to persons other than the resident's legal representative or other persons selected by the resident. With the consent of the resident (if the resident is able and willing to give consent), the administrator may turn over personal funds belonging to the resident to a close relative or friend to purchase a particular item. However, an itemized dated receipt signed by the resident or the representative shall be deposited in the resident's file.
- ◆ The receipts for each resident must be kept until canceled by auditors. The ledger and receipts for each resident shall be made available for periodic audits by an accredited DIA representative. The representative shall make an audit certification at the bottom of the ledger sheet. Support receipts may then be destroyed.
- ◆ Upon a resident's death, a receipt must be obtained from the next of kin or the resident's guardian before releasing the balance of personal needs funds. When the resident has been receiving a grant from the Department for all or part of the personal needs, any funds shall revert to the Department. The Department shall turn the funds over to the resident's estate.



b. Resident Records

The facility must:

- ◆ Develop and maintain a record keeping system that:
 - Includes a separate record for each resident, and
 - Documents the resident's health care, active treatment, social information, and protection of the resident's rights.
- ◆ Provide each identified residential living unit with appropriate aspects of each resident's record.
- ◆ Keep confidential all information contained in the resident's records, regardless of the form or storage method of the records.
- ◆ Develop and implement policies and procedures governing the release of any resident information, including consents necessary from the resident or parents (if the resident is a minor) or legal guardian.
- ◆ The resident record must include, at a minimum:
 - Physician orders
 - Progress or status notes
 - Preliminary evaluation
 - Comprehensive functional assessment
 - Individual program plan
 - [Form 470-0374, ICF/ID Resident Care Agreement](#)
 - Program documentation
 - Medication administration records
 - Nurses' notes
 - [Form 470-0042, Case Activity Report](#)

Any person who makes an entry in a resident's record must make it legibly, date it, and sign it. The facility must provide a legend to explain any symbol or abbreviation used in a resident's record.



3. Services Provided Under Agreements with Outside Sources

If a service required under this manual is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care. The agreement shall:

- ◆ Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.
- ◆ Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this manual. If living quarters are not provided in a facility owned by the ICF/ID, the ICF/ID remains directly responsible for the standards relating to physical environment.

The facility shall ensure that outside services meet the needs of each resident.

C. APPEALS OF ADVERSE ACTIONS

Any action of the Department with respect to the facility (not the resident) which an ICF/ID believes is unwarranted or incorrect may be appealed to the director of the Department. If the appeal involves a particular resident, the resident must appeal, but may be helped by the facility or any other interested person.

This appeal process should be used only after exhausting normal administrative processes. Any person or facility wishing to appeal a Department action or decision must do so within 30 days of notification of the action or decision. Appeal requests should be directed to the office taking the action.

Information concerning appeals may be obtained by contacting:

Appeals Liaison
Department of Human Services
1305 E Walnut Street
Des Moines, IA 50319-0114

When the Department takes a decertification action for reasons unrelated to the survey report, the appeal is filed with the Department. The hearing is held by the Department of Inspections and Appeals, but the final decision is issued by the Department of Human Services.



Appeals of decertification actions not initiated by the Department are handled differently from other appeal proceedings. When the Department of Inspections and Appeals has surveyed a facility and found the facility to be in substantial noncompliance with Medicaid rules, the Department of Human Services may deny continued program certification. For decertification, the following conditions apply:

- ◆ When decertification is contemplated, the Department of Human Services shall send timely and adequate notice to the facility.
- ◆ Request for a hearing shall be made to the Department of Inspections and Appeals within 15 days of the notice of decertification.
- ◆ At any time before or after an evidentiary hearing, the Department of Inspections and Appeals will be willing to negotiate an amicable resolution or discuss the possibility of settlement with the facility owner.

When a final decision is issued, that decision is binding upon the Department of Human Services.

D. ARRANGEMENTS MADE WITH THE RESIDENT

1. Financial Participation

A resident's payment for care may include any voluntary payments made by family members toward the cost of care. The resident's financial participation and medical payments from a third party shall be paid toward the total cost of care for the month before any Medicaid payment is made.

All of a resident's income in excess of authorized exemptions is applied toward the cost of care. The resident retains \$50 of income for personal needs. After the resident's financial participation is exhausted, the state makes up the difference between the resident's income and the cost of ICF/ID care for the month. The facility is responsible for collecting the resident's financial participation.



All resident income above the authorized exemption is applied to the cost of care, beginning with the first month of admission as a Medicaid resident in the following instances:

- ◆ Residents leaving the facility for the purpose of hospitalization, nursing facility care or skilled care who remain on the Medicaid program and later return to the ICF/ID
- ◆ Residents changing from private-pay status to Medicaid status while residing in an ICF/ID
- ◆ Residents transferring from an out-of-state ICF/ID to an Iowa facility

A resident who has moved from an independent living arrangement to an ICF/ID may have limited first-month financial participation due to maintenance or living expenses connected with the previous living arrangement. A Department income maintenance worker determines how much of the resident's income may be protected in order to defray expenses.

It is essential that the resident, someone acting in the resident's behalf, or the administrator of the ICF/ID immediately notify the district office of the Social Security Administration and the Department's Centralized Facility Eligibility Unit when an SSI beneficiary enters the facility and when an SSI beneficiary is discharged. Use form [470-0042, Case Activity Report](#), to notify the Department.

This is necessary so that incorrect SSI payments can be avoided and overpayments or underpayments through the Medicaid program do not occur.

If a resident transfers from one ICF/ID to another during a month, any remaining financial participation shall be taken to the new facility and applied to the cost of care at that facility. Present policy concerning differential payment for reserve bed days may change the use of financial participation when residents are absent from the facility. See [Periods of Service for Which Payment Will Be Authorized](#).

Administrators should ensure that the correct amount of financial participation is collected, particularly in cases where the resident may transfer from the facility.

The Department determines the member's financial participation and informs the facility via the Iowa Medicaid Portal Access (IMPA) system. Refer to [Informational Letter 1317](#) regarding instructions to register for access to the IMPA system. The facility is responsible to collect the client participation amount as indicated in IMPA.



2. Personal Needs Allowance

All Medicaid residents of an ICF/ID have a small income which is intended to cover the purchase of necessary clothing and incidentals. This is called the personal needs allowance.

If the resident has personal income, the first \$50 of income is retained for these personal needs and an additional amount up to \$65 is allowed from earned income only. If the resident's income is less than the personal needs allowance, the difference between the income and the personal needs allowance is usually paid to the resident through the Supplemental Security Income Program.

As its name suggests, the personal needs allowance is an allotment of money provided for the resident to spend on such personal needs and articles as the resident wishes. To the extent feasible, the resident should be encouraged to see the money as personal funds and should be managed by the resident.

If the resident is unable to manage personal funds, the guardian should manage the funds to meet the personal needs of the resident.

The personal needs allowance is seen as one method of improving the quality of life for those persons needing an ICF/ID living situation. The money can serve as a way for the resident to maintain control over a segment of personal life and environment, and a way for the resident to individualize himself or herself in an institutional setting.

No Medicaid resident or responsible party shall be charged for items not specifically requested by the resident or responsible party. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.



Policy concerning the responsibility for payment of non-legend drugs and for payment of certain legend drugs not payable through Medicaid is sometimes misinterpreted by facilities and the general public. The main points of the Department's long-standing policy in this area are as follows:

- ◆ If a physician prescribes a non-legend drug by brand name, the facility is expected to provide that particular brand to the resident. The expense is shown as an audit cost to the facility.
- ◆ If a physician does not specify a brand name in an order for a non-legend drug, it is proper that the facility offer a house brand stocked by the facility. If a resident insists upon other than the house item, it is always the responsibility of the facility to make the first offer to provide any non-legend drug prescribed by a physician.
- ◆ A physician may order a prescription drug for which the Medicaid program will not make payment, since the drug is on the list of products classified by the Food and Drug Administration as lacking adequate evidence of effectiveness.

