CHAPTER 81
NURSING FACILITIES

[Prior to 7/1/83 Social Services[770] Ch 81]
[Prior to 2/11/87, Human Services[498]]

DIVISION I
GENERAL POLICIES

441—81.1(249A) Definitions.

"Abuse" means any of the following which occurs as a result of the willful or negligent acts or omissions of a nursing facility employee:

1. Physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement or unreasonable punishment or assault as defined in Iowa Code section 708.1 of a resident.
2. The commission of a sexual offense under Iowa Code chapter 709 or Iowa Code section 726.2 or 728.12, subsection 1, or sexual exploitation under Iowa Code chapter 235B, as a result of the acts or omissions of the facility employee responsible for the care of the resident with or against a resident.
3. Exploitation of a resident which means the act or process of taking unfair advantage of a resident or the resident's physical or financial resources for one's own personal or pecuniary profit without the informed consent of the resident, including theft, by the use of undue influence, harassment, duress, deception, false representation or false pretenses.
4. The deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care, or other care necessary to maintain a resident's life or health.

"Advance directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the resident is incapacitated.

"Beginning eligibility date" means date of an individual's admission to the facility or date of eligibility for medical assistance, whichever is the later date.

"Case-mix add-on" means additional Medicaid reimbursement based on the acuity and care need level of residents of a nursing facility.

"Civil penalty" shall mean a civil money penalty not to exceed the amount authorized under Iowa Code section 135C.36 for health care facility violations.

"Clinical experience" means application or learned skills for direct resident care in a nursing facility.

"Denial of critical care" is a pattern of care in which the resident's basic needs are denied or ignored to such an extent that there is imminent or potential danger of the resident suffering injury or death, or is a denial of, or a failure to provide the mental health care necessary to adequately treat the resident's serious social maladjustment, or is a gross failure of the facility employee to meet the emotional needs of the resident necessary for normal functioning, or is a failure of the facility employee to provide for the proper supervision of the resident.

"Department" means the Iowa department of human services.

"Department's accounting firm" means the firm on contract with the department to calculate nursing facility rates and provide other accounting services as requested. The current accounting firm is Ryun, Givens, Wenthe & Company, 1601 48th Street, Suite 150, West Des Moines, Iowa 50266-6756.

"Department's fiscal agent" means the firm on contract with the department to enroll providers, process Medicaid claims, calculate skilled nursing facility rates, and perform other related functions. The current fiscal agent is Consultec, 7755 Office Park Drive, West Des Moines, Iowa 50266.

"Discharged resident" means a resident whose accounts and records have been closed out and whose personal effects have been taken from the facility. When a resident is discharged, the facility shall notify the department via Form 470-0042, Case Activity Report.

"Facility" means a licensed nursing facility certified in accordance with the provisions of 42 CFR Part 483, as amended to September 23, 1992, to provide health services and includes skilled nursing facilities and swing-bed hospitals providing care unless stated otherwise.

"Facility-based" means a nurse aide training program which is offered by a nursing facility and taught by facility employees or under the control of the licensee.

"Informed consent" means a resident's agreement to allow something to happen that is based on a full disclosure of known facts and circumstances needed to make the decision intelligently, i.e., with knowledge of the risks involved or alternatives.

"Iowa Foundation for Medical Care (IFMC)" is the peer review organization on contract with the department to provide level of care determinations. The address of IFMC is 6000 Westown Parkway, West Des Moines, Iowa 50266.

"Laboratory experience" means practicing care-giving skills prior to contact in the clinical setting.

"Minimum data set" or *"MDS"* refers to a federally required resident assessment tool. Information from the MDS is used by the federal Health Care Financing Administration to determine the facility's case-mix index for purposes of the case-mix add-on provided by paragraph 81.6(16)*"f."* MDS is described in subrule 81.13(9).

"Minimum food, shelter, clothing, supervision, physical or mental health care, or other care" means that food, shelter, clothing, supervision, physical or mental health care, or other care which, if not provided, would constitute denial of critical care.

"Mistreatment" means any intentional act, or threat of an act, coupled with the apparent ability to execute the act, which causes or puts another person in fear of mental anguish, humiliation, deprivation or physical contact which is or will be painful, insulting or offensive. Actions utilized in providing necessary treatment or care in accordance with accepted standards of practice are not considered mistreatment.

"Non-facility-based" means a nurse aide training program which is offered by an organization which is not licensed to provide nursing facility services.

