INTERMEDIATE CARE FACILITIES

OVERVIEW

An Intermediate Care Facility (ICF) provides treatment to individuals with Intellectual Disabilities (IID). An ICF is an institution which has its primary function as the provision of health and rehabilitative services for individuals with intellectual disabilities or who have other developmental disabilities. These facilities have the resources to provide active treatment to help mitigate maladaptive behaviors, and to provide the tools needed to allow individuals to return to their homes and communities safely. These facilities represent the most restrictive of placements and should be utilized only after all other community resources have been exhausted.

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirement.

South Dakota Medicaid has a streamlined enrollment process for ordering, referring, and attending physicians that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

To be eligible for Intermediate Care Facility (ICF) services under Medicaid, the following criteria must be met:

- The individual must be eligible for Medicaid;
- The individual must be determined developmentally disabled; and
- The utilization review team must have determined that the individual is in need of ICF/IID services through an initial level of care and annual redetermination.

Determining Developmental Disability

The facility must maintain in the recipient's medical record, a copy of documentation signed by a physician or psychologist which indicates that the recipient is developmentally disabled. A recipient is considered developmentally disabled if the individual meets all of the following criteria:

- The recipient has a severe, chronic disability attributable to intellectual disability, cerebral

palsy, epilepsy, head injury, brain disease, or autism, or any other condition, other than mental illness, closely related to intellectual disability and requires treatment or services similar to those required for recipients with intellectual disabilities. To be closely related to intellectual disability, a condition must cause impairment of general intellectual functioning or adaptive behavior similar to that of intellectual disability;

- The disability manifested itself before the recipient reached age 22; and
- The disability is likely to continue indefinitely.

If a recipient meets the criteria listed above, then he or she may be eligible for services if the following criteria are met:

- Current recipient or is eligible for Supplemental Security Income (SSI);
- Has an intellectual disability, an Intelligence Quotient (IQ) of 70 or lower (+/- 5 points), and has adaptive scoring of 70 or below (+/- 5 points); or
- Has a related condition (e.g., Autism, Cerebral Palsy, Epilepsy, Down Syndrome, etc.) and an Intelligence Quotient (IQ) of 70 or lower (+/- 5 points), or has adaptive scoring of 70 or below (+/- 5 points)

Participation in Medicaid as a provider of ICF/IID services is limited to facilities which accept Medicaid reimbursement as payment in full for the covered services.

Determining Level of Care

Determination of the need for ICF/IID services requires an initial level of care and annual redetermination. A recipient is in need of ICF/IID services if the Inventory for Client and Agency Planning (ICAP) completed indicates that the recipient has a substantial functional limitation in three or more of the following functional areas:

- Self-care: The daily activities enabling a person to meet basic life needs for food, hygiene, and appearance;
- Receptive and expressive language: Communication involving verbal and nonverbal behavior that enables a person to understand others and to express ideas and information to others;
- Learning/general cognitive competence: The ability to acquire new behaviors, perceptions, and information and to apply the experiences to new situations;
- Mobility: The ability to use fine or gross motor skills to move from one place to another with or without mechanical aids;
- Self-direction: The management of one's social and personal life; the ability to make decisions affecting and protecting one's self-interests;
- Capacity for independent living: Based on age, the ability to live without extraordinary assistance; and
- Economic self-sufficiency: The maintenance of financial support.

The utilization review team must annually redetermine that the recipient continues to need ICF/IID services for the individual to continue to remain eligible for services.

COVERED SERVICES AND LIMITS

General Coverage Principles

Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary; and
- The recipient must be eligible.

The manual also includes non-discrimination requirements providers must abide by.

Routine Services for Non-State Operated ICFs

South Dakota Medicaid considers the following items and services to be routine services that are included in the facility's reimbursement and must be provided to a recipient residing in an ICF as needed:

- All general nursing services including administration of oxygen and medications, hand-feeding, incontinent care, tray service, normal personal hygiene which includes bathing, skin care, hair care, nail care, shaving, and oral hygiene, enema, etc.;
- Items which are furnished routinely and relatively uniformly to all residents, such as resident gowns, water pitchers, bedpans, etc.;
- Items stocked at nursing stations or on the floor in gross supply and distributed or utilized individually or in small quantities, such as alcohol, cotton applicators, cotton balls, Band-Aids, linen savers, colostomy supplies, catheters and bags, irrigation equipment, needles, syringes, I.V. equipment, T.E.D. hose, hydrogen peroxide, over-the-counter enemas, tongue depressors, facial tissue, personal hygiene items (soap, lotion, powder, shampoo, deodorant, toothbrushes, toothpaste, denture cups and cleaner, mouthwash, peri-care products, etc.);
- Items which are utilized by individual residents but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, alternating pressure pad and pump, other durable medical equipment (excluding customized medically necessary equipment), etc.;
- Social Services and activities including supplies for these services;
- At least 3 meals a day planned from the basic food groups in quantity and variety to provide the medically prescribed diets. This includes special oral, enteral, or parenteral dietary supplements used for meal or nourishment supplementation, even if written as prescription item by a physician. These supplements have been classified by the FDA as a food rather than a drug;
- Laundry services;
- Active treatment services for developmentally disabled residents;
- Therapy services;
- Transportation services necessary to meet the medical and activity needs of the residents exclusive of ambulance services and specialized wheelchair transportation services;
- Oxygen and equipment necessary for the administration of oxygen (concentrators, regulators, tubing, masks, tents, etc.); and
- Mental health services.