If so, the physician and resident shall be advised that Medicaid does not pay for the item and that the facility cannot accept responsibility for payment, since such non-covered drugs are not to be shown as an audit cost on the financial and statistical report. If the physician or the resident insists on the item in question, it becomes the responsibility of the resident or a responsible third party to deal with the pharmacy providing the drug.

If the amount in the personal needs fund exceeds the Medicaid eligibility resource limit, the member loses Medicaid eligibility until resources are within this limit as of the first moment of the first day of a month.

3. Medicare, Veterans, and Similar Benefits

All medical resources available to the resident must be used to pay for the cost of the resident's ICF/ID care. Such resources include private health or accident insurance carried by the resident, or by others on the resident's behalf, trusts set up for medical care, and services reasonably available through other publicly supported programs, such as Medicare, veterans benefits, vocational rehabilitation, etc.



When a facility receives information that not all resources available to a resident are being used, notify the Department in writing.

The following is a suggested format:

To: _____ County Department of Human Services
From: _____ (Name of Facility)
Subject: _____ (Member Name)

We have received information that this resident may:

- ◆ Be eligible for veteran's benefits
- ◆ Have other potential resources to pay for care as described below...
- ◆ Not be eligible for Medicaid because...

Send documentation to:

Centralized Facility Eligibility Unit
Imaging Center 1
Iowa Department of Human Services
417 E. Kaneshville Blvd.
Council Bluffs, IA 51503-4470

Fax: (515) 564-4040
email: facilities@dhs.state.ia.us

4. Resident Care Agreement

Iowa law requires that each person residing in a health care facility be covered by a contract that lists the duties, rights, and obligations of all parties.

The ICF/ID shall enter into an agreement with a Medicaid-eligible resident (or the resident's relative, guardian, or trustee) upon admission to the facility. The [*ICF/ID Resident Care Agreement, form 470-0374*](#), is a three-party contract between the ICF/ID, the resident, and the Department, which will serve to meet this requirement.

The ICF/ID is responsible for the distribution of the form to all parties. One copy of the form is given to the member, one copy is retained in the resident's record at the facility, and is uploaded to the Department's Iowa Medicaid Portal Access (IMPA) system.



E. AUDITS OF BILLING AND HANDLING OF RESIDENT FUNDS

Upon proper identification, the Iowa Medicaid Enterprise (IME), the Department's contracted managed care organizations (MCOs), field auditors of the Department of Inspections and Appeals or representatives of the U.S. Department of Health and Human Services shall have the right to audit the following:

- ◆ Billings to the Department,
- ◆ Receipts of the member's financial participation, and
- ◆ Record of the facility to determine proper handling of personal needs funds.

The audit shall ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed.

The resident or family shall not be charged for such items as Chux, toilet paper, hospital gowns, or other maintenance items, since these items are properly included in the computation of the audit cost.

The Department reserves the right to charge back to the facility any maintenance items that are charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility.

On the auditor's recommendation, the Department shall request repayment of sums inappropriately billed to the Department or collected from the resident. Repayment shall be made by the facility either to the Department or to the resident involved.

The facility has 60 days to review the audit and repay the requested funds or present supporting documentation which shows that the requested refund amount, or part of it, is not justified.

When the facility fails to comply, the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25% of the average of the last six monthly payments to the facility. The withholding shall continue until the entire refund is recovered.

In the event the audit results indicate significant problems, they may be referred to the attorney general's office for whatever action is appropriate.



When exceptions are taken during an audit which are similar to the exceptions taken in a previous audit, the Department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75% of the current payment rate.

F. CERTIFICATION PROCESS

A public or private facility wishing to obtain a provider agreement to serve Medicaid-eligible residents in an ICF/ID must proceed in the manner set forth below.

1. Certification of Need

Service providers seeking Medicaid certification for ICF/ID conversion or construction shall address the following requirements of the Iowa Medicaid program before filing certificate of need applications.

a. Inclusion in the Community

Written plans shall demonstrate individualized consumer access to and utilization of service and resources typically used by other residents of the area in which the proposed facility is to be located. The distance, availability of transportation, convenience of parking and physical accessibility to people with a range of disabilities shall be considered.

The program name and home location must blend with characteristics of other homes in the area. There must be a broad range, number, and type of opportunities for social activities and interactions for individuals or groups small enough in size to be assimilated into the activity.

b. Family-Scale Size

Written plans shall demonstrate that the proposed facility will meet family-scale size conditions of two to eight persons per environment or be a size that would be common to the area or neighborhood in which the facility is proposed to be located.

c. Location in Community Residential Neighborhood

If the proposed facility is located within a community residential neighborhood, written plans shall demonstrate the use of an existing structure or new construction which is consistent with the size and style of the neighborhood.



The proposed facility shall not be located contiguous to another licensed health care facility or residential program for persons with disabilities. The number of residential programs for persons with disabilities in a community should be relative to community size, so that the number of programs is in keeping with the number, types, and range of services and supports in the community.

If the proposed facility is located outside a community residential neighborhood, written plans shall demonstrate how these conditions shall be met and shall explain why a location outside a community residential neighborhood would be beneficial for the particular consumer population to be served.

Written plans shall be submitted to the following addresses:

Iowa Medicaid Enterprise
Bureau of Medical and LTSS
100 Army Post Road
Des Moines, IA 50315

Health Facilities Council
Iowa Department of Public Health
321 E 12th Street
Des Moines, IA 50319

The Health Facilities Council shall consider the requirements set forth in this rule when reviewing certificate of need applications.

2. License

To participate in the Medicaid program, a facility shall be licensed as an intermediate care facility for the intellectually disabled by the Department of Inspections and Appeals (DIA) under the Department of Inspections and Appeals rules 481 IAC Chapter 64.

A conditional license can be granted to a new facility when there is a finding that in all probability the facility will be in full compliance upon commencement of operations.

The DIA shall grant the applicant a conditional license based upon information supplied by the applicant and the approved facility plans and construction.



3. Provider Agreements

An ICF/ID must be certified by the DIA for participation as an ICF/ID before a provider agreement may be issued. The effective date of a provider agreement may not be earlier than the date of certification.

For facilities without deficiencies, the provider agreement shall be issued for a period not to exceed 15 months. The agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the Department may:

- ◆ Elect to execute an agreement for a term less than the period of certification,
- ◆ Elect not to execute an agreement, or
- ◆ Cancel an agreement.

For facilities with deficiencies, a new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies, up to a period of 15 months. Or a new provider agreement may be issued for a period of up to 15 months, subject to automatic cancellation 60 days following the scheduled date for correction, unless:

- ◆ Required corrections have been completed, or
- ◆ The survey agency finds and notifies the Department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.

There will be no new agreement if the facility continues to be out of compliance with the same standards at the end of the term of agreement.

The Department may, for good cause, elect not to execute an agreement. Good cause is defined as a continued or repeated failure to operate an ICF/ID in compliance with Medicaid rules.



The Department may at its option extend an agreement with a facility for two months under either of the following conditions:

- ◆ The health and safety of the residents will not be jeopardized thereby, and, the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.
- ◆ It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.

When it becomes necessary to cancel or refuse to renew a Medicaid provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation, if the extension is necessary to ensure the orderly transfer of residents. See also [APPEALS OF ADVERSE ACTION](#).

4. Survey and Certification

The procedures to be followed in certifying a facility as meeting Medicaid requirements involve the facility, the Department of Inspections and Appeals (DIA), and the Department of Human Services. Before a provider agreement may be issued, the DIA must recommend certification as an ICF/ID, and the Department must certify the facility as a Medicaid vendor.

