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12.1 Description

- a) Nursing facility providers can be either freestanding nursing facilities or acute care hospitals, with SNF/ICF/Subacute Levels of Care (LOC). The types of long-term care facility levels currently recognized by the Hawaii Medicaid Program are as follows:
- Skilled Nursing Facilities (SNFs) or Nursing Facilities (NFs) – Level “C”
 - Intermediate Care Facilities (ICFs) or Nursing Facilities (NFs) – Level “A”
 - Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) or Nursing Facilities (NFs) – Level “B”
- b) Under federal Medicaid rules, the level of care provided at Care Homes (CHs) is custodial and does not qualify for Medicaid coverage.
- c) Although Medicare considers certain services as SNF care, Medicaid is not bound by Medicare guidelines.
- d) In making determinations of level of care (SNF, ICF, CH or other), the patient’s situation and facility availability, etc., are to be considered. The availability, training, and capability of the family as primary caregivers should also be considered.
- e) Level of care determinations is made on a case-by-case basis and involves an evaluation of the patient’s unique situation and medical care needs. The following is a clarification of criteria and definitions currently used by the Medicaid Program to assist Medicaid’s reviewers in the determination of the level of long-term care (SNF or ICF) appropriate to the medical needs of the Medicaid recipient.
- f) Resident rights are to be adhered to and are a Federal Requirement.

12.2 Amount, Duration and Scope

12.2.1 *Subacute Level of Care*

The level of care is “Subacute” if the patient’s medical condition does not require acute inpatient care, but requires more intensive skilled nursing care than is provided to the majority of patients at a skilled nursing facility level of care. The Subacute level of care is designated either as Level I or II.

Subacute Level I

Patients who require continuous mechanical ventilation for at least 50% of each day and are medically stable.

Subacute Level II

Patients who do not require continuous mechanical ventilation for at least 50% of each day, are medically stable, and require the following services:

- Tracheostomy care with suctioning at least once per hour
- Any combination of mechanical ventilation, tracheostomy care with suctioning, and inhalation treatment at least once every eight hours
- Total parenteral nutrition (TPN)
- Continuous intravenous therapy or intermittent intravenous therapy at least once every eight hours
- Stable newborns/premature infants under age one year who are inpatients in an acute care hospital for at least one week and require manual stimulation for bradycardia/apnea or nasogastric or gastrostomy feedings
- Stable patients who are admitted to an acute hospital for an infection for training of intravenous antibiotic administration or for close monitoring of oral antibiotics

Two or more of the following services:

- Tracheostomy care with suctioning at least once every eight hours
- Traction (excluding Buck's traction) and pin care
- Medically necessary isolation precautions
- Treatment of Stage III and above pressure ulcers or wound infections
- Ventilation or inhalation therapy services at least daily
- Complex skilled nursing care of patients with conditions such as HIV/AIDS, terminal disease, and chronic dialysis who are at high risk of medical complications if discharged
- Complex skilled nursing care of patients who are receiving radiation therapy, hydration, or parenteral pain control medications who are at high risk for significant medical complications

- Complex skilled nursing care of psychiatric patients at high risk for imminent life-threatening complications to themselves or others if discharged or with bulimia/anorexia nervosa who are at high risk of medical complications if discharged.

12.2.2 Skilled Nursing Facility (SNF)

- a) The patient must require daily skilled nursing services on more than one shift per day; daily restorative skilled rehabilitation services; or a combination of skilled nursing and skilled rehabilitative services. Examples of skilled nursing services include suctioning, IV therapy, and tube feedings in which use of enteral pumps is necessary. Examples of skilled rehabilitation services include physical therapy, occupational therapy or speech therapy.
- All IM medications (i.e., antibiotics) must be medically justified. IM medications given on more than 1 shift a day do not automatically qualify for SNF level of care.
 - All IV therapy must be medically justified. IV therapy (i.e., hydration, antibiotics) is considered an SNF service for the duration of the therapy.
 - Skilled rehabilitation services must be required and provided on a “daily basis” (7 days a week). However, if skilled rehabilitation services are not available on a 7-day-a-week basis, a patient whose SNF stay is based solely on the need for skilled rehabilitation service(s) would meet the “daily” requirement when he/she needs and receives therapy on at least 5 days a week. A break of 1 to 2 days during which no skilled rehabilitation services are furnished and discharge from a facility or lowering the level of care to ICF would not be practical would not violate the “daily” requirement. (For example, if the patient’s physician suspends therapy sessions for medical reasons for 1 to 2 days, payment for SNF stays would be allowed since discharge in such a case would not be practical.) However, no payment will be made for the specific rehabilitation services since services were not rendered.
- b) The patient must require 24-hour supervision and observation by a professional nurse – Registered Nurse (RN) or Licensed Practical Nurse (LPN).