Routine Services for State-Operated ICFs

South Dakota Medicaid considers the following items and services to be routine services that are included in the facility's reimbursement and must be provided to a recipient residing in a state-operated ICF as needed:

- Room and board;
- Nursing services;
- Nursing supplies;
- Therapy services;
- Habilitation services;
- Oxygen;
- Medical equipment;
- Catheters and bags;
- Special bed pads;
- Supplies for incontinency;
- Laundry of personal clothing; and
- All costs reflected on required accounting reports.

Non-Covered Services

General Non-Covered Services

Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Routine Services

Services that are listed as routine services are not separately reimbursable.

Documentation Requirements

General Requirements

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Reimbursement and Claim Instructions

Timely Filing

South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability

Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort, meaning Medicaid only pays for a service if there are no other liable third-party payers. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement for Non-State Operated ICFs

Payment for services to a participating ICF provider are determined by the Department of Human Services (DHS) based on reasonable costs. Allowable per diem rates are established prior to July 1 for each facility based on financial reports. The per diem rate is paid for each eligible Medicaid resident in a facility for resident days only. Resident days include the day of admission but exclude the day of discharge.

School Districts

School Districts are responsible for paying tuition costs. The tuition cost is typically only facility-based day service and must be paid directly from the school to the provider. Medicaid does not cover any tuition costs. Schools are also responsible for paying the non-federal portion of the children's claims. The school district must mail a check for the non-federal match to DHS. Once DHS verifies the amount is correct, DHS releases the claim to pay the provider.

Children's Auxiliary Placement Program

If a child is in auxiliary placement program with the Department of Social Services (DSS), it is DSS's responsibility to pay the tuition amount. The tuition cost is typically only a facility-based day service and must be paid directly from DSS to the provider.

Provisional Per Diem

The DHS establishes provisional per diem rates for newly constructed or expanded facilities. These facilities must submit their estimates of projected costs to DHS 30 days prior to entering into any contract negotiations with DHS. Provisional per diem rates are effective for up to 24 months. Rates may be adjusted based on actual costs after the initial provisional period.

Reserved Bed Days

Payments are made on behalf of an eligible recipient when it is necessary to reserve a recipient's bed during a temporary absence from an ICF. Payment is limited to a maximum of five days when the absence is due to an admission to a general hospital for an acute condition and/or therapeutic home visits when the absence has been documented in the recipient's plan of care.

Reimbursement for State-Operated ICFs

Payment to a participating state-operated ICF shall be determined by the DHS based on a uniform report generated by the State's accounting system including costs allocated to each facility under the federally-approved statewide cost allocation plan. Allowable per diem rates will be established prior to July 1 each year for each facility based on financial reports. The per diem rate is paid for each eligible

Medicaid resident in a facility for resident days only. Resident days include the day of admission but exclude the day of discharge.

Provisional Per Diem

A provisional per diem rate shall be established for the first quarter of each State fiscal year based upon each facility's operating budget and projected resident population. Provisional per diem rates shall be established for the second, third, and fourth quarters of each State fiscal year based upon actual allowable visit and actual physical resident days for the previous quarter. Allowances may be made for known further costs not incurred in the previous quarter if those costs will be incurred prior to the end of the subsequent quarter. Following the end of each quarter, the Department of Human Services shall re-calculate the Medicaid rate from the reports submitted. This rate shall be compared to the provisional rate paid for that quarter, and a financial adjustment shall be made to adjust for any over or underpayment.

Required Financial Report

A uniform report generated by the State's accounting system must be submitted to the DHS within 30 days following the close of each facility's calendar quarter. The following criteria apply to all reports:

- Reports must be completed in accordance with accounting procedures established by the State of South Dakota.
- Reports shall include costs allocated to each facility under the federally-approved statewide cost allocation plan.
- Reports must include DHS's administrative support costs allocated to each facility in accordance with that department's annual cost allocation plan submitted to and approved by the federal Department of Health and Human Services.

Reserved Bed Days

The State will not pay for reserve bed days in State institutions.

Reimbursement for Out-of-Sate Facilities

The reimbursement rate for out-of-state facilities providing ICF/IID services to Medicaid recipients of the State of South Dakota is the lesser of the Medicaid rate established by the state in which the facilities are located or the average Medicaid rate for the bed size and type of service level applicable to in-state facilities.

DEFINITIONS

1. "Active Treatment," refers to aggressive, consistent implementation of a program of specialized and generic training, treatment, and health services. Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program;

2. "Assessment," refers to the process of identifying an individual's specific strengths, developmental needs and need for services. This should include identification of the individual's present developmental level and health status and where possible, the cause of the disability;

the expressed needs and desires of the individual and his or her family; and the environmental conditions that would facilitate or impede the individual's growth, development and performance;

3. "Auxiliary placement program," the program that reimburses educational expenses for eligible youth in residential placement;

4. “Developmental Disability,” any severe, chronic disability of a person that:
   a. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
   b. Is manifested before the person attains the age of twenty-two;
   c. Is likely to continue indefinitely;
   d. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and
   e. Reflects the person's need for an array of generic services, met through a system of individualized planning and supports over an extended time, including those of a life-long duration;

5. “Institution,” means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor;

6. “Intellectual Disability,” a disability characterized by significant limitations in both intellectual functioning (intelligence quotient of 70 or below, +/-5 points) and in adaptive behavior, which covers many everyday social and practical skills originating before the age of 22;

7. “Utilization Review Team,” a team consisting of a physician, a registered nurse, and a qualified developmental disability professional as defined in SDCL 27B-1-17; and

8. “Utilization Review,” the utilization review team's assessment of the necessity for initial medical care and rehabilitation services and the periodic reassessment of the continued need for such care and services.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations