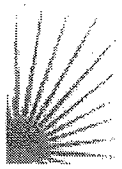

Connecticut Department of Social Services

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Provider Manual

Chapter 7 - Nursing Facilities and ICF/MR

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Connecticut Department of Social Services (DSS)
25 Sigourney Street
Hartford, CT 06106

EDS
US Government Solutions
195 Scott Swamp Road
Farmington, CT 06032

EDS
an HP company

CONNECTICUT MEDICAL ASSISTANCE PRPGRAM
Nursing Facility and ICF/MR Regulations
Chapter 7

Medical Services Policy **7.1**

This section of the provider Manual contains the Medical Services policy section pertaining to nursing facilities and ICFs/MR.

Policy updates, additions, and revisions are approved in accordance with the Connecticut Uniform Administrative Procedure Act. Should this occur, providers are notified through the Provider Bulletin process and sent policy update pages to place in Chapter 7 of their manuals.

Requirements for Payment of Nursing Facilities

Requirements for Payment of Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Requirements for Payment of Nursing Facilities

The Regulations of Connecticut State Agencies are amended by adding sections 17b-262-701 to 17b-262-711, inclusive, as follows:

Section 17b-262-701

Scope

Sections 17b-262-701 to 17b-262-711, inclusive, set forth the Department of Social Services requirements for payment to nursing facilities for services to clients eligible to receive such services under Connecticut's Medicaid program pursuant to section 17b-262 of the Connecticut General Statutes.

Section 17b-262-702

Definitions

For the purposes of sections 17b-262-701 to 17b-262-711, inclusive, the following definitions shall apply:

(1) "Applied income" means the amount of income that each client receiving nursing facility services is expected to pay each month toward the cost of his or her care, calculated according to the department's Uniform Policy Manual, section 5045.20;

(2) "Client" means a person eligible for goods or services under the department's Medicaid program;

(3) "Chronic disease hospital" means "chronic disease hospital" as defined in section 19-13-D1 of the Regulations of Connecticut State Agencies;

(4) "Commissioner" means the Commissioner of Social Services, or the commissioner's designee;

(5) "Department" means the Department of Social Services or its agent;

(6) "DMHAS" means the Department of Mental Health and Addiction Services or its agent;

(7) "DMR" means the Department of Mental Retardation or its agent;

(8) "Home leave" means an absence from the nursing facility for any reason other than admission to a hospital. It is taken at the discretion of the resident;

(9) "Hospital" means "hospital" as defined in section 19a-537 of the Connecticut General Statutes;

(10) "Institution for Mental Diseases" or "IMD" means "institution for mental diseases" as defined in 42 CFR 435.1009, as amended from time to time ;

(11) Licensed practitioner" means any person licensed by the state of Connecticut, any other state, District of Columbia, or the Commonwealth of Puerto Rico and authorized to prescribe treatments within the scope of his or her practice as defined and limited by federal and state law;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Nursing facility" or "NF" means "nursing facility" as defined in 42 USC 1396r(a), as amended from time to time;

(16) "Preadmission screening and resident review" or "PASRR" means the program defined in 42 USC 1396r(e)(7) and 42 CFR Part 483, Subpart C, as amended from time to time;

(17) "Preadmission MI/MR screen" means the level I screen required under the PASRR program and described in 42 CFR 483.106 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(18) "Preadmission screening level II evaluation" means the level II screen as described in 42 CFR 483.112 and 42 CFR 483.128, as amended from time to time. It shall be completed on the forms and in the manner prescribed by the department;

(19) "Provider" means a nursing facility that is enrolled in the Medicaid program;

(20) "Provider agreement" means the signed, written, contractual agreement between the department and the provider;

(21) "Reserve bed day" means a day when a nursing facility client is temporarily absent from the nursing facility and for which payment is made by the department in accordance with section 19a-537 of the Connecticut General Statutes;

(22) "Resident" means a person living in a nursing facility; and

(23) "Usual and customary charge" means the amount that the provider charges for the service or procedure in the majority of non-Medicaid cases. If the provider varies the charges so that no one amount is charged in the majority of cases, usual and customary shall be defined as the median charge. Token charges for charity patients and other exceptional charges are to be excluded.

