



INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

Chapter Twenty-Six of the Medicaid Services Manual

Issued October 1, 2010

Claims/authorizations for dates of service on or after October 1, 2015 must use the applicable ICD-10 diagnosis code that reflects the policy intent. References in this manual to ICD-9 diagnosis codes only apply to claims/authorizations with dates of service prior to October 1, 2015.

**State of Louisiana
Bureau of Health Services Financing**

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OVERVIEW

Services provided by intermediate care facilities for individuals with intellectual disabilities (ICF/IID) are designed for those individuals diagnosed as having developmental lags which are considered amendable to treatment in a 24-hour managed care environment where they will achieve maximum growth. Individuals are admitted to an ICF/IID after it has been determined by an interdisciplinary team (IDT) of health professionals that admission is the best available plan.

This chapter specifies the requirements for maintaining an ICF/IID and is a combination of federal and state laws, Louisiana Department of Health (LDH) regulations and policy. This document is not all inclusive of the regulatory process. Providers should also refer to the ICF/IID regulations found at 42 Code of Federal Regulations (CFR) Part 483, LDH published ICF/IID Standards for Payment, and the LDH- Health Standards Section (HSS) Minimum Licensing Standards. There is no intent to include contradictory statements in this manual. If there is a conflict between material in these standards and the federal and state laws or policies governing the program, the state laws or policies governing the program have precedence. These standards provide the ICF/IID with information necessary to fulfill the provider enrollment contract with LDH. The ICF/IID Standards for Payment will take precedence over the language in the manual chapter.

The standards set forth in this and subsequent sections comply with the Title XIX requirements of the amended Social Security Act (the ACT). The Act sets the standards for the care, treatment, health, safety, welfare and comfort of medical assistance beneficiaries in facilities providing ICF/IID services. These standards apply to ICF/IIDs certified and enrolled by LDH for vendor participation in the Louisiana Medicaid program and supplement current licensing requirements applicable to ICF/IIDs. Any infraction of these standards will be considered a violation of the provider agreement between LDH and the ICF/IID.

If any of these standards are not maintained, LDH will determine whether facility certification will continue with deficiencies as allowed under Title XIX regulations or whether termination of the provider agreement is warranted. During the determination period, vendor payment will not be suspended; however, deficiencies, which may affect the health, safety, rights, and welfare of the beneficiaries, must be corrected expeditiously in order for the ICF/IID to continue to participate in, and to operate as, a licensed ICF-IID facility.

If a certified ICF/IID is found to have deficiencies which immediately jeopardize the health, safety, rights, and welfare of its beneficiaries, LDH may impose interim sanctions or initiate proceedings to terminate the ICF/IID's certification or licensure in accordance with minimum licensing standards.

Monitoring of an ICF/IID's compliance with state and federal regulations is the responsibility of LDH's Bureau of Health Services Financing (BHSF). The BHSF HSS is responsible for

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determining an ICF/IID's compliance with state licensing requirements and compliance with specific Title XIX certification requirements.

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ADMISSION PROCESS**Interdisciplinary Team**

Prior to admission to an intermediate care facility for individuals with intellectual disabilities (ICF/IID), or before authorization for payment, an interdisciplinary team (IDT) of health professionals will complete a comprehensive medical, social and psychological evaluation of each individual's need for care in the ICF/IID. As appropriate, other professionals will be included on the IDT, and at least one member will meet the definition of qualified intellectual disabilities professional (QIDP). Participation of a nursing professional on the IDT shall be by a Louisiana licensed registered nurse (RN).

Exploration of Alternative Services

If the results of comprehensive evaluations recommend ICF/IID services for an individual whose needs could be met by alternative services, the ICF/IID will also seek alternative services for this individual. If alternative services are unavailable, this information will be entered into the individual's record.

ICF/IID Submission of Data

Evaluative data for medical certification for ICF/IID level of care (LOC) will be submitted to the appropriate local governing entity (LGE) on each individual. This information will include the following applications:

1. Initial;
2. Individuals transferring from one ICF/IID to another;
3. Individuals transferring from an acute care hospital to an ICF/IID;
4. Individuals who are patients in a mental health facility;
5. Individuals already in an ICF/IID program;
6. Individuals being readmitted; and
7. Individuals who are being converted from private pay to Medicaid coverage.

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A complete packet of admission information must be received by the LGE **within 20 working days** following the completion of the individual habilitation plan (IHP) for newly admitted individuals.

Please note the following:

1. Notice within the 20-day time frame will be required for readmission and transfers;
2. If an incomplete packet is received, denial of certification will be issued with the reasons(s) for denial;
3. If additional information is subsequently *received within* the initial 20 working day time frame, and the individual meets all requirements, the effective date of certification is the date of admission; and
4. If the additional information is *received after* the initial 20 working day time frame and the individual meets all requirements, *the effective date is no earlier than the date a completed packet is received by the Office for Citizens with Developmental Disabilities (OCDD).*

Data may be submitted before admission of the individual if all other conditions for the admission are met.

Requirements for Certification

Documentation to obtain medical certification for ICF/IID Medicaid vendor payment should be submitted to the appropriate LGE. The following documentation and procedures are required:

1. Social evaluation;
2. Psychological evaluation;
3. Psychiatric evaluation;
4. Other evaluations (if applicable);
5. Individual service plan (ISP);
6. Form 90-L;

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7. Form 148;
8. Inventory for Client and Agency Planning; and
9. Statement of Approval (SOA).

Social Evaluation

The social evaluation must be completed no more than 90 days prior to admission and no later than the date of admission. The social evaluation must address the following:

1. Family, educational and social history including any previous placements;
2. Treatment history that discusses past and current interventions, treatment effectiveness and negative side effects;
3. Current living arrangements;
4. Family involvement, if any;
5. Availability and utilization of community, educational, and other sources of support;
6. Habilitation needs;
7. Family and/or individual expectations for services;
8. Prognosis for independent living; and
9. Social needs and recommendation for ICF/IID placement.

Psychological Evaluation

A psychological evaluation must be completed no more than 90 days prior to admission and no later than the date of admission. The psychological evaluation must include the following components:

1. Comprehensive measurement of intellectual functioning;
2. Developmental and psychological history and an assessment of current psychological functioning;

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3. Measurement of adaptive behavior using multiple informants when possible;
4. Statements regarding the reliability and validity of informant data including discussion of potential informant bias;
5. Detailed description of adaptive behavior strengths and functional impairments in self-care, language, learning, mobility, self-direction, and capacity for independent living;
6. Discussion of whether impairments are due to a lack of skills or noncompliance and whether reasonable learning opportunities for skill acquisition have been provided;
7. Recommendations for the least restrictive treatment alternative, habilitation and custodial needs, supervision needs, and monitoring to ensure the individual's safety; and
8. Diagnosis/diagnoses conforming to the current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.

If an intellectual assessment is attempted, but cannot be completed, documentation will include the assessment tool attempted and an explanation as to why the assessment could not be completed.

If an updated psychological evaluation is submitted, the agency will submit the prior comprehensive psychological report that is referenced in the update.

Psychiatric Evaluation

A psychiatric evaluation must be completed if the individual has a primary or secondary diagnosis of mental illness, is receiving psychotropic medication, has been hospitalized in the past three years for psychiatric problems, or if significant psychiatric symptoms were noted in the psychological evaluation or social assessment. The psychiatric evaluation shall be completed no more than 90 days prior to admission and no later than the date of admission. The psychiatric evaluation should include the following:

1. History of present illness;
2. Mental status exam;
3. Diagnostic impression;

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4. Assessment of strengths and weaknesses;
5. Recommendations for therapeutic interventions; and
6. Prognosis.

A psychiatric evaluation may be requested at the discretion of OCDD to determine the appropriateness of placement if admission material indicates the possible need for psychiatric intervention due to behavior problems.

Other Evaluations

Additional evaluations may be requested when the individual currently receives, or is in need of, one or more of the following therapies:

1. Physical;
2. Occupational; or
3. Speech.

Individual Service Plan

The ISP, which may also be referred to as the support plan, developed by the IDT within 30 days of admission, shall include the following:

1. Habilitation needs;
2. Specific assessment based objectives;
3. Specific services, accommodations, and/or equipment needed to assist the individual's placement in an ICF/IID; and
4. Participation by the individual, the parent(s), or legal guardian unless impossible or inappropriate. If the individual is a competent major, the family or advocate participation is only allowed with the consent of the individual. The IDT minutes with signatures from the participant or legal guardian must be submitted with the ISP.

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NOTE: Document the reason(s) for ANY non-participation by the individual, the individual's parent(s), or the individual's legal guardian.

Level of Care Determination (Form 90-L)

A request for LOC Determination (Form 90-L) must be submitted on each admission or readmission. This form must:

1. Be completed no more than 30 days before admission and not later than the date of admission;
2. Be fully completed and include prior living arrangements and previous institutional care;
3. Be signed and dated by a physician licensed to practice in Louisiana. ***Certification will not be effective any earlier than the date the Form 90-L is signed and dated by the physician;***
4. Include a diagnosis of developmental disability or related condition as well as any other medical condition; and
5. Indicate the ICF/IID LOC.

Notification of Admission or Change (Form 148)

A Notification of Admission or Change (Form 148) must be submitted for each new admission and when there is a change in a beneficiary's status such as, death, discharge, transfer, or readmission from a hospital.

For individuals whose application for Medicaid is later than the date of admission, the date of application must be indicated on the form.

Inventory for Client and Agency Planning

The Inventory for Client and Agency Planning (ICAP) assessment must be submitted for each new admission. The ICAP should be completed no more than 90 days prior to date of admission and no later than 30 calendar days after the date of admission.

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Statement of Approval

The participant must have a current SOA from an LGE.

Transfers**Transfer within an Organization**

The following must be completed for a beneficiary transferring from an organization:

1. Form 148 must be submitted by both the discharging facility and the admitting facility;
2. Form 148 shall indicate the date the beneficiary was discharged from the transferring facility, the name of the receiving facility, and the date of admission; and
3. An updated ISP must be submitted by the discharging facility to the receiving facility. The receiving facility IDT may adjust the ISP if they feel it is necessary.

The receiving facility must submit minutes of an IDT meeting addressing the reason(s) for the transfer, the family and beneficiary's response to the move, and the signatures of the persons attending the meeting.

Transfer of a Beneficiary outside the Organization

Certification requirements involving the transfer of a beneficiary from one ICF/IID to another ICF/IID (which is not part of the same organization or network) will be treated the same as for a new admission. Therefore, the receiving facility must follow all the steps for a new admission.

The discharging facility will notify OCDD of the discharge by submitting Form 148 giving the date of discharge and destination.

Transfer from an ICF/IID to a Nursing Facility

When a beneficiary's medical condition has deteriorated to the extent that they cannot participate in or benefit from active treatment and requires 24-hour nursing care, the ICF/IID may request prior approval from OCDD to transfer the beneficiary to a nursing facility by submitting the following information:

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1. Form 148 showing that transfer to a nursing facility is being requested;
2. Form 90-L completed within 30 days prior to request for transfer indicating that nursing facility level of care (NFLOC) is needed; and
3. Level 1 Preadmission Screening and Resident Review (PASRR) completed within 30 days prior to request for transfer.

The IDT meeting minutes must address the reason for the transfer, along with the family and beneficiary's response to the move and the signature of the persons attending the meeting, and any other medical information that will support the need for nursing facility placement.

Readmission to the Facility**Readmission Following Hospitalization**

The Form 148 must be submitted showing the date Medicaid billing was discontinued and the date of readmission to the facility.

Documentation must be submitted that specifies the beneficiary's diagnosis, medication regime, and include the physician's signature and date. The documentation may be one of the following:

1. Form 90-L;
2. Hospital transfer form;
3. Hospital discharge summary; or
4. Physician's orders.

An updated ISP must be submitted to the local OCDD regional office/LGE showing changes, if any, as a result of the hospitalization.

Readmission Following Exhausted Home Leave Days

The following documentation must be submitted for readmission following exhausted home leave days:

1. Form 148 showing the date Medicaid billing was discontinued and the date of readmission; and

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2. An updated ISP showing changes, if any, as a result of the extended home leave.

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COVERED SERVICES

The primary purpose of an intermediate care facility for individuals with intellectual disabilities (ICF/IID) is to provide habilitative or health services to individuals with an intellectual disability. The facility must provide internal or external active treatment program interventions and services as to support the achievement of the objectives identified in the individual habilitation plan (IHP), which is also referred to as the individual service plan (ISP). These services include, but are not limited to, occupational, speech, physical and recreational therapies, psychological, psychiatric, audiological, social work, special education, dietary and rehabilitation counseling.

NOTE: Supplies, equipment, etc., needed to meet the goals of the IHP cannot be charged to the beneficiaries or their responsible parties.

Active Treatment Components**Individual Habilitation Plan**

Each beneficiary must have an IHP developed by an interdisciplinary team (IDT) that represents the professions or resource areas that are relevant to that beneficiary's needs.

At the beneficiary's staffing conference, the IDT member's presence or absence must be documented in the IHP, as well as the reasons for the absence. Within 30 days after admission, the IDT must complete assessments or reassessments to supplement the evaluation conducted prior to admission. The IDT must prepare an IHP for each beneficiary that states specific objectives necessary to meet the beneficiary's needs, and a plan for achieving these objectives. These objectives are derived from the comprehensive functional assessment. The comprehensive functional assessment must take into consideration the beneficiary's age and contain the following:

1. Presenting problems and disabilities, including diagnosis, symptoms, complaints and complications;
2. Beneficiary's specific developmental strengths;
3. Beneficiary's specific developmental and behavioral management needs; and
4. Identification of the beneficiary's needs for services.

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The comprehensive functional assessment must cover the following developmental areas:

1. Physical development and health;
2. Nutritional status;
3. Sensorimotor development;
4. Affective development;
5. Speech and language development;
6. Auditory functioning;
7. Cognitive development;
8. Social development;
9. Adaptive behaviors or independent living skills necessary for the beneficiary to be able to function in the community;
10. Vocational skills as applicable; and
11. Psychological development.

Components of specific IHP objectives must be:

1. Stated separately, in terms of a single behavior outcome;
2. Assigned projected completion dates;
3. Expressed in behavior terms that provide measurable indices of performance;
4. Organized to reflect a developmental disability; and
5. Assigned priorities.

A copy of each beneficiary's IHP must be made available to all relevant staff, including staff of other agencies who work with the beneficiary, the beneficiary's parents, or legal guardian (if the beneficiary is a minor). The IHP must be implemented within 14 calendar days of its development. The facility must develop and make available to relevant staff an outline of the treatment schedule

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for the current active treatment program. Each written training program designed to implement these objectives in the IHP shall specify:

1. Methods to be used;
2. Schedule for use of the methods;
3. Person responsible for the program;
4. Type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives;
5. Inappropriate beneficiary behavior(s), if applicable; and
6. Provision for the appropriate expression and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

The IHP must describe relevant interventions to support the beneficiary toward independence that includes training in personal skills essential for privacy and independence, such as activities of daily living (ADL). These interventions must continue until it has been demonstrated that the beneficiary is developmentally incapable of applying them. The IHP must also identify the location where program strategy information can be found (this must be accessible to any person responsible for implementation) and plans for discharge.

The IHP must identify any needed supports to achieve proper body position, balance, or alignment and should indicate the schedule, reason, and situations in which each support is applied and used.

Beneficiaries who have multiple disabling conditions must be provided the opportunity to spend a major portion of each day out of bed and outside the bedroom area, whenever possible.

The IHP must include opportunities for beneficiary choice and self-management.

Documentation

The facility must document data relevant to the accomplishment of IHP objectives. This data must meet the following criteria:

1. Be documented in measurable outcomes;
2. Include significant events that contribute to an overall understanding of their ongoing level and quality of function; and

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3. Be reviewed at least quarterly, or as needed, by a qualified intellectual disability professional (QIDP).

In addition, the IHP must be revised as necessary including, but not limited to, situations in which the beneficiary:

1. Has successfully completed any objective(s) identified in the individual habilitation plan;
2. Is regressing or losing skills;
3. Is failing to progress toward identified objectives after reasonable efforts have been made; or
4. Is being considered for training toward new objectives.

At least annually, the comprehensive assessment of each beneficiary must be reviewed by the interdisciplinary team (IDT) for relevancy and updated as needed. The IHP must be revised as needed or at least by the 365th day after the last review.

NOTE: For Admission Requirements, refer to section 26.1 of this Chapter.

Professional Services

The health care of each beneficiary shall be under the continuing supervision of a Louisiana licensed physician. **The facility must ensure the availability of physician services 24 hours a day.** The facility must provide or obtain preventive and general medical care plus annual physical examinations of each beneficiary. The beneficiary, the family or the responsible party shall be allowed a choice of physicians. If the beneficiary does not have a personal physician, the ICF/IID shall provide referrals to physicians in the area, identifying physicians that participate in the Medicaid program.

NOTE: The cost of physician and nursing services cannot be charged to the beneficiaries or their responsible party.

Nursing Services

The facility must provide each beneficiary with nursing services as prescribed by the physician, identified by the IHP, or as needed.

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Nursing services must include:

1. Development, with a physician, of a **medical care plan of treatment** for a beneficiary when the physician has determined that the beneficiary requires such a plan;
2. 24-hour nursing service as indicated by the medical care plan or other nursing care as prescribed by the physician or as identified in the beneficiary's IHP;
3. Quarterly review of the individual beneficiary's health status, or more frequently if needed;
4. Beneficiary and staff training, as needed, in appropriate health and hygiene methods and self-administration of medications; and
5. Physician notification of any changes in the beneficiary's health status.

The facility must have a **formal** arrangement with a registered nurse (RN), licensed to practice in Louisiana, to provide or oversee the nursing services for the beneficiaries.

This RN must also be available to provide verbal or on-site consultation to the licensed practical nurse (LPN) or to a facility that has no nurse on staff.

Dental Services

The facility must provide or arrange for comprehensive dental diagnosis and treatment services for each beneficiary. These services are to be provided in-house or through other arrangements by qualified personnel, by licensed dentists and dental hygienists.

The facility must provide comprehensive services that include dental care needed for relief of pain and infections, restoration of teeth, and general dental maintenance. The facility must ensure the availability of emergency treatment on a 24-hour per day basis by a licensed dentist.

NOTE: The cost for these dental services cannot be charged to the beneficiaries or their responsible party.

Pharmaceutical Services

The facility must provide or arrange for the provision of routine and emergency drugs and biologicals for its beneficiaries. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

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Routine administration of medications shall be done at the facility where the beneficiary resides. Beneficiaries may not be transported elsewhere for the sole purpose of medication administration.

The ICF/IID shall neither expect, nor require, any provider to give a discount or rebate for prescription services rendered by the pharmacists. The ICF/IID shall order at least a one month supply of medications from a pharmacy of the beneficiaries, the beneficiary's family, or responsible party's choice. Less than one month's supply is ordered only when the attending physician specifies that a smaller quantity of medication is necessary for a special medical reason.

