

**MEDICAID SERVICES MANUAL  
TRANSMITTAL LETTER**

July 21, 2011

**TO:** CUSTODIANS OF MEDICAID SERVICES MANUAL

**FROM:** MARTA E. STAGLIANO, CHIEF, COMPLIANCE

**SUBJECT:** MEDICAID SERVICES MANUAL CHANGES  
CHAPTER 1600 – INTERMEDIATE CARE FOR THE MENTALLY  
RETARDED

**BACKGROUND AND EXPLANATION**

The policy has been revised in the area of transportation to provide examples of services not reimbursable to the facility and refer the reader to Medicaid Services Manual (MSM) Chapter 1900, Transportation Services. The changes reduce conflict of information between program chapters and provide additional direction regarding transportation to an Adult Day Health Care (ADHC) setting. The second revision addresses a provider’s use of ADHC services. Further changes direct the provider to the Rates and Cost Containment Unit for information regarding the Uniform Cost Report. Lastly, additional direction has been provided for the management of a patient’s trust fund account.

To bring the chapter into formatting consistent with other manual chapters the Definitions section and the References and Cross References section have been deleted and are being reserved for future use.

Throughout the chapter, grammar, punctuation, and capitalization changes were made, duplications removed, acronyms used and standardized, and language reworded for clarity. Renumbering and re-arranging of sections was necessary.

These policy changes are effective July 22, 2011.

**MATERIAL TRANSMITTED**

MTL 12/11  
CHAPTER 1600 - INTERMEDIATE CARE  
FOR THE MENTALLY RETARDED

**MATERIAL SUPERSEDED**

MTL 36/03, 38/08, 21/10  
CHAPTER 1600 - INTERMEDIATE CARE  
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<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
<b>1602</b>	<b>Definitions</b>	The section was deleted and is being reserved for

<b>Manual Section</b>	<b>Section Title</b>	<b>Background and Explanation of Policy Changes, Clarifications and Updates</b>
		future use.
<b>1603.4</b>	<b>Transportation</b>	Added types of transportation a facility must provide that are not reimbursable, the word “ambulance” to specify the type of emergency transportation that is reimbursable, and reference to Chapter 1900 as the authority regarding transportation policy.
<b>1603.6</b>	<b>Professional Services</b>	Added explanation of ADHC as part of an Active Treatment Program but separate reimbursement is not allowed.
<b>1603.7</b>	<b>Reimbursement Rate and Allowable Costs</b>	Revisions made to directions regarding contact and instructions for Uniform Cost Report. Added new sub-section “Patient Trust Fund Management” explaining the handling of patient trust funds and refers reader to MSM Chapter 500, Nursing Facilities
<b>1605</b>	<b>References and Cross References</b>	The section was deleted and is being reserved for future use.

DIVISION OF HEALTH CARE FINANCING AND POLICY

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1600 INTRODUCTION

Nevada Medicaid’s Intermediate Care Facilities for the Mentally Retarded (ICF/MR) Program was established in 1971 to provide reimbursement for individuals residing in institutions for people with mental retardation or other related conditions. The Social Security Act specifies that these institutes must provide active treatment in addition to other Conditions of Participation. Many of the residents who are served by the program are also non-ambulatory, may have seizure disorders, behavioral problems, mental illness, can be visually or hearing impaired or have a combination of these conditions.

The Division of Health Care Financing and Policy (DHCFP) has opted to provide services for people residing in an ICF/MR as a benefit under the State Plan for Medical Assistance.

All DHCFP (Nevada – Medicaid) policies and requirements (such as prior authorization, etc.) are the same for Nevada Check Up (NCU), with the exception of the areas where Medicaid and NCU policies differ as documented in the NCU Manual Chapter 1000.

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1601 AUTHORITY

Federal Statutes, Regulations, and Policies Governing the Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program.

The following are the relevant statutes, regulations, and State Operations Manuals (SOM) that govern the ICF/MR Program.

FEDERAL STATUTES governing ICF/MR – Social Security Act:

- Section 1905(d) – Defines ICF/MR
- Section 1905(a)(15) – Defines ICF/MR
- Section 1902(a)(33) – Directs Centers for Medicare and Medicaid Services (CMS) to make independent and binding determinations
- Section 1902(i)(1) – State plans for medical assistance and the ICF/MR program.
- Section 1922 – Correction and Reduction Plans for ICF/MR
- REGULATIONS governing the ICF/MR program – Title 42 of the Code of Federal Regulations (CFR)
- 42 CFR 435.1009 – Definitions relating to institutional status for the purpose of Federal Financial Participation (FFP)
- 42 CFR 440.150 – ICF/MR services
- 42 CFR 440.220 – Required services for the medically needy
- 42 CFR 442.118-119 – Denial of new admissions
- 42 CFR 483.10 – Resident Rights
- 42 CFR 483.400-480 – Conditions of Participation for ICF/MR
- 42 CFR 498.3-5 – Appeals procedures for determinations that affect participation in the Medicare program and for determinations that affect the participation of ICF/MR and certain Nursing Facilities in the Medicaid program.
- SURVEY procedures governing the ICF/MR program – State Operations Manual (SOM), Chapters 1, 2, 3, 9 – Exhibit 80 and Appendix J.

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1602      **RESERVED**

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1603 POLICY

1603.1 Intermediate Care Facilities for the Mentally Retarded (ICF/MR) must be certified and comply with all Federal Conditions of Participation in eight areas, including management, client protections, facility staffing, active treatment services, client behavior and facility practices, health care services, physical environment and dietetic services.

In Nevada, the Bureau of Health Care Quality and Compliance (HCQC) of the State Health Division licenses ICF/MR facilities, conducts surveys and recommends certification of the facilities as Medicaid providers.