Section 17b-262-703

Provider Participation

In order to enroll in the Medicaid program and receive payment from the department, a nursing facility shall comply with sections 17b-262-522 through 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies. Licensing and certification requirements for nursing facilities referenced in sections 17b-262-701 to 17b-262-711, inclusive, of the Regulations of Connecticut State Agencies include, but are not limited to, the criteria described in section 19-13-D8t of the Regulations of Connecticut State Agencies and the criteria described in 42 CFR Part 483, subpart B, as amended from time to time.

Section 17b-262-704

Eligibility

Payment for nursing facility services is available to all persons eligible for the Medicaid program subject to the conditions and limitations that apply to these services.

Section 17b-262-705

Services Covered and Limitations

The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, to the provider for each Medicaid resident. This rate represents payment for the following goods and services:

(a) all services as required by section 19-13-D8t of the Regulations of Connecticut State Agencies and 42 CFR Part 483, subpart B, as amended from time to time, including, but not limited to:

(1) medical direction in accordance with sections 19-13-D8t(h) and (i) of the Regulations of Connecticut State Agencies;

(2) nursing service in accordance with 42 CFR 483.30, as amended from time to time, and sections 19-13-D8t(j),(k),(m) and (n) of the Regulations of Connecticut State Agencies;

(3) social services in accordance with 42 CFR 483.15(g), as amended from time to time, and section 19-13-D8t(s) of the Regulations of Connecticut State Agencies;

(4) therapeutic recreation in accordance with 42 CFR 483.15(f), as amended from time to time, and section 19-13-D8t(r) of the Regulations of Connecticut State Agencies;

(5) specialized rehabilitative services in accordance with 42 CFR 483.45, as amended from time to time;

(6) room and board in accordance with 42 CFR 483.10(c)(8)(i)(D), 42 CFR 483.35, and 42 CFR 483.70, as amended from time to time, and sections 19-13-D8t(q) and 19-13-D8t(v) of the Regulations of Connecticut State Agencies;

(7) consultation and assistance to residents in obtaining other needed services including:

(A) vision and hearing services in accordance with 42 CFR 483.25(b), as amended from time to time;

(B) services to address mental and psychosocial functioning in accordance with 42 CFR 483.25(f), as amended from time to time;
(C) dental services in accordance with 42 CFR 483.55, as amended from time to time; and
(D) pharmacy services in accordance with 42 CFR 483.60(b) and (c), as amended from time to time;

(b) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(c) over the counter medications except insulin;

(d) durable medical equipment except those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies that are payable separately for nursing facility clients;

(e) supplies used in the routine care of the Medicaid resident that are included on the department's medical and surgical fee schedule including:

(1) antiseptics and solutions;
(2) bandages and dressing supplies;
(3) catheters and urinary incontinent supplies;
(4) diabetic supplies;
(5) diapers and underpads;
(6) compression, burns and specialized medical garments;
(7) ostomy supplies;
(8) respiratory and tracheotomy supplies;
(9) enteral and parenteral supplies; and
(10) miscellaneous supplies;

Some of these supplies are covered by and should be billed to Part B of the Medicare program. Such supplies are not included in the per diem rate as per section 17b-340(f)(1) of the Connecticut General Statutes.

(f) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the nursing facility as described in sections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies;

(g) oxygen concentrators as described in section 17b-281 of the Connecticut General Statutes and the regulations promulgated thereunder;

(h) prescription drugs for those providers that have approval from the department to include prescription drug costs in the per diem rate; and

(i) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section. Transportation to services listed in subdivision (a)(7) of this section, which the nursing facility shall help obtain but not provide directly, is not included in the per diem rate. Nursing facilities shall follow the customary authorization procedure in arranging for such transportation.

Section 17b-262-706

Service Limitations

(a) The department shall pay to reserve a bed in a nursing facility for a Medicaid resident during a temporary absence in a hospital or a temporary absence for home leave in accordance with the provisions of section 19a-537 of the Connecticut General Statutes.

(b) Payment shall be made for the date of admission and not for the date of discharge. Exceptions to this are:

(1) Payment may be made for the date of death when the resident dies in the nursing facility. If the resident dies while in the hospital or on home leave, the date of death may be paid as a reserve bed day, provided all other bed reservation requirements as described in section 19a-537 of the Connecticut General Statutes are met; and

(2) In the case of a resident admitted and discharged on the same day, payment shall be made for one day of care.

(c) The department shall not pay nursing facilities that are characterized as institutions for mental diseases (IMD) except for services to clients aged 65 and older or under age 22 in accordance with section 17-134d-68 of the Regulations of Connecticut State Agencies and 42 CFR 435.1008.