The ICF/IID chief executive officer (CEO) or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy billing.

NOTE: The cost for drugs and biologicals cannot be charged to the beneficiary, family, or responsible party including any additional charges for the use of the unit dose or blister pack system of packing and storing medications.

Aids and Equipment

The facility must furnish, maintain in good repair, and teach beneficiaries to use and to make informed choices about the use of dentures, eyeglasses, hearing aids and other communication aids, braces, and other devices identified by the IDT as needed by the beneficiary.

NOTE: The costs for aids and equipment cannot be charged to the beneficiaries or their responsible party.

Nutritional Services

The facility must provide a nourishing, well-balanced diet for each beneficiary, including modified and specially prescribed diets. The nutritional component must be under the guidance of a licensed dietitian.

NOTE: Nutritional services are included in the per diem rate. Residents of an ICF/IID are not eligible for Supplemental Nutrition Assistance Program (SNAP) benefits, commodities, or other subsidized food programs.

Clothing

The facility should provide adequate seasonal clothing for the beneficiary and must maintain a current clothing inventory for each beneficiary. Adequate is defined as a seven day supply in good repair and properly fitting. Work uniforms or special clothing/equipment for training will be

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provided in addition to the seven day supply. A beneficiary with adequate clothing may purchase additional clothing using their personal funds if they desires. If a beneficiary desires to purchase a certain brand, the beneficiary has the right to use their personal funds in this manner; however, the beneficiary must be made aware of what the facility is providing prior to making their decision. It must be documented that the beneficiary was made aware of what the facility is obligated to provide.

NOTE: For more information on services that must be provided by the ICF/IID or may be purchased by the beneficiary, see Section 26.7 *Income Consideration in Determining Payment* of this manual chapter.

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BENEFICIARY BEHAVIOR**Written Policies and Procedures****Staff and Beneficiary Interactions and Conduct**

Facilities must have written policies and procedures for the management of conduct between staff and beneficiaries. These policies and procedures will:

1. Specify allowable and non-allowable conduct by the staff and the beneficiaries;
2. Provide for beneficiary choice and self-determination to the extent possible;
3. Be readily available to all beneficiaries, parent(s), staff, and legal guardians; and
4. Be developed with the participation of beneficiaries to the extent possible.

Management of Inappropriate Beneficiary Behavior

A facility must develop and implement written policies and procedures for the management of inappropriate beneficiary behavior. These policies and procedures must:

1. Specify all facility approved interventions to manage inappropriate beneficiary behavior;
2. Designate these interventions on a hierarchy ranging from the most positive and least restrictive to the least positive and most restrictive;
3. Insure that, prior to the use of more restrictive techniques, the beneficiary's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried and were ineffective;
4. Address the use of extraordinary and least restrictive measures such as time-out rooms, physical restraints, drugs used to manage inappropriate behavior, and the application of painful or noxious stimuli; and
5. Identify the staff members who may authorize use of a particular intervention, and a mechanism for monitoring and controlling use of the intervention.

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Interventions to Manage Inappropriate Behavior**Safety and Supervision**

Interventions to manage inappropriate beneficiary behavior must be used with sufficient safeguards and supervision to insure that the safety, welfare, and civil and human rights of beneficiaries are adequately protected. These interventions must never:

1. Be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program;
2. Include corporal punishment; nor
3. Include discipline of one beneficiary by another except as part of an organized system of self-government as set forth in facility policy.

Behavior Management Plan

Individual programs to manage inappropriate beneficiary behavior such as time-out rooms, restraints, etc. must be incorporated into the beneficiary's individual habilitation plan (IHP) and must be reviewed, approved, and monitored by the specially constituted Human Rights Committee.

Written informed consent by the beneficiary or responsible party is required prior to implementation of a behavior management plan involving any risks to beneficiary's rights. See Section 26.4 Beneficiary Rights in this manual chapter, which addresses informed consent.

Standing Programs

Standing or as needed programs to control inappropriate behavior are not permitted. Sending a beneficiary to their room to control inappropriate behavior is not acceptable unless it is a part of a systematic program of behavioral interventions for that beneficiary.

Time-out Rooms

Use of time-out rooms is **not** permitted in group or community homes.

In institutional settings (over 16 beds), emergency placement in time out rooms is allowed. Time-out is **only** permitted when professional staff is on-site and only under the following conditions:

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1. The placement in a time-out room is part of an approved systematic behavior program as required in the IHP to manage inappropriate behavior;
2. The beneficiary is under constant, direct visual supervision of designated staff;
3. If the door to the room is closed, it must be held shut only by use of constant physical pressure from a staff member;
4. Placement in time-out room does not exceed one hour;
5. Beneficiaries are protected from hazardous conditions while in time-out rooms; and
6. A record is kept of time-out activities.

Physical Restraint

Physical restraint is defined as any manual method, physical or mechanical device that the beneficiary cannot remove easily and that restricts free movement.

Examples of manual methods include:

1. Holds:
 - a. Therapeutic, or
 - b. Basket.
2. Containment:
 - a. Prone; or
 - b. Supine containment.

Examples of physical or mechanical devices include:

1. Barred enclosure that is no more than three feet in height;
2. Chair with a lap tray, to keep an ambulatory beneficiary seated;
3. Wheelchair tied to prevent movement of a wheelchair mobile beneficiary; and
4. Straps to prevent movement while the beneficiary is in a chair or bed.

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Physical restraints can be used only:

1. When absolutely necessary to protect the beneficiary or others from injury in an emergency situation;
2. When part of an individual program plan intended to lead to less restrictive means of managing the behavior the restraints are being used to control;
3. As a health related protection prescribed by a physician, but only if absolutely necessary during a specific medical, dental, or surgical procedure or while a medical condition exists; and
4. When the following conditions are met:
 - a. Restraints are designed and used so as not to cause physical injury and to cause the least possible discomfort;
 - b. Restraints are applied only by staff who have had training in the use of these interventions;
 - c. Orders for restraints shall not be obtained for use on a standing or on an as needed basis;
 - d. Restraint authorizations are not in effect longer than 12 consecutive hours and are obtained as soon as possible after restraint has occurred in emergency situations;
 - e. Beneficiaries in restraints shall be checked at least every 30 minutes and released by staff trained in the use of restraints, as soon as the behavior has subsided. Record of restraint checks and usage is required; and
 - f. Opportunities for motion and exercise are provided for not less than 10 minutes during each two-hour period and a record is kept.

Medications

Medications used for the control of inappropriate behavior may be used only under the following conditions:

1. In doses that do not interfere with the beneficiary's activities of daily living (ADL); and

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2. With approval from the interdisciplinary team (IDT), the beneficiary, or legal representative, and the specially constituted committee.

Prescribed medications must be directed toward eliminating the inappropriate behavior, and used only as part of the beneficiary's IHP.

Prior to the use of any program involving a risk to beneficiary protection and rights, including the use of prescribed medications to manage inappropriate behavior, written informed consent must be obtained from:

1. The beneficiary; or
2. Family, legal representative, or advocate if beneficiary is a minor or beneficiary is unable to understand the intended program or treatment.

Informed consent consists of permission given voluntarily by the beneficiary or the legally appropriate party, on a time limited basis not to exceed 365 days after having been informed of the following:

1. Specific issue, treatment or procedure;
2. Beneficiary's specific status with regard to the issue;
3. Attendant risks regarding the issue;
4. Acceptable alternatives to the issue;
5. Right to refuse; and
6. Consequences of refusal.

Medication must not be used until it can be justified that the beneficial effects of the prescribed medication on the beneficiary's behavior outweigh the potentially harmful effects of the medication. Prescribed medication must be monitored in conjunction with the physician, the pharmacist, and facility staff.

If clinical evidence justifies that a medication used for control of inappropriate behavior is a contraindication, it must be gradually reduced at least annually in a carefully monitored program conducted in conjunction with the IDT.

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BENEFICIARY RIGHTS AND RESPONSIBILITIES**Written Policies**

The facility will establish written policies that protect the beneficiary's legal rights, promote quality of life, and maintain their sense of dignity and self-determination. The chief executive officer (CEO) will be responsible for assuring the staff comply with these policies.

Notification of Rights

All beneficiaries, families, and/or responsible parties will sign a statement verifying that they have been fully informed, both verbally and in writing, at the time of admission, and when changes occur during the beneficiary's stay in the facility, of the following:

1. Facility rules and regulations;
2. Beneficiary rights;
3. Beneficiary responsibilities to obey all rules and regulations and respect the personal rights and private property of the residents; and
4. Rules for conduct at the time of beneficiary admission and subsequent changes during their stay in the facility.

Changes in the beneficiary rights or responsibilities will be conveyed both verbally and in writing to each beneficiary, family member, and/or responsible party at the time of or before the change.

Receipt of the change will be acknowledged, in writing, by each capable beneficiary, family member, and/or responsible party. This written acknowledgment will be witnessed by a third person.

Each beneficiary must be fully informed, in writing, of all chargeable services available in the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). This will include any charges for services not paid for by Medicaid or not included in the facility's basic rate per day charges. The facility must provide this information either before or at the time of admission and on a continuing basis as changes occur in services or charges during the beneficiary's stay.

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Legislation**Civil Rights Act of 1964 (Title VI)**

Title VI of the **Civil Rights Act of 1964** states, "*No persons in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.*"

The facility will meet the following criteria in regard to Title VI:

1. **Compliance:**

The facility will be in compliance with **Title VI** and will not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin;

2. **Written Policies:**

The facility will adopt and implement written policies for compliance with Title VI. All employees and contract service providers who provide services to beneficiaries will be notified in writing of the Civil Rights policy;

3. **Community Notification:**

The facility will notify the community that the ICF/IID activities and services are provided to beneficiaries without regard to race, color, or national origin. The notice to the community may be given by letters to and meetings with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity. Notices published in newspapers and signs posted in the facility may also be used to inform the public;

4. **Housing:**

All beneficiaries will be housed without regard to race, color, or national origin. An ICF/IID will not have dual accommodations to effect racial segregation. Occupancy of rooms on a nondiscriminatory basis will be required. There will be a policy prohibiting assignment of rooms by race. Beneficiaries **will not be asked** if they are willing to share a room with a person of another race, color, or national origin. Beneficiary transfer will not be used to evade compliance with Title VI;

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5. Open Admission Policy:

An open admission policy and desegregation of the ICF/IID will be required, particularly when the facility previously excluded or primarily serviced beneficiaries of a particular race, color, or national origin. Facilities that exclusively serve beneficiaries of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices; and

6. Beneficiary Services:

All beneficiaries will be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical and non-medical services are covered by this requirement.

An ICF/IID's staff will provide beneficiary services without regard to race, color, or national origin.

The facility also must not discriminate in hiring or firing of employees, including in contractual and consultative capacities.

Section 504 of the Rehabilitation Act of 1973

Facilities will comply with **Section 504** of the **Rehabilitation Act of 1973** that states, "*No qualified person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.*"

Age Discrimination Act of 1975

This act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All ICF/IID must be in compliance with this Act.

Americans with Disabilities Act of 1990

All facilities must be in compliance with this Act.

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Beneficiary Rights**Resident Bill of Rights**

Upon admission to the facility, the ICF/IID shall provide to each beneficiary or their responsible party a copy of the residents' bill of rights. Each beneficiary must be:

1. Fully informed by a physician of his health and medical condition unless the physician decides that informing the resident is medically contraindicated;
2. Given the opportunity to participate in planning his total care and medical treatment;
3. Given the opportunity to refuse treatment; and
4. Given informed, written consent before participating in experimental research.

If the physician decides that informing the beneficiary of their health and medical condition is medically contraindicated, it must be documented in the beneficiary's record.

Each beneficiary must be transferred or discharged in accordance with the discharge plans in the individual habilitation plan (IHP) and/or the procedures on transfers and discharges as stated in this manual. (See Sections 26.2 Covered Services and 26.5 Transfers and Discharges).

Beneficiaries must be encouraged and assisted in exercising their rights as a beneficiary of the facility and as a citizen. Beneficiaries must be allowed to submit complaints or recommendations concerning the policies and services of the ICF/IID to staff and/or to outside representatives free from restraint, interference, coercion, discrimination, or reprisal. This includes the right to due process.

Beneficiaries must be allowed to manage their personal financial affairs and taught to do so to the extent of individual capability. If a beneficiary requests assistance from the facility in managing their personal financial affairs, the request must be in WRITING and the facility must comply with the record keeping requirements of this manual chapter.

Beneficiaries must be free from physical, verbal, sexual or psychological abuse or punishment. Beneficiaries must be free from chemical and physical restraints unless the restraints are used in accordance with beneficiary health, safety, and habilitation regulations. (Refer to Section 26.3 Beneficiary Behavior).

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Privacy

Beneficiaries must be treated with consideration, respect, and full recognition of their dignity and individuality and must be given privacy during treatment and care of personal needs. Beneficiary's records, including information in an automated database, must be treated confidentially. Beneficiaries must give written consent before the facility may release information from their records to anyone not authorized by law to receive it.

A married beneficiary must be given privacy during visits by their spouse. If both the beneficiary and their spouse are residents of the facility, they must be permitted to share a room.

No beneficiary may be required to perform services for the facility. Those beneficiaries who work by choice for the facility must be compensated for their efforts at prevailing wages and commensurate with their abilities.

Each beneficiary must be allowed to:

1. Communicate, associate, and meet privately with individuals of their choice, unless this infringes on the rights of another beneficiary(s);
2. Send and receive personal mail *unopened*; and
3. Have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their IHP.

Beneficiaries must be allowed to participate in social, religious, and community group activities.

Beneficiaries must be allowed to retain and use their personal possessions and clothing as space permits.

Beneficiaries may be allowed to have burial insurance policy(s). The ICF/IID's administrator or designee, with the beneficiary's permission, may assist the beneficiary in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy.

Violation of Rights

A person who submits or reports a complaint concerning a suspected violation of a beneficiary's rights, services or conditions in an ICF/IID, or who testifies in any administrative or judicial proceeding arising from such complaints, will have immunity from any criminal or civil liability

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unless that person has acted in bad faith with malicious purpose, or if the court finds that there was an absence of a justifiable issue of either law or fact by the complaining party.

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TRANSFERS AND DISCHARGES**Written Agreements with Outside Resources**

Each beneficiary must receive the services that are required to meet their needs including emergency and other health care. If the service is not provided by the intermediate care facilities for individuals with intellectual disabilities (ICF/IID), there must be a written agreement to provide the service with an outside resource. Written agreements for hospital transfers must be with nearby hospitals and must provide for the prompt transfer of beneficiaries.

Facility Responsibilities for Transfers or Discharges

Facility records shall document that the beneficiary was transferred or discharged for “good cause.” Good cause is any reason that is in the best interest of the individual.

Any decision to move a beneficiary shall be part of an interdisciplinary team (IDT) process. The beneficiary, family, legal representative, and advocate (as applicable), shall participate in the decision making process.

Except in cases of emergency, planning for a beneficiary’s discharge or transfer shall allow for at least 30 days to prepare the beneficiary and parents/guardian for the change.

Planning for release of a beneficiary shall include providing for appropriate services in the beneficiary’s new environment, including protective supervision and other follow-up services detailed in the discharge plan.

The beneficiary and/or legal representative must give their written consent in all non-emergency situations. Notification shall be made to the parents or responsible parties as soon as possible.

Both the discharging and receiving facilities shall share responsibility for ensuring the exchange of medical and other programmatic information, including but not limited to:

1. Updated active treatment plan;
2. Appropriate care and transportation of the beneficiary during transfer; and
3. Transfer of personal effects and of information related to such items.

Staff from the sending and receiving facilities shall confer on a continuing basis to share pertinent information regarding all aspects of the beneficiary’s care and habilitation training.

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The transferring facility is responsible for developing a final summary of the beneficiary's developmental, behavioral, social, health, and nutritional status. With the consent of the beneficiary and/or responsible party, a copy of this summary must also be provided to authorized persons and agencies.

The facility shall establish procedures for counseling beneficiaries or legal representatives, concerning the advantages and disadvantages of the discharge. This counseling shall include information regarding after care services available through agency and community resources.

All beneficiaries being transferred or discharged shall be given appropriate information about the new living arrangement. Counseling shall be provided if the beneficiary is not in agreement with this living arrangement. See **Involuntary Transfer or Discharge** if beneficiary is being transferred against their will.

The beneficiary's right to the most appropriate placement that will meet their needs shall govern all transfer/discharge planning. **Beneficiaries are not to be maintained in inappropriate placements in which their needs cannot adequately be met.**

Involuntary Transfer or Discharge

Involuntary transfer or discharge of a beneficiary may occur only under the following conditions:

1. It is necessary for the beneficiary's welfare and the beneficiary's needs cannot be met in the facility;
2. It is appropriate because the beneficiary's health has improved sufficiently, therefore, the beneficiary no longer needs the services provided by the facility;
3. Safety of individuals in the facility is endangered;
4. Health of individuals in the facility would otherwise be endangered;
5. Beneficiary has failed, after reasonable and appropriate notice, to pay for the portion of the bill for services which they are liable or when the beneficiary loses financial eligibility for Medicaid; or
6. Facility ceases to operate.

NOTE: When a beneficiary becomes eligible for Medicaid after admission to a facility, the facility may charge the beneficiary only allowable charges under Medicaid.

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Facility Responsibilities

When a beneficiary is involuntarily transferred or discharged, the beneficiary's clinical record must be fully documented and documentation must be made by the following:

1. **Beneficiary's physician** if the transfer or discharge is necessary for the beneficiary's welfare or the beneficiary's condition has sufficiently improved and no longer needs the services provided by the facility; or
2. **Any physician** if the health of the individuals in the facility would be endangered.

Before an inter-facility transfer or discharge occurs, the facility must:

1. Notify the beneficiary of the transfer or discharge and the reason for the move. The notification must be written in a language and manner that the beneficiary understands. A copy of the notice must be placed in the beneficiary's clinical record and transmitted to the following:
 - a. Beneficiary;
 - b. Family member of the beneficiary, if known;
 - c. Beneficiary's legal representative and legal guardian, if known;
 - d. Community Living Ombudsman Program;
 - e. Louisiana Department of Health (LDH) Health Standards Section (HSS);
 - f. Office of Citizens with Developmental Disabilities (OCDD) regional office for assistance with the placement decision;
 - g. Beneficiary's physician;
 - h. Appropriate educational authorities; and
 - i. Representative of the beneficiary's choice.
2. Record the reasons in the beneficiary's clinical records; and
3. Conduct an IDT conference with the beneficiary, family member or legal representative and an appropriate agency representative to update the plan and

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develop discharge options that will provide a reasonable assurance that the transfer or discharge is to a setting that can be expected to meet the beneficiary's needs.