12.2.3 Intermediate Care Facility (ICF)

- a) The patient must require intermittent skilled nursing, daily skilled nursing assessment and 24-hour supervision. The skilled nursing services and daily skilled nursing assessments must be provided by professional nurses – RNs or LPNs.
- b) Examples of intermittent skilled nursing services: Changing of indwelling Foley catheters, administering IM medications three times a week.

c) The patient may require other services furnished by ICFs such as:

- Non-Skilled Nursing Services (see examples listed below)
- Significant assistance with activities of daily living (ADLs)
- Maintenance therapies, medical gases

d) Non-Skilled Nursing Services:

- Administration of routine oral medications, eye drops and ointments.
- General maintenance care of colostomies or ileostomies.
- Routine services in connection with indwelling catheters or tubes. This would include emptying and cleaning containers, changing tubing and refilling irrigation containers with solution.
- Changes of dressings for non-infected post-operative wounds or for chronic conditions not involving sterile dressings and prescription medication.
- Prophylactic and palliative skin care, including bathing and topical application (includes foot care).
- General methods of treating incontinence, including use of diapers, bed pads, rubber sheets and bedpans. (All incontinent patients are not automatically ICF. Care Home residents may have daily incontinence, but should not require attention at night or be excessively incontinent.)
- General maintenance care in connection with plaster casts.
- Routine care in connection with braces and similar devices.
- Use of heat for palliative and comfort purposes.
- Administration of medical gases after initial institution and stabilization of treatment and after the patient has received teaching and training.
- General supervision of exercises which have been taught to the patient.
- Assistance in dressing, eating and toileting.

12.2.4 *Intermediate Care Facility/Mentally Retarded (ICF/MR)*

- a) Individuals that have been diagnosed as having retardation as the result of developmental disability or who have acquired the disability because of injury or illness before the eighteenth birthday are considered to be mentally retarded and may be considered for care under these provisions.
- b) Individuals with retardation may require institutionalization where they receive a continuous active program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment and related services. Those that do not require these services and can be managed in a less restrictive environment may be granted a waiver in accordance with the Home and Community Based Services.
- c) Application for admission to the ICF/MR program requires the submission of Form 1150 or for those being re-admitted from acute hospital care, Form 1150A. Form 1150 or the Department of Health Form DDIS 2 (4/94) may also be submitted for the Waiver Program authorization. These forms are utilized for admission to a facility or entry into a program and are in force for 30 days. They may be renewed if implementation is not made within the 30-day period. A copy of the Form and instructions are located in Appendix 4.
- d) Subsequent to the DHS/Med-QUEST consultant's determination/authorization of the applicant's or recipient's level of care, copies of the Form 1150 shall be distributed as follows: one (1) copy shall be retained by the Med-QUEST Division/Medical Standards Branch (MQD/MSB), and the ICF-MR facility and the Medicaid Program's Fiscal Agent shall respectively receive their copies.
- e) Payment Requirements/Requirements for Participation – Payment for ICF-MR services are predicated on the following:
 - ICF-MR services must be provided by facilities meeting the eligibility requirements specified in the Hawaii Administrative Rules (HAR), Title 17, Department of Human Services, Subtitle 12 Med-QUEST Division, Chapters 17-1736 and 17-1722;
 - ICF-MR facilities must provide inpatient or authorized community-based services that are designed primarily for the treatment and rehabilitation of persons with mental retardation or persons with related conditions. At a minimum, these services include:
 - 1) Twenty-four (24) hour supervision of persons with mental retardation or persons with related conditions in the least restrictive protected residential setting;
 - 2) A continuous, individualized, active treatment program that includes aggressive, consistent implementation of specialized and generic training, specific therapies or treatments, activities, health services and related services that are directed towards:

- The acquisition of behaviors necessary for the client 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.
- f) Active treatment does not include services to maintain generally independent clients who are able to function in the absence of a continuous active treatment program or with little supervision;
- g) Interventions to manage inappropriate client behavior used with sufficient safeguards and supervision, to ensure that client's safety, welfare, and civil and human rights are adequately protected;
- h) Sufficient direct care staff to manage and supervise clients in accordance with their individual program plans, to respond to injuries and symptoms of illness and to handle emergencies in each defined residential living unit;
- i) Preventive and general medical care as well as annual physical exams that include:
- Evaluation of each client's vision and hearing;
 - Administration of immunizations, using the recommended guidelines from either the Public Health Service Advisory Committee on Immunization practices, or the American Academy of Pediatrics' Committee on the Control of Infectious Diseases;
 - Routine laboratory screening exams and special studies; and
 - TB control, appropriate to the facility's population, that is in accord with recommendations from the College of Chest Physicians and/or the Communicable Disease section of the American Academy of Pediatrics.
- j) Licensed nursing services sufficient to care for client's health needs, including those clients with medical care plans;
- k) Provision of, or arrangements for comprehensive dental diagnostic services and comprehensive dental treatment services that include:
- The availability of emergency dental treatment on a twenty-four (24) hours per day basis by a licensed dentist; and