Section 17b-262-707

Need for Service and Authorization Process

(a) The department shall pay for an admission that is medically necessary and medically appropriate as evidenced by the following:

(1) certification by a licensed practitioner that a client admitted to a nursing facility meets the criteria outlined in section 19-13-D8t(d)(1) of the Regulations of Connecticut State Agencies. This certification of the need for care shall be made prior to the department's authorization of payment. The licensed practitioner shall use and sign all forms specified by the department;

(2) the department's evaluation and written authorization of the client's need for nursing facility services as ordered by the licensed practitioner;

(3) a health screen for clients eligible for the Connecticut Home Care Program for Elders as described in section 17b-342-4(a) of the Regulations of Connecticut State Agencies;

(4) a preadmission MI/MR screen signed by the department; or an exemption form, in accordance with 42 CFR 483.106(b), as amended from time to time, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen was not completed; and

(5) a preadmission screening level II evaluation for any individual suspected of having mental illness or mental retardation as identified by the preadmission MI/MR screen.

(b) The department shall pay a provider only when the department has authorized payment for the client's admission to that nursing facility.

(c) A nursing facility may admit a client on an emergency basis only if:

(1) the Office of Protection and Advocacy, established in accordance with section 46a-10 of the Connecticut General Statutes, in conjunction with DMHAS or DMR authorizes the emergency admission of a client with mental illness or mental retardation to a nursing facility for up to seven (7) days in accordance with 42 CFR 483.130(d)(5), as amended from time to time; or

(2) the Commissioner of Public Health authorizes an emergency transfer as prescribed in section 19a-534 of the Connecticut General Statutes.

(d) If a client is admitted on an emergency basis, the nursing facility is not required to meet:

(1) the waiting list requirements of section 19a-533 of the Connecticut General Statutes and sections 17-311-200 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies, as long as emergency admissions are uniformly and consistently made without regard to source of payment; and

(2) the requirements of subsections (a)(3) to (a)(5) of this section.

(e) A client who requires admission after hours is not considered an emergency admission.

Section 17b-262-708

Applied Income

(a) The department is responsible for calculating the applied income. The department shall notify the nursing facility of the amount of any applied income that the nursing facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the department's monthly payment to the nursing facility.

(b) The nursing facility shall notify the department's caseworker of any errors in the amount of applied income processed against the claim using the form specified by the department. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a resident returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the resident was in the nursing facility multiplied by the per diem rate.

(d) Applied income is not pro rated. It is used to cover the cost of care until it is expended.

Section 17b-262-709

Billing and Payment Procedures

(a) The nursing facility shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to nursing facilities established by the department.

(b) The nursing facility is responsible for:

(1) completing the daily admission and discharge forms in accordance with the department's instructions;

(2) notifying the department caseworker if the nursing facility is aware that the Medicaid resident's asset level exceeds the established resource limit. The report shall be made on the form specified by the department;

(3) notifying the convalescent payment unit of the department of any and all credits due the department on the form specified by the department; and

(4) exhausting other payment sources of which the nursing facility is aware before billing the department.

(5)

Section 17b-262-710

Rates

(a) The per diem rates for nursing facilities services are determined annually pursuant to section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-209, inclusive, of the Regulations of Connecticut State Agencies.

(b) The department shall reimburse the nursing facility at the lower of:

(1) the per diem rate minus the applied income; or

(2) the usual and customary charge minus the applied income.

Section 17b-262-711

Documentation

(a) The nursing facility shall maintain all documentation required for rate setting purposes in accordance with section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(5) of this section. This documentation is subject to review and audit by the department.

(b) The nursing facility shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the nursing facility shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation may result in the disallowance and recovery by the department of any amounts paid to the nursing facility for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the Provider Agreement for Nursing Facilities and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) The department requires that nursing facilities maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for nursing facilities.