The facility must issue the written notice of discharge or transfer at least 30 days before the beneficiary is transferred or discharged; however, the notice may be made as soon as practicable before transfer or discharge, under the following circumstances:

1. Safety of the individuals in the facility would be endangered;
2. Health of individuals in the facility would be endangered;
3. Beneficiary's health improves sufficiently to allow a more immediate transfer or discharge; or
4. Immediate transfer or discharge is required by the beneficiary's urgent medical needs as determined by a physician.

NOTE: Notice may be made at least 15 days before transfer or discharge in cases of nonpayment of a bill for cost of care.

The written notice must include:

1. Reason for transfer or discharge;
2. Effective date of transfer or discharge;
3. Location to which the beneficiary is transferred or discharged;
4. Explanation of the beneficiary's right to have personal and/or third party representation at all stages of the transfer or discharge process;
5. Address and telephone number of the Community Living Ombudsman Program;
6. Mailing address and telephone number of the agency responsible for the protection of individuals with developmental disabilities;
7. Names of facility personnel available to assist the beneficiary and family in decision making and transfer arrangements;

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8. Date, time and place for the follow-up IDT conference to make a final decision on the beneficiary's/legal representative's choice of new facility or alternative living arrangement; and
9. Explanation of the beneficiary's right to register a complaint with LDH within three days after the follow-up IDT conference.

The facility shall provide all services required prior to discharge, that are contained in the final update of the individual habilitation plan (IHP) and in the transfer or discharge plan.

The facility shall be responsible for keeping the beneficiary, whenever medical or other conditions warrant, for as long as necessary even if beyond the proposed date of transfer or discharge, except in emergency situations.

The facility shall provide transportation to the new residence unless other arrangements are preferred by the beneficiary/legal representative or the receiving facility.

If a beneficiary requests a hearing, LDH shall hold a hearing at the ICF/IID, or by telephone if agreed upon by the appellant, within 30 days from the date the hearing request is filed with the Division of Administration (DAL) and witness and exhibit lists are submitted by the facility. The DAL shall issue a decision within 30 days from the date of the beneficiary's hearing.

OCDD Regional Office Responsibilities

The OCDD regional office responsibilities when involuntary transfer or discharge occurs, include the following:

1. Review written notice of involuntary discharge;
2. Ensure that the beneficiary's rights are protected during transfer;
3. Refer any rights violations to the Bureau of Health Services Financing (BHSF) HSS for investigation; and
4. Complete medical certification for receiving facility after review of appropriate data.

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BHSF Medicaid Eligibility Local Office Responsibilities

When an involuntary transfer or discharge occurs, the local office is responsible for the following:

1. Referring complaints related to health care filed by beneficiaries, beneficiary's families or legal representatives to BHSF HSS for investigation; and
2. Completing financial eligibility determination for transfer to appropriate facility or non-institutional living arrangement.

Mass Transfer of Beneficiaries

The following provisions shall apply to any mass transfer.

ICF/IID Decertification

When BHSF determines that an ICF/IID no longer meets State and Federal Title XIX certification requirements, decertification action is taken. Usually an advance decertification date is set, unless the beneficiaries are in immediate danger.

ICF/IID Decertification Notice

On the date the ICF/IID is notified of its decertification, OCDD shall immediately begin notifying beneficiaries, families, responsible parties, and other appropriate agencies or individuals of the decertification action and of the services available to ensure an orderly transfer and continuity of care.

Coordination of Decertification Process

The process of decertification requires concentrated and prompt coordination among the following groups: the BHSF HSS, BHSF Medicaid eligibility parish office, the facility, OCDD, and other offices designated by LDH.

The coordination effort shall have the following objectives:

1. Protection of beneficiaries;
2. Assistance in finding the most appropriate placements for beneficiaries when requested by beneficiaries, families and/or responsible parties; and

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3. Timely termination of vendor payment upon beneficiary's discharge from the ICF/IID.

NOTE: The ICF/IID still retains its usual responsibility during the transfer/discharge process to notify the BHSF Medicaid eligibility parish office promptly of all changes in the beneficiary's status.

ICF/IID Closing or Withdrawing from the Medicaid Program

When an ICF/IID either voluntarily or involuntarily discontinues its operations or participation in the Medicaid program, beneficiaries, families, responsible parties, and other appropriate agencies or individuals must be given sufficient notice of the effective closure date to insure an orderly transfer and continuity of care.

If the ICF/IID is voluntarily or involuntarily **withdrawing** from Medicaid participation, the beneficiary has the option of remaining in the ICF/IID on a private-pay basis.

If the ICF/IID is **closing** its operations, plans shall be made for transfer.

Payment Limitation

Payments may continue for beneficiaries up to 30 days following the effective date of the ICF/IID's decertification. However, no payment will be approved for Medicaid beneficiaries admitted after an ICF/IID receives a notice of decertification. The payment limitation also applies to Medicaid beneficiaries admitted prior to the decertification notice.

Payment will continue for beneficiaries certified prior to the decertification **only** if the ICF/IID totally cooperates in the orderly transfer of beneficiaries to other Medicaid facilities or other placements of their choice.

Transfer Team

LDH shall designate certain staff members as a transfer team when a mass transfer is necessary. The team's responsibilities shall include supervising transfer activities in the event of a proposed ICF/IID decertification or voluntary termination of Medicaid participation.

This team is responsible for:

1. **Identification and Coordination:**

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When a provider agreement is extended for up to two months beyond its original expiration date, the transfer team shall immediately identify the ICF/IID receiving the affected beneficiaries, and determine the last date for which vendor payment for beneficiary services can be made. The team members will assist in making the most appropriate arrangements for the beneficiaries by providing members' names as contact persons if assistance is needed;

2. Supervision and Assistance:

When payments are continued for up to 30 days following decertification, the transfer team shall supervise the decertification and transfer of its Medicaid beneficiaries. The team will assist in making the most appropriate arrangements for the beneficiaries by providing the members' names as contact persons if assistance is needed. They will also determine the last date for which vendor payment for beneficiary services can be made; and

3. Effecting the Transfer:

In order to insure an orderly transfer or discharge, the transfer team shall also be responsible for performing the following tasks:

- a. Meeting with appropriate ICF/IID administrative staff and other personnel as soon as possible after termination of a provider agreement to discuss the transfer planning process;
- b. Continuing to meet periodically with the ICF/IID personnel throughout the transfer planning process;
- c. Identifying any potential problems;
- d. Monitoring the ICF/IID's compliance with transfer procedures;
- e. Resolving disputes in the beneficiary's best interest;
- f. Encouraging the ICF/IID to take an active role in the transfer planning;
- g. Arranging for the social services necessary in the transfer or discharge plan or otherwise necessary to ensure an orderly transfer or discharge; and

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- h. Obtaining other services available under Medicaid.

NOTE: The ICF/IID's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

BHSF Medicaid Eligibility Local Office Responsibilities

The BHSF Medicaid Eligibility local office is responsible for maintaining a list of each beneficiary's status as authorization forms are submitted regarding transfer or discharge. At the conclusion of the 30 or 60-day period (referred to under **Transfer Team** above), the team shall submit a report to the BHSF state office, outlining arrangements made for all beneficiaries.

Transfer to or from Hospice

Beneficiaries residing in an ICF/IID may receive hospice services while residing in the ICF/IID; however, the ICF/IID must enter into a written agreement in accordance with the provisions set forth in the Licensing Standards for Hospices (LAC 48: I. Chapter 82), under which the hospice program takes full responsibility for the professional management of the beneficiary's hospice care and the facility agrees to provide room and board to the individual.

Beneficiary Rights

Nothing in the transfer or discharge plan shall interfere with a beneficiary's rights. (See **Section 26.4 Beneficiary Rights and Responsibilities** for a description of a beneficiary's rights and responsibilities).

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COMPLAINTS

It is the responsibility of the Louisiana Department of Health (LDH) to offer protection and relief from abuse to beneficiaries in institutions. This is a responsibility that LDH takes seriously, and to that end, has instituted a series of procedures to follow in reporting and preventing the abuse and neglect of beneficiaries. The following procedures are established for receiving, evaluating, investigating, and correcting grievances concerning beneficiary care, and for the mandatory reporting of abuse and neglect in intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

Applicability

Any person having knowledge of alleged abuse or neglect of a beneficiary or a beneficiary being denied care or treatment may submit a complaint, preferably in writing. Any person may submit a complaint if they have knowledge that a state law, standard, rule, regulation, correction order, or certification rule issued by LDH has been violated.

Duty to Report Abuse and Neglect

All incidents or allegations of abuse and/or neglect must be reported by telephone or fax within 24 hours to Bureau of Health Services Financing (BHSF)/Health Standards Section (HSS). The facility shall investigate all allegations of abuse and neglect and report results of such investigation to the HSS within the prescribed timeframe in accordance with licensing regulations. Copies of all pertinent documents shall be made available to the HSS as required and/or requested. Failure to comply with this requirement could result in a deficiency and/or imposition of a sanction. Those who must make a report of abuse and/or neglect are:

1. Physicians or other allied health professionals;
2. Social services personnel;
3. Facility administration;
4. Psychological or psychiatric treatment personnel;
5. Registered nurses (RNs);
6. Licensed practical nurses (LPNs); and
7. Direct or indirect care staff who have knowledge of abuse or neglect of a resident of the facility.

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Penalties for Failure to Make a Complaint

Any person who knowingly and willfully fails to report an abuse or neglect situation or files a false report shall be fined not more than \$500.00 or imprisoned not more than two months or both.

Penalties for committing cruelty or negligent mistreatment to a beneficiary of ICF/IID services shall be fined not more than \$10,000.00 or imprisoned with or without hard labor for more than 10 years, or both.

Where to Submit a Complaint

Complaints involving beneficiaries of all ages in institutions received by LDH shall be referred to the BHSF HSS. (Refer to Appendix C for contact information). Complaints may also be submitted to any local law enforcement agency.

Disposition of Complaints

If it has been determined that complaints involving alleged violations of any criminal law concerning an ICF/IID are valid, the investigating office of LDH shall furnish copies of the complaints for further investigation to both the Medicaid Fraud Control Unit (MFCU) of the Louisiana Department of Justice, Attorney General's Office and the local office of the district attorney.

Substantiated Complaint

LDH shall notify the administrator who must provide an acceptable plan of correction as specified below:

1. If a situation presents a threat to the health and safety of the beneficiaries, the ICF/IID shall be required to take immediate corrective action. LDH may certify non-compliance and initiate termination, revocation or suspension of the license, or impose sanctions; and
2. In all other violations, an expeditious correction, not to exceed 90 days, shall be required. If the provider is unable or unwilling to correct the violation, LDH may certify non-compliance and initiate termination, non-renewal, or impose sanctions.

In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the MFCU.

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1. Unsubstantiated Complaint:

LDH shall notify the complainant and the facility of the finding;

2. Repeat Violations:

When violations continue to exist after the corrective action is taken, LDH may take appropriate action including decertification or revocation of the facility's license;

3. Follow-up Activity:

Facilities with deficiencies will be scheduled for follow-up visits as soon as possible after the approved provider completion date on the plan of correction; and

4. Results of Complaint Investigation:

The results of the complaint investigation may be considered in conducting annual surveys and making certification decisions.

Informal Reconsideration

A complainant or a facility dissatisfied with LDH's response to the complaint investigation may request an informal reconsideration.

Retaliatory actions against complainants are prohibited. Persons aware of retaliatory action or threats in this regard should contact LDH.

Reporting of Incidents

For beneficiaries involved in an accident or incident, an incident report shall be completed. This report shall include:

1. Name;
2. Date;
3. Time;
4. Details of the accident or incident;

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5. Circumstances under which the accident or incident occurred;
6. Witnesses; and
7. Action taken.

Incident reports are an administrative tool to pinpoint problem areas and shall result in corrective action. These reports shall be made available to representatives of the U. S. Department of Health and Human Services (DHHS) and LDH.

Incidents or accidents involving beneficiaries must be documented in the beneficiary's record with all pertinent information.

The examples listed below are not all-inclusive, but are presented to assist facility employees in completing incident reports:

1. **Suspicious Death** - Death of a beneficiary or on-duty employee when there is suspicion of death other than by natural causes;
2. **Abuse and/or Neglect** - All incidents or allegations of abuse and/or neglect;
3. **Runaways** - Runaways considered being dangerous to self or others;
4. **Law Enforcement Involvement** - Arrest, incarceration, or other serious involvement of beneficiaries with law enforcement authorities;
5. **Mass Transfer** - The voluntary closing of a facility or involuntary mass transfer of beneficiaries from a facility;
6. **Violence** - Riot or other extreme violence;
7. **Disasters** - Explosions, bombings, serious fires; and
8. **Accidents/Injuries** - Severe accidents or serious injury involving beneficiaries or on-duty employees caused by beneficiaries such as life threatening, or possible permanent and/or causing lasting damage.

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RECORD KEEPING**Retention of Records**

Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) shall retain all such records on file as required by the Louisiana Department of Health (LDH) and shall have them available for inspection at request for six years from the date of service or until all audit exceptions are resolved, whichever period is longer.

In the case of minors, retain all records for three years after they become 18 years of age; **or** six years after the date of discharge, transfer, or death of the beneficiary.

Accounting Records

Accounting records must be maintained in accordance with generally accepted accounting principles as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers.

NOTE: Purchase discounts, allowances and refunds will be recorded as a reduction of the cost to which they relate.

Each facility must maintain all accounting records, books, invoices, canceled checks, payroll records, and other documents relative to beneficiary care costs for a period of five years or until all audit exceptions are resolved, whichever period is longer.

All fiscal and other records pertaining to beneficiary care costs shall be subject at all times to inspection and audit by LDH, the legislative auditor, and auditors of appropriate federal funding agencies or their agents.

Daily Census Records

Each facility must maintain statistical information related to the daily census and/or attendance records for **all** beneficiaries receiving care in the facility.

Employee Records

The ICF/IID shall retain written verification of hours worked by individual employees. The records may be sign-in sheets or time cards but shall indicate the date and hours worked. Records shall include all employees even those on a contractual or consultant basis.

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The ICF/IID shall retain verification of each employee's criminal background check and disposition of charges, if any, communicable disease screening in accordance with the LDH-Office of Public Health (OPH) guidelines, employee orientation and in-service training.

Billing Records

The ICF/IID shall maintain billing records in accordance with recognized fiscal and accounting procedures. Individual records shall be maintained for each beneficiary. These records shall:

1. Clearly detail each charge and each payment made on behalf of the beneficiary;
2. Be current and shall clearly reveal to whom charges were made and for whom payments were received;
3. Itemize each billing entry; and
4. Show the amount of each payment received and the date received.

The ICF/IID shall maintain supporting fiscal documents and other records necessary to ensure that claims are made in accordance with federal and state requirements.

Beneficiary Records General Requirements

An ICF/IID facility shall have written policies and procedures governing access, publication, and dissemination of information from beneficiary records. Beneficiary records are the property of the ICF/IID and must be protected from loss, damage, tampering, or use by unauthorized individuals. Records may be removed from the ICF/IID's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

An ICF/IID shall ensure confidential treatment of beneficiary records, including information contained in automatic data banks. The beneficiary's written consent, if the beneficiary is determined competent, shall be required for the release of information to any persons not otherwise authorized under law to receive it. If the beneficiary is not considered competent, a member of the family, responsible party or advocate shall be required to sign.

NOTE: "Blanket" signed authorizations for release of information from beneficiary records are prohibited.

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The facility shall adhere to the following criteria regarding beneficiary confidentiality:

1. A record of all disclosures from beneficiary's records shall be kept;
2. All staff shall be trained in the policies regarding confidentiality during orientation and in subsequent on-the-job and in-service training; and
3. Any information concerning a beneficiary or family considered confidential for general knowledge by the ICF/IID staff shall be kept in a separate file by the chief executive officer (CEO), his designee, or social worker. A notation regarding the location of this information shall be made in the beneficiary's record.

The ICF/IID shall make necessary records available to appropriate state and federal personnel upon request.

Records Service System

The ICF/IID shall maintain an organized central record service for collecting and releasing beneficiary information in such a fashion as to protect the legal rights of the beneficiaries, ICF/IID, and ICF/IID staff.

Copies of appropriate information shall be available in the beneficiary living units. There must also be a written policy regarding a "charge out system" by which a beneficiary's record may be located when it is out of file.

The ICF/IID shall maintain a master alphabetical index of all beneficiaries.

General Contents of Records

A written record shall be maintained for each beneficiary and shall:

1. Be adequate for planning and for continuously evaluating each beneficiary's individual habilitation plan (IHP) and providing documentation of each beneficiary's response to and progress made in the IHP; and
2. Contain sufficient information to allow staff members to execute, monitor and evaluate each beneficiary's habilitation program.

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Specifics Regarding Entries into Beneficiary Records

The ICF/IID shall maintain a roster of signatures, initials and identification of individuals making entries in each record. All entries in beneficiary records shall be:

1. Legible, signed, and dated by the person making the entry;
2. All corrections must be initialed and completed in such a manner that the original entry remains legible (no white out); and
3. Dated **only** on the date when they are made.

Components of Beneficiary Records

Components of beneficiary records shall include, but shall not be limited to, the following:

1. Admission records;
2. Personal property records;
3. Financial records;
4. Medical records. This includes:
 - a. Records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program; and
 - b. Authorization for and the date of administration of such treatment, drugs, or services.

NOTE: The ICF/IID shall provide sufficient documentation to enable LDH to verify that each charge is due and proper prior to payment.

5. All other records that LDH finds necessary to determine an ICF/IID's compliance with any federal or state law, rule or regulation promulgated by LDH.

Interdicted Beneficiary

If the ICF/IID beneficiary has been interdicted, a copy of the legal documents shall be contained in the beneficiary's records.

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Beneficiary Admission Records**Time of Admission**

At the time of admission to the ICF/IID, information shall be entered into the beneficiary's record which shall identify and give a history of the beneficiary. This identifying information shall at least include the following:

1. A recent photograph;
2. Full name;
3. Sex;
4. Date of birth (DOB);
5. Ethnic group;
6. Birthplace;
7. Height;
8. Weight;
9. Color of hair and eyes;
10. Identifying marks;
11. Home address, including street address, city, parish and state;
12. Social security number (SSN);
13. Medical assistance identification number;
14. Medicare claim number, if applicable;
15. Citizenship;
16. Marital status;
17. Religious preference;

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18. Language spoken or understood;
19. Dates of service in the United States Armed Forces, if applicable;
20. Legal competency status if other than competent;
21. Sources of support: Social Security, Veterans benefits, etc.;
22. Father's name, birthplace, SSN, current address, and current phone number;
23. Mother's maiden name, birthplace, SSN, current address, and current phone number;
24. Name, address, and phone number of next of kin, legal guardian, or other responsible party;
25. Date of admission;
26. Name, address and telephone number of referral agency or hospital;
27. Reason for admission;
28. Admitting diagnosis;
29. Current diagnosis, including primary and secondary DSM-5-TR diagnosis, if applicable;
30. Medical information, such as allergies and general health conditions;
31. Legal status at time of admission;
32. Primary care physician (PCP) and alternate, if applicable;
33. Choice of other service providers;
34. Name of funeral home, if appropriate; and
35. Any other useful identifying information. (Refer to Section 26.1 for Admission Process).