1603.1A COVERAGE AND LIMITATIONS

1. ADMISSION AND CONTINUED STAY CRITERIA

- a. The recipient must be diagnosed as mentally retarded or have a condition related to mental retardation. Some standardized scales which can be used to determine level of mental retardation include, but are not limited to, the Vineland Social Maturity Scale, the Adaptive Behavior Scale, and the Behavior Development Survey.
- b. The recipient must have an Individual Program Plan (IPP).
- c. A physician must certify the need for ICF/MR care prior to or on the day of admission (or if the applicant becomes eligible for Medicaid while in the ICF/MR, before the Nevada Medicaid Office (NMO) authorizes payment).
- d. The certification must refer to the need for the ICF/MR level of care, be signed and dated by the physician, and be incorporated into the resident's record in the physician's orders.
- e. Recertification by a physician or a nurse practitioner of the continuing need for ICF/MR care is required within 365 days of the last certification.  
  
In no instance is recertification acceptable after the expiration of the previous certification.
- f. The physical exam must document the resident does not have any active communicable, contagious, or infectious disease.
- g. The Interdisciplinary Team (IDT) evaluation documents that the recipient needs more intensive treatment than can be provided in a day treatment program or a community residential program.

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The IDT evaluation documents that the recipient needs and can probably benefit from the active treatment program. The program is directed toward the acquisition of behaviors necessary to maximize the recipient's possible independence and self determination or to prevent or decelerate regression or loss of the recipient's current level of functioning for a recipient for whom no further positive growth is demonstrable.

- h. The IDT has developed an appropriate IPP based on its evaluation and reevaluated the plan as required.
- i. The recipient had Medicaid Eligibility on the date(s) of service.
- j. Services are provided in a Medicaid certified participating facility.

1603.1B PROVIDER RESPONSIBILITY

1. MEDICAID ELIGIBILITY

The provider is responsible to verify a recipient's Medicaid eligibility. The Electronic Verification System (EVS) may be used.

Refer to Chapter 100 of the Medicaid Services Manual (MSM) for detailed information on application and eligibility categories.

2. FACILITY CERTIFICATION

Certification of compliance with federal requirements for participation in the Medicaid program is required; contact the HCQC of the State Health Division for information and procedures.

The facility must also have a valid Provider Agreement with the Nevada Medicaid Office; the Agreement must be co-terminus with Medicaid's period of certification, including any automatic cancellation dates imposed by **Centers for Medicare and Medicaid Services (CMS)**. The maximum duration of a Provider Agreement is 12 months.

3. PRELIMINARY ASSESSMENT

The IDT must complete a preliminary assessment of each recipient prior to admission to the facility.

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The preliminary assessment must include background information and current valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the recipient's needs, if the recipient is likely to benefit from placement in the facility, and what services are needed to meet those needs.

#### 4. PSYCHOLOGICAL EVALUATION

There must be a psychological evaluation documenting the need for care which must be completed within three months before admission and prior to authorization of payment.

For an urgent or emergency initial ICF/MR placement, a psychologist may review the most recent psychological evaluation and document with a progress note or addendum to the psychological evaluation that the recipient is eligible and needs ICF/MR placement. The note or addendum must confirm the recipient's specific level of retardation or identify the condition related to mental retardation and be signed and dated within 90 days prior to admission or on the admission date. This progress note or addendum must be attached to the most recent psychological evaluation.

For readmission and discharge to another ICF/MR, a new psychological evaluation is not required unless the IDT determines the existing evaluation is no longer accurate.

#### 5. PHYSICIAN'S CERTIFICATION AND MEDICAL PLAN OF CARE

The physician must complete a medical plan of care if the resident requires 24-hour licensed nursing care. It must include:

- a. Diagnoses, symptoms, complaints, and complications indicating the need for admission;
- b. Any orders for:
  1. medications;
  2. treatments;
  3. restorative and rehabilitative services;
  4. activities;
  5. therapies;

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6. diet;
7. medical equipment utilized to help treat medical conditions, such as helmets or orthopedic splints; and
8. special procedures designed to meet the objectives of the plan of care.

#### 6. THIRTY-DAY EVALUATION RECORD REQUIREMENTS

Within 30 days of admission, the following assessments and evaluation which were completed (as appropriate to the recipient's needs) must be entered in the resident's record.

- a. A physical examination and history which was completed within five days prior to or 30 days after admission. The examination and history may be conducted by an advanced practitioner of nursing or physician's assistant, if within their scope of practice, or a physician. The examination must include screening for vision and hearing.
- b. A complete dental examination which is completed within 12 months prior to or one month after admission.
- c. Evaluation of nutritional status which includes the determination of diet adequacy, total food intake, potential need for additives or supplements, and the skills associated with eating or feeding, food services practices, monitoring, and supervision of the resident's own nutritional status.
- d. Routine laboratory examinations as determined necessary by a physician.
- e. Speech and language screening.
- f. Social assessment which includes, but is not limited to, family history, social relationships and interactions with peers, friends and relatives, and social development.
- g. Active Treatment Schedule.
- h. A nursing assessment which includes medication and immunization history, developmental history, and current health care needs.
- i. Assessment of sensorimotor development which includes the development of perceptual skills which are involved in observing the environment and making sense of it; the development of those behaviors which primarily involve muscular,

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neuromuscular, or physical skills and varying degrees of physical dexterity; identifying the extent to which corrective, orthotic, prosthetic, or support devices would impact on functional status.

- j. Assessment of affective development which includes the development of behaviors which relate to the recipient's interests, attitudes, values, and emotional expressions.
- k. Assessment of cognitive development which refers to the development of those processes by which information received by the senses is stored, recovered, and used including the development of the processes and abilities involved in memory and reasoning.
- l. Assessment of adaptive behaviors and independent living skills which includes the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected of their age and cultural group and skills such as meal preparation, laundry, bed making, budgeting.
- m. Assessment of vocational or prevocational development, as applicable, which includes work interests, work skills, work attitudes, work related behaviors and present and future employment options.

All of the assessments must describe what recipients can and cannot do in terms of skills needed within the context of their daily lives.

In addition, the assessments must:

- n. Identify the recipient's present problems and disabilities and where possible, their causes;
- o. Identify the recipient's specific developmental strengths;
- p. Identify the recipient's specific developmental and behavioral management skills;
- q. Identify the recipient's need for services without regard to the actual availability of services needed.

7. INDIVIDUAL PROGRAM PLAN (IPP)

- a. Within 30 days of admission, the IDT develops an IPP for each resident based on the interdisciplinary professional comprehensive evaluations.

