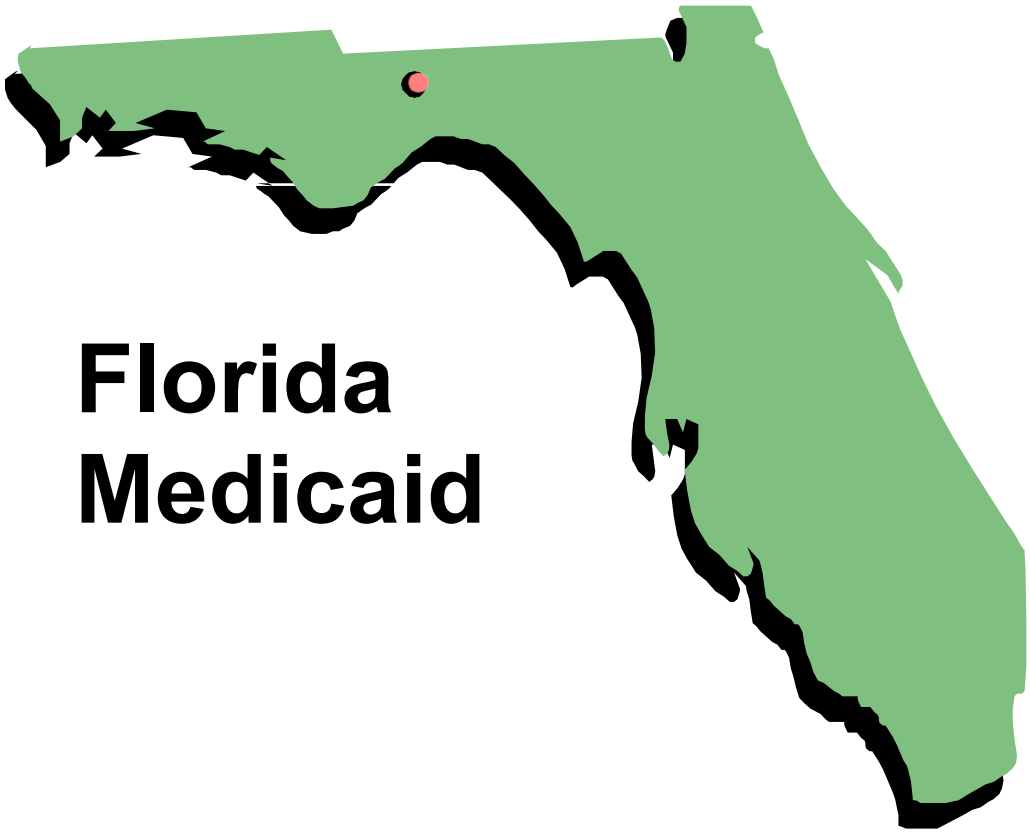

Florida Medicaid

Intermediate Care Facility for Individuals with Intellectual Disabilities Services Coverage Policy

Agency for Health Care Administration

January 2023

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1.0 Introduction

1.1 Description

Intermediate care facility for individuals with intellectual disabilities services (ICF/IID) provide 24-hour medical, habilitative, and health-related services to recipients diagnosed with an intellectual disability or related condition.

1.1.1 Florida Medicaid Policies

This policy is intended for use by ICF/IID providers that render services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Florida Medicaid fiscal agent's Web site at http://portal.flmmis.com/flpublic.

1.1.2 Statewide Medicaid Managed Care Plans

This is not a covered service in the Statewide Medicaid Managed Care program.

1.2 Legal Authority

Intermediate care facility for individuals with intellectual disabilities services are authorized by the following:

- Title 42, Code of Federal Regulations (CFR), Parts 442 and 483
- Section 409.906, Florida Statutes (F.S.)

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Continued Stay Review

An assessment to determine the appropriateness of continuing ICF/IID services.

1.3.3 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.4 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.5 Institutional Care Program

The Institutional Care Program (ICP) is an eligibility category that covers individuals who meet the eligibility requirements for Florida Medicaid services in a skilled nursing facility or swing bed, ICF/IID, state mental health hospital, or hospice.

1.3.6 Leave Days

When a recipient leaves the facility overnight for hospitalization or therapeutic leave.

1.3.7 Level of Need

A determination by the Agency for Persons with Disabilities (APD) that an individual who has an intellectual disability as defined in Chapter 393, F.S. requires treatment in an ICF/IID.

1.3.8 Levels of Reimbursement

A method developed by APD to assess and classify recipient service needs while the recipient is residing in an ICF/IDD, as follows:

- One: A reimbursement level for recipients who are ambulatory or self-mobile using mechanical devices and who are able to transfer themselves without

human assistance but may require assistance and oversight to ensure safe evacuation.
- Two: A reimbursement level for recipients who are capable of mobility with human assistance or require human assistance to transfer to or from a mobility device, or who require continuous medical and nursing supervision.
- Three: A reimbursement level for recipients with severe maladaptive behaviors, severe maladaptive behaviors and co-occurring complex medical conditions, or a dual diagnosis of developmental disability and mental illness.

1.3.9 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.3.10 Provider
The term used to describe any entity, facility, person, or group that is enrolled to furnish services under the Florida Medicaid Program.

1.3.11 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

1.3.12 Utilization Review
A process to determine if ICF/IID services are of the quality and cost to meet professionally recognized standards of health care for recipients.

1.3.13 Therapeutic Leave
A non-medical visit outside the facility used for overnight visits with family or friends.

2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary ICF/IID services who:

- Have a level of need and level of reimbursement determined by APD in the last six months.
- Meet the requirements for the ICP

Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible
There is no coinsurance, copayment, or deductible for this service.

2.4 Patient Responsibility
Providers may not change a recipient's patient responsibility without approval from the Department of Children and Families (DCF).