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First Month after Admission

Within 30 calendar days after a beneficiary's admission, the following shall be completed and updated:

1. A review and update of the pre-admission evaluation;
2. A prognosis for programming and placement; and
3. A comprehensive evaluation and an IHP for the beneficiary which includes a 24-hour schedule.

Entries in Beneficiary Records

The following information shall be added to each beneficiary's record during their stay at the ICF/IID:

1. Reports of accidents, seizures, illnesses, and treatments for these conditions;
2. Records of immunizations;
3. Behavior incidents and plans to manage inappropriate behavior;
4. Records of all periods where restraints were used, with justification and authorization for each, and records of monitoring in accordance with these standards;
5. Reports of at least an annual review and evaluation of the beneficiary's program, developmental progress, and status, as required in these standards;
6. Records of visits and contacts with family and other persons;
7. Records of attendance, absences, and visits away from the ICF/IID;
8. Correspondence pertaining to the beneficiary;
9. Periodic updates of the admission information (such updating shall be performed in accordance with the written policy of the ICF/IID) at least annually; and
10. Appropriate authorizations and consents.

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Entries at Discharge

At the time of a beneficiary's discharge, professional staff, as appropriate, shall enter a discharge summary into the beneficiary's record. This summary shall address the findings, events, and progress of the beneficiary while at the ICF/IID and a diagnosis, prognosis, and recommendations for future programming.

Medical Records

The ICF/IID shall maintain medical records that include clinical, medical, and psycho-social information on each beneficiary.

Components of Medical Records

Each beneficiary's record shall consist of a current, active medical section and the ICF/IID's medical files or folders.

Active Medical Section

The active medical section shall contain the following information:

1. Physician certification of the beneficiary's need for admission to the ICF/IID;
2. Six months of current, pertinent information relating to the active on-going medical care;
3. Physician re-certification that the beneficiary continues to require the services of the ICF/IID;
4. Nurses' quarterly physical assessment;
5. Pharmacy consultant's quarterly review of all medication administered to each beneficiary; and
6. Certification that each IHP has been periodically reviewed and revised.

As the active medical section becomes bulky, the outdated information shall be periodically removed and filed in the ICF/IID's medical files.

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Beneficiary Personal Property Records

The ICF/IID shall permit beneficiaries to maintain and use their personal property. The number of personal possessions may be limited only for health and safety reasons. When such limitations are imposed, documentation is required in the beneficiary's records.

Within 24 hours after admission, the ICF/IID shall prepare a written inventory of the personal property a beneficiary brings to the ICF/IID. The authorized representative shall sign and retain the written inventory and shall give a copy to the beneficiary, family or responsible party. The written inventory shall be revised to show if acquired property is lost, destroyed, damaged, replaced or supplemented.

Beneficiary Financial Records

Beneficiaries have the right to maintain their personal funds or to designate someone to assume this responsibility for them. Beneficiary's income may be from Social Security, Supplemental Security Income (SSI), optional State Supplementation, other sources (VA or insurance benefits, etc.) or earnings of the beneficiary. A portion of the beneficiary's income is used to pay the beneficiary's share (liability) of the monthly charges for the ICF/IID. The ICF/IID shall:

1. Have written policies and procedures for protecting beneficiaries funds and for counseling beneficiaries concerning the use of their funds;
2. Develop written procedures for the recording and accounting of beneficiary's personal funds;

NOTE: ICF/IIDs shall ensure the soundness and accuracy of the beneficiary fund account system.

3. Train beneficiaries to manage as many of their financial affairs as they are capable. (Documentation **must** support that training was provided and the results of that training);
4. Maintain current records that include the name of the person (beneficiary or person designated) handling each beneficiary's personal funds;
5. Be responsible for the disbursements, deposits, soundness, and accuracy of the beneficiary's personal funds account. (Arrangements should be made with a federal or state insured banking institution to provide banking services for the beneficiaries);

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NOTE: All bank charges, including charges for ordering checks, shall be paid by the ICF/IID and *not* charged to the beneficiary's personal funds account(s).

6. Maintain current, written individual ledger sheet records of all financial transactions involving beneficiary's personal funds, which the facility is holding and safeguarding; and
7. Make personal fund account records available upon request to the beneficiary, family, responsible party, and LDH.

Components Necessary for a Beneficiary Fund Account System

The ICF/IID shall maintain current, written individual records of all financial transactions involving beneficiary's personal funds for which the ICF/IID is responsible. This individual beneficiary participation file shall contain a ledger sheet which includes all transactions pertinent to each beneficiary's account, and includes the following:

1. Name of the beneficiary and date of admission;
2. Deposits, which include:
 - a. Date;
 - b. Source; and
 - c. Amount.
3. Withdrawals which include:
 - a. Date;
 - b. Amount;
 - c. Check/petty cash voucher number;
 - d. Payee (if check is issued); and
 - e. Purpose of withdrawal.
4. Fund balance after each transaction.

NOTE: Checks shall not be payable to "cash" or employees of the facility.

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Receipts or invoices for disbursements shall include the following:

1. Date;
2. Amount of the disbursement;
3. Description of items purchased;
4. Signature of the beneficiary, family, or responsible party to support receipt of items; and
5. Supporting documentation for each withdrawal as follows:
 - a. Cash register receipt with canceled check or petty cash voucher signed by the beneficiary;
 - b. Invoices with canceled check or petty cash voucher signed by the beneficiary;
 - c. Petty cash voucher signed by the beneficiary; or
 - d. Canceled check.

NOTE: Canceled checks written to family members or responsible parties are sufficient receipts for disbursements if coupled with information regarding the purpose of the expenditures.

Supporting documentation for each deposit shall include the following:

1. Receipts for all cash received on behalf of the beneficiaries;
2. Copies of all checks received on behalf of the beneficiaries; and
3. Monies either spent on behalf of the beneficiary or withdrawn by the beneficiary, family, or responsible party shall be supported on the individual ledger sheet by a receipt, invoice, canceled check or signed voucher on file.

NOTE: It is highly recommended that the functions for actual disbursement of cash and reconciling of the cash disbursement record be performed by separate individuals.

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The file shall be available to the beneficiary, family, or other responsible party upon request during the normal administrative work day.

Beneficiary Personal Funds Bank Account(s)

ICF/IID may deposit beneficiary's money in individual or collective bank account(s), which shall:

1. Be separate and distinct from all ICF/IID facility accounts;
2. Consist solely of beneficiary's money and shall not be commingled with the ICF/IID facility account(s);
3. Be available daily upon request during banking hours; and
4. Be maintained at the facility.

Reconciliations of Beneficiary's Personal Funds Account(s)

There shall be a written reconciliation, at least monthly, by someone other than the custodian of the beneficiary's personal funds account(s). "Assets" (cash in bank, both checking and savings) must equal "liabilities" (ledger sheet balance(s)). Collective bank accounts shall be reconciled to the total of beneficiary's ledger sheet balances. The reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the beneficiary's personal funds account.

Unallowable Charges to Beneficiary's Personal Funds Account(s)

It is the State's intent that ICF/IIDs provide total maintenance for beneficiaries. The beneficiary's personal funds should be set aside for their individual wants and be spent as the beneficiary sees fit. In the event that a beneficiary desires to purchase a certain brand item, they have the right to do so; however, the beneficiary must be made aware of what the facility is providing prior to their making that decision. Written documentation must be maintained to support that the beneficiary was made aware of products or services the facility is obligated to provide.

Listed below (but not limited to) are items that **shall not** be charged to a beneficiary's personal funds account(s), the beneficiary's family or responsible party(s):

1. Clothing – if a beneficiary does not have adequate seasonal clothing (including shoes, etc.), it is the responsibility of the facility to provide the clothing;
2. Personal hygiene items;
3. Haircuts;

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4. Dentures/braces, etc.;
5. Eyeglasses;
6. Hearing and other communication aids;
7. Support braces;
8. Any other devices identified by the interdisciplinary team (IDT);
9. Wheelchairs;
10. Repair and maintenance of dentures/braces, eyeglasses, hearing and other communication aids, support braces, wheelchairs or any other device identified by the IDT;
11. Transportation;
12. Prescription or over-the-counter drugs;
13. Recreational costs included in the IHP;
14. Medical expenses of any nature;
15. Tips, gifts, expenses for staff;
16. Supplies or items to meet goals of IHP; and
17. Damage to facility property or the beneficiary's possessions.

NOTE: The beneficiary may not be charged for damage to facility property or the property of others caused by that individual's destructive behavior. ICF/IID have a general responsibility to maintain the environment as a cost of doing business. Property of beneficiaries damaged or stolen by others must be replaced by the facility.

Cash On Hand

ICF/IID shall have a minimum of cash on hand to meet beneficiary's spending needs. Cash on hand shall be maintained on an imprest petty cash system that includes pre-numbered petty cash vouchers. Petty cash shall be maintained at the facility and shall be available to the beneficiaries 24 hours a day, 7 days a week.

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The facility shall provide the funds to implement the petty cash system and replenish it, as necessary, from the beneficiary's personal funds through the use of signed vouchers. Vouchers may be signed by beneficiaries, families, or responsible parties. When beneficiaries cannot sign their name, vouchers shall be signed by two witnesses. Checks issued to replenish the fund should be made payable to "Custodian of Petty Cash." When funds are withdrawn from the beneficiary's savings account to cover signed vouchers, a receipt signed by the custodian of petty cash shall be maintained in lieu of a canceled check.

There shall be at least a weekly written reconciliation by someone other than the custodian of the petty cash fund. This reconciliation shall be reviewed and approved by someone other than the preparer or custodian of the petty cash fund.

NOTE: The facility is responsible for any shortage in the petty cash fund.

Access to Funds

Beneficiaries shall have access to their funds during hours comparable to those of banking institutions in their local community. Large ICF/IID shall post the times when beneficiaries shall have access to their funds.

Closing a Discharged Beneficiary's Fund Account

When a beneficiary is discharged, the ICF/IID shall refund the balance of a beneficiary's personal fund account and that portion of any advance payment not applied directly to the ICF/IID fee. The amount shall be refunded to the beneficiary, family or other responsible party within 30 days following the date of discharge. Date, check number, and "to close account" should be noted on the ledger sheet. When the facility is the payee for a Social Security check or other third party payments, the change in payee should be initiated immediately by the facility upon knowledge of the discharge.

NOTE: The facility shall allow the beneficiary to withdraw a minimum of \$25.00 from their personal funds account on the day of discharge.

Disposition of a Deceased Beneficiary's Personal Funds

Upon a beneficiary's death, an ICF/IID shall submit written notification within 10 business days to the next of kin disclosing the amount of funds in the deceased's account as of the date of death. The ICF/IID shall hold the funds until one of the following occurs:

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1. **Succession Judicially Opened with Appointment or Confirmation of Succession Representative**

If the beneficiary's succession is judicially opened (that is, if legal proceedings are filed in court to affect the transfer of the beneficiary's property to their heirs) and a succession representative (executor or administrator) is appointed or confirmed, the ICF/IID shall pay the funds to the succession representative upon receipt of a certified copy of the letters testamentary or letters of administration issued by the court to the representative; and

2. **Succession Judicially Opened Without Appointment or Confirmation of Succession Representative (Succession Opened by Affidavit in Accordance with Articles 3431-3434 of the Louisiana Code of Civil Procedure)**

If the procedure set forth in Articles 3431-3434 of the Louisiana Code of Civil Procedure (see explanation below) is used for the beneficiary's succession, the ICF/IID shall pay the funds in accordance with the affidavit executed by the heirs upon receipt of a multiple original of the affidavit endorsed by Louisiana's inheritance tax collector.

Explanation: Articles 3431-3434 of the Louisiana Code of Civil Procedure provide for a special procedure which may be used if:

1. The deceased leaves property in Louisiana having a gross value of \$50,000 or less;
2. The deceased leaves no immovable property; and
3. All of the heirs are either descendants, ascendants, brothers or sisters (or descendants thereof), or the surviving spouse.

Under this procedure, the heirs of the deceased execute an affidavit containing certain required information and submit it to Louisiana's inheritance tax collector. Multiple originals of that affidavit, endorsed by the inheritance tax collector, is full and sufficient authority for payment of any money or property of the deceased to the heirs.

If within three months after the beneficiary's death, the ICF/IID has not received a certified copy of letters testamentary or letters of administration, a certified copy of a judgment of possession, or a certified copy of an endorsed affidavit, the ICF/IID shall give notice to the secretary of the Louisiana Department of Revenue (LDR), Unclaimed Property Section, including detailed information about the beneficiary, their next of kin, and the amount of funds.

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The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to the secretary of the LDR. If no order or judgment is forthcoming, the ICF/IID shall retain the funds for five years after date of death. After five years, the ICF/IID is responsible for delivering the unclaimed funds to the secretary of LDR. A termination date of the account and the reason for termination shall be recorded on the beneficiary's participation file. A notation shall read, "to close account." An endorsed, cancelled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

Where the legislature has enacted a law governing the disposition of personal funds belonging to residents of state developmental centers for the intellectually or developmentally disabled, that law shall be applicable.

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INCOME CONSIDERATION IN DETERMINING PAYMENT**Beneficiaries Receiving Care under Title XIX**

The Louisiana Department of Health (LDH), Bureau of Health Services Financing (BHSF), Medicaid Eligibility Section determines the beneficiary's applicable income (liability) when computing the Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID's) vendor payments. Vendor payments are subject to the following conditions:

1. Vendor payments will begin with the first day the beneficiary is determined to be categorically and medically eligible or the date of admission, whichever is later;
2. Vendor payment will be made for the number of eligible days as determined by the ICF/IID per diem rate less the beneficiary's per diem applicable income; and
3. If a beneficiary transfers from one facility to another, the vendor payment to each facility will be calculated by multiplying the number of eligible days times the ICF/IID per diem rate less the beneficiary's liability.

Beneficiary Personal Care Allowance

The ICF/IID will not require that any part of a beneficiary's personal care allowance be paid as part of the ICF/IID's fee. Personal care allowance is an amount set apart from a beneficiary's available income to be used by the beneficiary for their personal use. The amount is determined by LDH.

Payment Policy and Limitations**Temporary Absence of the Beneficiary**

A beneficiary's temporary absence from an ICF/IID will not interrupt the monthly vendor payment provided a bed is kept available for the beneficiary's return, and the absence is for one of the following reasons:

1. Hospitalization, which does not exceed 7 days per hospitalization for treatment of an acute condition; or
2. Leave of Absence.

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Hospitalization

The reimbursement for hospital leave days is 85 percent of the applicable ICF/IID per diem rate.

Leave of Absence

A leave of absence is a temporary stay outside the ICF/IID provided for in the beneficiary's individualized habilitation program (IHP). A leave of absence will not exceed 60 days per fiscal year (FY) (July 1 through June 30), and will not exceed 45 consecutive days in any single occurrence.

Certain leaves of absence will be excluded from the annual 60-day limit as long as the leave does not exceed the 45 consecutive day limit and is included in the written IHP. These exceptions are as follows:

1. Special Olympics;
2. Official state holidays;
3. Road Runners Club of America events, including but not limited to events intended to raise money to help ICF/IID beneficiaries participate in the Special Olympics;
4. Louisiana planned conferences such as, but not limited to, those sponsored by the Community Residential Services Association (CRSA) a consumer driven support system that advocates choices for persons with disabilities;
5. Trial discharge leave - 14 days per occurrence (must be in the plan of care (POC)); and
6. Two days for bereavement of close family members as outlined below:
 - a. Parent;
 - b. Stepparent;
 - c. Stepsister;
 - d. Stepbrother;
 - e. Child;

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- f. Stepchild;
- g. Grandchild;
- h. Grandparent;
- i. Spouse;
- j. Mother-in-law;
- k. Father-in-law;
- l. Brother; and
- m. Sister.

The ICF/IID shall **promptly notify** LDH of absences beyond the applicable 45 or 7-day hospital limitations. Payment to the ICF/IID shall be terminated from the 46th or the 8th day, depending upon the type of absence. **Payment will commence after the individual has been determined eligible for Medicaid benefits and has remained in the ICF/IID for 30 consecutive days.**

NOTE: Elopements and unauthorized absences count against allowable leave days; however, Title XIX eligibility is not affected if the absence does not exceed 30 days and if the ICF/IID has not discharged the beneficiary.

The period of absence shall be determined by counting the first day of absence as the day on which the first 24-hour time period is used.

Only a period of 24 continuous hours or more shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or a home visit is broken only if the beneficiary returns to the ICF/IID for 24 hours or longer.

Upon admission, a beneficiary must remain in the ICF/IID at least 24 continuous hours in order for the ICF/IID to submit a payment claim for a day of service or reserve a bed. A beneficiary admitted to an ICF/IID in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for ICF/IID services.

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The following are examples in how to calculate leave days:

Reason for Leave	Left Facility	Returned to Facility	How Leave is Reported	
Hospital or Home Leave	Jan 3 rd at 9:00 am	Jan 10 th at 8:00 am	Jan 4 th – Jan 9 th	Leave days
Hospital or Home Leave	Jan 3 rd at 9:00 am	Jan 10 th at 10:00 am	Jan 4 th – Jan 10 th	Leave days
Hospital	Jan 3 rd at 9:00 am	Jan 21 st at 8:00 am	Jan 4 th – Jan 10 th	Leave days
			Jan 11 th – Jan 20 th	Paid or unpaid bed hold days
Hospital	Jan 3 rd at 9:00 am	Jan 21 st at 10:00 am	Jan 4 th – Jan 10 th	Leave days
			Jan 11 th – Jan 21 st	Paid or unpaid bed hold days
Home Leave with State Holiday	July 3 rd at 9:00 am	July 5 th at 8:00 am	No Home Leave Reported	
Home Leave with State Holiday*	July 3 rd at 9:00 am	July 5 th at 1:00 pm	July 5 th	Home Leave Day

*Do not report official or declared state holidays as home leave on the claim form; however, this should be noted in the beneficiary's record.

Paid bed hold days are claimed when payment is received from the beneficiary or family for leave days over the LDH allowable leave days, or payment is received for a non-Medicaid resident when the resident is not in the facility.

Unpaid bed hold days are claimed when no payment is received, but the facility is holding the bed for the beneficiary. Related days should not be reported on the cost report.