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- b. The purpose of the IPP is to help the individual function at the greatest physical, intellectual, social, or vocational level the recipient has presently or can potentially achieve.
- c. The interdisciplinary team must prepare an IPP which includes opportunities for individual choice and self management and identifies the discrete measurable criteria-based objective the recipient is to achieve, and the specific individualized program of specialized and generic strategies, supports and techniques to be employed. The IPP must be directed toward the acquisition of the behaviors necessary for the recipient to function with as much self-determination and independence as possible, and the prevention or deceleration of regression or loss of current optimal functional status.

#### 8. IMPLEMENTATION OF CONTINUOUS ACTIVE TREATMENT

- a. The ICF/MR must provide active treatment. Once the IDT has developed the recipient's IPP, the recipient must 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 plan.
- b. The individual's time in the home or living unit must maximize toward further development and refinement (including self-initiation) of appropriate skills.
- c. For the active treatment process to be effective, the overall pattern of interaction between staff and a recipient must be related to the comprehensive functional assessment and the IPP.
- d. Except for those facets of the IPP which must be implemented by licensed personnel, each recipient's program plan must be implemented by all staff who work with the recipient, including professional, para-professional, and other staff, including direct care staff.
- e. The facility must ensure that during staff time spent with each recipient, the staff members are able to provide needed interventions or reinforce acquired skills in accordance with the program plan. The activities of the ICF/MR must be coordinated with other habilitation and training activities in which the recipient may participate outside of the ICF/MR and vice versa, i.e. school or Community Training Center (CTC).

#### 9. ACTIVE TREATMENT SCHEDULE

Within 30 days of admission to the facility, staff must develop an active treatment schedule which outlines the current active treatment program and is readily available for

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review by relevant staff. The schedule should direct the intensity of the daily work of the staff and the recipient in implementing the individual program plan. To the extent possible, the schedule should allow for flexible participation of the recipient in a broad range of options, rather than on a fixed regimen.

The facility must develop an active treatment schedule for each recipient which:

- a. Does not allow for periods of unscheduled activity of longer than three continuous hours;
- b. Allows free time for individual or group activities using appropriate materials;
- c. Includes planned outdoor period year-round;
- d. Reflects some of the specific programs for the individual rather than a facility or unit-wide generic calendar.

#### 10. QUALIFIED MENTAL RETARDATION PROFESSIONAL (QMRP) REVIEWS

##### a. Reviews

A facility must have one or more QMRP's review the IPP and assure it is revised as necessary. The frequency of the QMRP reviews are determined by the facility. The duties of the QMRP are:

1. Monitoring the delivery of each IPP;
2. Integrating and coordinating the various aspects of the active treatment program;
3. Reviewing each recipient's program plan and insuring it is revised as necessary, including but not limited to, situations in which the recipient:
  - a. Has successfully completed an objective or objectives identified in the IPP;
  - b. Is regressing or losing skills already gained;
  - c. Is failing to progress toward identified objectives after reasonable efforts have been made; or
  - d. Is being considered for new training.

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4. Obtaining input and review by other IDT members when the revisions result in significant differences from the team's original intent;
5. Documents information relevant to the IPP, assuring it is recorded as changes occur.

#### 11. ANNUAL INTERDISCIPLINARY TEAM (IDT) REVIEW

Within one year of the resident's admission date and at least once annually thereafter, the IDT must re-evaluate each recipient and revise the IPP. Revisions must be developed and implemented and recommendations acted upon within 30 days of the IDT meeting, unless other time frames are justified.

- a. The annual review must include:
  1. The advisability of continued ICF/MR placement versus an alternative placement;
  2. When the recipient is an adult, the need for guardianship and how the recipient can exercise his/her civil and legal rights;
  3. The continuing appropriateness of the IPP objectives;
  4. The continuing appropriateness of services provided to reach the plan's objectives;
  5. The progress or failure to progress toward the plan's objectives;
  6. Modification of the activities, objectives and/or training programs of the IPP as are necessary; and
  7. A comprehensive functional reassessment to be based upon:
    - a. Physical examination including a vision and hearing screening, which may be completed by a physician or an advanced nurse practitioner;
    - b. Dental examination;
    - c. Social reassessment;
    - d. Physician's recertification of need for ICF/MR;

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- e. Nursing reassessment;
  - f. Routine screening laboratory tests as determined necessary by the physician;
  - g. Nutritional reassessment;
  - h. The IDT must determine whether other assessments are still accurate.
8. Accurate assessments must include:
- a. Current, relevant and valid data;
  - b. Skills, abilities and training needs identified which correspond to the resident's actual status; and
  - c. The cultural background and experiences of the resident are reflected in the choice, administration and interpretation of the assessments.

Assessments which are no longer accurate must be revised. The case record must document that the IDT has reviewed the assessments and determined which need updating.

Assessments which must be reviewed by the IDT and revised as recommended by the IDT are:

- d. Sensorimotor, affective and cognitive development;
- e. Adaptive behaviors and independent living skills; and
- f. Vocational and prevocational development as applicable.

## 12. OCCUPANCY REPORTS

To assist in appropriate use of available beds, the facility must complete the Monthly Facility Occupancy Report indicating the actual census as of the first day of each month. This report is due by the fifth day of each month. The occupancy report may be submitted by fax to Division of Health Care Financing and Policy (DHCFP), Continuum of Care Unit, (775) 687-8724.

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### 13. INCIDENT REPORTS

Incidents involving any potential harm to a resident in or around the facility must be:

- a. Recorded on an adequate form;
- b. Reported to the resident's physician or his alternate immediately if there is serious harm;
- c. Reported to the family member, authorized representative or legal guardian; and
- d. Evaluated by a nurse.

Incident documentation may be maintained apart from the resident's chart but, upon request, must be made available to authorized representatives of the DHCFP and/or Nevada State Health Division.

A facility must report to the Nevada Medicaid Office by telephone, within 48 hours, any incident in or about the facility that results in the death of or serious injury to any Medicaid resident by other than natural causes.