(e) Required documentation includes:

(1) certification for nursing facility admission as required by the department. The form shall be signed by the licensed practitioner;

(2) the department's written authorization of the client's need for nursing facility care;

(3) a health screen signed by the department for clients eligible for the Connecticut Home Care Program for Elders;

(4) all admission and discharge forms supporting the claim;

(5) all documentation required to support the nursing facility's billing for and the department's payment of bed reserve days as described in section 19a-537 of the Connecticut General Statutes;

(6) all documentation required by the PASRR process including:

(A) a preadmission MI/MR screen signed by the department or an exemption letter, in the form and manner prescribed by the department, for any hospital discharge, readmission or transfer for which a preadmission MI/MR screen is not on file; and

(B) a preadmission screening level II evaluation, signed by DMHAS or DMR, for any resident suspected of having mental illness or mental retardation, respectively, as identified on the preadmission MI/MR screen.

(7) medical records in accordance with section 19-13-D8t(o) of the Regulations of Connecticut State Agencies.

Requirements for Payment of Services Provided by Intermediate Care Facilities for the Mentally Retarded (ICFs/MR)

Section 17b-262-299. Scope

Sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies set forth the requirements for payment of services provided by Intermediate Care Facilities for the Mentally Retarded to clients eligible to receive such services under Medicaid pursuant to section 17b-262 of the Connecticut General Statutes.

Section 17b-262-300. Definitions

As used in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies the following definitions shall apply:

(1) "Active treatment" means the treatment as described in 42 CFR 483.440(a), as amended from time to time;

(2) "Applied income" means the amount of income that each client receiving ICF/MR services is expected to pay each month toward the cost of his or her care, calculated according to the DSS Uniform Policy Manual, section 5045.20;

(3) "Client" means a person eligible for services under the Connecticut Medicaid program;

(4) "DMR" means the Department of Mental Retardation or its agent;

(5) "DPH" means the Department of Public Health or its agent;

(6) "Department" or "DSS" means the Department of Social Services or its agent;

(7) "Discharge" means the movement of a client out of an ICF/MR;

(8) "Home leave" means an overnight absence from the ICF/MR for any reason other than admission to a hospital. It is taken at the discretion of the client;

(9) "Hospital" means a general hospital, special hospital or chronic disease hospital as defined in section 19-13-D1(b) of the Regulations of Connecticut State Agencies;

(10) "Interdisciplinary team" or "IDT" means a group of persons, as described in 42 CFR 483.440(c)(2), as amended from time to time;

(11) "Intermediate care facility for the mentally retarded" or "ICF/MR" means a residential facility for the mentally retarded licensed pursuant to section 17a-227 of the Connecticut General Statutes and certified and enrolled to participate in Medicaid as an intermediate care facility for the mentally retarded pursuant to 42 CFR 442.101, as amended from time to time;

(12) "Medical appropriateness" or "medically appropriate" means health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate medical setting; and, is the least costly of multiple, equally-effective, alternate treatments or diagnostic modalities;

(13) "Medicaid" means the program operated by the Department of Social Services pursuant to section 17b-260 of the Connecticut General Statutes and authorized by Title XIX of the Social Security Act;

(14) "Medical necessity" or "medically necessary" means health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist a client in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring;

(15) "Objective information" means an estimate of the client's projected length of hospital stay obtained by the ICF/MR from a hospital staff person. This prognosis may be obtained from the client's record or the overall plan of service (OPS) or given by a physician or other health professional under his or her direction or by another qualified professional such as a social worker or discharge planner;

(16) "Overall plan of services" or "OPS" means a document that specifies a strategy to guide the delivery of services to a client for up to one year. It is the document required for a client that meets the federal requirements for a plan of care as outlined in 42 CFR 456.380, as amended from time to time, and an individual program plan as outlined in 42 CFR 483.440, as amended from time to time; and

(17) "Provider" means an ICF/MR that is enrolled in the Medicaid program.

Section 17b-262-301. Provider Participation

In order to enroll in Medicaid and receive payment from the department, providers shall comply with sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies and be certified, in accordance with federal regulations, to participate in the Medicaid program.

Section 17b-262-302. Eligibility

Payment to Intermediate Care Facilities for the Mentally Retarded is available on behalf of all clients who are determined to be in need of ICF/MR care by the Department of Mental Retardation and the Department of Social Services, subject to the conditions and limitations set forth in sections 17b-262-299 to 17b-262-311, inclusive, of the Regulations of Connecticut State Agencies. Clients shall be receiving active treatment as described in 42 CFR 483.440(a), as amended from time to time.