All survey procedures and the certification process shall be in accordance with the U.S. Department of Health and Human Services publication "Providers Certification State Operations Manual." The necessary steps leading to certification and issuance of a provider agreement for an existing facility are as follows:

- ◆ The facility shall request an application form from the Department.
- ◆ The Department shall transmit [Iowa Medicaid – Universal Provider Enrollment Application, form 470-0254](#), and a provider manual to the facility. The facility shall complete its portion of the application form and submit it to the Department.
- ◆ The Department shall review the application form and retain it until the DIA completes the *Medicare/Medicaid Certification and Transmittal*, CMS-1539. Download a sample of the form at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1539.pdf>.



- ◆ DIA schedules and completes a survey of the facility in conjunction with the Fire Marshal's office. At the time of initial survey for a new facility, the applicant must meet as many physical, administrative, and service contract requirements as possible. The applicant should plan on meeting all other requirements for full compliance including those for staff, services, and operations for the residents at the scheduled resurvey.

The initial survey of the facility shall be for the purpose of determining what recommended limited-term (less than 15 months) provider agreement should be entered into with the applicant. In the event the facility is to be recommended for limited or conditional certification, a revisit shall occur no later than 30 days before the expiration of the facility's certification. At that time, survey for full compliance for recertification shall occur.

- ◆ The DIA notifies the applicant of any deficiencies and asks for a plan for correction of the deficiencies. In the event the facility is not to be recommended for limited or conditional certification, the DIA shall notify the applicant regarding reasons for its negative recommendations. The applicant shall then arrange for a revisit by the DIA to occur when the objections which caused the negative recommendations to be made are removed.
- ◆ The facility shall submit a plan of correction within 10 days after receipt of the written statement of deficiencies from the DIA Health Facilities Division. The DIA must approve this plan before the facility can be certified.
- ◆ The DIA evaluates the survey findings and the full compliance plan of correction, and either recommends the facility for certification as an ICF/ID or recommends denial of certification. The date of certification will be the date of approval for the plan of correction.

If the DIA survey indicated deficiencies in the areas of American National Standards Institution, Life Safety Code, or environment and sanitation, a timetable detailing corrective measures shall be submitted to the DIA before a provider agreement can be issued. This timetable will not exceed two years from the date of initial certification and will detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances:

- The DIA determines that the facility can make corrections within the two-year period.
- During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.



- The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.
- ◆ When certification is recommended, the DIA notifies the Department recommending terms and conditions of a provider agreement.
- ◆ The Department reviews the certification data and:
 - Transmits the provider agreement as recommended, or
 - Transmits the provider agreement for a term less than recommended by the DIA or elects not to execute an agreement.

G. MEDICAID ELIGIBILITY

See [CHAPTER II. MEMBER ELIGIBILITY](#) for rules regarding Medicaid eligibility.

1. Application Procedure

Medicaid eligibility is determined by the Department Centralized Facility Eligibility Unit (CFEU) under rules established by the Department. Facilities should advise persons needing help with the costs of medical care to contact the Department office in the county in which they reside.

Persons whose monthly income indicates they would be eligible for SSI must apply for the SSI program at the district office of the Social Security Administration serving the area in which the facility is located. (After the month of entry to the facility, only persons with a monthly income less than \$50 need to apply for SSI.)

Persons whose income is over SSI standards must apply to the Department. Such people, commonly referred to as persons in the “300% group,” are:

- ◆ Financially eligible for Medicaid in a medical facility providing monthly income is not in excess of 300% of SSI income limits, and
- ◆ Resources are within SSI limits.

Eligibility requires a 30-consecutive-day period of residence in a medical institution. A resident may have been in more than one facility during the month or needed more than one level of care but must have been in a medical institution during the 30-day period. Residents whose deaths occur during the 30-consecutive-day period of residency will be considered eligible if there was continuous residency.



2. Continued Stay Reviews

Continued stay reviews are performed at least yearly. Their purpose is to determine if the resident continues to need the ICF/ID level of care. For members not enrolled with an MCO, continued stay reviews are the responsibility of the IME. For members enrolled with an MCO, the MCO will review the member's need for continued stay. For any review by an MCO which indicates a change in the member's level of care, the MCO will submit documentation of the change to the IME and the IME will make a final determination.

3. Eligibility for Services

Contact the Department on, or preferably before, admission of a resident who is expected to be eligible for Medicaid. Also contact the Department when a resident who has been admitted on private pay decides to apply for Medicaid.

The IME reviews ICF/ID admissions and transfers only when documentation is provided which verifies a referral from a case management program. For members enrolled with an MCO, the referral shall be made by the member's case manager assigned by the MCO. For members not enrolled with an MCO, the referral shall be made through the Department's selected case management program.

The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified intellectual disability professional.

The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

- ◆ Diagnoses; summaries of present medical; social and, where appropriate, developmental findings; medical and social family history; mental and physical functional capacity; prognoses; range of service needs; and amounts of care required.
- ◆ An evaluation of the resources available in the home, family, and community.



- ◆ An explicit recommendation with respect to admission (or in the case of persons who make application while in the facility, with respect to continued care in the facility).
- ◆ Where it is determined that ICF/ID services are required by a person whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.
- ◆ An individual plan for care, which shall include:
 - Diagnosis, symptoms, complaints or complications indicating the need for admission;
 - A description of the functional level of the resident;
 - Written objective;
 - Orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives;
 - Plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.
- ◆ Written reports of the evaluation and the written individual plan of care, which shall be delivered to the facility and entered in the resident's record at the time of admission or, in the case of persons already in the facility, immediately upon completion.

Medicaid-eligible persons may be admitted to an ICF/ID upon the certification of a licensed physician of medicine or osteopathy that there is a necessity for care at the facility. Members enrolled in an MCO must also obtain authorization from the MCO. Medicaid payment will be made for ICF/ID care only upon certification of need for this level of care by a licensed physician of medicine or osteopathy and approval by the IME Medical Services Unit.

a. Placement Approved

When placement has final approval of the Department, payment will be authorized retroactive to the date of the resident's admission to the facility, if appropriate.

The beginning date of eligibility shall be no more than 90 days before the first day of the month in which application was filed with the Department.



b. Placement Not Approved

Denial decisions are made in writing and sent to the member, the attending physician, the case manager, and the facility.

Upon notice of disapproval, the facility should put the resident's discharge plan into effect, in cooperation with the resident and the resident's family. A county office worker will be contacting the facility to monitor the progress made in effecting the discharge plan.

H. PHYSICAL ENVIRONMENT

The facility shall provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately-equipped and sound-treated areas for hearing and other evaluations conducted in the facility) to enable staff to provide residents with needed services as required by this manual and as identified in each resident's individual program plan.

1. Bedrooms

Bedrooms shall be rooms that have at least one outside wall. Each bedroom shall have direct outside ventilation by means of windows, air conditioning, or mechanical ventilation. If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the resident. The window shall be no more than 44 inches measured to the window sill above the floor. If the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, the window must be no more than 36 inches measured to the window sill above the floor.

Bedrooms shall accommodate no more than four residents, unless granted a variance. DIA may grant a variance from the limit of four residents per room only if a physician, who is a member of the interdisciplinary team and who is a qualified intellectual disability professional, certifies that each additional resident is so severely medically impaired as to require direct and continuous monitoring during sleeping hours. The certifying physician shall document the reasons why housing in a room of four or fewer persons would not be medically feasible.



Bedrooms shall be equipped with or located near toilet and bathing facilities. Multiple-resident bedrooms must measure at least 60 square feet per resident. Single rooms must measure at least 80 square feet. In all facilities initially certified or in buildings constructed or with major renovations or conversions, bedrooms shall have walls that extend from floor to ceiling.

The facility shall provide each resident with:

- ◆ A separate bed of proper size and height for the convenience of the resident
- ◆ A clean, comfortable mattress and bedding appropriate to the weather and climate
- ◆ Functional furniture appropriate to the resident's needs and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident
- ◆ Suitable storage space, accessible to residents, for personal possessions such as televisions, radios, prosthetic equipment, and clothing
- ◆ Adequate clean linen and dirty linen storage areas

The facility shall provide space and equipment for daily out-of-bed activity for all residents who are not yet mobile, except those who have a short-term illness or those few residents for whom out-of-bed activity is a threat to health and safety.