#### 1603.1C RECIPIENT RESPONSIBILITY

1. Recipients and/or their authorized representative are responsible to apply for and to maintain Nevada Medicaid eligibility by cooperating with the **Division of Welfare and Supportive Services (DWSS)** in providing information necessary to determine eligibility.
2. Application for services is made directly through the service provider in conjunction with the Health Division's Mental Health and Development Services (MHDS).
3. The recipient and the recipient's family/guardian should participate in developing the IPP unless the QMRP documents that such participation is inappropriate or unobtainable. If the recipient is a legally competent adult, he/she may request that his/her family not be involved in the planning process.
4. The recipient is responsible to participate in the active treatment program as described in the IPP.

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1603.1D AUTHORIZATION PROCESS

1. GENERAL REQUIREMENTS

- a. Prior authorization by the **Quality Improvement Organization (QIO-like vendor)** is required for payment for care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- b. Authorization will be given only after a determination by the QIO-like vendor that ICF/MR admission criteria have been met.
- c. Authorization cannot be given for a resident whose eligibility status is pending. However, if eligibility is established retroactively, Medicaid may authorize retroactive payment to the facility for necessary services at the ICF/MR level of care which have been certified by a physician.

2. ICF/MR TRACKING FORM

The facility must submit an ICF/MR Tracking Form within 72 hours of an admission, readmission, discharge, Medicaid eligibility determination or annual continued stay review.

This form is to be submitted to the DHCFP or their QIO-like vendor. Failure to submit the Tracking form may result in a delay or denial of payment.

3. PRE-PAYMENT REVIEW

Pre-Payment Review packets must be submitted to Nevada Medicaid's QIO-like vendor within 45 days of admission, readmission, or newly Medicaid eligible (first time billing).

The below required attachments are referred to as a Pre-Payment Review packet. The pre-payment review packet serves as documentation to assess the appropriateness of placement. Once the Pre-Payment Review packet has been approved the facility will be notified by receiving a Billing Authorization letter. An ICF/MR will not be able to bill for services until they have received the Billing Authorization letter.

- a. Required Attachments for Pre-Payment Review Packets
  1. Copy of the original ICF/MR Tracking Form;
  2. History & Physical Examination (most recent);

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3. Acute Discharge Summary (if there was a hospital stay which lasted longer than 48 hours);
4. The most recent psychological test results documenting the recipient's level of retardation or existence of a "related condition";
5. Minutes of the most recent IDT meeting (Initial, Readmission, or Annual) that includes a dated sign-in sheet, a Nursing Assessment, Nutritional Assessment, Social Services Assessment and documentation of a dental exam within the past year.
6. The current IPP developed by the IDT and Active Treatment Schedule.
7. Physicians admission orders and certification for ICF/MR level of care.

b. Complete Pre-Payment Review Packet

If the packet has information which is incomplete or inaccurate, the packet will be returned to the facility, with the Additional Information form identifying the problem. The facility must review this request, make necessary corrections or provide additional information to assure all areas are addressed prior to resubmitting the packet. A facility staff member(s) must initial any alterations.

4. ANNUAL CONTINUED STAY PAYMENT REVIEW PACKET

Annually, the ICF/MR must submit to Nevada Medicaid documentation verifying the need for a recipient's continued stay.

a. Required attachments for the Annual Continued Stay Payment Review Packets:

1. Most recent annual IDT review with signatures and titles of the participants.
2. The Physician's signed recertification of continued need for ICF/MR level of care.
3. Most recent annual History and Physical with listed diagnoses.
4. Copy of the ICF/MR Tracking form.

Continued payment will not be approved without the annual review packet.

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1603.2 READMISSION PROCEDURES

1603.2A COVERAGE AND LIMITATIONS

Refer to Section 1603.1A of this Chapter.

1603.2B PROVIDER RESPONSIBILITIES

1. HOSPITAL OR NURSING FACILITY DISCHARGE/READMISSION

If a recipient is discharged to a hospital or nursing facility from the ICF/MR and returns to the same ICF/MR, the following procedures are required:

- a. Within 72 hours of the recipient's discharge, the facility must complete and submit to the DHCFP QIO-like vendor an ICF/MR Tracking Form.
- b. Within 72 hours of the recipient's return to the ICF/MR, the facility must complete and submit the ICF/MR Tracking form.
- c. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification and update the physician's orders.
- d. The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

On or prior to the date of admission, the IDT must review and revise the IPP. If the IDT finds the objectives are appropriate and do not need revising, they must so note in the case records. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

- e. The facility must obtain the hospital's discharge summary if the hospital stay was for longer than 48 hours and file it in the recipient's record.
- f. Within 45 days submit the Pre-Payment packet to Nevada Medicaid's QIO-like vendor.
- g. If the recipient has been out of the ICF/MR for more than 30 days, all the requirements for a new admission must be met.

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h. Admission to an ICF/MR from another ICF/MR is a new admission to the accepting facility. Each ICF/MR has a separate Medicaid provider number and each is considered a separate facility even if multiple facilities share a governing body.

2. DISCHARGE/READMISSION TO/FROM HOME OR COMMUNITY BASED PLACEMENT

If a recipient is transferred from an ICF/MR into a residential community based home or home placement, the following procedures apply:

- a. The facility must submit the ICF/MR Tracking form to Nevada Medicaid's QIO-like vendor within 72 hours of when the recipient is transferred.
- b. If the recipient returns to the ICF/MR within the trial placement period (within 30 days of leaving the ICF/MR) the facility must:
  1. Complete the tracking form within 72 hours of the recipient's return and submit it to Nevada Medicaid's QIO-like vendor.
  2. On or prior to the date of readmission, the IDT determines whether assessments are still accurate. Assessments which are no longer accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating.
- c. If a recipient is transferred from one ICF/MR to another ICF/MR, the following procedures must be followed:
  1. The discharging facility must complete an ICF/MR tracking form within 72 hours of discharge and submit to Nevada Medicaid's QIO-like vendor.
  2. The discharging facility must develop a final summary of the recipient's developmental, behavioral, social, health and nutritional status and plan to help the recipient adjust to the new placement. With the consent of the recipient/parents (if a minor child)/legal guardian, the summary must be provided to authorized persons and agencies.
  3. Within 30 days after admission, the admitting ICF/MR IDT must perform accurate assessments or reassessments as needed (defined in Manual Section 1603.1B11.a.8 of this chapter).