The limit on Title XIX payment for leave days does not mean that further leave days are prohibited when provided for in the IHP. After the payment limit is met, further leave days may be arranged between the ICF/IID and the beneficiary, family or responsible party. Such arrangements may include the following options:

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1. The ICF/IID may charge the beneficiary, family or responsible party an amount not to exceed the Title XIX daily rate;
2. The ICF/IID may charge the beneficiary, family or responsible party a portion of the daily rate; or
3. The ICF/IID may absorb the cost into its operating costs.

If a beneficiary transfers from one facility to another, the unused leave days for the FY also transfers. No additional leave days are allocated.

Temporary Absences Due to Evacuations

When local conditions require beneficiary evacuation, the following payment procedures apply:

1. When beneficiaries are evacuated for less than 24 hours, the monthly vendor payment is not interrupted;
2. When staff is sent with beneficiaries to the evacuation site, the monthly vendor payment is not interrupted;
3. When beneficiaries are evacuated to a family's or friend's home, the ICF/IID shall not submit a claim for a day of service or leave day, and the beneficiary's liability shall not be collected;
4. When beneficiaries go home at the family's request or on their own initiative, a leave day shall be charged; and
5. When beneficiaries are admitted to the hospital for the purpose of evacuation of the ICF/IID, Medicaid payment shall not be made for hospital charges.

Evacuating and Temporary Sheltering Provisions

Certified, licensed ICF/IID's required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

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ICF/IID must first apply for evacuation or sheltering reimbursement from all other sources and request that LDH apply for FEMA assistance on their behalf. This request must be submitted in writing along with expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid residents to LDH.

Eligible Expenses

Eligible expenses for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at LDH's discretion and may include the following:

1. Evacuation expenses;
2. Temporary sheltering expenses; and
3. Host temporary sheltering expenses.

Evacuation Expenses

Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another ICF/IID. Evacuation expenses include:

1. Resident transportation expenses during travel;
2. Nursing staff expenses when accompanying residents, including:
 - a. Transportation; and
 - b. Additional direct care expenses, when a direct care expense increase of 10 percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by LDH.
3. Any additional allowable costs that are directly related to the evacuation and that would normally be allowed under the ICF/IID rate methodology.

Temporary Sheltering Expenses

Non-ICF/IID facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-ICF/IID facility temporary shelter to the date all Medicaid residents leave

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the shelter. A non-ICF/IID facility temporary shelter includes both Medicare/Medicaid –licensed facilities and non-licensed facilities that are not part of a licensed ICF/IID and are not billing for the residents under the ICF/IID reimbursement methodology for any other Medicaid reimbursement system. Non-ICF/IID facility temporary sheltering expenses may include:

1. Additional nursing staff expenses including:
 - a. Additional direct care expenses, when a direct care expense increase of 10 percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or period comparisons determined acceptable by LDH;
 - b. Care-related expenses incurred in excess of care-related expenses prior to the evacuation;
 - c. Additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents in accordance with the following:
 - i. These expenses will be capped at a daily rental fee not to exceed the total purchase price of the item; and
 - ii. The allowable daily rental fee will be determined by LDH.
 - d. Any additional allowable costs as determined by LDH and that are directly related to the temporary sheltering and that would normally be allowed under the ICF/IID reimbursement methodology.

NOTE: Reimbursement for room and board costs is not available when beneficiaries are sheltered at facilities not licensed as Medicare/Medicaid providers.

Host Temporary Sheltering Expenses

Host ICF/IID temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed ICF/IID to the date all temporary sheltered Medicaid residents are discharged from the ICF/IID, not to exceed a six-month period.

The host ICF/IID shall bill for the residents under Medicaid's ICF/IID reimbursement methodology. Additional direct care expenses may be submitted when a direct care expense

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increase of 10 percent or more is documented. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by LDH.

Payment of Eligible Expenses for Medicare and/or Medicaid Licensed Facilities

For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to LDH by the end of each calendar quarter.

All eligible expenses documented and allowed will be removed from allowable expenses when the ICF/IID's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set ICF/IID reimbursement rates in future years.

Equipment purchases that are reimbursed on a rental rate may have their remaining basis included as allowable cost on future cost reports provided that the equipment is in the ICF/IID and being used. If the remaining basis requires capitalization, then depreciation will be recognized.

Payments shall remain under the upper payment limit cap for ICF/IID.

ICF/IID may also be entitled to reimbursement in accordance with the Medicaid leave day provisions.

Admission

Medicaid payments become effective as of the admission date provided the beneficiary is medically certified as of that date and either of the following conditions is met:

1. The beneficiary is eligible for Medicaid benefits in the ICF/IID (excluding the medically needy); **or**
2. The beneficiary was in a continuous institutional living arrangement (nursing home, hospital, ICF/IID, or a combination of these institutional living arrangements) for 30 consecutive days. The beneficiary must also be determined financially eligible for Medical Assistance.

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Continuous Stay

The continuous stay requirement is met if:

1. The beneficiary dies during the first 30 consecutive days; or
2. The stay is not interrupted by the beneficiary's absence from the ICF/IID when the absence is for hospitalization or leave of absence and is in the written IHP.

Discharge and Death

ICF/IIDs must comply with payment criteria:

1. The beneficiary's applicable income is applied toward the ICF/IID fee effective with the date Medicaid payment is to begin;
2. Medicaid payment is not made for the date of discharge. The beneficiary, family, nor responsible party is to be billed for the date of discharge; and
3. Medicaid payment is made for the day of beneficiary's death.

NOTE: The ICF/IID shall promptly notify BHSF of all admissions, deaths, and all discharges.

Advance Deposits

An advance deposit shall not be required or accepted from an individual whose Medicaid (Title XIX) eligibility has been established.

Exception: An ICF/IID may require an advance deposit for the current month only on that part of the total payment, which is the beneficiary's liability.

If advance deposits or payments are required from the beneficiary, family, or responsible party upon admission when Medicaid (Title XIX) eligibility has not been established, then such a deposit **shall be refunded or credited** to the person upon receipt of vendor payment.

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Retroactive Payment

When individuals enter an ICF/IID prior to the date Medicaid (Title XIX) eligibility has been established, payment for ICF/IID services are made retroactive to the first day of eligibility after admission.

Timely Filing for Reimbursements

Vendor payments cannot be made if more than 12 months have elapsed between the month of initial services and submittal of a claim for these services. Exceptions for payments of claims over 12 months old can be made only with authorization from BHSF.

Refunds**Refunds to Beneficiaries**

When the facility receives vendor payments, it **shall** refund any fees for services collected from the beneficiary, family or responsible party by the end of the month in which vendor payment is received.

Advance payments for a beneficiary's liability (applicable income) shall be refunded promptly if they leave the facility. The ICF/IID shall adhere to the following procedures for refunds:

1. The proportionate amount for the remaining days of the month shall be refunded to the beneficiary, family, or the responsible party no later than 30 days following the date of discharge. If the beneficiary has not yet been certified, any fees for services collected from the beneficiary, family or responsible party shall be refunded by the end of the month in which vendor payment is received; and
2. No penalty shall be charged to the beneficiary, family, or responsible party even if the following circumstances surrounding the discharge occur:
 - a. Without prior notice;
 - b. Within the initial month; or
 - c. Within some other "minimum stay" period established by the ICF/IID.

Proof of refund of the unused portion of the applicable income shall be furnished to BHSF upon request.

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Refunds to the Department**Participating ICF/IID**

Billing or payment errors shall be corrected by using the appropriate adjustment void or Patient Liability adjustment forms.

Non-Participating ICF/IID

Vendor payments made for services performed while an ICF/IID is in a non-participating status with the Medicaid Program must be refunded. The refund shall be made payable to "LDH - Medicaid Program."

Sitters

A sitter shall not be required or expected. However, beneficiaries, families, or responsible parties may directly employ and pay sitters when indicated, subject to the following limitations:

1. The use of sitters will be entirely at the beneficiary, family, or responsible party's discretion. However, the ICF/IID shall have the right to approve the selection of a sitter. If the ICF/IID disapproves the selection of the sitter, the ICF/IID must provide written notification to the beneficiary, family, and/or responsible party, and to the LDH stating the reasons for disapproval;
2. Payment to sitters is the direct responsibility of the beneficiary, family or responsible party, unless:
 - a. The hospital's policy requires a sitter;
 - b. The attending physician requires a sitter; or
 - c. The IHP requires a sitter.
3. Payment to sitters is the direct responsibility of the ICF/IID facility when:
 - a. The hospital's policy requires a sitter, and the beneficiary is on hospital leave days;
 - b. The attending physician requires a sitter; or

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- c. The IHP requires a sitter.

A sitter will be expected to abide by the ICF/IID's policies and procedures in accordance with LDH rules and regulations, including the LDH Health Standards Section (HSS), and professional ethics as applicable.

The presence of a sitter does not absolve the ICF/IID of its full responsibility for the beneficiary's care.

The ICF/IID is not responsible for providing a sitter if one is required while the resident is on home leave.

NOTE: Psychiatric Hospitals are excluded from this requirement.

Tips

The ICF/IID shall not permit tips for services rendered by its employees.

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SECTION 26.9: EMERGENCY AWARENESS**PAGE(S) 1**

EMERGENCY AWARENESS**Disaster Preparedness**

The intermediate care facilities for individuals with intellectual disabilities (ICF/IID) must have written procedures complete with instructions to be followed in the event of an internal or external disaster such as fire or other emergency actions that include:

1. Specifications of evacuation routes and procedures;
2. Instructions for the care of injuries and/or casualties (beneficiary and personnel) arising from such disaster;
3. Procedures for the prompt transfer of records;
4. Instructions regarding methods of containing fire; and
5. Procedures for notifications of appropriate persons.

Employee Training

All ICF/IID employees must be trained in disaster preparedness in accordance with licensing regulations and federal certification requirements. Training must be part of employment orientation and ongoing training.

Disaster preparedness must include drills for all personnel so that each employee promptly and correctly carries out their specific role in the event of a disaster. The facility shall periodically rehearse these procedures for disaster preparedness.

The minimum requirements shall be fire drills once each quarter for each shift for a minimum of 12 fire drills annually. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, and other natural disaster.

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DECERTIFICATION**Termination of Certification of an Intermediate Care Facility for Individuals with Intellectual Disabilities**

An intermediate care facility for individuals with intellectual disabilities (ICF/IID) may voluntarily cease to participate in the Medicaid program or may involuntarily be terminated from the program.

Reasons for Decertification of an ICF/IID

An ICF/IID may be decertified for the following reasons:

1. The ICF/IID may voluntarily withdraw from the program for reasons of its own by having the owner and administrator submit a written notice of withdrawal to the Louisiana Department of Health (LDH) Health Standards Section (HSS) at least 60 days in advance;
2. A new owner may decide against participation in the program by submitting a written notice 60 days in advance to LDH HSS;
3. LDH may decertify an ICF/IID for failure to comply with Title XIX standards, thus canceling the facility's provider agreement;
4. LDH may decertify an ICF/IID if deficiencies pose immediate jeopardy to the beneficiary's health, safety, rights, or welfare;
5. The ICF/IID may allow its provider agreement to expire by submitting a written notice to LDH HSS at least 60 days in advance; or
6. LDH may cancel the provider agreement if and when it is determined that the ICF/IID is in material breach of the contract.

Recertification of an Involuntarily Decertified ICF/IID

After involuntary decertification, an ICF/IID cannot participate as a licensed medical assistance provider unless the following conditions are met:

1. Reasons for the decertification or nonrenewal of the contract no longer exist;

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2. Reasonable assurance exists that the factors causing the decertification will not recur;
3. The ICF/IID demonstrates compliance with the required standards for a 60-day period prior to reinstatement in a participating status; and
4. A professional medical review reports that beneficiaries are receiving proper care and services.

In the event an ICF/IID's license is revoked or renewal is denied, (other than for cessation of business or non-operational status) any owner, officer, member, director, manager, or administrator of such ICF/IID facility may be prohibited from opening, managing, directing, operating, or owning another ICF/IID facility for a period of two years from the date of the final disposition of the revocation or denial action.

Examples of Situations Determined to Pose Immediate Jeopardy

Listed below are examples of situations that may result in death, serious injury or directly threatens the health, safety, or welfare of a beneficiary or other situations adversely affecting beneficiaries that could result in sanctions. These examples are not intended to be all-inclusive. Other situations adversely affecting beneficiaries could constitute sufficient basis for the imposition of sanctions.

1. **Poisonous Substances**

Failure of an ICF/IID to provide proper storage of poisonous substances;

2. **Falls**

Failure of an ICF/IID to maintain required direct care staffing and/or a safe environment as set forth in the regulations such as equipment not being properly maintained or personnel not responding to a beneficiary's request for assistance;

3. **Assaults**

Failure of an ICF/IID to maintain required direct care staffing and to take measures when it is known that a beneficiary is combative and assaultive to other beneficiaries, or the ICF/IID fails to take corrective action against an employee who has a history of beneficiary abuse and assaults a beneficiary;

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4. Physical Restraints Resulting in Permanent Injury

Failure of an ICF/IID employee to properly apply physical restraints contrary to published regulations or failure to check and release restraints as directed by regulations or physician's written instructions;

5. Control of Infections

Failure of an ICF/IID to follow or meet infection control standards as ordered in writing by the physician;

6. Medical Care

- a. Failure of an ICF/IID to secure proper medical assistance for a beneficiary.
- b. Failure of an ICF/IID to inform a physician when a beneficiary's condition has declined. This includes the following:
 - i. Failure to follow up on unusual occurrences of negative findings;
 - ii. Failure to obtain information regarding appropriate care before and after a beneficiary's hospitalization; and
 - iii. Failure to timely hospitalize a beneficiary during a serious illness.
- c. Failure of an ICF/IID to follow written physician's orders. This includes failure to fill prescriptions timely.

7. Medications

Failure of an ICF/IID to properly store and distribute medications. This would include the following:

- a. Knowingly withholding a beneficiary's medications;

NOTE: The beneficiary **does** have the right to refuse medications. Such refusal *must be documented* in the beneficiary's record and *brought to the attention of the physician and interdisciplinary team (IDT)*.

- b. Omitting medications without justification;

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- c. Excessive medication errors; and
- d. Improperly storing narcotics or other prescribed drugs, mishandling of drugs or other pharmaceutical problems.

8. Improper Treatments

An ICF/IID employee knowingly does the following:

- a. Performs treatment contrary to a physician's order;
- b. Fails to feed beneficiaries who are unable to feed themselves as set forth in physician's instructions;
- c. Fails to obtain a physician's order for use of chemical or physical restraints; or
- d. Fails to check and release physical restraints as specified in state regulations.

9. Natural Disaster/Fire

Failure of an ICF/IID to train its staff members in disaster/fire procedures as required for licensing or failure to meet staffing requirements;

10. Decubitus Ulcers

Failure of an ICF/IID to follow decubitus ulcer care measures in accordance with a physician's written orders;

11. Elopement

Failure of an ICF/IID to provide necessary supervision of its beneficiaries or take measures to prevent a beneficiary with a history of elopement problems from wandering away. Examples of preventative measures include, but are not limited to the following:

- a. Documentation that the elopement problem has been discussed with the beneficiary's family IDT; and

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- b. Personnel have been trained to make additional efforts to monitor these beneficiaries.

12. Environment/Temperature

Failure of an ICF/IID to reasonably maintain its temperature control system as required by regulations. Isolated incidents of breakdown or power failure will not be considered immediate jeopardy;

13. Life Safety

An ICF/IID knowingly fails to maintain the required Life Safety code system such as:

- a. Properly functioning sprinklers, fire alarms, smoke sensors, fire doors, electrical wiring;
- b. The practice of fire or emergency evacuation plans; or
- c. Stairways, hallways and exits are kept free from obstruction.

14. Staffing

Consistent failure of an ICF/IID to maintain minimum staffing. Isolated incidents where the facility does not maintain staffing due to personnel calling in sick or other emergencies are excluded. However, the ICF-DD shall have policies and procedures to ensure a plan is in place for back-up staffing for the provision of sufficient care and services;

15. Dietary Services

Failure of an ICF/IID to follow the minimum dietary needs or special dietary needs as ordered by a physician. The special diets must be prepared in accordance with physician's orders or a diet manual approved by the American Dietary Association;

16. Sanitation

Failure of an ICF/IID to adhere to state and federal sanitation regulations. The following are examples of poor sanitation:

- a. Strong odors linked to a lack of cleanliness;

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- b. Dirty buildup on floors and walls;
- c. Dirty utensils, glasses and flatware; and
- d. Insect or rodent infestation.

17. Equipment and Supplies

Failure of an ICF/IID to provide equipment and supplies authorized in writing by a physician as necessary for a beneficiary's care; and

18. Beneficiary Rights

An ICF/IID violates beneficiary's rights and such violations result in the beneficiary's distress to such an extent that their psychosocial functions are impaired, or such violations directly threaten their psychosocial functioning. This includes the following:

- a. Psychological abuse;
- b. Use of corporal punishment;
- c. Allowance of the following responses to beneficiaries by staff members and employment supervisors:
 - i. Physical exercise or repeated physical motions;
 - ii. Excessive denial of usual services;
 - iii. Any type of physical hitting or other painful physical contacts except as required by medical, dental, or first aid procedures necessary to preserve the beneficiary's life or health;
 - iv. Requiring the beneficiary to take on an extremely uncomfortable position;
 - v. Verbal abuse, ridicule, or humiliation;
 - vi. Requiring the beneficiary to remain silent for a long period of time;
 - vii. Denial of shelter, warmth, clothing or bedding; or

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- viii. Assignment of harsh physical work.
- d. Failure of an ICF/IID to afford the beneficiary with the opportunity to attend religious services;
- e. Denial of a beneficiary's meal without a doctor's order; and
- f. Failure of an ICF/IID to afford the beneficiary with suitable supervised opportunities for interaction with members of the opposite sex, except where a qualified professional responsible for the formulation of a particular individual's treatment/habilitation plan writes an order to the contrary and explains the reasons.

The secretary of LDH has the final authority to determine what constitutes "immediate jeopardy" or serious threat.

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RATE DETERMINATION

The State Plan amendment and/or published rule are the final authority for rate setting for intermediate care facilities for individuals with intellectual disabilities (ICF/IID). The authority for this rate setting system is found in LA R.S. 15: 1081-1086 and in Federal Regulations at 42 Code of Federal Regulations (CFR) 447.250 through 42 CFR 447.274.

Rate Structure

Private ICF/IID facilities are reimbursed on the Inventory for Client and Agency Planning (ICAP) rate methodology. This methodology is based on the facility's bed size and the individual's level of care (LOC). The ICAP scoring sheet is part of the admission papers reviewed by the Office for Citizens with Developmental Disabilities (OCDD).