- Dental care needed for relief of pain, infection or management of trauma by a licensed dentist for residents 21 years of age and older. Residents under the age of 21 receive a wider range of benefits as listed in Chapter 14 “Dental Services”.
- l) Provision of, or arrangements for routine and/or emergency drugs and biologicals administered in compliance with physician’s orders;
- m) A nourishing well-balanced diet, including modified and specially prescribed diets, on at least, a three (3) meals-per-day basis;
- n) Physician services available twenty-four (24) hours a day:
- To develop and maintain, in coordination with licensed nursing personnel, a physician-directed medical care plan of treatment for individual clients determined to need licensed nursing care on a twenty-four (24) hour basis, and
 - To participate in establishing an initial individualized program plan for a newly admitted client.
- o) Provision of necessary services, including emergency and other health care services through contractual agreements that:
- Stipulate the responsibilities, functions, objectives, service fees and other terms agreed to by the ICF-MR facility and the contractor, and
 - Provide that the ICF-MR is responsible for assuring that these services meet the standards for quality services.
- 1) Payment for ICF-MR services shall also be contingent upon:
- The determination by the department that the applicant or client requires ICF-MR level of care services.
 - Authorization by the department, for admission to a free-standing or distinct section of a facility that is for ICF-MR clients or to an authorized Medicaid Home and Community-Based Services (HCBS) waiver program.
- 2) Compliance with utilization control processes, developed and administered in accordance with State and Federal regulations, shall also be required as a basis for reimbursement. Refer to HAR section 17-1737-37 for the specific ICF-MR utilization control provisions.

- 3) Inspection of care (IOC) reviews can be conducted by departmental personnel to evaluate the provider’s performance relating to utilization of care and services provided to clients.
- 4) Additional requirements for payment of ICF-MR services are as follows. Briefly, providers shall:
 - Establish and implement written policies and procedures that govern access to, duplication of, and dissemination of information from applicants’ or clients’ records;
 - Ensure that recipients have freedom to select any qualified Medicaid provider of ICF-MR services;
 - Submit a written report (Form 1147i) to the Department within seventy-two (72) hours of any incident that results in harm to the Medicaid recipient (See Appendix 5 for a sample of the Incident Report , 1147i);
 - Ensure that clients at the ICF-MR level of care are provided treatment and services without discrimination, separation or any other distinction on the basis of race, color, national origin, or mental or physical handicap; and
 - Ensure that medical records are retained in accordance with State law.

12.2.5 Coding and Claims Submittal

For each change in level of care, the provider must generate a discharge claim for the prior level of care and readmit the patient at the lower level of care. In addition, at the time the patient becomes waitlisted, the provider will generate a discharge claim for the acute status.

The following lists the requisite Revenue Code and Bill Type required to bill the appropriate level of care:

Level of Care	Revenue Code	Bill Type
Subacute	19X	17X or 27X
ICF	1XX	61X
ICF MR	1XX	65X
SNF	1XX	21X
Swing Bed SNF	1XX	28X
Swing Bed ICF	1XX	68X
Waitlisted Subacute	19X	17X
Waitlisted SNF	11X (with occurrence span code 75)	11X
Waitlisted ICF	11X (with occurrence span code 74)	11X or 21X
LTC Ancillary Services	Use appropriate Revenue Codes	11X, 17X, 21X, 27X, 28X, 61X, 65X, 68X

12.3 Reimbursement

- a) There is no limit on days covered by the Medicaid program, however Medicaid is the last payer.
- b) Services included in the basic PPS rate for SNF, ICF, ICF/MR and Subacute are:

The reasonable and necessary costs of providing the following items and services shall be included in the basic PPS rate and shall not be separately reimbursable, unless specifically excluded under subsection (c):