On or prior to the date of readmission, the IDT must review and revise the IPP. If the IDT finds that the objectives are appropriate and do not need

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revising, it must be noted in the case record. This notation may be in the IDT minutes or on the plan objectives which are not being revised.

- a. Prior to or on the date of return to the ICF/MR, a physician must complete the physician's certification (See Manual Section 1603.1A2) and update the physician's orders.
- b. Within 45 days of the readmission, the facility must submit the Pre-Payment Review Packet, defined in Manual Section 1603.1D.3 of this chapter, to Nevada Medicaid's QIO-like vendor.
- c. If the recipient returns to the ICF/MR after the trial placement period has ended, all the requirements for a new admission must be met with one exception.

The IDT determines whether assessments are still accurate. Assessments which are not accurate must be revised. The case record must show that the IDT has reviewed all assessments and determined which need updating. This could be noted on each assessment which does not need revising or in the minutes of the IDT meeting.

### 1603.3 OUT-OF-STATE ICF/MR PLACEMENT

Nevada Medicaid must prior authorize all out-of-state ICF/MR placements for all Medicaid recipients arranged by any agency, individual, or district office. Nevada Medicaid will issue a Prior Authorization (PA) to the out-of-state facility and the Medicaid District Office may assist to arrange transportation. A recipient residing in an out-of-state facility without Medicaid authorization may place the out-of-state facility at risk for delayed or non-payment of services and the resident may be considered a resident of the state of location.

### 1603.3A COVERAGE AND LIMITATIONS

#### PRE-PLACEMENT PROCEDURES

The following pre-placement procedures must be followed before Nevada Medicaid will authorize an out-of-state ICF/MR placement:

1. All appropriate facilities within Nevada must first be contacted for a possible placement. The facilities contacted and reasons for not accepting the recipient must be documented.

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2. Documentation, if applicable, is required from a state or county agency verifying responsibility for payment of educational expenses, since this is not a Medicaid benefit. Documentation is required for recipients under age 22 and who have not completed state schooling requirements.
3. If there is no burial coverage and family is not willing/able to purchase it, a burial guarantee must be obtained from the Division of Child and Family Services (DCFS), or the county of origin.
4. If the individual is incompetent or suffers from diminished capacity and there is no family, legal guardian or significant other involvement, efforts must be made to have the Public Administrator or a guardian appointed to handle possible legal, health or financial matters prior to out-of-state placement.
5. The individual (and family or custodial agency if applicable) must agree in writing to out-of-state placement.
6. The out-of-state ICF/MR must be a Nevada Medicaid provider.

#### 1603.3B PROVIDER RESPONSIBILITY

All of the following are required for authorization for an out-of-state placement:

1. Completed Out-of-State Intake Questionnaire.
2. Current History and Physical exam and list of current medications.
3. Proof of burial coverage or guarantee (if available) and a signed statement from the recipient or responsible party acknowledging that Medicaid benefits end with death of the recipient.
4. Statement from the recipient, if a minor from his/her parent, or from a legal guardian agreeing to an out-of-state placement.
5. A list of all Nevada ICF/MR facilities contacted including date contacted the name of the person at the ICF/MR who denied placement and the reason for denial.
6. A letter verifying coverage of educational costs for a recipient who is under age 22 and has not completed high school.
7. Social history and assessment.

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8. Psychological evaluation verifying the person with mental retardation or with a condition related to mental retardation will benefit from placement in an ICF/MR.

All documents must be sent to the DHCFP, Attention: Out-of-State Placement Coordinator.

#### 1603.4 TRANSPORTATION

Transportation for services that a facility is required to provide is not reimbursable, **such as but not limited to medical appointments, social events and Adult Day Health Care (ADHC) attendance.**

Medicaid will reimburse for **ambulance** transportation in a medical emergency situation.

Refer to **MSM Chapter 1900, Transportation Services**, for **further** details on transportation.

#### 1603.5 ABSENCES

##### 1603.5A COVERAGE AND LIMITATIONS

1. Payment for therapeutic leave of absence, or reserved beds, may be made to an ICF/MR, subject to the following conditions:
  - a. The purpose of the therapeutic leave of absence is for rehabilitative home and community visits including preparation for discharge to community living;
  - b. The patient's attending physician authorizes the therapeutic leave of absence and the plan of care provides for such absences;
  - c. An ICF/MR will be reimbursed their per diem rate for reserving beds for Medicaid recipients who are absent from the facility on therapeutic leave up to a maximum of twenty-four (24) days annually. For this purpose, annually is defined as a calendar year beginning on January 1 and ending on December 31 of the same year.
2. An absence for hospitalization or placement in a nursing facility which exceeds the Medicaid authorized maximum is not reimbursable.
3. If a recipient does not return from a home visit or family emergency and if the absence has been appropriately documented by the recipient's physician and the facility, the facility will not be penalized for the recipient's failure to return. This absence will be treated as a discharge effective the day the recipient was expected to return from leave.

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1603.6 PROFESSIONAL SERVICES

In order to qualify for Medicaid reimbursement and provide services necessary to assure a comprehensive Active Treatment Program, ICF/MR employ or contract with individuals who can assess recipient needs, participate in the IPP, and provide appropriate training and habilitation services. These support staff assist in providing those physical and social modifications or interventions allowing the recipient to function and adapt to his/her physical and social environment.

**ADHC services may be considered part of an Active Treatment Program. This service is not Medicaid reimbursable outside of the facility's routine per diem rate.**

1603.6A COVERAGE AND LIMITATIONS

1. RECREATION

a. Services for Recipients with Handicapping Conditions

Multiple handicapped or non-ambulatory recipients must:

1. Spend a major portion of the waking day out of bed;
2. Spend a portion of the waking day out of the bedroom area;
3. Have planned daily activity and exercise periods;
4. Move around with various methods and devices whenever possible; and
5. Have recreation areas and facilities designed and constructed or modified so that they, regardless of their disabilities, have access to them.

b. Coordination with the IPP

Recreation services should be a coordinated part of the recipient's IPP.