The ICAP is a standardized instrument for assessing adaptive and maladaptive behavior and includes a service score which indicates the overall LOC, supervision or training the individual requires. The ICAP utilizes the following five support levels to describe the levels of support needed for individuals with disabilities:

1. Intermittent – supports on an “as needed basis.” Characterized as episodic in nature, the person does not always need the support(s), or short-term supports needed during life-span transition (e.g., job loss or an acute medical crisis). Intermittent supports may be high or low intensity when provided;
2. Limited – supports characterized by consistency over time, time-limited but not of an intermittent nature, may require fewer staff members and less costs than more intense levels of support (e.g., time-limited employment training or transitional supports during the school to adult provided period);
3. Extensive – supports characterized by regular involvement (e.g., daily) in at least some environment (such as work or home) and not time-limited (e.g., long-term support and long-term home living support);
4. Pervasive – supports characterized by their constancy, high intensity; provided across environments; and/or potential life-sustaining nature. Pervasive supports typically involve more staff members and intrusiveness than do extensive or time-limited supports; and
5. Pervasive Plus – is a time-limited specific assignment to supplement required Level of Need services or staff for the provision of complex medical care (> 180 minutes

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of nursing care a week) or to supplement required direct care staff (> 16 hours a week of 1:1 staff) due to extremely life threatening behavior. Requests for Pervasive Plus will be reviewed and approved by the Louisiana Department of Health (LDH) Pervasive Plus Committee.

Facilities are divided into peer groups, based on bed size. Peer groups are as follows:

1. 1 – 8 beds;
2. 9 – 15 beds;
3. 16 – 32 beds; and
4. 33 or more beds.

Resident Per Diem Rates

Resident per diem rates are calculated based on information reported on the cost report. ICF/IID will receive a rate for each resident. The rates are based on cost components appropriate for an economic and efficient ICF/IID providing quality service. The resident per diem rates represent the best judgment of the state to provide reasonable and adequate reimbursement required to cover the costs of economic and efficient ICF/IID.

Cost data used in setting base rates is from the latest available audited or desk reviewed cost reports. The initial rates are adjusted to maintain budget neutrality upon transition to the ICAP reimbursement methodology. For rate periods between rebasing, the rates are trended forward using the index factor contingent upon appropriation by the legislature.

A beneficiary's per diem rate is the sum of the following:

1. Direct care per diem rate;
2. Care related per diem rate;
3. Administrative and operating per diem rate;
4. Capital rate; and
5. Provider fee.

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The direct care per diem rate is a set percentage over the median adjusted for the acuity of the resident based on the ICAP, tier based on peer group. The direct care per diem rate is determined as follows:

1. **Median Cost:** The direct care per diem median cost for each ICF/IID is determined by dividing the facility's total direct care costs reported on the cost report by the facility's total days during the cost reporting period. Direct care costs for providers in each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group;
2. **Median Adjustment:** The direct care component shall be adjusted to 105 percent of the direct care per diem median cost in order to achieve reasonable access to care;
3. **Inflationary Factor:** These costs are trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor;
4. **Acuity Factor:** Each of the ICAP levels will have a corresponding acuity factor. The median cost by peer group, after adjustments, shall be further adjusted by the acuity factor (or multiplier) as follows:

ICAP Support Level	Acuity Factor (Multiplier)
Pervasive	1.35
Extensive	1.17
Limited	1.00
Intermittent	.90

5. **Direct Service Provider (DSP) Wage Enhancement:** For dates of service on or after February 2007. The direct care reimbursement to ICD/IID providers must include a direct service worker (DSW) incentive in the amount of \$2 per hour. It is the intent that this wage enhancement be paid to the direct care staff. Non-compliance with the wage enhancement shall be subject to recoupment:
 - a. At least 75 percent of the wage enhancement must be paid to the direct support professional and 25 percent must be used to pay employer-related taxes, insurance and employee benefits; and

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- b. The wage enhancement will be added on to the current ICAP rate methodology as follows:
 - i. Per diem rates for beneficiaries residing in 1-8 bed facilities will increase \$16.00;
 - ii. Per diem rates for beneficiaries residing in 9-16 bed facilities will increase \$14.93; and
 - iii. Per diem rates for beneficiaries residing in 16+ bed facilities will increase \$8.

The direct care costs consist of all the costs related to direct care interaction with the beneficiary. Direct care costs include the following:

- 1. In-house and contractual salaries;
- 2. Benefits;
- 3. Payroll taxes for all positions directly related to patient care;
- 4. Worker's compensation;
- 5. Medical services (routine, and extraordinary);
- 6. Medical supplies;
- 7. Therapeutic and training supplies;
- 8. Habilitation costs;
- 9. Recreational supplies; and
- 10. Consultants.

Care Related Per Diem Rate

The care related per diem rate shall be a statewide price at a set percentage over the median and shall be determined as follows:

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1. Median cost – the care related per diem median cost for each ICF/IID is determined by dividing the facility’s total care related costs reported on the cost report by the facility’s actual total resident days during the cost reporting period. Care related costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined;
2. Median Adjustment – the care related component shall be adjusted to 105 percent of the care related per diem median cost in order to achieve reasonable access to care; and
3. Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Care related costs include the following:

1. In-house and contractual salaries;
2. Benefits;
3. Payroll taxes;
4. Supplies that help support direct care but do not directly involve caring for the patient and ensuring their well-being (e.g., dietary and educational); and
5. Personal items, such as clothing and personal hygiene items.

Administrative and Operating Per Diem Rate

The administrative and operating per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The administrative and operating component shall be determined as follows:

1. Median cost – the administrative and operating per diem median cost for each ICF/IID is determined by dividing the facility’s total administrative and operating costs reported on the cost report by the facility’s actual total resident days during the cost reporting period. Administrative and operating costs for all providers are arrayed from low to high and the median (50th percentile) cost is determined;
2. Median Adjustment – the administrative and operating component shall be adjusted to 103 percent of the administrative and operating per diem median cost in order to achieve reasonable access to care; and

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3. Inflationary Factor – these costs shall be trended forward from the midpoint of the cost report period to the midpoint of the rate year using the index factor.

Administrative and operating costs include the following:

1. In-house and contractual salaries;
2. Benefits;
3. Payroll taxes for administration and plant operation maintenance staff;
4. Utilities;
5. Accounting;
6. Insurance;
7. Maintenance staff;
8. Maintenance supplies;
9. Laundry and linen;
10. Housekeeping; and
11. Other administrative type expenditures.

Capital Per Diem Rate

The capital per diem rate shall be a statewide price at a set percentage over the median, tier based on peer group. The capital per diem rate shall be determined as follows:

1. Median costs – the capital per diem median cost for each ICF/IID is determined by dividing the facility's total capital costs reported on the cost report by the facility's actual total resident days during the cost reporting period. Capital costs for providers of each peer group are arrayed from low to high and the median (50th percentile) cost is determined for each peer group;
2. Median adjustment – the capital cost component shall be adjusted to 103 percent of the capital per diem median cost in order to achieve reasonable access to care; and

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3. Inflationary factor – capital costs shall not be trended forward.

Capital costs include the following:

1. Depreciation;
2. Interest expense on capital assets;
3. Leasing expenses;
4. Property taxes; and
5. Other expenses related to capital assets.

Provider Fee

The provider fee shall be calculated by the department in accordance with state and federal rules. Effective April 1, 2014, the provider fee is \$16.15.

A bed fee shall be paid by each ICF/IID facility for each bed utilized for the provision of care on a daily basis. ICF/IID facilities shall provide documentation quarterly of utilization for all licensed beds in conjunction with payment of the fee. Quarters are defined as:

1. December through February;
2. March through May;
3. June through August; and
4. September through November.

LDH will mail a Quarterly Fee Report to each ICF/IID before the end of the quarter. Reports of quarterly utilization and fees shall be submitted to the department and shall be due on the 20th calendar day of the month following the close of the quarter and shall be deemed delinquent on the 30th calendar day of the month. Submission of the report is mandatory regardless if no fee is due.

The rates for the 1-8 bed peer group shall be set based on costs in accordance with the direct care per diem rate, care-related per diem rate, administrative and operating per diem rate, capital per diem rate and provider fee. The reimbursement rates for peer groups of larger facilities will also be set in accordance with the same criteria; however, the rates will be limited as follows:

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1. The 9-15 bed peer group reimbursement rates will be limited to 95 percent of the 1-8 bed peer group reimbursement rates;
2. The 16-32 bed peer group reimbursement rates will be limited to 95 percent of the 9-15 bed peer group reimbursement rates; and
3. The 33 and greater bed peer group reimbursement rates will be limited to 95 percent of the 16-32 bed peer group reimbursement rates.

Adjustments to the Medicaid daily rate may be made when changes occur that eventually will be recognized in updated cost report data (such as a change in the minimum wage or Federal Insurance Contributions Act (FICA) tax rates). These adjustments would be effective until such time as the data base used to calculate rates fully reflect the change. Adjustments to rates may also be made when legislative appropriations would increase or decrease the rates calculated in accordance with this rule. The LDH Secretary makes the final determination as to the amount and when adjustments to rates are warranted.

A facility requesting a pervasive plus rate supplement shall bear the burden of proof in establishing the facts and circumstances necessary to support the supplement in a format and with supporting documentation specified by the LDH ICAP Review Committee. The LDH ICAP Review Committee shall make a determination of the most appropriate staff required to provide requested supplemental services. The amount of the Pervasive Plus supplement shall be calculated using the Louisiana Civil Service pay grid for the appropriate position as determined by the LDH ICAP Review Committee and shall be the 25th percentile salary level plus 20 percent for related benefits times the number of hours approved.

Other Beneficiary Specific Adjustments to the Rate

A facility may request a beneficiary specific rate supplement for reimbursement of the costs for enteral nutrition, ostomy or tracheotomy medical supplies or a vagus nerve stimulator. The provider must submit sufficient medical supportive documentation to the LDH ICAP Review Committee to establish medical need for enteral nutrition, ostomy or tracheotomy medical supplies. The amount of reimbursement determined by the ICAP Review Committee shall be based on the average daily cost for the provision of the medical supplies. The provider must submit annual documentation to support the need for the adjustment to the rate.

Prior authorization (PA) for implementation for the vagus nerve stimulator shall be requested after the evaluation has been completed but prior to stimulator implantation. The request to initiate implantation shall come from the interdisciplinary team (IDT) as a packet with the team's written decision regarding the beneficiary's candidacy for the implant and the results of all pre-operative

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testing. The PA form for the device and surgeon shall be included in the packet forwarded to the prior authorization unit (PAU).

The amount of reimbursement shall be the established fee on the Medicaid Fee Schedule for medical equipment and supplies.

ICAP Requirements

An ICAP assessment must be completed for each beneficiary of ICF/IID services upon admission and while residing in an ICF/IID in accordance with departmental regulations. Providers must keep a copy of the beneficiary's current ICAP protocol and computer scored summary sheets in the beneficiary's file. If a beneficiary has changed ICAP service level, providers must also keep a copy of the beneficiary's ICAP protocol and computer scored summary sheets supporting the prior level. ICAPs must reflect the resident's current LOC.

ICAP Monitoring

ICAP scores and assessments will be subject to review by LDH and its contracted agents. The reviews of ICAP submissions include, but are not limited to the following:

1. Reviews when statistically significant changes occur within an ICAP submission or submissions;
2. Random selections of ICAP submissions;
3. Desk reviews of a sample of ICAP submissions; and
4. On-site field reviews of ICAPs.

ICAP Review Committee

The ICAP Review Committee reviews requests for the pervasive plus supplement or medical supply add-on. Pervasive plus is a time-limited specific assignment of staff to supplement the required level of need services which may include staff to provide life sustaining complex medical care (> 180 minutes of nursing care a week) or to supplement required direct care staff (>16 hours a week of 1:1 staff) due to dangerous life threatening behavior so serious that the beneficiary could cause serious physical injury to self or others and requires additional trained support staff to be at "arm's length" during waking hours. Medical add-on covers the average daily cost for certain medical supplies.

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Providers requesting the pervasive plus supplement or medical add-on rate supplement bear the burden of proof in establishing the facts and circumstances necessary to support the request with supporting documentation specified by the ICAP Review Committee.

For providers receiving pervasive plus supplements or other client specific adjustment to the rate, the facility-wide direct care floor is established at 94 percent of the per diem direct care payment and at 100 percent of any rate supplements or add on payments received by the provider, including the pervasive plus supplement, the complex care add-on payment and other client specific adjustment to the rate. The facility-wide direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or client specific rate adjustment. In no case however, shall a facility receiving a pervasive plus supplement and/or client specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

The support staff member assigned to supervise the person has no other duties during the assignment. The assignment is specific to the type of and duration of services to be provided. The assigned staff is educated and able to follow the behavior management plan. **The support member does not replace the minimum staff required for the LOC.**

The ICAP Review Committee shall represent LDH should a provider request an informal reconsideration regarding the Regional Health Standards' determination. The ICAP Review Committee shall make final determination on any ICAP LOC changes prior to the appeals process. The ICAP Review Committee shall be made up of the following:

1. Director of the Health Standards Section (HSS) or their appointee;
2. Director of Rate and Audit Review Section or their appointee;
3. Assistant Secretary for OCDD or their appointee; and
4. Other persons as appointed by the secretary.

When an ICAP score is determined to be inaccurate, LDH shall notify the provider and request documentation to support the LOC. If the additional information does not support the LOC, an ICAP rate adjustment will be made to the appropriate ICAP level effective the first day of the month following the determination.

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Facility Direct Care Staffing Requirements

There must be a responsible direct care staff on duty and awake on a 24 hour basis (when beneficiaries are present) to take prompt, appropriate action in case of injury, illness, fire or other emergency.

There must be sufficient direct care staff to manage and supervise beneficiaries in accordance with their individual program plans. Direct care staff is defined as present on-duty staff calculated over all shifts in a 24-hour period for each defined residential unit. Minimum staffing ratios of direct care staff to beneficiary does not include any 1:1 staff provided for under Pervasive Plus assignments. Pervasive Plus assignments are in addition to minimum staffing requirements.

Complex Care

Effective for dates of service on or after October 1, 2014, non-state ICF/IID, may receive an add-on payment to the per diem rate for providing complex medical care to Medicaid beneficiaries who require such services. The add-on rate adjustment shall be a flat fee amount and may consist of payment for any of the following components:

1. Equipment only (only Medicaid allowable equipment);
2. DSW;
3. Nursing only;
4. Equipment and DSW;
5. DSW and nursing;
6. Nursing and equipment; or
7. DSW, nursing and equipment.

Non-State owned ICFs/IID, may qualify for an add-on rate for beneficiaries meeting documented major medical or behavioral complex care criteria. This must be documented on the complex support need screening tool provided by LDH. All medical documentation indicated by the screening tool form and any additional documentation requested by LDH must be provided to qualify for the add-on payment. Documentation must be recent within the last year.

The complex support need screening tool shall be completed and submitted to LDH annually from the date of initial approval of each add-on payment. This annual submittal shall be accompanied

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by all medical documentation indicated by the screening tool form and any additional documentation requested by LDH. It is the provider's responsibility to submit for renewals annually.

In order to meet the complex care criteria, the presence of a significant medical or behavioral health need must exist and be documented. This must include:

1. Endorsement of at least one qualifying condition with supporting documentation; and
2. Endorsement of symptom severity in the appropriate category based on qualifying condition(s) with supporting documentation.

Qualifying conditions for complex care must include at least one of the following as documented on the complex support need screening tool:

1. Significant physical and nutritional needs requiring full assistance with nutrition, mobility and activities of daily living (ADL);
2. Complex medical needs/medically fragile; or
3. Complex behavioral/mental health needs.

Enhanced supports must be already being provided and verified with supporting documentation to qualify for the add-on payments. Additional criteria and information is found in the Louisiana Administrative Code (LAC) 50: VII, §32915.

Complex Care packets are received and reviewed by the complex care team. All packets are initially submitted to the complex care team coordinator. If the information is received in its entirety and reviewed by the complex care team prior to the 15th of the month, the rate will be approved retroactively to the 1st of the month in which it was submitted.

If the information is received in its entirety and reviewed after the 15th of the month, the rate will be effective the first day of the next month. This is done to reduce billing errors and to encourage complete information submissions. Only recent relative information is considered when determining the appropriate add-on rate.

Providers receiving complex care add-on rates will be required to meet the direct care floor at 85 percent of the direct care component of the rate and 100 percent of the add-on amount. This is applied facility wide and within the cost report year the complex care add-on is received.

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If a facility is receiving both the complex care add-on and pervasive plus add-on in the same facility, then the direct care floor is facility-wide at 94 percent of the direct care component of the rate and 100 percent of the add-on amounts.

Determinations for pervasive plus or complex care add-on rates will be made in accordance with what is best for the beneficiary and what the beneficiary needs or would best benefit from. If it is determined the beneficiary would best be served with 1:1 supports under the pervasive plus supplement, the provider will be offered this option. If the provider refuses, then complex care is not an alternative as the two add-on rates serve different purposes.

Transfer of Beneficiaries with Add-On Rates

If a beneficiary is receiving an add-on payment for pervasive plus, complex care or other specific adjustment to the rate, and transfers to a new provider, the transferring provider must notify the ICAP coordinator of the transfer. The new provider has the responsibility of notifying LDH if they do not want to continue with the add-on payment. This notification must be in writing and submitted to the Complex Care team coordinator and/or ICAP coordinator within seven days of receiving the new transfer. Failure of the new provider to notify LDH will result in the facility being required to meet the facility-wide direct care floor without further notification from LDH.

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Description	Staff to Beneficiary Ratio
For each defined residential living unit serving: 1. Children under the 12 years of age; 2. Severely and profoundly retarded beneficiaries; 3. Beneficiaries with severe physical disabilities; 4. Beneficiaries who are aggressive, assaulting or security risks; or 5. Beneficiaries who manifest severely hyperactive or psychotic-like behavior.	1 to 3.2
For each defined residential living unit serving moderately regarded beneficiaries	1 to 4
For each defined residential living unit serving beneficiaries who function within the range of mild retardation	1 to 6.4

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COST REPORTS

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers are required to file annual cost reports to the Louisiana Department of Health (LDH) in accordance with instructions as follows:

1. Each ICF/IID is required to report all reasonable and allowable costs on a regular facility cost report including any supplemental schedules designated by LDH; and
2. Separate cost reports must be submitted by central/home office(s) and habilitation programs when costs of those entities are reported on the facility cost report.

Cost reports must be prepared in accordance with cost reporting instructions adopted by the Bureau of Health Services Financing (BHSF) using definitions of allowable and non-allowable cost contained in the *Medicare Provider Reimbursement Manual* (HIM-15) unless other definitions of allowable and non-allowable cost are adopted by BHSF.

Each provider must submit an annual cost report for fiscal year (FY) ending June 30. The cost reports must be filed within 90 days after the state's FY ends.