- Room and board;
- Administration of medication and treatment and all nursing services;
- Development, management and evaluation of the written patient care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the recipient's care needs, promote recovery and ensure the recipient's health and safety;
- Respiratory services provided by nursing and/or respiratory therapy staff;
- Observation and assessment of the recipient's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the recipient's need for possible medical intervention, modification of treatment, or both, to stabilize the recipient's condition;
- Health education services, such as gait training and training in the administration of medications, provided by skilled technical or professional personnel to teach the recipient self-care;
- Provision of therapeutic diet and dietary supplement as ordered by the attending physician;
- Laundry services, including items of recipient's washable personal clothing;
- Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton balls, gauze, adhesive tape, Band-Aids, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment and douche equipment;
- Non-customized durable medical equipment and supplies used by individual recipients, but which are reusable. Examples include items such as ice bags, hot water bottles,

urinals, bedpans, commodes, canes, crutches, walkers, wheelchairs, and side-rail and traction equipment;

- Activities of the patient's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well being;
 - Social services provided by qualified personnel;
 - Maintenance therapy; provided, however, that only the costs that would have been incurred if nursing staff had provided the Maintenance therapy will be included in calculating the basic PPS rates;
 - Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and the other terms agreed to by the provider and the person or entity that contracts to provide the service; and
 - Recurring, reasonable and incremental costs incurred to comply with OBRA 87.
- c) The costs of providing the following items and services shall be specifically excluded from reimbursement under this plan, and shall be billed separately to the department by the providers:
- Physician services, except those of the medical director and quality assurance or drug use review board, or all three;
 - Drugs that are provided to residents in accordance with Title XIX policy;
 - Laboratory, x-ray, and EKG;
 - Ambulance and any other transportation for a medical reason that is not provided by the provider and not included in the costs used to calculate the basic PPS rates;
 - Dental – Refer to Chapter 14 Dental Services for details;
 - Optical;
 - Audiology;
 - Podiatry;

- Physical therapy, excluding maintenance therapy. Refer to Chapter 17, Rehabilitative Therapy Services for details;
- Occupational therapy, excluding maintenance therapy. Refer to Chapter 17, Rehabilitative Therapy Services for details;
- Speech and hearing therapies. Refer to Chapter 17, Rehabilitative Therapy Services for details; and
- Customized durable medical equipment and other such equipment or items that are designed to meet special needs of a resident and are authorized by the Department, subject to the guidelines in Chapter 10, Durable Medical Equipment, Prosthetic and Orthotic Devices and Medical Supplies (DMEPOS).

12.4 Bedhold Requirements for Long Term Care

12.4.1 Description

A Medicaid recipient's bed may be reserved during a recipient's temporary absence from the long-term care facility if:

- The recipient's plan of care provides for absences other than for hospitalization and is approved by the recipient's attending physician;
- Any single episode during which a bed is reserved does not exceed a period of three consecutive days, unless a request for prior approval is submitted to the program, reviewed and approved by DHS;
- The total number of days a recipient reserves a bed does not exceed twelve days in a service year (consecutive 12 months from the first date of service); and
- A record is maintained in the recipient's medical charges which accounts for the number of days and specific dates for any year that a recipient reserved a bed, subject to periodic review by the department's representatives.

12.4.2 Coding and Claims Submittal

Bedhold services must be billed using Revenue Code '180' with Bill Type '21X', '28X', '61X', '65X' or '68X'. Each new incidence of bedhold days must be billed as a separate line item.

12.4.3 Authorization

The DHS 1147 or 1150 forms are used for the Medicaid Program only. If a patient has not applied to Medicaid, do not submit any 1147 or 1150 form. See the section below and refer to

Appendix 4 for specific instructions. The patient's admission to a long-term care facility must be recommended by the attending physician and approved by the DHS Consultant or his representative.

12.5 Long Term Care Evaluation Form 1147

12.5.1 Submission of Form 1147

a) Form 1147 must be completed and submitted to the DHS Consultant or his representative for the following:

- Admission from residence to a long term care facility,
- Transfer from an acute hospital to a long term care facility for admission or readmission,
- Transfer between SNF, ICF and Hospice facilities,
- Changes in level of care within a facility (includes swing bed),
- Transfer from a Medicare or other health insurance status at a long term care institution to a Medicaid status, even though Medicaid may have been paying the co-insurance or deductible,
- Private patients already confined in long term care institutions that apply for medical assistance.

b) Forms should be submitted prior to admission, transfer or change in status. The use of any other form is not permitted.

12.5.2 Action by DHS Consultant or his/her Representative

a) This section will be completed by MQD staff or his/her representative when performing medical reviews or an independent professional review.

b) The Consultant will indicate the determination of level of care and the effective date. Approval, when granted, is for the indicated level of care and medical care. It does not establish eligibility for the Medicaid Program or authorize payment for care. Payment is contingent on the patient being eligible under the Medicaid Program, the services being a benefit of the Program, and the provider of service being Medicaid certified at the time services are rendered.

c) The DHS Consultant or his representative will sign and date the form. Medical authorization for admission expires thirty (30) days from the date of approval.