Section 17b-262-303. Services Covered and Limitations

(a) Services Covered

(1) The department shall pay an all-inclusive per diem rate, computed in accordance with section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies, to the ICF/MR for each client. This rate represents an inclusive payment for all services and items that are required to be provided by the facility as a condition for participation as an ICF/MR, including but not necessarily limited to the following:

(A) services provided by qualified staff engaged by the ICF/MR, as described in 42 CFR 483.430, as amended from time to time;

(B) active treatment services as described in 42 CFR 483.440, as amended from time to time;

(C) client behavior and facility practice as described in 42 CFR 483.450, as amended from time to time;

(D) health care services as described in 42 CFR 483.460, as amended from time to time;

(E) physical environment management as described in 42 CFR 483.470, as amended from time to time;

(F) dietetic services as described in 42 CFR 483.480, as amended from time to time;

(G) routine personal hygiene items as defined in 42 CFR 483.10(c)(8)(i)(E), as amended from time to time;

(H) over the counter medications except insulin;

(I) durable medical equipment, except for those items listed in section 17b-262-676(a)(2) of the Regulations of Connecticut State Agencies where Medicaid payment is available directly to the supplier of durable medical equipment if the item is medically necessary;

(J) supplies used in the routine care of the client that are included on the department's medical and surgical fee schedule including:

(i) antiseptics and solutions;
(ii) bandages and dressing supplies;
(iii) catheters and urinary incontinent supplies;
(iv) diabetic supplies;
(v) diapers and underpads;
(vi) compression, burns and specialized medical garments;
(vii) ostomy supplies;
(viii) respiratory and tracheotomy supplies;
(ix) enteral and parenteral supplies; and
(x) miscellaneous supplies;

(K) services related to the provision or arrangement for provision of customized wheelchairs that are the responsibility of the ICF/MR as described in subsections 17-134d-46(m) and (n) of the Regulations of Connecticut State Agencies; and

(L) transportation services necessary to transport a client to and from any service included in the per diem rate as described in this section.

(2) The department shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital as described in section 17b-262-306 of the Regulations of Connecticut State Agencies.

(3) The department shall pay to reserve a bed in an ICF/MR for home leave in accordance with section 17b-262-307 of the Regulations of Connecticut State Agencies.

(b) Limitations

(1) The department shall not pay for anything of an unproven, experimental or research nature or for services in excess of those deemed medically necessary by the department to treat the client's condition or for services not directly related to the client's diagnosis, symptoms or medical history.

(2) The department shall pay for the date of admission and not for the date of discharge. Exceptions to this are:

(A) the department shall pay for the date of death when the client dies in the ICF/MR. If the client dies while in the hospital or on home leave, the date of death is paid as a reserve bed day, provided all other bed reservation requirements as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies are met; and

(B) in the case of a client admitted and discharged on the same day, payment is authorized for one day of care.

Section 17b-262-304. Need for Services and Authorization Process

(a) The decision to admit and the subsequent admission to a facility must be made by the Department of Mental Retardation or the admitting ICF/MR in conjunction with the client's interdisciplinary team, subject to review by DSS.

(b) DSS shall evaluate and approve in writing the client's need for ICF/MR services ordered by the physician, as described in 42 CFR 456.372, as amended from time to time.

(c) In order for DSS to pay for ICF/MR services, the ICF/MR shall document the need for the admission by all of the following:

(1) certification of the need for care by a physician as described in 42 CFR 456.360(a), as amended from time to time;

(2) medical, psychological and social evaluations as described in 42 CFR 456.370, as amended from time to time;

(3) an admissions review as described in 42 CFR 483.440(b), as amended from time to time;

(4) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(5) an OPS; and

(6) a written report of each evaluation and OPS entered in the client's record, as described in 42 CFR 456.381, as amended from time to time.

(7) DSS written approval of the client's need for ICF/MR services in accordance with 42 CFR 456.372, as amended from time to time.

(d) Beginning no later than six months after admission, or earlier if indicated at the time of admission, the ICF/MR shall document the need for continued stay by all of the following:

(1) recertification of need for care as described in 42 CFR 456.360(b), as amended from to time, on forms prescribed by DSS;

(2) exploration of alternative services as described in 42 CFR 456.371, as amended from time to time;

(3) a continued stay review process in accordance with 42 CFR 456.431 to 42 CFR 456.438, inclusive, as amended from time to time;

(4) a review of the OPS as described in 42 CFR 456.380(c), as amended from time to time; and

(5) monitoring of the program plan as described in 42 CFR 483.440(f), as amended from time to time.