Exceptions

Limited exceptions for extensions to the cost report filing requirements will be considered on an individual facility basis upon written request by the provider to the Medicaid director or designee. Providers must attach a statement describing fully the nature of the exception request. The extension must be requested by the normal due date of the cost report.

Direct Care Floor

A facility wide direct care floor may be enforced upon deficiencies related to direct care staffing requirements cited during the Health Standards Section (HSS) annual survey or during a complaint investigation in accordance with the Louisiana Administrative Code (LAC) 50:I.5501, et seq. The floor shall be applied in the cost report year of the violation.

For providers receiving pervasive plus supplements and other beneficiary specific adjustments to the rate in accordance with Section 26.11 – Other Beneficiary Specific Adjustments to the Rate, the facility wide direct care floor is established at 94 percent of the per diem direct care payment, the pervasive plus supplement, and other beneficiary specific adjustments to the rate. The direct care floor will be applied to the cost reporting year in which the facility receives a pervasive plus supplement and/or a beneficiary specific rate adjustment.

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In no case, however, shall a facility receiving a pervasive plus supplement and/or beneficiary specific rate adjustment have total facility payments reduced to less than 104 percent of the total facility cost as a result of imposition of the direct care floor.

For facilities for which the direct care floor applies, if the direct care cost the facility incurred on a per diem basis is less than the appropriate facility direct care floor, the facility shall remit to BHSF the difference between these two amounts times the number of facility Medicaid days paid during the cost reporting period. This remittance shall be payable to BHSF upon submission of the cost report.

The direct care floor recoupment as a result of a facility not meeting the required direct care per diem floor is considered effective 30 days from the issuance of the original notice of determination. Should an informal reconsideration be requested, the recoupment will be considered effective 30 days from the issuance of the results of an informal hearing. The filing of a timely and adequate notice of an administrative appeal does not suspend or delay the imposition of the recoupment(s).

Upon completion of desk reviews or audits, facilities will be notified by BHSF of any changes in amounts due based on audit or desk review adjustments.

All costs submitted on cost reports must be beneficiary care related. An acceptable cost report is one that is prepared in accordance with the requirements of this Section and for which the provider has supporting documentation necessary for completion of a desk review or audit. The provider contract contains a penalty provision for cost reports with all forms completed, not received on a timely basis. (See Section 26.14 – Sanctions and Appeals for additional information regarding sanctions).

Providers are required to maintain adequate financial records and statistical data for proper determination of reimbursable costs. All ICF/IID providers receiving Medicaid funding will maintain, for five years following submission of the cost report, all financial and statistical information necessary to substantiate cost data. Providers are required to make these records available upon request to representatives of LDH the State of Louisiana, or the United States Department of Health and Human Services (DHHS).

Cost information must be current, accurate and in sufficient detail to support amounts reported in the cost report. This includes all ledgers, journals, records, and original evidences of cost (canceled checks, purchase orders, invoices, vouchers, inventories, time cards, payrolls, basis for apportioning costs, etc.) that pertain to the reported costs.

Census data reported on the cost report must be supportable by daily census records. Such information must be adequate and available for auditing. The census records must include totals for each resident for each month and also must reflect monthly totals by payor-type. Census days must be segregated between Medicaid and other payors. All census occurrences must be reflected

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on the census document. Supporting documentation for admission, discharges, death, hospital and home leaves must be maintained and should include dates and times.

Each facility receiving funds from other public sources must report such on the cost report form, even if the funding is provided for other programs, and make available additional information on this funding as requested by LDH.

The data submitted on the cost report will reflect Balance Sheet and Income Statement information for the 12-month period being submitted. Cost data will be appropriately adjusted for rate setting purposes.

All costs submitted on cost reports must be care related. A knowing inclusion of costs in violation of this requirement, as well as other requirements of the HIM-15, could subject the provider to criminal prosecution under La. R. S. 14:70.1 or La. R. S. 14:133.

For allocated or shared costs, a separate cost report must be completed showing the total costs prior to allocation. The method of allocation and the percentage of allocation to each individual provider must also be shown.

Providers are required to submit the following documents with their cost report submission:

1. Cost Report;
2. Detailed fixed asset depreciation schedule;
3. Copies of leases;
4. Working Trial Balance; and
5. Central office and habilitation schedules.

Cost Report Adjustments

The following guidelines are provided to aid in determining allowable and non-allowable costs for rate setting and cost reporting purposes. Allowable costs generally require no adjustment when reported. Non-allowable costs should be reflected as such by an adjustment to the proper cost category on the cost report schedule.

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Salaries

Salaries are an allowable cost if:

1. The number of employees is based upon individual facility requirements determined in conjunction with LDH Licensing and Certification and the appropriate program office;
2. Functions performed are related to the provision of care in the facility; and
3. Individual salaries do not exceed the maximum allowable under Louisiana State Civil Service Salary Schedules for comparable positions. The salary maximums are published periodically by LDH.

Taxes

Taxes are an allowable cost with the following specific exemptions:

1. Federal income or excess profit tax;
2. State income or franchise tax;
3. Taxes relating to financing;
4. Special assessments (this would be capitalized and amortized);
5. Taxes for which exemptions are available;
6. Taxes on property not related to direct beneficiary care; and
7. Self-employment (Federal Insurance Contributions Act (FICA)) taxes applicable to individual proprietors, partners, etc.

Advertising Costs

The following types of advertising costs are allowable:

1. Classified newspaper advertising to recruit personnel or solicit bids; and
2. Telephone "Yellow page" advertising, except in the event that such advertisement is promotional in nature. Allowable cost is limited to the cost of a 1" x 1" size advertisement.

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Costs for fund raising, public relations and promotional advertising are income producing items which should be offset against income provided.

Bad Debts

Bad debts, charity and courtesy allowances are deductions from revenue and are not an allowable cost.

Dues

Dues are not an allowable expense with the exception of dues to one's professional organizations.

Interest Expense

Necessary and proper interest on both current and capital indebtedness is an allowable cost.

"Necessary" requires that interest be:

1. Incurred on a loan made to satisfy a financial need of the provider;
2. Incurred on a loan reasonably related to patient care; and
3. Reduced by investment income.

"Proper" requires that interest be:

1. Incurred at a rate not in excess of what a prudent borrower would have to pay; and
2. Paid to a lender not related through control or ownership or personal relationship to the provider. Exceptions are allowable only in accordance with HIM-15, Section 218.

Attorney Fees

Only actual and reasonable attorney fees incurred for non-litigation legal services which are directly related to beneficiary care will be allowed. Monies paid to an attorney or a law firm as a retainer, rather than as legal fees for services actually performed, are non-allowable expenses.

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Health Costs

In all of the examples of allowable expenses below, it is required that a facility will attempt to utilize public resources prior to employing or contracting with totally private medical providers or purchasing medical supplies.

Examples of public resources would include Medicaid medical providers for eligible individuals:

1. State or city supported clinics and hospitals for immunizations;
2. Examinations and other screening services;
3. Emergency treatment; and
4. On-going special treatment needs such as:
 - a. Handicapped Children's Program for orthopedic problems;
 - b. Charity Hospital system for dialysis needs;
 - c. Mental health clinics for counseling and medication;
 - d. Local education agencies for evaluation;
 - e. Physical therapy;
 - f. Occupational therapy and speech therapy services for individuals under age 22; and
 - g. Local civic organizations for glasses, wheelchairs, etc.

Medical services provided by the facility that may be included for cost reporting purposes if it is documented that these services are not available by Title XIX providers or other public resources include:

1. Periodic medical examinations that include vision, hearing, and routine screening and laboratory examinations as determined necessary by the physician;
2. Immunization;
3. Tuberculosis (TB) control;

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4. Physician services, minimally to supervise the general health conditions and practices of the facility and be available for emergencies on a 24-hour, seven days a week basis;
5. Initial and periodic dental examinations and routine treatment, including provisions for emergency treatment at all times;
6. Dental hygiene program;
7. Psychological testing and counseling when provided routinely to all beneficiaries;
8. Psychiatric examination and treatment when provided routinely for facility beneficiaries; and
9. Medical appliance upkeep, repairs, and purchase of medical supplies for the general facility population.

The cost for the above services will be limited to that which is considered reasonable, not to exceed the Medicaid payment where applicable.

Income Producing Expenses

Any income from such items as sale of medical records, sale of scrap and waste, rental of space, etc. (when the item was included as an allowable cost) shall be offset. Purchase discounts, allowances, and refunds will be recorded as a reduction of the cost to which they relate.

Transportation Costs

Allowable costs include transportation intrinsic to the well-being of the beneficiary, including but not limited to visits with relatives, prospective foster or adoptive parents, and other activities or events that are an integral part of the 24-hour program and not available through another resource. Expenses for an attendant, when required, may be allowed if not already charged to the State's program under Titles XIX, XX, IV-B, or other publicly funded programs.

Other Non-Allowable Expenses

The following is a list of other non-allowable expenses:

1. Appraisal costs;
2. Capital expenditures;

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3. Collection costs;
4. Payments to directors on the facility's Board of Directors. This does not include reimbursement for expenses;
5. Educational costs;
6. Fines, penalties, judgments or settlements of any kind;
7. Any costs not related to care in the facility;
8. Payments made by the facility as gifts, assessments or paybacks to parent organizations;
9. Expenses reimbursable by other state or federally funded programs;
10. Vending machine expenses;
11. Expenses for gifts, flower and coffee shops; and
12. Depreciation of equipment used to secure self-generated revenue.

Start-up Costs

In the period of developing a facility's ability to furnish beneficiary care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to beneficiary care services rendered after the time of preparation, they may be capitalized as deferred charges and amortized. Start-up costs include allowable costs incident to the start-up period. Costs that are properly identifiable as organization costs or capitalized as construction costs must be appropriately classified as such and excluded from start-up costs.

Start-up costs are amortized over a period of 60 months, beginning from the month of first admission of a beneficiary.

Depreciation

An appropriate allowance for depreciation on buildings and equipment related directly to beneficiary care services is an allowable cost. Depreciation must be computed by the straight-line method only. The estimated useful life of fixed assets will be based on the American Hospital Association's "Estimated Useful Lives of Depreciation Hospital Assets" according to the HIM-15, Part I, Section §104.17.

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Facilities must maintain adequate records to determine cost, value, and reasonable useful life of buildings and equipment. Assets must be capitalized if cost is at least \$5,000 and if they have a useful life of at least two years.

For depreciation expense to be allowable, the depreciation schedule must:

1. Include each asset in use with adequate description of the asset;
2. Include the historical cost and accumulated depreciation;
3. Include the assets' dates of acquisition;
4. Indicate useful life and depreciation method;
5. Reconcile to the provider's trial balance; and
6. Correspond to the cost report period.

If the provider uses an accelerated depreciation method for book purposes, the provider must prepare and submit a straight-line depreciation schedule for the cost reporting period.

So long as an asset is being used, its useful life is considered not to have ended, and consequently the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by LDH.

For example, if a 50-year old building is used at the time the provider enters the program, depreciation is allowable on the building even though it has been fully depreciated on the provider's books. Assuming that a reasonable estimate of the asset's continued life is 20 years, (70 years from the date of acquisition) the provider may claim depreciation over the next 20 years if the asset is in use that long.

Valuation of In-Kind Contributions

In-kind contributions represent the value of non-cost contributions related to the direct care of beneficiaries provided by private organizations and individuals. In-kind contributions may consist of charges for real property and equipment and value of goods and services directly benefiting and specifically identifiable to all beneficiaries in the approved program.

Specific procedures for the facilities in placing a value on in-kind contributions from private organizations and individuals are set forth below.

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Valuation of Volunteer Services

Volunteer services may be counted as a program cost only if the requirements of the HIM-15, Part I, Chapter 7 are met. In order to qualify under this chapter, volunteers must work more than 20 hours per week in various types of full-time positions that are normally occupied by paid personnel of providers not operated by or related to religious orders. Services must be related directly to beneficiary care or in administrative positions essential to the provision of that care.

Volunteers must be members of an organization of non-paid workers that has arrangements with the provider for the performance of services by volunteer workers without direct remuneration to the volunteer by either organization.

Value for volunteers cannot exceed the amounts for regular working hours (excluding overtime) of paid employees who perform similar services. If there are no similar positions within the organization, the valuation cannot exceed the amount paid for such services by other providers in the area of similar size, scope of services, and utilization.

Normal fringe benefits can be included in the valuation, but social security taxes, workmen's compensation, State unemployment insurance and any other costs stemming from legislative requirement cannot be included.

Valuation of Donated Equipment, Buildings, and Land, or Use of Space

The value of donated property will be determined as follows:

1. The value of donated equipment or buildings should be based on the donor's cost less depreciation or the current market prices of similar property, whichever is less. The current market price should be established by a recognized appraisal expert. The title of the donated equipment and building must be legally in the name of the facility; and
2. The value of donated land should be based on the donor's cost or the current market price of similar property. The current market prices should be established by a recognized appraisal expert. Use of space will not be considered in determining allowable cost with one exception: If the provider and the donor organization are both part of a larger organizational entity, such as units of a state or parish government, the cost related to the donated space is included in the allowable cost of the provider.

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Valuation of Other Costs

Other necessary costs incurred specifically for an indirect benefit to the program on behalf of all beneficiaries may be accepted as program costs provided they are adequately supported and permissible under the approved program. Such costs must be reasonable and properly documented.

Consultants, such as pharmacy consultants, not qualifying under the provisions for valuation of volunteer services, will qualify for valuation under this section, provided the service is an integral and necessary part of an approved program.

The following requirements pertain to the facility's supporting records for in-kind contributions from private organizations and individuals:

1. The extent of volunteer services must be supported by the same methods used by the facilities for its employees; and
2. The basis for determining the costs for personal services, equipment, and buildings must be documented.

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SECTION 26.13: AUDITS AND DESK REVIEWS**PAGE(S) 3**

AUDITS AND DESK REVIEWS**Audits**

Intermediate care facilities for individuals with intellectual disabilities (ICF/IID) shall be subject to financial and compliance audits.

The following reports shall be filled by each ICF/IID:

1. Annual facility cost report;
2. Central office cost report;
3. Central habilitation cost report; and
4. Cost report indicating the cost for services provided to each resident eligible for an extraordinary rate.

All providers will be subject to an audit of their books and records from time to time by state and/or federal regulators, or contractual auditors of the Louisiana Department of Health (LDH). Audit selection shall be at the discretion of LDH. The audit will be designed to gain assurances, including, but not limited to, the following:

1. Monies paid to the provider by LDH for services to beneficiaries are properly used for the purpose intended as reflected in the cost reports submitted by the provider;
2. Non-allowable costs are removed for cost reporting purposes;
3. Costs are properly reflected on reports to LDH, and that significant misclassifications have not occurred; and
4. Reported occupancy is accurate.

Whenever possible, the records necessary to verify information submitted to LDH on Medicaid cost reports, including related-party transactions and other business activities engaged in by the provider, must be accessible to LDH audit staff in the state of Louisiana.

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Facility Cooperation

The ICF/IID shall cooperate with the audit process by:

1. Promptly providing all documents needed for review;
2. Providing adequate space for uninterrupted review of records;
3. Making persons responsible for facility records and cost report preparation available during the audit;
4. Arranging for all pertinent personnel to attend the exit conference;
5. Insuring that complete information is maintained in beneficiary's records; and
6. Correcting areas of noncompliance with state and federal regulations **immediately** after the exit conference time limit of 15 days.

Cost of Out-of-State Audits

When records are not available to LDH audit staff within Louisiana, the provider must pay the actual costs for LDH staff to travel and review the records out-of-state.

If a provider fails to reimburse LDH for these costs within 60 days of the request for payment, LDH may place a hold on the vendor payments until the costs are paid in full.

Desk Reviews

In addition to the exclusions and adjustments made during desk reviews and on-site audits, LDH may exclude or adjust certain expenses in the cost report data base in order to base rates on the reasonable and necessary costs that an economical and efficient provider must incur.

Providers will be subject to an annual desk review. Field audits will be conducted for a reasonable number of providers each year.

Records Retention

The facility shall retain such records or files as required by LDH and shall have them available for inspection for six years from the date of service or until all audit exceptions are resolved, whichever period is longer.

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If LDH's auditors determine that a facility's records are un-auditable, the vendor payments may be withheld until the facility submits an acceptable plan of correction to reconstruct the records. Any additional costs incurred to complete the audit shall be paid by the provider.

Errors

If audit findings of the residents' personal funds account reveal a material number of transactions were not sufficiently supported or material non-compliance, LDH shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments.

Exclusions from Database

Providers with disclaimed audits and cost reports for other than a 12-month period will be excluded from the database used to calculate the rates.

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SECTION 26.14: SANCTIONS AND APPEALS**PAGE(S) 3**

SANCTIONS AND APPEALS**Sanctions**

Providers should refer to Chapter 1 – General Information and Administration of the *Medicaid Services Manual* and/or in the Louisiana Administrative Code (LAC), 50: VII, Chapters 321 and 323 for additional information on sanctions and appeals.

When intermediate care facilities for individuals with intellectual disabilities (ICF/IID) do not comply with the requirements set forth in the **ICF/IID Standards for Payment**, the Louisiana Department of Health (LDH) may impose sanctions. Sanctions may involve the following:

1. Special staffing requirements;
2. Withholding of vendor payments;
3. Civil fines;
4. Denial of payments for new admissions; or
5. Termination of the ICF/IID's certification as a Medicaid provider.

Special Staffing Requirements

When the LDH secretary determines additional staffing or staff with specific qualifications would be beneficial in correcting deficient practices, LDH may require an ICF/IID to hire additional staff on a full-time or consultant basis until the deficient practices have been corrected. This provision may be invoked in concert with, **or** instead of, the sanctions cited below.