- d) Upon completion of the form by the DHS Consultant or his representative, the approved copy will be returned to the sender, or, if the person is in a medical facility, to the long-term care institution, or as requested by an appropriate note on the form.

12.5.3 Authorization Period

Medical authorization for admission expires 30 days from the date of approval. If the 30-day authorization period expires before the patient is admitted or transferred, a new Form 1147 should be submitted to MQD with a copy of the old form. A statement such as “For Updating” should be prominently written on the form to avoid confusion in handling.

12.5.4 Payment Requirement

Approval of the patient’s admission or transfer is not an authorization for payment or an approval of charges. All payments by the Medicaid Program are dependent on the following criteria:

- The patient must be eligible under the Medicaid Program at the time services are rendered.
- The provider of the service must be approved for Medicaid participation by DHS to render services to Medicaid recipients.

12.5.5 Form Availability

The Long Term Care Evaluation form 1147 may be obtained from the Medicaid Fiscal Agent. A copy of the forms and instructions can be found in Appendix 4.

12.6 Preadmission Screening and Resident Review (PAS/RR)

12.6.1 PAS/RR Overview

- a) Nursing facilities must not admit any individual with a serious mental illness (SMI), or mental retardation (MR) or developmental disability (DD) unless the state health authority or mental retardation authority has determined, prior to admission, that the individual requires the level of services provided by a nursing facility and if so, whether the individual requires specialized services.
- b) Preadmission Screening and Resident Review (PAS/RR) is a requirement for nursing facility Medicaid participation and, therefore, a nursing facility is subject to withdrawal or recovery of Medicaid payment or decertification action for failure to perform PAS/RR for all individuals.
- c) PAS/RR involves three distinct processes:
- Level I requires the identification of individuals with SMI or MR/DD;

- Level II requires evaluation of individuals suspected of having SMI or MR/DD by the Department of Health/Adult Mental Health Division (DOH/AMHD) or the Department of Health/Developmental Disabilities Division (DOH/DDD); and
 - Notification of the DOH/AMHD or DOH/DDD promptly after a change in the physical or mental condition of nursing facility residents with or without a diagnosis of SMI or MR/DD.
- d) For PAS/RR Level I Screen, Form DHS 1178, instructions, definitions, and flow chart of the PAS/RR process, refer to Appendix 5.

12.6.2 PAS/RR-Level I

- a) The Level I process involves the identification of individuals suspected of having SMI or MR/DD that would involve further screening.
- b) All individuals (regardless of payment source and known diagnoses) who apply as a new admission to a Medicaid certified nursing facility must have a Preadmission Screening Resident Review (PAS/RR) Level I Screen, Form DHS 1178 completed by the attending physician, social worker, discharge planner or facility designee.
- c) There are three exceptions to having a completed Level I Screen:
- Acute care patients who are admitted to a nursing facility directly from the hospital for continuing care of their acute care condition and the attending physician certifies prior to admission that they will require less than thirty days of care in the nursing facility;
 - Individuals readmitted to a nursing facility from a hospital to which he/she was transferred for care; and
 - Individuals transferred from one nursing facility to another nursing facility with or without an intervening acute hospital stay. The transferring facility is responsible for ensuring that the most recent PAS/RR forms accompany the transferring resident.
- d) An individual may be admitted to a nursing facility if:
- The Level I Screen is negative for SMI or MR/DD; or
 - If no referral for Level II evaluation and determination is necessary at this time.

e) When an individual is admitted to a nursing facility:

- If the Level I Screen is negative for SMI or MR/DD, the date the Level I Screen determination was made should be recorded on the Monthly Census Report (the Level I Screen should not be submitted). A sample of the Monthly Census Report, 1137, is in Appendix 5.
- If the Level I Screen is positive for SMI or MR/DD, but a Level II evaluation was waived by an exception, the date the Level I determination was made and the exception should be recorded on the Monthly Census Report and the Level I Screen should be submitted.
- The original Level I form should be retained in the resident's medical record.