A recreation assessment must be completed or updated within 30 days of admission into an ICF/MR. If recreation therapy is provided, an annual re-evaluation by the recreational therapist is required. If the IDT recommends during an IDT meeting that a re-assessment be completed by the recreational therapist, one must be completed within 30 days of the recommendation.

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c. Recreation Services Objectives

Recreation services should:

1. Provide activities designed to meet individual, personal, and therapeutic needs in self-expression, social interaction, and entertainment;
2. Develop skills, including physical and motor skills, and interests leading to enjoyable and satisfying use of leisure time; and
3. Improve socialization and increase interaction with others.

d. Recreational Staff Qualifications

1. To be designated as a professional recreation therapist the staff member must have a Bachelor's Degree in recreation, or a related specialty area, such as art, dance, music, or physical education.
2. Sufficient qualified staff and support staff should be available to carry out recreational services in accordance with the stated objective(s) in the IPP.

2. SOCIAL SERVICES

a. Purpose of Social Services

Social Services must be directed toward:

1. Maximizing the social functioning of each recipient;
2. Enhancing the coping capacity of each recipient's family;
3. Asserting and safeguarding the human and civil rights of the recipient and his/her family; and
4. Fostering the human dignity and personal worth of each recipient.

b. Pre-Admission Services

During the evaluation process to determine whether or not admission to the ICF/MR is necessary, social workers must help the recipient and his/her family:

1. Consider alternative services, based on the individual's status and relevant family and community factors; and

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2. Make a responsible choice as to whether and when residential placement is indicated.

c. Ongoing Evaluation and Monitoring of Residents

Social workers must participate in the IDT meetings for each recipient for the purposes of monitoring and following up on program plans.

d. Liaison with Recipient's Family and the Community

The social worker must, as appropriate, provide liaison between the recipient, the ICF/MR, the family, and the community.

e. Discharge Planning

1. In addition to participation in the development of the discharge plan, social workers must:

- a. Help the family participate in planning for the recipient's return to home or other community placement; and
- b. Provide systematic follow-up to assure referral to appropriate community agencies after the recipient leaves the facility.

2. If a recipient is to be either transferred or discharged, the facility must:

- a. Have documentation in the resident's record that the resident was transferred or discharged for good cause.

Transfer means the temporary movement of an individual between facilities or the permanent movement of an individual between living units of the same facility. Discharge means the permanent movement of an individual to another residence that is not under the jurisdiction of the facility's governing body. Moving an individual for good cause means for any reason that is in the best interest of the individual.

The recipient, his/her family, advocate and/or guardian should be involved in any decision to move him/her.

- b. Provide a reasonable time to prepare the recipient and his or her parents or guardian for the transfer or discharge (except in emergencies).

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f. Social Work Staff Qualifications

A social worker must be licensed as an Associate in Social Work or a Social Worker by the Nevada State Board of Examiners for Social Work.

3. PSYCHOLOGICAL AND PSYCHIATRIC SERVICES

a. Purpose of Psychological Services

Psychological services must be provided to:

1. Maximize each recipient's development; and
2. Help recipients acquire:
  - a. Perceptual skills;
  - b. Sensorimotor skills;
  - c. Self-help skills;
  - d. Communication skills;
  - e. Social skills;
  - f. Self-direction;
  - g. Emotional stability; and
  - h. Effective use of time, including leisure time.

b. Psychological Services

The facility must provide a psychological service program for recipients which includes:

1. Evaluations which must be done at least every three years for recipients under age 18 and every five years for recipients aged 18 or older. The evaluations must document that the resident has mental retardation. The level of retardation may be two levels if the recipient's functioning is in between them, e.g., moderate-severe.
2. Consultation;

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3. Therapy;
4. Program development;
5. Administration and supervision of psychological services;
6. Staff training;
7. Continuing inter-disciplinary evaluation of each recipient and development of plans for habilitation services; and
8. When appropriate, periodic review and revision of program plans.

c. Psychological Staff Qualifications

1. A psychologist must have at least a Master's degree from an accredited program and experience or training in the field of mental retardation. If hired or subcontracted with after July 1, 1986, the psychologist must be certified by the Nevada State Board of Psychological Examiners.
2. A psychologist who is the facility's QMRP must meet the qualifications in Manual Section 1603.1B.10 of this chapter.

d. Psychiatric Services

1. Psychiatric services should be provided when indicated by the IDT for psychotherapy, medication management and/or consultation.
2. To provide services in an ICF/MR a psychiatrist must be a medical doctor licensed to practice psychiatry in the State of Nevada.

4. DENTAL SERVICES

Through a formal arrangement with a dentist licensed to practice dentistry or dental surgery as defined in Nevada Revised Statutes (NRS) 631.215, the ICF/MR facility must provide:

- a. A comprehensive diagnostic dental examination within one month of admission to the facility unless the recipient has had a dental examination within the 12 months prior to admission.
- b. Periodic examination and diagnosis done at least annually for each recipient.

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- c. Necessary access to the services specified under the MSM Chapter 1000, excluding sealants, orthodontia, pharmacy services, fluoride treatments, and fluoride treatments with prophylaxis.
- d. For children under 21 years of age residing in an ICF/MR referred for dental care through the Healthy Kids Program, also known as Early and Periodic Screening Diagnosis and Treatment (EPSDT), a Medicaid dental provider may bill directly to Medicaid.
- e. For adults 21 years and older residing in an ICF/MR, dental treatment for emergency extractions, palliative care, and dentures can be billed to Medicaid by a Medicaid dental provider in accordance with the MSM Chapter 1000 guidelines and limitations.
- f. If appropriate, the dentist or dental hygienist may participate in the development, review, and updating of the IPP as part of the IDT process, either in person or by written report.

## 5. PHARMACEUTICAL SERVICES

### a. Pharmacist Duties

- 1. Upon admission, the pharmacist or registered nurse must obtain a history of prescription and non-prescription drugs used and enter this in the resident's record. This must be updated yearly.
- 2. The pharmacist must receive a copy for each resident of the physician's drug treatment order.
- 3. The pharmacist must maintain for each resident a record of all prescription and non-prescription medications dispensed including quantities and frequency of refills.
- 4. As appropriate the pharmacist should participate in the ongoing IDT evaluations and development of the individual program plan.
- 5. The pharmacist must establish quantity specifications for drug purchases and insure that they are met.
- 6. The pharmacist must review each resident's drug regimen at least quarterly.

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7. On a monthly basis the pharmacist must complete the Checklist for Pharmacist Consultant (3232). The facility must retain the checklist for a period of three fiscal years from the year to which they pertain (NRS 239.073).

b. Staff or Consultant

1. If a facility does not employ a licensed pharmacist, it must have an agreement, with a licensed pharmacist to provide consultation on methods and procedures for ordering, storage, administration, disposal, and recording of drugs and biologicals.
2. Payment for consultant pharmacist services are separate from payment for filling of prescriptions. With the consultant pharmacist, payment is made by the facility for a service to the facility. In the case of prescribed drugs, a provider payment is made by Medicaid to a pharmacy on behalf of the recipient. The individual furnishing consultant pharmacist services to a facility may or may not also be providing prescribed drugs to residents in that facility. However, when it is feasible, separation of consultant services and prescription services is encouraged.

c. Limitations

Nevada Medicaid reimburses the pharmaceutical provider directly for prescriptions that meet the definition of essential in Section 1602.6 of this chapter.

The consultant pharmacist must review every drug ordered for compliance with this definition.

If drug therapy is observed which does not meet the definition of essential as stated in Section 1602.11 of this chapter, future charges for the medication will be denied. Before this sanction is imposed, the facility and the pharmacy will receive advance notice. If Nevada Medicaid does not receive appropriate justification within 10 days from the date of notification, all future charges for the medication will be denied.

6. PHYSICAL AND OCCUPATIONAL THERAPY (OT)

a. Services

1. Physical and OT staff must provide treatment training programs which are designed to:

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- a. Preserve and improve abilities for independent function such as range of motion, strength, tolerance, coordination, and activities of daily living; and
  - b. Prevent, insofar as possible, irreducible or progressive disabilities through means such as the use of orthotic and prosthetic appliances, assistive and adaptive devices, positioning, behavior adaptations, and sensory stimulation.
2. Services must be coordinated with the recipient's physician and other medical specialists.
  3. Services must include:
    - a. Evaluation;
    - b. Participation in developing treatment objectives as part of the IPP;
    - c. Procedures to reach objectives; and
    - d. Revision of objectives and procedures based on progress (or lack of progress).
  - b. Staff and Qualifications
    1. The ICF/MR must have available enough qualified staff and support personnel available either on staff or under contract to carry out the various physical and occupational therapy services in accordance with stated objectives in recipients' individual treatment plans.
    2. Therapy assistants must work under the supervision of a qualified therapist.
    3. To be designated as an occupational therapist, an individual must have a current registration issued by the American Occupational Therapy Association or another comparable body.
    4. To be designated as a physical therapist an individual must have a current registration to practice physical therapy issued by the Nevada State Board of Physical Therapy Examiners.

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7. SPEECH PATHOLOGY AND AUDIOLOGY SERVICES

a. Services

Speech pathology and audiology services available to the ICF/MR must include:

1. Screening of recipients with respect to hearing functions which is completed by the physician or advanced nurse practitioner as part of the annual physical examination, and screening of recipients regarding speech functions;
2. Comprehensive audiological assessments of recipients as indicated by screening results, which were part of the recipient's physical examination, that include tests of puretone air and bone conduction, speech audiometry, and other procedures, as necessary, and the assessment of the use of visual cues;
3. Assessment of the use of amplification;
4. Provision for procurement, maintenance, and replacement of hearing aids, as specified by a qualified audiologist;
5. Comprehensive speech and language evaluations of recipients as indicated by screening results, including appraisal of articulation, voice, rhythm, and language;
6. Participation in the IDT Process and IPP development for individual recipients;
7. Treatment services as an extension of the evaluation process, which include:
  - a. Direct counseling with recipients;
  - b. Consultation with appropriate staff for speech improvement and speech education activities; and
  - c. Work with appropriate staff to develop specialized programs for developing each recipient's communication skills in comprehension, including speech, reading, auditory training, hearing aid utilization, and skills in expression, including improvement in articulation, voice, rhythm, and language;

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8. Participation in in-service training programs for direct-care and other staff.

b. Staff and Qualifications

A speech pathologist or audiologist must be licensed by the State of Nevada Board of Audiology and Speech Pathology and have a current certificate of clinical competence issued by the American Speech and Hearing Association or a comparable body.

## 8. LABORATORY SERVICES

a. Management Requirements

If a facility chooses to provide laboratory services, the laboratory must:

1. Meet the management requirements specified in 42 CFR 405.1316; and
2. Provide personnel to direct and conduct the laboratory services.

b. Qualifications of Laboratory Director

The laboratory director must be technically qualified to supervise the laboratory personnel and test performance and must meet licensing or other qualification standards established by the State with respect to directors of clinical laboratories. For those States that do not have licensure or qualification requirements pertaining to directors of clinical laboratories the director must be either:

1. A pathologist or other doctor of medicine or osteopathy with training and experience in clinical laboratory services; or
2. A laboratory specialist with a doctoral degree in physical, chemical, or biological sciences, and training and experience in clinical laboratory services.

c. Duties of Laboratory Director

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

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The laboratory director must ensure that the staff:

1. has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently;
2. is sufficient in number for the scope and complexity of the services provided; and
3. receives in-service training appropriate to the type and complexity of the laboratory services offered.

d. Other Laboratory Requirements

1. The laboratory must meet the proficiency testing requirements specified in 42 CFR 405.1314(a).
2. The laboratory must meet the quality control requirements specified in 42 CFR 405.1317.
3. If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be approved by the Medicare program either as a hospital or an independent laboratory.

1603.7 REIMBURSEMENT RATE AND ALLOWABLE COSTS

1603.7A COVERAGE AND LIMITATIONS

1. PUBLIC ICF/MR – COST REIMBURSEMENT

A public ICF/MR is reimbursed under Medicare principles of retrospective reimbursement described in the Medicaid State Plan, Attachment 4.19D and HCFA Publication 15.