Section 17b-262-305. Client's Bill of Rights

(a) An ICF/MR shall protect and promote the rights of each client as described in 42 CFR 483.420, as amended from time to time.

(b) Requirements for the administration of the patient's personal allowance shall be in accordance with sections 17-2-140 to 17-2-145, inclusive, of the Regulations of Connecticut State Agencies.

Section 17b-262-306. Bed Reserve for Hospitalization

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence in a hospital for up to fifteen (15) days in accordance with subsection (e) of this section.

(b) The ICF/MR shall inform the client and guardian or other responsible person, upon admission to the ICF/MR and upon transfer of a client to the hospital, that the bed of a client shall be reserved if the conditions outlined in this section are met.

(c) The ICF/MR shall reserve the bed of any client who is absent from the ICF/MR due to hospitalization unless the ICF/MR has obtained objective information from the hospital that the client shall not return to the ICF/MR within the fifteen day period, including the day of admission, to the hospital.

(d) The ICF/MR shall not make the reserved bed available for use by any other person.

(e) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the ICF/MR for each day that the ICF/MR reserves the bed of a client in accordance with the following conditions:

(1) an ICF/MR shall be reimbursed for reserving the bed of a client who is hospitalized for a maximum of seven (7) days including the admission date of hospitalization, if on the date of admission the ICF/MR documents that it contacted the hospital and the hospital failed to provide objective information confirming that the person would be unable to return to the ICF/MR within fifteen (15) days of the date of hospitalization;

(2) the ICF/MR shall be reimbursed for a maximum of eight (8) additional days provided on or before the seventh day, but not before the third day of the hospitalization of a client, the ICF/MR contacts the hospital for an update on the client's status and the ICF/MR documents in the client's file that the information obtained through the contact does not indicate that the client shall be unable to return to the ICF/MR within fifteen (15) days of the hospital admission;

(3) documentation of the hospital contact described in subdivisions (1) and (2) of this subsection shall include the date of the contact, the hospital representative's name, the source of the information and the estimated length of stay;

(4) if at any time the ICF/MR is provided with information from the hospital that the client shall not return to the ICF/MR within fifteen (15) days of the hospital admission, the ICF/MR is not eligible to receive reimbursement for reserving the client's bed for any days after such information is received, including the day the information is received; and

(5) for the purposes of determining the beginning of the bed reservation period, admission to the hospital shall mean the time at which the client, on recommendation of a physician, is formally admitted as an inpatient to the hospital. When a client is transferred to the hospital and is not formally admitted, it shall not be considered a discharge, regardless of the length of the stay. It shall be considered a discharge from the ICF/MR only when the client is formally admitted by the hospital. Any other hospital stay, whether in the emergency room or otherwise shall be considered an outpatient visit.

(f) If the client's hospitalization exceeds the period of time that an ICF/MR is required to reserve the client's bed, the ICF/MR:

(1) shall provide the client the first available bed at the time notice is received of the client's discharge from the hospital;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For hospital leave beyond fifteen (15) days per hospital admission, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

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Section 17b-262-307. Bed Reserve for Home Leave

(a) DSS shall pay to reserve a bed in an ICF/MR for a client during a temporary absence for home leave for up to thirty-six (36) days per calendar year. The ICF/MR shall not make the reserved bed available for use by any other person.

(b) The ICF/MR shall inform the client and guardian or other responsible person upon admission to the facility, that a bed shall be reserved for home leave if the conditions outlined in subsection (d) of this section are met.

(c) The ICF/MR shall reserve a client's bed for up to thirty-six (36) days per calendar year. No facility shall require, or request, a client to provide payment for authorized home leave.

(d) DSS shall reimburse an ICF/MR at the per diem Connecticut Medicaid program rate of the facility for each day that the facility reserves the bed in accordance with the following conditions:

(1) the client has not used more than thirty-six (36) days of home leave during the calendar year;

(2) the facility has not refused to take the client back during or upon completion of the authorized home leave. If so, no payment shall be made for the entire home leave; and

(3) the client has not failed to return to the ICF/MR. If the client has not returned, the liability for payment to the ICF/MR shall terminate on the date the ICF/MR is notified that the client will not be returning.