12.6.3 PAS/RR-Level II

- a) The Level II process involves the performance of necessary evaluation(s) and determination of need for nursing facility placement and specialized services.
- b) All individuals (regardless of payment source) that are suspected of having SMI on Level I screening must be referred to the Department of Health/Adult Mental Health Division (DOH/AMHD), for diagnostic evaluation and determination of need for nursing facility services and specialized services. All individuals (regardless of payment source) that are suspected of having MR/DD must be referred to the Department of Health/Developmental Disabilities Division (DOH/DDD) for diagnostic evaluation and determination of need for nursing facility services and specialized services. Individuals with a dual diagnosis (SMI and MR/DD) must be referred to both authorities concurrently.
- c) Written notice to the individual or his/her legal representative that the individual is suspected of having SMI and/or MR/DD and is being referred to AMHD and/or DDD must be provided.
- d) The following SMI or MR/DD individual who is not a danger to self or other and requires nursing facility services, but does not require specialized services need not be referred for Level II evaluation and determination:
 - An individual who is being discharged from an acute care hospital and admitted to a nursing facility for recovery from an illness or surgery for a period not to exceed one hundred twenty (120) days;
 - An individual who is certified by a physician to be terminally ill with a medical prognosis for life expectancy of six (6) months or less;

- An individual who is comatose, ventilator dependent, functioning at a brainstem level, or diagnosed as having a severe physical illness which results in a level of impairment so severe that the person cannot be expected to benefit from specialized services;
 - An individual requiring provisional admission pending further assessment in cases of delirium where an accurate diagnosis cannot be made until the delirium clears;
 - An individual requiring provisional admission not to exceed seven (7) days for further assessment for emergency situations requiring protective services; and
 - An individual requiring admission for a brief stay up to thirty (30) days to provide respite to caregivers to whom the individual is expected to return following the nursing facility stay.
- e) DOH/AMHD and/or DOH/DDD should make the following written determinations (using forms described in the policy and procedures of AMHD and/or DDD):
- The individual is or is not SMI/MR/DD;
 - The individual requires or does not require specialized services; and
 - Nursing facility placement is or is not appropriate.
- f) The written notice should be sent to the evaluated individual and his/her legal representative, the admitting or retaining nursing facility, the attending physician and the discharging hospital. The notice should include whether nursing facility level of service is needed, whether specialized services are needed, the placement options that are available consistent with the determination and the right of the individual to appeal the determination.
- g) If the individual or his/her legal representative requests an appeal of the determination, the DOH/AMHD and/or DOH/DDD appeal process should be used.
- h) An individual may be admitted to a nursing facility if it is determined that:
- the individual does not have a diagnosis of SMI, MR, or DD or
 - the individual has a diagnosis of SMI, MR, or DD and it is determined that nursing facility level of service is needed and specialized services are not needed.

- i) An individual may not be admitted to a nursing facility and alternative placement options discussed with the individual and his/her representative if it is determined that:
- nursing facility level of service is not needed and specialized services are not needed;
 - nursing facility level of service is not needed and specialized services are needed; or
 - nursing facility level of services is needed and the individual also requires specialized services.
- j) When the individual is admitted to a nursing facility, including new and re-admissions, copies of the Level I Screen and Level II evaluation and determination should be submitted with the Monthly Census Report. The original Level I Screen and Level II evaluation and determination should be retained in the individual's medical record.

12.6.4 Annual Resident Review (ARR)

- a) The implementation of Public Law 104-315, an amendment to Title XIX of the Social Security Act (the Act) which was signed on October 19, 1996, repealed the requirements for annual resident reviews (ARRs) of residents in long-term care facilities. Instead of ARR, the nursing facility should notify the State Department of Health/Adult Mental Health Division (DOH/AMHD) and/or the State Department of Health/Developmental Disabilities Division (DOH/DDD) promptly after a significant change in the physical or mental condition of a resident. A review and determination should be done promptly after a nursing facility has notified the DOH/AMHD and/or DDD. This review and determination would apply to a significant change that results in a new suspected diagnosis of SMI or MR/DD or in a change in the previous determinations concerning specialized services needs or nursing facility care. "Previous determinations" refers to those residents who were diagnosed as SMI or MR/DD through the Level II process at a previous time.
- b) A significant change in the resident's condition which would be sufficient to require a review by the nursing facility would involve any of the following:
- Use of a psychiatric or psychological consultation to effectively treat/care for behavioral changes observed in the resident or use of other consultants (i.e., physical or speech therapist) to evaluate/treat for physical changes in the resident;
 - Initial prescription of a psychotropic medication to effectively treat/care for behavioral changes observed in the resident or change in prescription of a psychotropic agent or other medication(s) to treat/care for behavioral/physical changes observed in the resident;
 - An update or revision in the resident's care plan to effectively treat/care for behavioral/physical change.