"Nurse aide" means any individual who is not a licensed health professional or volunteer providing nursing or nursing-related services to residents in a nursing facility.

"Nurse aide registry" means Nurse Aide Registry, Department of Inspections and Appeals, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

"Nurse aide training and competency evaluation programs (NATCEP)" are educational programs approved by the department of inspections and appeals for nurse aide training as designated in subrule 81.16(3).

"Physical abuse" means any nonaccidental physical injury, or injury which is at variance with the history given of it, suffered by a resident as the result of the acts or omissions of a person responsible for the care of the resident.

"Physical injury" means damage to any bodily tissue to the extent that the tissue must undergo a healing process in order to be restored to a sound and healthy condition, or damage to any bodily tissue to the extent that the tissue cannot be restored to a sound and healthy condition, or damage to any bodily tissue which results in the death of the person who has sustained the damage.

"Poor performing facility (PPF)" is a facility designated by the department of inspections and appeals as a poor performing facility (PPF) based on surveys conducted by the department of inspections and appeals pursuant to subrule 81.13(1). A facility shall be designated a PPF if it has been cited for substandard quality of care on the current standard survey and it:

1. Has been cited for substandard quality of care or immediate jeopardy on at least one of the previous two standard surveys;
2. Has a history of substantiated complaints during the last two years;
3. Has a current deficiency for not having a quality assurance program; or
4. Does not have an effective quality assurance program as defined in paragraph 81.13(19)*"o."*

"Primary instructor" means a registered nurse responsible for teaching a state-approved nurse aide training course.

"Program coordinator" means a registered nurse responsible for administrative aspects of a state-approved nurse aide training course.

"Skills performance record" means a record of major duties and skills taught which consists of, at a minimum:

1. A listing of the duties and skills expected to be learned in the program.
2. Space to record the date when the aide performs the duty or skill.
3. Space to note satisfactory or unsatisfactory performance.
4. The signature of the instructor supervising the performance.

"Terminated from the Medicare or Medicaid program" means a facility has lost the final appeal to which it is entitled.

"Testing entity" means a person, agency, institution, or facility approved by the department of inspections and appeals to take responsibility for obtaining, keeping secure and administering the competency test and reporting nurse aide scores to the nurse aide registry.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)*"a,"* and 249A.4.

441—81.2 Rescinded, effective 11/21/79.

441—81.3(249A) Initial approval for nursing facility care.

81.3(1) *Need for nursing facility care.* Residents of nursing facilities must be in need of either nursing facility care or skilled nursing care. Payment will be made for nursing facility care residents only upon certification of the need for the level of care by a licensed physician of medicine or osteopathy and approval of the level of care by the department. Initial decisions on level of care shall be made for the department by the Iowa Foundation for Medical Care (IFMC) within two working days of receipt of medical information. After notice of an adverse decision by IFMC, the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician, or the nursing facility may request reconsideration by IFMC by sending a letter requesting a review to IFMC not more than 60 days after the date of the notice of adverse decision. On initial and reconsideration decisions, IFMC determines whether the level of care provided or to be provided should be approved based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2). Adverse decisions by IFMC on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, IFMC will complete its reconsidered determination and send written notice including appeal rights to the Medicaid applicant or recipient, the applicant's or recipient's representative, the attending physician or the facility provider within the following time limits:

(1) Within three working days after IFMC receives the request for reconsideration and a copy of the medical record, if the initial determination was made before the Medicaid applicant or recipient was admitted to the nursing facility.

(2) Within ten working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made and is still in the nursing facility when the request for reconsideration is received.

(3) Within 30 working days after IFMC receives the request for reconsideration and a copy of the medical record, if the Medicaid applicant or recipient was admitted to the nursing facility when the initial determination was made but is no longer in the nursing facility when the request for reconsideration is received.

b. If a copy of the medical record is not submitted with the reconsideration request, IFMC shall request a copy from the facility within two working days.

c. Written notice of the IFMC reconsidered determination shall contain the following:

(1) The basis for the reconsidered determination.

(2) A detailed rationale for the reconsidered determination.

(3) A statement explaining the Medicaid payment consequences of the reconsidered determination.

(4) A statement informing the parties of their appeal rights, including the information that must be included in the request for an administrative hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to IFMC within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this subrule will be treated as an overpayment to be repaid to the department.

81.3(2) *Skilled nursing care level of need.* Payment will be approved for skilled nursing care in Medicare-certified beds under the same conditions as the Medicare program in nursing facilities. Nursing facilities which are Medicare-certified as skilled nursing facilities are eligible for skilled level payment for care provided to Medicaid recipients who require skilled nursing care.