2. Disaster Plans and Drills

The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents. The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions. Drills shall ensure that all personnel on all shifts, including live-in and relief staff, are trained to perform assigned tasks, and are familiar with the use of the facility's fire protection features.

The facility shall actually evacuate residents during at least one drill each year on each shift and make special provisions for the evacuation of residents with physical disabilities. During fire drills, residents may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.



The facility shall:

- ◆ File a report and evaluation on each evacuation drill;
- ◆ Evaluate the effectiveness of emergency and disaster plans and procedures;
- ◆ Investigate all problems with evacuation drills, including accidents; and
- ◆ Take corrective action.

3. Resident Bathrooms

The facility shall provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the residents. The facility shall provide for individual privacy in toilets, bathtubs, and showers.

4. Safety

The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations, and codes pertaining to health, safety, and sanitation.

The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning, or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to residents.

In areas of the facility where residents who have not been trained to regulate water temperature are exposed to hot water, the facility shall ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases. The facility shall implement successful corrective action in affected problem areas. The facility shall maintain a record of incidents and corrective actions related to infections. The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with residents and their food.



The facility shall have floors that have a resilient, nonabrasive, and slip-resistant surface. If the area used by residents is carpeted and serves residents who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor, the carpeting shall be nonabrasive. Exposed floor surfaces and floor coverings shall promote mobility in areas used by residents and promote maintenance of sanitary conditions.

The facility shall remove or cover interior paint or plaster containing lead so that it is not accessible to residents. Lead-free paint shall be used inside the facility.

Except as specified in this manual, the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference. DIA may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings, as permitted by the LSC.

A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

For facilities that meet the LSC definition of a health care occupancy, the Health Care Financing Administration may waive specific provisions of the LSC for a period it considers appropriate, if the waiver would not adversely affect the health and safety of the residents and rigid application of specific provisions would result in an unreasonable hardship for the facility.

DIA may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's residents.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard, as long as the facility continues to remain in compliance with that edition of the code.

For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the DIA may apply the state's fire and safety code as specified above.



I. PROTECTION OF RESIDENTS' RIGHTS

The facility shall ensure the rights of all residents. Therefore the facility shall:

- ◆ Inform each resident, parent (if the resident is a minor), or legal guardian of the resident's rights and the rules of the facility.
- ◆ Inform each resident, parent (if the resident is a minor), or legal guardian, of the resident's:
 - Medical condition,
 - Developmental and behavioral status,
 - Attendant risks of treatment, and
 - Right to refuse treatment.
- ◆ Allow and encourage individual residents to exercise their rights as residents of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.
- ◆ Allow individual residents to manage their financial affairs and teach them to do so to the extent of their capabilities.
- ◆ Ensure that residents are not subjected to physical, verbal, sexual, or psychological abuse or punishment.
- ◆ Ensure that residents are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.
- ◆ Provide each resident with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.
- ◆ Ensure that residents are not compelled to perform services for the facility and ensure that residents who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.
- ◆ Ensure residents the opportunity to communicate, associate, and meet privately with individuals of their choice, and to send and receive unopened mail.
- ◆ Ensure that residents have access to telephone with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.



- ◆ Ensure residents the opportunity to participate in social, religious, and community group activities.
- ◆ Ensure that residents have the right to retain and use appropriate personal possessions and clothing, and ensure that each resident is dressed in the resident's own clothing each day.
- ◆ Permit a husband and wife who both reside in the facility to share a room.

The facility shall establish and maintain a system that ensures a full and complete accounting of residents' personal funds entrusted to the facility on behalf of residents and precludes any commingling of resident funds with facility funds or with the funds of any person other than another resident. The resident's financial record shall be available on request to the resident, parent (if the resident is a minor), or legal guardian.

1. Communication with Residents, Parents, and Guardians

The facility shall promote participation of parents (if the resident is a minor) and legal guardians in the process of providing active treatment to a resident, unless their participation is unobtainable or inappropriate. The facility shall answer communications from residents' families and friends promptly and appropriately. The facility shall promptly notify the resident's parents or guardian, and the resident's case manager for those members enrolled with an MCO, of any significant incidents or changes in the resident's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

The facility shall promote visits by persons with a relationship to the resident (such as family, close friends, legal guardians, case managers, and advocates) at any reasonable hour, without prior notice. This is consistent with the right of that resident's and other residents' privacy, unless the interdisciplinary team determines that the visit would not be appropriate. The facility shall promote visits by parents or guardians to any area of the facility that provides direct resident care services to the resident, consistent with the rights of that resident and other residents' privacy.

The facility shall promote frequent and informal leaves from the facility for visits, trips, or vacations.



2. Health Care Services

The facility shall furnish, maintain in good repair, and teach residents to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the residents.

a. Dental Services

The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each resident from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the resident's oral condition, shall be performed no later than one month after admission to the facility, unless the examination was completed within 12 months before admission.

Periodic examination and diagnosis shall be performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease. A review of the results of examination and entry of the results shall be entered in the resident's dental record.

If appropriate, dental professionals shall participate in the development, review, and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

The facility shall provide education and training in the maintenance of oral health.

The facility shall ensure comprehensive dental treatment services that include the availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist. Dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health shall be available to resident.

If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each resident, with a dental summary maintained in the resident's living unit. If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the resident's living unit.



b. Dietetic Services

Each resident shall receive a nourishing, well-balanced diet, including modified and specially prescribed diets. The resident's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets, including those used as a part of a program to manage inappropriate resident behavior.

A qualified dietitian shall be employed either full-time, part-time, or on a consultant basis, at the facility's discretion. If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability, and activity. Foods proposed for use as a primary reinforcement of adaptive behavior shall be evaluated in light of the resident's nutritional status and needs.

Each resident shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community. Not more than 14 hours shall elapse between a substantial evening meal and breakfast of the following day. On weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast. Not less than 10 hours shall elapse between breakfast and the evening meal of the same day, except as provided above.

Menus shall be prepared in advance and shall provide a variety of foods at each meal.

Menus shall be different for the same days of each week and adjusted for seasonal change. Menus shall include the average portion sizes for menu items. Menus for food actually served shall be kept on file for 30 days.

Food shall be served in appropriate quantity, at appropriate temperature, and in a form consistent with the developmental level of the resident.



The facility shall serve meals for all residents, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician. The facility shall provide table service for all residents who can and will eat at a table, including residents in wheelchairs. The facility shall equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident.

The facility shall supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each resident receives enough food, and to ensure that each resident eats in a manner consistent with the resident's developmental level. Staff shall ensure that each resident eats in an upright position, unless otherwise specified by the interdisciplinary team or the physician.

c. Laboratory Services

Laboratory means an entity for the microbiological, serological, chemical, hematological, radio-bioassay, cytological, immunohematological, pathological, or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded, and reported.



The laboratory director shall ensure that the staff:

- ◆ Has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;
- ◆ Is sufficient in number for the scope and complexity of the services provided; and
- ◆ Receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801. The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

d. Pharmacy Services

The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its residents. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

A pharmacist with input from the interdisciplinary team shall review the drug regimen of each resident at least quarterly. The pharmacist shall report any irregularities in residents' drug regimens to the prescribing physician and interdisciplinary team. The pharmacist shall prepare a record of each resident's drug regimen reviews and the facility shall maintain that record.

As appropriate, the pharmacist shall participate in the development, implementation, and review of each resident's individual program plan, either in person or through written report to the interdisciplinary team.