- c) Nursing facilities have a maximum of twenty-one (21) days to begin treatment, attempt to stabilize a resident, or develop a revised care plan and determine whether the changes in the resident's condition merit a review by the State DOH. The standard of "promptness" for the State after notification by the nursing facility continues to be an annual average of seven (7) to nine (9) working days.

12.7 Incident Reports

12.7.1 Description

- a) Providers of long-term institutional services shall submit to the department a written incident report for each incident that results in harm to the Medicaid recipient. These reportable incidents include reaction to a drug or therapy, all bodily injuries that require medical intervention, and absence without leave for one or more nights. An incident shall be in writing and shall be submitted to the department within seventy-two hours of a reportable incident. (Refer to reporting requirements below.)
- b) Only reports of "reportable incidents" should be submitted to MQD/MSB. To reiterate, reportable incidents include:
- Adverse reaction to a drug or treatment. Adverse reaction or injury resulting from medication errors should also be reported.
 - Bodily injuries requiring medical intervention. In addition to treatment of the injury, medical intervention includes diagnostic assessment such as radiological procedures and laboratory studies, emergency room visits, physician assessments, and hospitalization. At the time of submission or as an addendum to the initial incident report, results of a diagnostic assessment should be provided so that the actual extent of injury can be assessed by the Medical Standards Branch (MSB). Reports should be submitted within seventy-two (72) hours of the incident. This should allow enough time to include the results of a preliminary diagnostic assessment with the initial report.
 - Absence without leave, i.e., without physician orders for one or more nights.
- c) Non-reportable incidents include:
- Medication errors that do not result in injury or adverse reaction.
 - Bodily injuries such as minor skin tears and bruises, which do not require significant medical intervention. If these injuries are a result of suspected abuse, mistreatment or neglect, then it should be reported to the Adult Protective Service (APS) and the Department of Health (DOH) Survey and Certification Agency.

- Cases of abuse, mistreatment or neglect between residents and between resident and staff. These reports should be sent to APS, DOH, and/or the Medicaid Investigation Division (MID).

d) If reports of “reportable incidents” have been submitted to other agencies, this should be stated in the report to MQD/MSB.

12.7.2 Reporting Requirements

- a) The form DHS 1147i is to be used for the reporting of incidents. However, if a facility chooses not to use this form, it may do so provided that all the required information is included. A copy of this form is included in Appendix 5.
- b) Do not submit copies of a facility’s internal incident reports. The submission of such reports does not constitute acceptable reporting.
- c) Written reports shall include the following: (1) Name of the NF or ICF-MR; (2) Name, age, and birthdate of the resident; (3) Resident’s diagnosis; (4) Resident’s acuity level at time of incident; (5) Date, time, and place of the incident; (6) Description of how the incident occurred; (7) Description of the kind and extent of medical intervention; and (8) Date incident report was written and signature and title of the reporting individual.
- d) If a facility does not have any reportable incidents in a quarter, this should be reported to the MSB by the fifth (5th) day of the month following the quarter. The absence of incidents can be reported using the attached form (see bottom of form DHS 1147i).

12.8 Medicaid Recipients in Long Term Care - Resident Rights and Obligations

12.8.1 General Information

- a) The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) requires the State Agency to make known and distribute to all nursing facilities participating in the Medicaid Program written notice of Resident Rights and Obligations while in a nursing facility. These rights became effective on April 1, 1988.
- b) These Rights are to be made available to the resident at the time of admission and periodically during a resident’s stay in a nursing facility. The Medicaid Resident Rights and Obligations do not and should not supplant or supersede any Federal or State rights or obligation that are in effect at the time for residents in a nursing facility. Rather, the “Medicaid Resident Rights and Obligations” was meant to complement and strengthen all or any rights afforded to a resident in a nursing facility.

12.8.2 General Rights

- Right to choose a personal attending physician and to be fully informed in advance about care and treatment and of any changes in care or treatment that may affect his/her well being.
- Right to participate in planning care and treatment or changes in care or treatment (unless the resident is judged incompetent).
- Right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat medical symptoms. Restraints may only be imposed:
 - a) To ensure the physical safety of the resident, other residents and others, and
 - b) Only upon the written order of a physician that specified the duration and circumstances under which restraints are to be used, but the duration must be in compliance with facility certification standards. Exception: under emergency circumstances until a written physician order could reasonably be obtained.
- Right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.
- Right to confidentiality of personal and clinical records and to approve or refuse their release to any individual outside the facility, except, in cases of transfer to another health care institution, or as required by law or third party payment contract.
- Right to reside and receive services with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.
- Right to receive notice before the room or roommate of the resident in the facility is changed.
- Right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.
- Right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.
- Right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