(e) If the client has used more than thirty-six (36) days of home leave in a calendar year the facility shall not be required to reserve the bed; however, the ICF/MR:

(1) shall provide the client the first bed available after notice is received that the client wishes to return;

(2) shall grant the client priority admission over applicants for new admission to the ICF/MR; and

(3) may charge a fee to reserve the bed if the client, his or her family or responsible party wishes to pay to reserve the bed. For home leave beyond thirty-six (36) days per calendar year, the facility shall reserve the bed as long as payment is available. The fee shall not exceed the per diem Connecticut Medicaid program rate for that bed.

(f) The ICF/MR shall document in the client's medical record:

(1) the contact person;
(2) the duration of the absence;
(3) the client's condition before leaving, and upon returning, to the facility; and
(4) the dates of home leave.

(g) The medical record does not need to be closed nor does the client need to be readmitted after home leave.

Section 17b-262-308. Applied Income

(a) DSS is responsible for calculating the applied income. DSS shall notify the ICF/MR of the amount of any applied income that the facility is responsible for collecting. Applied income shall be deducted from what otherwise would have been the DSS monthly payment to the ICF/MR on behalf of the client.

(b) The ICF/MR shall notify DSS of any errors in the amount of applied income processed against the claim using the form specified by DSS. Payment adjustments resulting from retroactive applied income corrections shall be processed periodically.

(c) In any month that a client returns to the community or dies, and the cost of care is less than the applied income, the department shall adjust the applied income as follows: the applied income shall equal the number of days that the client was in the ICF/MR multiplied by the per diem rate.

(d) Applied income shall not be pro rated. It shall be used to cover the cost of care until it is expended.

Section 17b-262-309. Billing and Payment Procedures

(a) The ICF/MR shall submit claims to the department as described in section 17b-262-529 of the Regulations of Connecticut State Agencies and the billing instructions specific to ICFs/MR.

(b) The ICF/MR shall:

(1) complete the daily admission and discharge forms in accordance with DSS instructions;

(2) notify the DSS caseworker if the ICF/MR is aware that the ICF/MR client's asset level exceeds the established resource limit. The report shall be made on the form specified by DSS.

(3) notify the convalescent payment unit of DSS of any and all credits due DSS on the form specified by DSS.

Section 17b-262-310. Rates

The per diem rates for an ICF/MR shall be determined annually, pursuant to section 17b-340 of the Connecticut General Statutes and sections 17-311-1 to 17-311-120, inclusive, of the Regulations of Connecticut State Agencies. DSS shall reimburse the ICF/MR at the per diem rate minus the applied income.

Section 17b-262-311. Documentation

(a) The ICF/MR shall maintain all documentation required for rate setting purposes for a minimum of 10 years pursuant to section 17-311-56 of the Regulations of Connecticut State Agencies, including all documentation required to support the billing for bed reserve days described in subsection (e)(4) of this section. This documentation shall be subject to review by the department.

(b) The ICF/MR shall maintain all other documentation required by this section for at least five (5) years or longer as required by statute or regulation, and shall be subject to review by authorized department personnel. In the event of a dispute concerning a service provided, the ICF/MR shall maintain all documentation until the end of the dispute, for five (5) years, or for the length of time required by statute or regulation, whichever is longest.

(c) Failure to maintain all required documentation shall result in the disallowance and recovery by the department of any amounts paid to the ICF/MR for which the required documentation is not maintained and provided to the department upon request. Documentation requirements are described in detail in the Provider Agreement for ICFs/MR and sections 17b-262-522 to 17b-262-533, inclusive, of the Regulations of Connecticut State Agencies.

(d) An ICF/MR shall maintain fiscal and medical records to fully disclose services and goods rendered or delivered to Medicaid residents. Records shall be maintained in accordance with the department's Provider Agreement for ICFs/MR.

(e) Required documentation shall include:

(1) all reports, evaluations, certifications, reviews and approvals documenting the need for admission as described in subsection 17b-262-304(b) of the Regulations of Connecticut State Agencies;

(2) all certifications and reviews documenting the need for continued stay as described in subsection 17b-262-304(c) of the Regulations of Connecticut State Agencies;

(3) all admission and discharge forms required by DSS; and

(4) all documentation required to support the ICF's/MR billing for and the DSS payment of bed reserve days as described in sections 17b-262-306 and 17b-262-307 of the Regulations of Connecticut State Agencies.

(f) Providers shall maintain all medical records pursuant to sections 17a-227-17 and 17a-227-18 of the Regulations of Connecticut State Agencies.