The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. An individual medication administration record shall be maintained for each resident. The system shall ensure that:

- ◆ All drugs are administered in compliance with the physician's orders.
- ◆ All drugs, including those that are self-administered, are administered without error.
- ◆ Unlicensed personnel are allowed to administer drugs only if state law permits.
- ◆ Residents are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.
- ◆ The resident's physician is informed of the interdisciplinary team's decision that self-administration of medications is an object for the resident.
- ◆ No resident self-administers medications until the resident demonstrates the competency to do so.
- ◆ Drugs used by residents while not under the direct care of the facility are packaged and labeled in accordance with state law.
- ◆ Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security. The facility shall keep all drugs and biologicals locked, except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Residents who have been trained to self-administer drugs may have access to keys to their individual drug supply.

The facility shall maintain records of the receipt and disposition of all controlled drugs. The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.). If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.



Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable. The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

Drugs and biologicals packaged in containers designated for a particular resident shall be immediately removed from the resident's current medication supply if discontinued by the physician.

e. Physician Services

The facility shall provide or obtain preventive and general medical care for each resident. The facility shall ensure the availability of physician services 24 hours a day. To the extent permitted by state law, the facility may use physician assistants and nurse practitioners to provide physician services as described in this manual.

A physician shall participate in the establishment of each newly admitted resident's initial individual program plan.

The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a resident if the physician determines that an individual resident requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

The facility shall provide or obtain annual physical examinations of each resident that include, at a minimum, the following:

- ◆ Evaluation of vision and hearing.
- ◆ Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.
- ◆ Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.
- ◆ Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American academy of Pediatrics, or both.



f. Nursing Services

The facility shall provide residents with nursing services in accordance with their needs. These services shall include:

- ◆ Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.
- ◆ The development, with a physician, of a medical care plan of treatment for a resident when the physician has determined that an individual resident requires such a plan.
- ◆ A review of their health status for those residents certified as not needing a medical care plan. This review shall be by a direct physical examination by a licensed nurse.
 - Reviews shall be done quarterly or more frequently, depending on resident need, and be recorded in the resident's record.
 - Reviewers shall result in any necessary action including referral to a physician to address resident health problems.
- ◆ Other nursing care as prescribed by the physician or as identified by resident needs.
- ◆ Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:
 - Training residents and staff as needed in appropriate health and hygiene methods.
 - Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.
 - Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the residents.



3. Management of Inappropriate Resident Behavior

The facility shall develop and implement written policies and procedures that govern the management of inappropriate resident behavior, consistent with the provisions regarding staff conduct toward residents. These procedures shall specify all facility-approved interventions to manage inappropriate resident behavior.

Procedures shall address:

- ◆ The use of time-out rooms, physical restraints, and drugs to manage inappropriate behavior,
- ◆ The application of painful or noxious stimuli,
- ◆ Staff members who may authorize the use of specified interventions, and
- ◆ A mechanism for monitoring and controlling the use of these interventions.

The procedures shall designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.

Before using more restrictive techniques, the facility shall ensure that the resident's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.

Interventions to manage inappropriate resident behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare, and civil and human rights of residents are adequately protected. Techniques to manage inappropriate behavior shall never be used for disciplinary purposes, for the convenience of staff, or as a substitute for an active treatment program.

The use of systematic interventions to manage inappropriate resident behavior shall be incorporated into the resident's individual program plan. Standing or as-needed programs to control inappropriate behavior are not permitted.



a. Drug Usage

Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team. Drugs shall be used only as an integral part of the resident's individual program plan that is directed specifically towards the reduction and eventual elimination of the behaviors for which the drugs are employed. Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

The facility shall not use drugs in doses that interfere with the individual resident's daily living activities. Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirements, for desired responses and adverse consequences by facility staff. These drugs shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

b. Oversight Committee

The facility shall designate and use a specially constituted committee or committees consisting of:

- ◆ Members of facility staff,
- ◆ Parents,
- ◆ Legal guardians,
- ◆ Residents (as appropriate),
- ◆ Qualified persons who have either experience or training in contemporary practices to change inappropriate resident behavior, and
- ◆ Persons with no ownership or controlling interest in the facility to:
 - Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to resident protection and rights.



- Ensure that these programs are conducted only with the written informed consent of the resident, parent (if the resident is a minor), or legal guardian.
- Review, monitor, and make suggestions to the facility about its practices and programs as they relate to:
 - Drug usage,
 - Physical restraints,
 - Time-out rooms,
 - Application of painful or noxious stimuli,
 - Control of inappropriate behavior,
 - Protection of resident rights and funds, and
 - Any other area that the committee believes needs to be addressed.

These provisions for committee review may be modified only if, in the judgment of the Department of Inspections and Appeals, court decrees, state law, or regulations provide for equivalent resident protection and consultation.

c. Physical Restraints

The facility may employ physical restraint only:

- ◆ As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.
- ◆ As an emergency measure, but only if absolutely necessary to protect the resident or others from injury.
- ◆ As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for resident protection during the time that a medical condition exists.

Authorization to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the resident is restrained or stable. The facility shall not issue orders for restraint on a standing or as needed basis.



A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints and shall be released from the restraint as quickly as possible. A record of these checks and usage shall be kept.

Restraints shall be designated and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort. Barred enclosures shall not be more than three feet in height and shall not have tops. Opportunity for motion and exercise shall be provided for a period of not less than 10 minutes during each two-hour period in which restraint is employed. A record of the activity shall be kept.

d. Time-Out Rooms

A resident may be placed in a room from which egress is prevented only if the following conditions are met:

- ◆ The placement is a part of an approved systematic time-out program.
- ◆ The resident is under the direct constant visual supervision of designated staff.
- ◆ The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.

Placement of a resident in a time-out room shall not exceed one hour. Residents placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets. The facility shall keep a record of time-out activities.

4. Safeguarding Personal Property

The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

- ◆ Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.
- ◆ Providing adequate storage facilities for the resident's personal effects.



- ◆ Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

5. Staff Treatment of Residents

The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the resident. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment. Staff should not punish a resident by withholding food or hydration that contributes to a nutritionally adequate diet.

The facility shall prohibit the employment of people with a conviction or previous employment history of child or resident abuse, neglect or mistreatment.

The facility shall ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures. The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.



J. PROVISION OF SERVICES

Each resident shall receive a continuous active treatment program. "Active treatment" means aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this manual. Active treatment shall be directed toward:

- ◆ The acquisition of the behaviors necessary for the resident to function with as much self-determination and independence as possible.
- ◆ The prevention or deceleration of regression or loss of current optimal functional status.

"Active treatment" does not include services to maintain generally independent residents who are able to function with little supervision or in the absence of a continuous active treatment program.

Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the resident is encouraged. Participation by the resident, the resident's parents (if the resident is a minor), or the resident's legal guardian is required unless that participation is unobtainable or inappropriate.

1. Individual Program Plan

Each resident shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the resident's needs, as described by the comprehensive functional assessments, and to designing programs that meet the resident's needs. For those members enrolled with a managed care organization, the client's case manager shall participate as appropriate and allowed by the member. Participation by the client, the client's parents (if the client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

Within 30 days after admission, the interdisciplinary team shall prepare for each resident an individual program plan.

The individual program plan shall describe relevant interventions to support the resident toward independence. Plans shall include, for those residents who lack them, training in personal skills essential for privacy and independence until it has been demonstrated that the resident is developmentally incapable of acquiring them.



Personal skills include, but are not limited to:

- ◆ Toilet training,
- ◆ Personal hygiene,
- ◆ Dental hygiene,
- ◆ Self-feeding,
- ◆ Bathing,
- ◆ Dressing,
- ◆ Grooming, and
- ◆ Communication of basic needs.

The plan shall identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support. Plans shall provide the residents who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.

Plans shall include opportunities for resident choice and self-management.

The plan shall state the specific objectives necessary to meet the resident's needs, as identified by the comprehensive assessment and the planned sequence for dealing with those objectives. These objectives shall be stated separately, in terms of a single behavioral outcome. They shall be assigned projected completion dates and be expressed in behavioral terms that provide measurable indices of performance. Objectives shall be organized to reflect a developmental progression appropriate to the individual and be assigned priorities.