Withholding of Vendor Payments

LDH may withhold vendor payments in whole or in part in the following situations, which are not all inclusive:

1. **Delinquent Staffing Report** – when the ICF/IID provider fails to timely submit a required, completed staffing report. After LDH notifies the provider of the delinquent report, vendor payments may be withheld until the completed report is received;

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2. **Unapproved Staffing Shortage** – when a report indicates an unapproved staffing shortage, vendor payments may be withheld until staffing is brought into compliance;
3. **Incorrect/Inappropriate Charges** – when LDH determines that the ICF/IID incorrectly or inappropriately charged beneficiaries, families, or responsible parties, or there has been misapplication of beneficiary funds, vendor payments may be withheld until the facility does the following:
 - a. Make restitution; and
 - b. Submit documentation of such restitution to LDH Bureau of Health Services Financing (BHSF).
4. **Delinquent Cost Report** – when an ICF/IID fails to submit a cost report within 90 days from the fiscal year (FY) end closing date, a penalty of five percent of the total monthly payment for the first month and a progressive penalty of five percent of the total monthly payment for each succeeding month may be levied and withheld from the vendor's payment for each month that the cost report is due, not extended, and not received. The penalty is nonrefundable;

NOTE: BHSF may grant a 30-day extension of the 90-day time limit, when requested by the ICF/IID provider, if just cause has been established. Extensions beyond 30 days may be approved for situations beyond the control of the ICF/IID.
5. **Cost Report Errors** – errors greater than 10 percent in the aggregate for the ICF/IID for the cost report year may result in a maximum penalty of 10 percent of the current per diem rate for each month the cost report errors are not corrected. The penalty is non-refundable;
6. **Corrective Action for Audit Findings** – vendor payments may be withheld when a facility fails to submit corrective action in response to financial and compliance audit findings within **15 days** after receiving the notification letter until such time compliance is achieved;
7. **Failure to Respond or Adequately Respond to Requests for Financial/Statistical Information** – failure of a facility to respond or adequately respond to requests from LDH for financial and statistical information within 15 days after receiving the notification letter may result in payments being withheld until the requested information is received;

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8. **Insufficient Medical Recertification** – when a facility fails to secure recertification of a beneficiary’s need for care and services, the vendor’s payment for that individual may be withheld or recouped until compliance is achieved;
9. **Inadequate Review/Revision of Plan of Care (POC)** – when a facility repeatedly fails to ensure that an adequate individual habilitation plan (IHP) for a beneficiary is reviewed and revised at least at the required intervals, payment may be withheld or recouped until compliance is achieved;
10. **Failure to Submit Response to Survey Reports** – when a facility fails to submit an acceptable response within 30 days after receiving a survey report from LDH, the Centers for Medicare and Medicaid Services (CMS), the Office of the Inspector General (OIG) or the Legislative Auditor, vendor payments may be withheld until an adequate response is received, unless the appropriate agency extends the time limit;
11. **Corrective Action on Complaints** – when a facility fails to submit an adequate corrective action plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective action plan is received, unless the time limit is extended by LDH;
12. **Delinquent Utilization Data Requests** – facilities will be required to submit utilization data in a timely manner when requested by LDH. Providers will be given written notice when the utilization data has not been received by the due date. The notice will advise the provider of the date by which the utilization data must be received to avoid withholding of vendor payments. The due date will never be less than 10 days from the date the notice is mailed to the provider. If the utilization data is not received by the due date indicated in the notice, payments will be withheld until the utilization data is received; and
13. **Termination or Withdrawal from the Medicaid Program** – when a provider is terminated or withdraws from the Medicaid program, vendor payments will be withheld until all programmatic and financial issues are resolved.

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GLOSSARY

American Association on Intellectual and Developmental Disabilities (AAIDD) - Promotes progressive policies, sound research, effective practices, and universal human rights for people with intellectual and developmental disabilities.

Abuse – The infliction of physical or mental injury to an individual or causing an individual's deterioration to such an extent that their health, moral or emotional well-being is endangered. Examples include, but are not limited to: sexual abuse, exploitation or extortion of funds or other things of value.

Active Treatment – Aggressive and consistent program of specialized and generic training, treatment, health and related services directed toward the acquisition of behaviors necessary for the individual to function with as much self-determination and independence as possible and the prevention and deceleration of regression or loss of current optimal functional status.

Acuity Factor – Adjustment factor which will modify the direct care portion of the Inventory for Client and Agency Planning (ICAP) rate based on the ICAP level for each resident.

Adaptive Behavior – The effectiveness or degree to which the individual meets the standards of personal independence and social responsibility expected for his age and cultural group. Since these exceptions vary for different age groups, deficits in adaptive behavior will vary at different ages.

Agency – See Medicaid Agency.

Ambulatory – The ability to walk.

American National Standards Institute (ANSI) – A private, non-profit organization that administers and coordinates the U.S. voluntary standards and conformity assessment system.

Applicant – Individual whose written application for Medicaid has been submitted to the Agency but whose eligibility has not yet been determined.

Accredited Record Technician (ART) – Refers to a Registered Health Information Technician (RHIT), or a similar credentialed health information professional.

Attending Physician – A physician, currently licensed by the Louisiana State Board of Medical Examiners, designated by the individual, family, agency, or responsible party as responsible for the direction of overall medical care of the individual.

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Autism – A condition characterized by disturbance in the rate of appearance and sequencing of developmental milestones: abnormal responses to sensations, delayed or absent speech and language skills while specific thinking capabilities may be present and abnormal ways of relating to people and things.

Beneficiary – An individual who has been determined eligible for Medicaid; may also be referred to as a client or participant.

Bureau of Health Services Financing (BHSF) – The program within the Louisiana Department of Health (LDH), approved under Title XIX of the Social Security Act, responsible for the administration of the state’s Medical Assistance Program (Medicaid).

Capacity for Independent Living – The ability to maintain a full and varied life in one's own home and community.

Cerebral Palsy – A permanently disabling condition resulting from damage to the developing brain which may occur before, during or after birth and results in loss or impairment of control over voluntary muscles.

Certification – A determination made by the LDH that an intermediate care facility for individuals with intellectual disabilities (ICF/IID) meets the necessary requirements to participate in Louisiana as a provider of Title XIX (Medicaid) services.

Change in Ownership (CHOW) – Any change in the legal entity responsible for the operation of an ICF/IID.

Chief Executive Officer/Facility Administrator (CEO/FA) – The individual responsible for the day-to-day administration/management of an ICF/IID.

Client – An applicant for or beneficiary of Title XIX (Medicaid) ICF/IID services. An individual receiving ICF/IID services may also be referred to as a beneficiary.

Centers for Medicare and Medicaid Services (CMS) – The federal agency responsible for administering the Medicaid Program and overseeing and monitoring the state’s Medicaid Program.

Code of Federal Regulations (CFR) – The regulations published by the federal government. **Section 42** includes regulations for ICF/IID.

Comprehensive Functional Assessment – Identifies the individual’s need for services and provides specific information about the individual’s ability to function in different environments, specific skills or lack of skills, and how function can be improved, either through training,

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environmental adaptations, or provision of adaptive, assistive, supportive, orthotic, or prosthetic equipment.

Intellectual Disabilities – As defined by the Louisiana Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2) found in Appendix B.

Developmental Period – A period from birth to before a person reaches age 22.

Department of Health and Human Services (DHHS) – A cabinet-level executive branch agency responsible for overseeing public health policy and administering funding for health programs and services.

Dual Diagnosis – When individuals are diagnosed with both a developmental disability and mental illness.

Enrollment – The process of executing a contract with a licensed and certified ICF/IID provider for participation in the Medical Assistance Program. Enrollment includes the execution of the **provider agreement** and assignment of the **provider number** used for payment.

Epilepsy – A disorder of the central nervous system, which is characterized by repeated seizures which are produced by uncontrolled electrical discharges in the brain.

Fiscal Intermediary (FI) – The private fiscal agent with which LDH contracts to operate the Medicaid Management Information System (MMIS) that processes the Title XIX (Medicaid) claims for services provided under the Medical Assistance Program and issue appropriate payment(s).

General Intellectual Functioning – Results obtained by assessment with one or more of the individually administered general intelligence tests developed for that purpose.

Health Standards Section (HSS) – Section within BHSF that is responsible for licensing and certification of ICF/IID.

ICAP Relationship – The relationship between the service level and service score for ICAP support levels is as follows:

ICAP Service Level	ICAP Service Score	ICAP Support Levels
		Pervasive Plus
1	1-19	Pervasive
2	20-29	Extensive
3	30-39	Extensive
4	40-49	Limited
5	50-59	Limited

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6	60-69	Limited
7	70-79	Intermittent
8	80-89	Intermittent
9	90+	Intermittent

ICAP Service Level – Ranges from 1 to 9 and indicates the service need intensity; the lower the score, the greater the need.

ICAP Service Score – Indicates the level of service intensity required by an individual, considering both adaptive and maladaptive behavior.

Index Factor – Measure of inflation based on the *Skilled Nursing Home without Capital Market Basket Index* published by Data Resources Incorporated or a comparable index if this index ceases to be published.

Individual Habilitation Plan (IHP) – Written ongoing program of services developed for each individual by an interdisciplinary team (IDT) in order for that individual to achieve or maintain their potential. The plan contains specific, measurable goals, objectives and provides for data collection. It is also referred to as the Individual Plan of Care (IPC), Individual Program Plan, Individual Service Plan (ISP) or the Support Plan.

Interdisciplinary Team (IDT) – Group of individuals representing the different disciplines in the formulation of an individual's IHP. That team meets at least annually to develop and review the plans, more frequently if necessary.

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) – Any 24-hour residential facility, whether public or private, that provides services to individuals that meet the criteria to reside in that facility.

Intelligence Quotient (IQ) – General measure of intellectual functioning obtained by assessment with one or more of the standardized, individually administered intelligence tests. Intellectual functioning refers to general mental capacity, such as learning, reasoning, and problem solving.

Inventory for Client and Agency Planning (ICAP) – Standardized instrument for assessing adaptive and maladaptive behavior and includes an overall service score. This ICAP service score combines adaptive and maladaptive behavior scores to indicate the overall level of care (LOC), supervision or training required.

Learning – General cognitive competence of the ability to acquire new behaviors, perceptions, and information and to apply previous experiences in new situations.

Legal Status – Designation indicative of an individual's competency to manage their affairs.

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Level of Care (LOC) – Service needs of the individual based upon their comprehensive functional status.

Licensed – Written certification, whether provisional or regular, of an ICF/IID’s authorization to operate under state law as determined by the LDH, BHSF HSS.

Licensed Certified Social Worker (LCSW) – Person holding a Master of Social Work (MSW) degree and is licensed by the Louisiana State Board of Certified Social Work Examiners.

Living Unit – Place where an individual lives including sleeping, training, dining and activity areas.

Louisiana Department of Health (LDH) – The state agency responsible for protecting and promoting public health in Louisiana. It provides various services, including Medicaid, public health services, behavioral health services, and services for people with developmental disabilities, aging Louisianans, and women's health. The LDH also ensures access to medical, preventive, and rehabilitative services for all residents.

Local Governing Entity (LGE) – The regional office, routinely referred to as the human services authority or district responsible for single point of entry, implementation, and oversight of the Residential Options Waiver (ROW) on behalf of the Office of Citizens with Developmental Disabilities (OCDD). There is one LGE for each service region. Refer to Appendix C to obtain the contact information for the LGE in your area.

Licensed Practical Nurse (LPN) – A healthcare professional who provides basic nursing care under the supervision of a registered nurse (RN) or physician.

Long-Term Care (LTC) – Encompasses a range of services and support for individuals with chronic illnesses or disabilities who need assistance with daily activities, such as dressing, bathing, and using the bathroom.

Major Life Activities – Any one of the following activities or abilities:

1. Self-care;
2. Understanding and Use of Language;
3. Learning;
4. Mobility;

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5. Self-direction; or
6. Capacity for Independent Living.

Measurable Outcome – Standard or goal by which performance is measured and evaluated.

Mechanical Support – Device used to achieve proper body position or balance.

Medicaid – Medical assistance provided under the State Plan approved under Title XIX of the Social Security Act.

Medicaid Agency – Is the single state agency responsible for the administration of the Medical Assistance Program (Title XIX). In Louisiana, the Department of Health is the single state agency.

Medicaid Management Information System (MMIS) – The computerized claims processing and information retrieval system that includes all ICF/IID providers eligible for participation in the Medical Assistance Program. This system is an organized method for payment for claims for all Title XIX Services.

Medical Assistance Program (MAP) – is another name for the Medicaid program.

Medicare – The federally administered health insurance program for the aged, blind and disabled under the Title XVIII of the Social Security Act.

Medicare Part A – The hospital insurance program authorized under Part A of Title XVIII of the Social Security Act.

Medicare Part B – Medical insurance program authorized under Part B of Title XVIII of the Social Security Act that helps cover medical services like doctors' services, outpatient care, and other medical services that Part A does not cover.

Intellectual Disability – Significantly sub-average general intellectual functioning existing concurrently with deficits in adaptive behavior, and manifested during the developmental period.

NOTE: It must be emphasized that a finding of low IQ is never by itself sufficient to make the diagnosis of intellectual disability or in evaluating its severity. A low IQ shall serve only to help in making a clinical judgment regarding the individual's adaptive behavioral capacity. This judgment shall also include present functioning: including academic and vocational achievement, motor skills, social and emotional maturity, community environment typical of the individual's peers and culture, linguistic diversity and cultural differences in the way people communicate, move and behave.

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Mobility – Motor development and ability to use fine and gross motor skills; the ability to move the extremities at will.

Mobile Non-ambulatory – Inability to walk without assistance, but the ability to move from place to place with the use of a device such as a walker, crutches, wheelchair or wheeled platform.

Neglect – Failure to provide proper or necessary medical care, nutrition or other care necessary for an individual's well-being.

New Facility – An ICF/IID **newly** opened or now currently participating in MAP.

Non-ambulatory – Inability to walk without assistance.

Nursing Facility or "Facility" – A health care facility such as a private home, institution, building, residence, or other place which provides maintenance, personal care, or nursing services for individuals who are unable to properly care for themselves because of illness, physical infirmity or age. These facilities serve two or more individuals who are not related by blood or marriage to the operator and may be operated for profit or nonprofit.

Office of Aging and Adult Services (OAAS) – The office within LDH that is responsible for programs serving aging adults and people with adult-onset disabilities.

Office for Citizens with Developmental Disabilities (OCDD) – The office within LDH that is responsible for programs serving people with developmental disabilities.

Operational – Admission of at least one individual, completion of functional assessments(s) and development of individual program plan(s) for the individual(s); and implementation of the program plan(s) in order that the facility actually demonstrates the ability, knowledge, and competence to provide active treatment.

Provider – Any individual or entity furnishing Medicaid Services under a provider agreement with the Medicaid Agency.

Qualified Intellectual Disabilities Professional (QIDP) – A person who has specialized training and at least one year or more of experience in treating and/or working directly with and in direct contact with individuals with intellectual disabilities. To qualify as a QIDP a person must meet the requirements of **42 CFR 483.430**.

Rate Year – A one-year period corresponding to the state fiscal year (FY) from July 1 through June 30.

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Rebasing – Recalculation of the per diem rate components using the latest available audited or desk reviewed cost reports.

Registered Nurse (RN) – A nurse currently registered and licensed by the Louisiana State Board of Nursing.

Representative Payee – A person designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the beneficiary.

Responsible Party – A person authorized by the individual or agency to act as an official delegate or agent in dealing with the LDH and/or the ICF/IID on behalf of the beneficiary.

Self-Care – Daily activities which enable a person to meet basic life needs for food, hygiene, appearance and health.

Self-Direction – Management and control over one's social and personal life and the ability to make decisions that affect and protect one's own interests. A substantial functional limitation in self-direction would require a person to need assistance in making independent decisions concerning social and individual activities and/or in handling personal finances and/or in protecting his own self-interest.

Significant Assistance – Help needed at least one-half of the time for one activity or a need for some help in more than one-half of all activities normally required for self-care.

Significantly Sub-average – For purposes of certification for LTC, an IQ score of below 70 on the Wechsler, Stanford-Binet, Cattell, or comparable test will be considered to establish significantly sub-average intellectual functioning.

Skilled Nursing Facility (SNF) – A type of LTC facility that provides a higher LOC than a typical nursing home or assisted living facility.

Sponsor – An adult relative, friend, or guardian of the individual who has a legitimate interest or responsibility in the individual's welfare. Preferably, this person is designated on the admission forms as "responsible party."

Substantial Functional Limitation – A condition that limits a person from performing normal life activities or makes it unsafe for a person to live alone to such an extent that assistance, supervision, or presence of a second person is required more than half of the time.

Title XIX – See Medicaid.

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Training and Habilitation Services – Services intended to aid the intellectual, sensor motor and emotional development of an individual as part of overall plans to help the individual function at the greatest physical, intellectual, social and vocational level they can presently or potentially achieve.

Understanding and Use of Language – Communication involved in both verbal and nonverbal behavior enabling the individual to both understand others and to express ideas and information to others.

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DEVELOPMENTAL DISABILITY LAW

A developmental disability is defined by the Developmental Disability Law (Louisiana Revised Statutes 28:451.1-28:455.2). The law states that a developmental disability means either:

1. A severe chronic disability of a person that:
 - a. Is attributable to an intellectual or physical impairment or combination of intellectual and physical impairments;
 - b. Is manifested before the person reaches age 22;
 - c. Is likely to continue indefinitely;
 - d. Results in substantial functional limitations in three or more of the following areas of major life activity:
 - i. Self-care;
 - ii. Receptive and expressive language;
 - iii. Learning;
 - iv. Mobility;
 - v. Self-direction;
 - vi. Capacity for independent living; and
 - vii. Economic self-sufficiency.
 - e. Is not attributed solely to mental illness; and
 - f. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

OR

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2. A substantial developmental delay or specific congenital or acquired condition in a person from birth through age nine which, without services and support, has a high probability of resulting in those criteria listed above later in life that may be considered to be a developmental disability.

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WITH INTELLECTUAL DISABILITIES (ICF/IID)****APPENDIX C: CONTACT INFORMATION****PAGE(S) 2****CONTACT INFORMATION**

OFFICE NAME	TYPE OF ASSISTANCE	CONTACT INFORMATION
Bureau of Health Services Financing (BHSF) Health Standards Section (HSS)	To file a complaint involving beneficiaries of all ages in licensed health care facilities	Louisiana Department of Health (LDH)/Office of Management and Finance (OMF)/HSS P.O. Box 3767 Baton Rouge, LA 70821 Phone: 1-877-343-5179 or (225-342-0138) Fax: (225-342-0453)
Division of Administration Law (DAL)	To file an appeal request	Division of Administration Law Services P. O. Box 44033 Baton Rouge, LA 70804-4033
LDH Rate and Audit Review Section	To obtain assistance with questions on cost reports and audits	Rate and Audit Review P. O. Box 91030 Baton Rouge, La 70821 Attention: Denis Beard Phone: 225-342-3613
Gainwell Technologies – Provider Relations Unit	To obtain assistance with questions regarding billing information	Gainwell Technologies – Provider Relations Unit P. O. Box 91024 Baton Rouge, LA 70821 Phone: (225) 924-5040 or (800) 473- 2783 Fax: (225) 216-6334

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OFFICE FOR CITIZENS WITH INTELLECTUAL DISABILITIES

Contact information for the central office and the regional local governing entities (LGEs) is found on the Office of Citizens with Developmental Disabilities (OCDD) website at:

<https://ldh.la.gov/office-for-citizens-with-developmental-disabilities>.

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APPENDIX D: CLAIMS FILING**PAGE(S) 1**

CLAIMS FILING

The [link](#) to the most recent instructions for completing the UB 04 form along with samples of UB 04 claim forms for intermediate care facilities for individuals with intellectual disabilities (ICF/IID) routine billing are located on the home page of the Louisiana Medicaid website.