Nursing facilities providing skilled nursing care which serve a disproportionate share of Medicaid recipients who are not Medicare-eligible shall be eligible for Medicaid skilled level payment and are not required to be Medicare-certified. These facilities must meet Medicare-certification requirements. In-state facilities must be certified as meeting Medicare requirements by the department of inspections and appeals. Out-of-state facilities must also be enrolled Medicaid providers in their state.

In order for a nursing facility to be eligible for Medicaid skilled level payment, the facility must be certified for participation in the Medicare skilled nursing program, the resident must require skilled level care, and, if applicable, Medicare care benefits must be exhausted.

a. Exceptions to the Medicare policies are as follows:

(1) Medicaid does not limit the number of days in skilled care as long as the services are medically necessary.

(2) Medicaid does not require that the person be previously hospitalized.

(3) Respite care for recipients eligible for the home and community-based services program. (See 441—Chapter 83.)

(4) Payments may be allowed with advance approval for a facility to reserve a bed for a resident while the resident is absent overnight for home visits or for participation in special social or rehabilitation programs. Approval shall be received prior to the absence and shall be requested by sending a letter to the Iowa Foundation for Medical Care giving the purpose for the absence and stating that the following conditions are met:

1. The resident or the resident's representative chooses to have the resident leave the facility for this purpose.
2. The family members or agency responsible for providing the alternative care can and will provide the care and make no charges to the department for the care.
3. The absence is approved in the physician's plan of care.
4. The facility provides the usual medical equipment and supplies needed by the resident.

Periods of paid absence from a skilled nursing facility shall not exceed 10 consecutive calendar days at a time with a maximum of 18 days in a calendar year and shall be available only after a resident has required care in a nursing facility or a skilled nursing facility for at least three consecutive months. Payments for periods of approved absence shall be made at 75 percent of the regular Medicaid rate.

(5) Payments may be allowed with approval prior to billing for a facility to reserve a bed for a resident while the resident is absent overnight for hospitalization if the resident has required care in a nursing facility or a skilled nursing facility for at least three consecutive months. Periods of paid absence from a skilled nursing facility shall not exceed ten days in any calendar month. Payment will not be authorized for over ten days for any continuous hospital stay whether or not the stay extends into a succeeding month or months. Payments for periods of approved absence shall be made at 75 percent of the regular Medicaid rate.

b. Nursing facilities providing skilled care in other states are also eligible for skilled level payment if the placement is approved by the department. Requests for payment shall be submitted to the Division of Medical Services, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114. Payment will be approved for out-of-state skilled nursing facility care when the following criteria are met:

(1) The facility is eligible to participate in the Iowa Medicaid program.

(2) The facility has been certified for Medicare and Medicaid participation by the state in which the facility is located.

(3) The placement is recommended because moving the resident back to Iowa would otherwise endanger the resident's health, services are not readily available in Iowa, or the out-of-state placement is cost-effective.

(4) The placement is temporary until services are available to the resident in Iowa or the program of treatment is completed.

81.3(3) *Screening.* All persons, regardless of the source of payment, seeking admission to a nursing facility shall also be screened by the Iowa Foundation for Medical Care to determine if mental illness, mental retardation, or a related condition is present. The Iowa Medicaid program will cover the cost of this screening through the managed mental health contractor.

Final approval for initial admissions and continued stay of persons with mental illness, mental retardation, or a related condition is determined by the department of human services, division of mental health, mental retardation and developmental disabilities.

Nursing facility payment under the Iowa Medicaid program will be made for persons with mental illness, mental retardation, or a related condition only if it is determined by the division of mental health, mental retardation and developmental disabilities that the person's treatment needs will be or are being met.

81.3(4) *Special care level of need.* Rescinded IAB 3/20/91, effective 3/1/91.

This rule is intended to implement Iowa Code sections 249A.2(6), 249A.3(2)"*a*" and 249A.4.

441—81.4(249A) Arrangements with residents.

81.4(1) *Resident care agreement.* Rescinded IAB 12/6/95, effective 2/1/96.

81.4(2) *Financial participation by resident.* A resident's payment for care may include any voluntary payments made by family members toward cost of care of the resident. The resident's client participation and medical payments from a third party shall be paid toward the total cost of care for the month before any state payment is made. The state will pay the balance of the cost of care for the remainder of the month. The facility shall make arrangements directly with the resident for payment of client participation.