- Right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction with respect to the facility.
- Right to be informed orally and in writing at the time of admission to the facility and periodically during his/her stay of his/her legal rights at the facility.
- Right to a written statement of resident rights upon reasonable request. The written statement shall include a description of the protection of personal funds and a statement that complaints may be filed with the State survey agency regarding resident abuse and neglect and misappropriation of resident property.
- Right to be informed at the time of admission, or if later, at the time eligibility for medical assistance is determined of the items and services included in the nursing facility services for which he/she may not be charged.
- Right to be informed in writing before or at the time of admission and periodically during his/her stay, of services available in the facility and of related charges for such services, including any charges for services not covered by Medicaid, Medicare or by the facility's basic per diem charge.
- Right to apply for Title XIX medical benefits free from threats of discouragement by anyone in the facility.
- Right to proper written and oral information about 'how' to apply for and use Title XIX Medicaid benefits.
- Right to admission in a nursing facility without requiring third party coverage and without obligation, solicitation or coercion into making gifts, monetary donations or other forms of consideration as a precondition for admittance into the nursing facility, or for continued stay in the facility.
- Right to manage his/her own personal funds while in a nursing facility, or to have the facility manage the funds.
- Once the facility accepts the resident's written authorization to manage personal funds, the nursing facility must:
 - a) provide a full and complete separate accounting, including a written record of all financial transactions;

- b) deposit personal funds in excess of \$50.00 in an interest bearing account separate from the facility's operating accounts and credit interest to the resident's account;
 - c) provide reasonable access to written records of all financial transactions;
 - d) give notice of the fact that the amount in the account may jeopardize eligibility for medical assistance; and
 - e) promptly convey upon the resident's death the personal funds to the individual administering the resident's estate.
- Right to deny or withdraw consent to reasonable access by any entity or individual that provides health, social, legal or other services to the resident.
 - Right to equal access regarding transfer, discharge and the provisions of services required under the State Plan regardless of the source of payment.
 - Right to immediate visitation by any representative of the Secretary, the State, by an ombudsman, or physician, right to immediate visitation by family, relatives, and other visitors (subject to reasonable restrictions) and the resident's right to deny or withdraw consent.
 - Right to remain in this facility. The resident may be transferred or discharged only for certain reasons and with proper notice. These reasons are:
 - a) resident's welfare cannot be met in the facility;
 - b) health has improved so the resident no longer needs the services provided by the facility;
 - c) the safety of individuals in the facility is endangered;
 - d) the resident has failed, after reasonable and appropriate notice, to pay, or to have paid by Medicare or Medicaid, an allowable charge imposed by the facility; and
 - e) the facility ceases to operate.
 - All discharges and reasons, therefore, except in the case of closure, must be documented in the clinical record by a physician (the attending physician in the first two instances).
 - Notice of transfer or discharge must be given to the resident and a known family member or legal representative at least 30 days in advance except for reasons (c) or (d) above if the resident's health improves sufficiently to allow a more immediate transfer. A 30-day notice

is not required if transfer or discharge is necessitated by the resident's urgent medical needs or if the resident has not resided in the facility for 30 days. In the case of such exceptions, notice must be given to the resident, as many days in advance as is practicable.

- a) Right to appeal, under the State established appeal process, the transfer or discharge (effective 10/01/89), and to be provided the name, mailing address, and telephone number of the State Long Term Care Ombudsman or if the resident is developmentally disabled or mentally ill, the mailing address and telephone number of the State Protection and Advocacy Agency.
 - b) Right to (the facility must provide the resident with) sufficient preparation and orientation to assure an orderly and safe transfer or discharge.
- Before the resident is transferred, and also at the time of transfer, for hospitalization or therapeutic leave, the facility must provide written information to the resident and a known family member or legal representative concerning the duration of the period, if any, during which the resident will be permitted to return and resume residence in the facility and the policies of the facility regarding such a period.
 - If such leave exceeds a period (if any) paid for under the State Plan, the resident will be permitted to return to the facility immediately upon the first availability of a semi-private room if at that time the resident requires the services provided by the facility.
- a) Right to the following conditions for the administration of psychopharmacologic drugs:
 - Administered only on the orders of a physician and only as part of a written plan of care;
 - Designed to eliminate or modify the symptoms for which the drugs are prescribed; and
 - Only if, at least annually, an independent external consultant reviews the appropriateness of the drug plan.
 - b) Right to any other right established by the Secretary.

12.8.3 Rights of Incompetent Residents

The rights of residents judged incompetent under State law shall be exercised by the person appointed by the court to act on the resident's behalf.