Each written training program designed to implement the objectives in the individual program plan shall specify:

- ◆ The person responsible for the program.
- ◆ The methods to be used and the schedule for use of the method.
- ◆ The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
- ◆ The inappropriate resident behaviors, if applicable.
- ◆ Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.



A copy of each resident's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the resident, and to the resident, parents (if the resident is a minor) or legal guardian. The plan shall identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.

a. Program Implementation

As soon as the interdisciplinary team has formulated a resident's individual program plan, each resident shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. Except for those facets of the individual program plan that must be implemented only by licensed personnel, each resident's individual program plan shall be implemented by all staff who work with the resident, including professional, paraprofessional and nonprofessional staff.

Data relative to accomplishment of the criteria specified in individual program plan objectives shall be documented in measurable terms. The facility shall document significant events that are related to the resident's individual program plan and assessments and that contribute to an overall understanding of the resident's ongoing level and quality of functioning.

b. Program Monitoring and Change

The individual program plan shall be reviewed at least by the qualified intellectual disability professional and revised as necessary. This includes, but is not limited to, situations in which the resident:

- ◆ Has successfully completed an objective or objectives identified in the individual program plan,
- ◆ Is regressing or losing skills already gained,
- ◆ Is failing to progress toward identified objectives after reasonable efforts have been made,
- ◆ Is being considered for training toward new objectives.



At least annually, the interdisciplinary team shall review the comprehensive functional assessment of each resident for relevancy and update it as needed. The individual program plan shall be revised, as appropriate.

2. Resident Assessment

Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted before admission. The comprehensive functional assessment shall take into consideration the resident's age (for example, child, young adult, older adult) and the implications for active treatment at each stage, as applicable. The assessment shall identify:

- ◆ The presenting problems and disabilities and, where possible, their causes,
- ◆ The resident's specific developmental strengths,
- ◆ The resident's specific developmental and behavioral management needs,
- ◆ The resident's need for services, without regard to the actual availability of the services needed, and
- ◆ Physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors, or independent living skills necessary for the resident to be able to function in the community, and vocational skills, as applicable.

3. Staff Conduct Toward Residents

The facility shall develop and implement written policies and procedures for the management of conduct between staff and residents. These policies and procedures shall:

- ◆ Promote the growth, development, and independence of the resident,
- ◆ Address the extent to which resident choice will be accommodated in daily decision-making, emphasizing self-determination and self-management, to the extent possible,
- ◆ Specify resident conduct to be allowed or not allowed, and
- ◆ Be available to all staff, residents, parents of minor children, and legal guardians.



To the extent possible, residents shall participate in the formulation of these policies and procedures.

Residents shall not discipline other residents, except as part of an organized system of self-government, as set forth in facility policy.

K. RESIDENT ADMISSIONS

Before placement in an ICF/ID, all eligible persons shall be referred through an approved case management program and through the Department. For members enrolled with an MCO, the member's case manager is assigned by the MCO.

The case management program shall identify any appropriate alternatives to the placement and shall inform the consumer or the consumer's representative of the alternatives. Once informed, the consumer or legal representative is free to select any option for which the consumer qualifies, including ICF/ID care.

Upon receipt of an initial ICF/ID request, the Department shall take one of the following actions:

- ◆ Refer the ICF/ID request to IME for level of care determination,
- ◆ Offer a home- or community-based alternative, or
- ◆ Refer the person back to the case management program for further consideration of service needs.

The Department's action must take place within 30 days of receipt of a referral.

If IME approves ICF/ID level of care, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

Persons who are admitted by the facility shall be in need of and receiving active treatment services. Admission decisions shall be based on a preliminary evaluation of the person that is conducted or updated by the facility or by outside sources.



The preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health, and nutritional status. The evaluation shall determine if the facility can provide for the person's needs and if the person is likely to benefit from placement in the facility.

The facility shall not house residents of grossly different ages, developmental levels, and social needs in close physical or social proximity, unless the housing is planned to promote the growth and development of all those housed together.

The facility shall not segregate residents solely on the basis of their physical disabilities. Integrate residents who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

It is important that people being placed feel that their needs and perceptions have been understood, and that placement is designed to achieve positive goals. The following procedures are recommended to enhance the comfort and early adjustment of a person to this new living arrangement:

- ◆ Orient the resident to the physical plant and the facility staff.
- ◆ Introduce the resident to other residents and encourage the resident to become well acquainted early with those in the immediate living area.
- ◆ Discuss the resident's medical records and care plan with the resident.
- ◆ Encourage the resident to continue with interests and social responsibilities and contacts as early as possible after admission.
- ◆ Discuss the resident's placement, feelings about the placement, and progress, goals, and plans with the resident periodically.
- ◆ Give the resident the opportunity to discuss with the administrator and other staff members the resident's condition and the reasons for coming to the facility.
- ◆ Encourage the resident to express feelings about admission and to ask questions to alleviate any concerns and anxieties.



L. STAFF

1. Direct Care Staff

The facility shall provide sufficient direct care staff to manage and supervise residents in accordance with their individual program plans. The facility shall not depend upon residents or volunteers to perform direct care services for the facility.

Direct care staff is defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. There shall be responsible direct care staff on duty and awake on a 24-hour basis when residents are present to take prompt, appropriate action in cases of injury, illness, fire or other emergency, in each defined residential living unit housing:

- ◆ Residents for whom a physician has ordered a medical care plan;
- ◆ Residents who are aggressive, assaultive or security risks;
- ◆ More than 16 residents; or
- ◆ Fewer than 16 residents within a multi-unit building.

There shall be a responsible direct care staff person on duty on a 24-hour basis when residents are present to respond to injuries and symptoms of illness and to handle emergencies in each defined residential living unit housing:

- ◆ Residents for whom a physician has not ordered a medical care plan;
- ◆ Residents who are not aggressive, assaultive or security risks; and
- ◆ 16 or fewer residents.

Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to residents:

- ◆ The staff-to-resident ratio is 1 to 3.2 for each defined residential living unit serving:
 - Children under the age of 12,
 - Severely and profoundly intellectually disabled residents,
 - Residents with severe physical disabilities,
 - Residents who are aggressive, assaultive, or security risks, or
 - Residents who manifest severely hyperactive or psychotic-like behavior.



- ◆ The staff-to-resident ratio is 1 to 4 for each defined residential living unit serving moderately intellectually disabled residents.
- ◆ The staff-to-resident ratio is 1 to 6.4 for each defined residential living unit serving residents who function within the range of mild intellectual disability.
- ◆ When there are no residents present in the living unit, a responsible staff member must be available by telephone.

Provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct resident care duties.

2. Nursing Staff

The facility shall employ or arrange for licensed nursing services sufficient to care for residents' health needs including those residents with medical care plans. Nurses providing services in the facility shall have a current license to practice in the state.

The facility shall use registered nurses as appropriate and required by state law to perform the health services specified in this manual. If the facility uses only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse. Non-licensed nursing personnel who work with residents under a medical care plan shall do so under the supervision of licensed persons.

3. Professional Program Staff

Each resident shall receive the professional program services needed to implement the active treatment program defined in each resident's individual program plan. The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.



Professional program staff shall be licensed, certified, or registered, as applicable to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

- ◆ To be designated as an occupational therapist, a person shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
- ◆ To be designated as an occupational therapy assistant, a person shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.
- ◆ To be designated as a physical therapist, a person shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
- ◆ To be designated as a physical therapy assistant, a person shall be eligible for certification as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.
- ◆ To be designated as a psychologist, a person shall have at least a master's degree in psychology from an accredited school.
- ◆ To be designated as a social worker, a person shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.
- ◆ To be designated as a speech-language pathologist or audiologist, a person shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.
- ◆ To be designated as a professional recreation staff member, a person shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music, or physical education.



- ◆ To be designated as a professional dietitian, a person shall be eligible for registration by the American Dietetic Association.
- ◆ To be designated as a human services professional, a person shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling, and psychology).

If the resident's individual program plan is being successfully implemented by the facility staff, professional program staff meeting these qualifications are not required, except for qualified intellectual disability professionals, who must meet the requirements set forth here or be a doctor or nurse.

Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process. Professional program staff shall work directly with residents and with paraprofessional, nonprofessional, and other professional program staff who work with residents. Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

4. Qualified Intellectual Disability Professional

Each resident's active treatment program shall be integrated, coordinated, and monitored by a qualified intellectual disability professional who has at least one year of experience working directly with persons with an intellectual disability or other developmental disability and is one of the following:

- ◆ A doctor of medicine or osteopathy
- ◆ A registered nurse
- ◆ A person who holds at least a bachelor's degree in a professional category as specified in [Professional Program Staff](#)

5. Staff Training Program

Provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently. For employees who work with residents, focus training on skills and competencies directed toward residents' developmental, behavioral, and health needs.



Staff shall be able to demonstrate the skills and techniques necessary to:

- ◆ Administer interventions to manage the inappropriate behavior of residents.
- ◆ Implement the individual program plans for each resident for whom they are responsible.

M. TRANSFER AND DISCHARGE

If a resident is to be either transferred or discharged, the facility shall have documentation in the resident's record that the resident was transferred or discharged for good cause. The facility shall provide a reasonable time to prepare the resident and the resident's parents or guardian for the transfer or discharge (except in emergencies).

A transfer or discharge from an ICF/ID should be planned as carefully and thoroughly as an admission to the facility. It is desirable that the resident and the facility staff achieve understanding about the resident's current needs, condition, and programs, and the probable duration of stay in the ICF/ID. Such understandings make for better morale and adjustment to facility life on the part of the resident, and are particularly important to good transfer and discharge planning.

Good transfer and discharge planning begins at the time of the resident's admission and continues during the stay in the facility. Such planning involves gathering information, much of which should be available from the social history completed at the resident's admission.

Important considerations include the resident's medical condition and prognosis, family support system, previous living arrangement, and the resident's preferred living arrangement. Based on these factors, a preliminary analysis of alternatives for the resident is used to develop a discharge plan, which is subject to revision as the resident's condition changes.

For a resident whose condition is improving, the plan shall be made progressively more specific and time-limited. If a resident's condition becomes worse, the plan may need to be revised accordingly.

Consequently every resident's situation must be periodically reviewed to assess the effectiveness of the current plan in response to individual needs.



The facility social worker is the interdisciplinary team member responsible for coordination. As such, the social worker is the staff person in the best position to conduct these reviews and monitor progress toward achievement of objectives which will make eventual discharge possible. This requires good communication channels with the resident, the family, the physician, and others involved with the resident.

The facility social worker must be aware of what community resources are available to assist the resident in making a successful transfer to a different living arrangement. The county office of the Department is a useful informational resource in this last regard, but primary responsibility for discharge planning remains with the ICF/ID.

In the event of a forced move, such a revocation of license or Medicaid certification, fire or other disaster, discharge assistance will be furnished by the Department.

The Department will also assist in particularly difficult or complex cases where the facility has been unsuccessful in arranging an appropriate alternative. But in most cases, the Department expects that the ICF/ID possesses the necessary information and professional resources to coordinate discharge planning efforts effectively.

1. Administrative Procedures

At the time of the discharge, the facility shall develop a final summary of the resident's developmental, behavioral, social, health, and nutritional status.

With the consent of the resident, parents (if the resident is a minor) or legal guardian, the facility shall provide a copy to authorized persons and agencies. The facility shall also provide a post-discharge plan of care that will assist the resident to adjust to the new living environment.

In the event that a resident is transferred to another health facility, transfer information should be summarized from the facility's records in a copy to accompany the resident. This information should include:

- ◆ A transfer form of diagnosis
- ◆ Activities of daily living information
- ◆ Transfer orders
- ◆ Nursing care plan
- ◆ Physician's orders for care
- ◆ The resident's personal record
- ◆ The resident's personal needs fund record



If a Medicaid resident requests transfer or discharge, or there is another person requesting this for the resident, the facility administrator shall promptly notify the Department by means of the [Case Activity Report, form 470-0042](#). The facility shall also notify the member's case manager for members enrolled with a managed care organization, or the Department's selected case management provider for members not enrolled with a managed care organization.

This should be done in sufficient time to permit the case manager to assist in the decision and planning for the transfer or discharge, if needed. This also allows the Department enough time to complete the necessary paperwork, assuring a smooth discharge or transfer for the resident.

When a resident leaves the ICF/ID during the month, any unused portion of the resident's income must be refunded. The following example illustrates the procedure used in calculating refunds due the resident:

Mr. S has a monthly member participation of \$300. The facility in which Mr. S resides has a per diem rate of \$100. In a normal month, Mr. S pays for the first three days of his care ($\$100 \times 3 \text{ days} = \300) and the state pays for the remainder of the month.

If Mr. S leaves the facility on the third of the month, the facility must make a \$100 refund to Mr. S ($\$300 \text{ minus } \$200 \text{ (2 days' care) equals } \100). If he leaves the home on the fourth of the month or later, no refund is normally due. An exception could arise if reserve bed days are involved.

2. Closing of Facility

The contract between the Department and an ICF/ID requires a 60-day notice before closing. Administrators planning or considering closing a facility should notify their county Department office, Iowa Medicaid Enterprise (IME) Bureau of Medical and LTSS, the Department's contracted MCOs with which the facility is enrolled, and the Iowa Department of Inspections and Appeals Health Care Facility Division as soon as possible. The moving of residents often takes longer than expected. Sufficient notice can ease the problem considerably.

We suggest that the administrator and the Department confer about the closing and together make plans so that the goal for closing can be accomplished in a smooth manner.



Facilities should not make their own plans to move residents. Residents must be given a choice of enrolled qualified providers. Those residents receiving care under Medicaid are a financial responsibility of the Department. All plans for these people must be approved by the Department.

The county and regional offices of the Department will help in planning for moving into or out of facilities. These services are available to all Medicaid residents and to other residents on request.

3. Department Procedures

When an ICF/ID notifies the Department by means of the [Case Activity Report, form 470-0042](#), that a resident has been discharged (through death, return to own home, etc.), the income maintenance worker will enter the necessary information to close the Medicaid ICF/ID case through the eligibility system.

When a resident is transferred to another Medicaid facility within the county, the income maintenance worker enters the necessary information concerning the transfer.

4. Reasons for Discharge or Transfer

A Medicaid resident may be **involuntarily** discharged from an ICF/ID only if one of the following conditions exists:

- ◆ Discharge is necessary for medical reasons.
- ◆ The resident must be discharged for the resident's welfare or for the welfare of other residents.
- ◆ The resident does not make payment for ICF/ID care (financial participation).

Other instances where a resident may be discharged or transferred include the following:

- ◆ The resident wants to leave the facility. In the absence of a guardianship or other legal restraint, the resident may do so upon request.
- ◆ The resident's physician or family requests transfer or discharge. With agreement by the resident, this must then be done.



- ◆ The resident's guardian or other legal representative may request it.
- ◆ A finding that ICF/ID care is no longer medically necessary may terminate Medicaid payments, causing a person to seek other living arrangements for financial reasons.
- ◆ Death of the resident, closing or sale of the facility, fire, remodeling, revocation of license, etc.

5. Transfer of Residents by Ambulance

In some emergency cases, such as the closing of a facility or the loss of Medicaid certification by a facility, residents may need to be transferred from one facility to another by ambulance. Arrangements can be made to pay for this service through the Medicaid program.

Before transfer by ambulance, a worker from the county office of the Department must provide the Bureau of Medical and LTSS with the information necessary to process the claim and authorize the Iowa Medicaid Enterprise (IME) to make payment. Close coordination between the Bureau of Medical and LTSS, county offices, and facilities will be required in all emergency situations.

N. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Iowa Medicaid enrolled nursing facilities and residential care facilities bill for services electronically as an institutional claim on a monthly basis. The IME offers free electronic billing software, PC-ACE Pro 32, available through <http://www.edissweb.com>. Click [here](#) for more information on how to obtain PC-ACE software or to view help resources.

1. ICF/ID Provider Assessment Fee

As required by Iowa Code section 249A.21, licensed ICFs/ID certified to participate in the Medicaid program that are not operated by the state are obligated to pay a quarterly assessment fee to the Department.

The amount of the provider assessment fee is 5.5 percent of actual paid claims, from all sources, for the facility's preceding quarter.



The Department will increase each facility's Medicaid rate by an amount equal to 5.5 percent of the total annual revenues for the preceding fiscal year to account for the provider assessment fee. The increase in Medicaid rates is effective upon implementation of the provider assessment fee.

2. Method of Reimbursement

For members not enrolled in an MCO the Medicaid program reimburses ICFs/ID under a cost-related vendor payment system, with a per diem set for each facility. This rate is established on the basis of financial and statistical data submitted by the facility on the [Financial and Statistical Report, form 470-0030](#). The financial data submitted by the facility is audited by the accounting firm under contract with the Department.

State owned ICF/ID facilities will be reimbursed at 100% of allowable costs. Non-state owned ICF/ID facilities will be reimbursed at the lower of:

- ◆ Their current cost plus inflation;
- ◆ The 80th percentile; or
- ◆ The maximum allowable base rate

For members enrolled in an MCO, reimbursement will be at a rate negotiated between the facility and the MCO, which shall not be lower than the provider-specific per diem rate in effect on July 1, 2015.

3. Time Frames for Submitting Claims

Claims for members not enrolled in an MCO can be submitted any time during the month for the previous month. However, for residents who are in the facility all month, only one claim should be submitted per month after the end of the month.

Payment will be made for covered services when the IME receives the initial claim within one year from the date of services. Claims submitted beyond the one-year limit may be paid only when they are delayed due to delays in receiving third-party payments or retroactive eligibility determinations.



The IME generates payments weekly.

Claims for members enrolled in an MCO must be submitted to the MCO in accordance with their billing procedures.

4. Periods of Service for Which Payment Will Be Authorized

Payment for care in an ICF/ID is authorized to begin on the date that the resident is certified as medically needing that level of care and is otherwise financially eligible for Medicaid. It can continue as long as both of these criteria are met and the resident remains in care.

If only a distinct part of the total facility has been certified as an ICF/ID, payment may be approved through the Medicaid program only for residents who occupy beds in the certified part of the facility. The facility shall not submit claims to the state nor request authorizations from the Department for residents who do not receive care in the certified part of the facility.

Payment for care in an ICF/ID is made on a per diem basis for the portion of the month the resident is in the facility. Payment is made for the day of admission but not the day of discharge or death. No payment shall be made for care of persons entering and leaving the facility the same day. If there is excess member financial participation because the resident leaves the facility early in the month, the facility must refund the excess to the resident.

Under certain conditions, a facility may receive Medicaid payments for days that a resident is absent for visits or hospitalization. The facility shall report all resident absences to the county office using the [Case Activity Report, form 470-0042](#).



a. Absence for Hospitalization

Payment will be approved to hold the bed while the resident is hospitalized (not in a skilled bed) for a period not to exceed ten days in a calendar month, as long as the resident intends to return to the facility. However, if the person enters a mental health institute, this provision no longer applies. Payment will not be made for over ten days per month.

For example:

A resident enters the hospital on September 21 and is discharged on October 14. The resident then reenters the hospital on October 18 and is discharged October 31.

For the first hospitalization, Medicaid pays to hold the bed for the 10-day period of September 21 through 30. The 10 days renews in October.

In the second month, Medicaid pays to reserve the bed for the period of October 1 through 10 (10 days). The periods of October 11 through 14 and October 18 through 31 are not covered due to the 10-day limit in any one month.

NOTE: Payment for reserving a bed is made only when a resident was admitted before the absence. No payments are made to reserve a bed in a facility to which a resident intends to transfer.

b. Absence for Visits

Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. These days may be taken at any time. There is no restriction as to the amount of days taken in any one month or on any one visit, as long as the days taken in the calendar year do not exceed 30. Visit days shall not be used to extend payment for hospital stays. The resident must intend to return to the facility.

Additional days may be approved for special programs of evaluation, treatment, or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified intellectual disability professional, shall be maintained at the facility.



c. Payment Rate for Reserved Beds

Medicaid payments for reserved bed days in an ICF/ID of over 15 beds are made at the rate of 80 percent of the allowable audited cost (facility costs plus any added factors). Facilities with 15 or fewer beds are reimbursed at 95 percent of the allowable audited cost for reserved bed days.

Since the reserved bed payment rate has the result of changing the financial participation in some cases, administrators must ensure that the correct amount of financial participation is collected. This is particularly important where a resident leaves the facility and is due a refund on financial participation previously collected.

d. Payment After Medical Eligibility Denial

The Department is bound by medical review determinations performed by the IME Medical Services Unit. The Department is not authorized to pay for ICF/ID services provided to persons who do not satisfy the medical necessity criteria, even if the person is financially eligible. However, in certain cases, the Department continues limited Medicaid coverage after the IME Medical Services Unit eligibility denial.

(1) Grace Days

Financially eligible persons who are (or would be) new admissions to an ICF/ID and are medically denied by the IME Medical Services Unit are not eligible for ICF/ID service payment from Medicaid. Medicaid members in ICFs/ID who receive "continued stay" medical denials may be eligible for a grace-day period of up to 30 working days in order to make alternate arrangements for the member.

If the facility and case manager reports document that no appropriate, alternate placement is available within a reasonable distance, this grace period may be extended until alternate placement becomes available. Extension of grace days beyond the standard 30 working days is determined by the Bureau of Medical and LTSS.



(2) Continuation of Other Medicaid Services

If the member is determined to no longer meet the requirements for ICF/ID Medicaid coverage, the member's eligibility will be redetermined to see if the person may still be eligible to receive another Medicaid coverage group, if applicable.

If a resident is determined eligible for another Medicaid coverage group, they will continue to receive Medicaid state plan benefits. If a resident has another payment source available to maintain the resident at the ICF/ID, the resident could potentially stay in the ICF/ID but Medicaid would not be covering the stay.

5. Supplementation

Medicaid rules prohibit supplementation of the Medicaid payment for care in an ICF/ID. Only the amount of member financial participation may be billed to the resident. No supplementation of the state payment shall be made by any person. Practices such as charging residents or their families extra money for a private room are considered to be supplementation and are not permissible, even if the payment is offered voluntarily.

EXCEPTIONS:

- ◆ A resident, the family, or friends shall be allowed to pay a facility to reserve a resident's bed beyond the maximum number of reserve bed days that the Department pays or allows to be paid from resident participation. When a resident is not discharged, payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate.

However, facilities which discharge a resident after the date the state discontinues payment may make arrangements with the resident or family to hold the bed at whatever rate is agreed upon by both parties. Facilities must make arrangements with residents or their families to reserve beds in advance of the date when the reserve bed days run out and the resident is billed for the bed.



Iowa
Department
of Human
Services

Provider and Chapter

**Intermediate Care Facilities for the
Intellectually Disabled (ICF/ID)**

Chapter III. Provider-Specific Policies

Page

58

Date

January 1, 2016

- ◆ There are cases when a family member or other interested person wishes to make an ongoing voluntary contribution toward the cost of care of a Medicaid resident. Such payments shall not be considered as supplementation, so long as they increase the resident's member participation and are not over and above the payment made by the state for care of the resident.

The [Voluntary Contribution Agreement, form 470-0373](#), may be used to implement such a voluntary contribution.