Each facility is paid the lower of either billed charges or an interim rate. In no case will payment exceed audited allowable costs.

2. PRIVATE ICF/MR – SMALL PROSPECTIVE RATE

Non state-operated ICF/MR – Small is defined as a facility having six beds or less.

Private ICF/MR–Small facilities are paid a prospective payment rate for basic service costs, other than day training costs and property costs, on a per–patient–day basis. Day

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training costs and property costs, excluded from the basic prospective rate, are reimbursed under Medicare principles of retrospective cost reimbursement.

The daily rate is to include services and items such as, but not limited to nursing services, dietary services, activity programs, laundry services, room/bed maintenance services, medically related social services, routine personal hygiene supplies, and active treatment programs.

Day training must be arranged by the ICF/MR, and must be approved by MHDS.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

### 3. PRIVATE ICF/MR – LARGE

Non state-operated ICF/MR-Large (is defined as a facility having more than six beds). It will be paid the lower of 1) billed charges or 2) an all-inclusive prospective per diem rate.

Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

### 4. ALLOWABLE COSTS

Any question of an allowable cost that is not addressed within this chapter will be resolved by reference to MSM Chapter 700, Rates and Cost Containment, and the CMS Publication 15.

Nevada Medicaid allows the costs for nutritional supplements (e.g., Ensure, Pediasure, etc.) when recommended in writing by a registered dietician and prescribed by a physician. The cost is included in the facility cost reports under Raw Food or Dietary.

### 5. UPPER LIMITS

In no case may Medicaid payment for an ICF/MR exceed the facility's customary charges to the general public.

In no case may Medicaid payment for an ICF/MR caring for more than 6 persons, exceed an upper limit determined by application of principles of reimbursement for provider costs under Title XVIII of the Social Security Act. All payment schedules under Medicaid are subject to the general payment limits imposed in 1861(v) and 1866 of the Act and implemented by regulations at 42 CFR 405.460 and 405.461.

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Refer to the Medicaid State Plan, Attachment 4.19-D and MSM Chapter 700, Rates and Cost Containment, for additional details.

6. ANCILLARIES

Medicaid may make direct payment for ancillary services provided to recipients when:

- a. Such services are not directly provided by the facility as part of the rate; and
- b. Required prior authorization has been obtained from the Nevada Medicaid Office.

1603.7B PROVIDER RESPONSIBILITY

COST REPORTING AND AUDIT

To obtain the Uniform Cost Report and instructions for completion contact DHCFP's Rates and Cost Containment Unit. Submission of alternate forms or any forms other than the most current does not constitute an acceptable filing.

A cost report must be submitted according to MSM Chapter 700, Rates and Cost Containment, Section 703.4.

Each facility must maintain financial and statistical records sufficient to substantiate its reported costs for three calendar years after submission. These records must be available upon request.

An annual audit of the facility's cost report will be completed by the DHCFP or its representative.

Refer to MSM Chapter 700, Rates and Cost Containment, for additional details.

PATIENT TRUST FUND MANAGEMENT

The ICF/MR must follow the requirements for appropriate handling of patient trust funds. Refer to MSM Chapter 500, Nursing Facilities, Section 503.8 and 42 CFR 483.420 for direction.

1603.8 PATIENT LIABILITY (PL)

DETERMINATION OF AMOUNT

PL is determined by eligibility personnel in the local DWSS district office.

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1603.8A      COVERAGE AND LIMITATIONS

The regulations at 42 CFR 435.725 require that the State (Nevada Medicaid) reduce its payment to the nursing facility by the amount of the PL. The established PL will be deducted from the Medicaid reimbursement. If the PL does not exceed billed charges, Medicaid will reimburse the difference between the established PL and the Medicaid maximum allowable. If the PL exceeds the billed charges, no Medicaid reimbursement will be made. PL will also be applied to subsequent claims submitted by providers entitled to PL until monthly obligations are fulfilled.

1603.8B      PROVIDER RESPONSIBILITY

A nursing facility must notify the DWSS immediately whenever there is a change/difference in any income source, as well as when any additional assets or resources come to the attention of the nursing facility.

When PL is established or changes, the recipient, facility and the fiscal agent are notified of the amount and effective date. Collection of PL is the facility's responsibility. If a nursing facility receives a notice adjusting the amount of the PL and facility has billed and received reimbursement for services, the facility must send a corrected claim to the fiscal agent to receive the appropriate adjustment within 60 days of the notice. The Surveillance and Utilization Review Section will follow-up to assure the appropriate adjustment has been completed.

When a recipient is discharged to an independent living arrangement or expires mid-month, PL is prorated by the Welfare District Office and a notice is sent regarding the PL adjustment. The nursing facility must refund any remaining balance to the recipient or their legal representative as required.

If a Medicaid recipient is transferred during a month from any provider entitled to collect PL, the discharging provider collects the total PL amount up to billed charges. The balance of the established PL must be transferred with the recipient at the time of transfer. The transferring and receiving providers are responsible for negotiating the collection of PL.

The facility may not charge recipients for items and services such as diapers, over the counter drugs (non-legend), combs, hairbrushes, toothbrushes, toothpaste, denture cream, shampoo, shaving cream, laxatives, shaves, shampooing, skin-care items, bedside tissues, disposable syringes, nail care, pads, catheters, laundry, durable or disposable medical equipment/supplies, stipends paid, based on recipient's needs, as part of the active treatment program, or any item covered by Medicaid in reimbursement to the facility or to other providers of care such as pharmacies, therapists, etc.

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1603.8C RECIPIENT RESPONSIBILITY

PERSONAL NEEDS

If a recipient so requests, the facility may provide and charge the recipient for such items as cosmetics, after shave lotion, non-medical equipment, smoking supplies, stationery, postage, pens, pencils, newspapers, periodicals, alcoholic beverages, personal clothing, professional haircuts, long-distance telephone calls, dry cleaning of personal clothing, and services in excess of program limitations. If a recipient is charged for the above, accurate records must be kept including the recipient's authorization for payment.

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1604 HEARINGS

Please reference Chapter 3100 for Medicaid Hearing process.