3.0 Eligible Provider

3.1 General Criteria
To be reimbursed for services rendered to eligible recipients, providers must be directly enrolled with Florida Medicaid.

3.2 Who Can Provide
Intermediate care facilities for individuals with intellectual disabilities licensed in accordance with Chapter 400, Part VIII, F.S., and that are compliant with section 393.0655, F.S.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for 365/6 days of ICF/IID services per year, per recipient, when the following are completed in accordance with 42 CFR 483.440:

- Preliminary evaluation
- Comprehensive functional assessment
- Individual program plan
- Behavioral service need assessment

Providers must provide or arrange for the provision of the necessary care and services required for each recipient to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with 42 CFR 483, Subpart I. Services include the following:

- Activity services
- Dental services
- Dietary services (including therapeutic diets)
- Nursing services
- Pharmacy services
- Physician services
- Rehabilitative services (including physical, speech, occupational, mental health therapies, and intensive behavioral therapy, as applicable)
- Room/bed and maintenance services
- Routine personal hygiene items
- Social services

4.2.1 Leave Days

Florida Medicaid reimburses for leave days when the recipient is expected to return to the facility, as follows:

- Hospitalization - 15 days per medically necessary hospital stay
- Therapeutic leave - 45 days per state fiscal year

Providers must notify recipients and their representatives of the leave policy, in writing, upon admission and upon a recipient leaving the facility due to a hospitalization or therapeutic leave.

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the Social Security Act, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0

- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- Services when a recipient is enrolled in a home and community-based services waiver
- Leave days once a facility receives notice that a recipient will not return to the facility

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Policy.

6.2 Specific Criteria

Providers must document services in accordance with Rule 59A-26, F.A.C.

Providers must maintain a completed Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Utilization Review (UR) Plan, AHCA Form 5000-3009, July 2016, incorporated by reference, and available at http://ahca.myflorida.com/Medicaid/review/index.shtml, in the recipient's file.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria

There are no specific authorization criteria for this service.

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Specific Criteria

8.2.1 Billing During Emergencies or Disasters

If a provider evacuates a recipient to another facility without discharging the recipient, the originating facility may continue to claim for reimbursement and must pay the receiving facility for its services.

8.3 Claim Type

Institutional (837I/UB-04)

8.4 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.5 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.6 Rate

Florida Medicaid reimburses ICF providers a per diem rate, per facility.

For per diem rates, see http://ahca.myflorida.com/medicaid/Finance/finance/index.shtml.

9.0 Appendix

9.1 Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Utilization Review (UR) Plan

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Utilization Review (UR) Plan

1. FACILITY IDENTIFICATION (To be completed and implemented by the listed ICF/IID (facility))

Facility Name**:**				
Physical Address-street	City:	State:	Zip:	County:
Facility Contact Person:		Contact Person's Title:		
Facility Contact Person's Telephone Number:	Fax Number:		Email Address:	
Mailing Address: (if different from physical address)- Street or P.O. Box		City:	State:	Zip:

2. ADMINISTRATIVE REQUIREMENTS

Utilization review and continued stay review will be performed by the UR committee no later than six months after admission, and every six months thereafter.

Utilization Review will be conducted using one of the following methods:

- On-site in the facility in which the individual being reviewed is receiving services
- Via a thorough record review at a location determined by the UR committee

Utilization review will be performed by a committee comprised of one physician who serves as chairperson for the UR committee and at least one other person knowledgeable in the treatment of intellectual disabilities or related conditions. The UR committee may not include individuals who meet any of the following criteria:

- Are directly responsible for the care of the recipient
- Are employed by the facility
- Have a financial interest in any facility

Member of UR committee who is a licensed physician. Name: Title:
Member of the UR committee who is knowledgeable in the treatment of intellectual disabilities or related conditions. Name: Title:

The facility is responsible for ensuring all pertinent information is in the recipient's record and is easily accessible to the UR committee when the review is performed on-site at the facility. For off-site reviews, the facility is responsible for preparing and availing any supporting documentation or additional information that may be needed or requested by the UR committee. Further, if the UR committee has any findings associated with its review that need to be addressed, the findings must be documented and discussed with the facility that is responsible for taking corrective action.

AHCA Form 5000-3009, July 2016, incorporated by reference in Rule 59G-4.170, F.A.C.

3. INFORMATION REQUIREMENTS

The following information, at a minimum, will be included in the recipient's record for review by the UR committee:

- Name of recipient
- Name of recipient's physician
- Name of qualified intellectual disabilities professional (QIDP)
- Date of admission and dates of application for Florida Medicaid, if after admission
- Plan of care
- Individualized Program Plan (IPP)
- Assessments/documentation/progress notes to support implementation of the IPP
- The reason and plan for continued stay, if continued stay is recommended.

4. CONFIDENTIALITY

The UR committee will comply with the Health Insurance Portability and Accountability Act to ensure the individual's information is kept confidential.

5. RECORDS MAINTENANCE

All decisions made by the UR committee must be documented. A copy of each recipient's utilization review and continued stay review will be maintained by the chairperson of the UR committee. Each recipient's original utilization review and continued stay review will be placed in his/her permanent record, by the facility administrative staff.

6. CONTINUED STAY CARE REQUIREMENT

The continued stay review will be conducted by the entire UR committee or its designee(s). At the time of admission, the UR committee will assign a specific date by which the continued stay review will be conducted.

The UR committee will assess the continued need for the recipient to receive active treatment. The following will be reviewed to make the determination for continued stay in the facility:

- The IPP to determine if it includes training objectives, behavioral interventions, plan of care, medical supports/treatments, therapeutic services and supports, etc.
- The comprehensive functional assessment supports the need of the services outline in the IPP.
- Data is available on objectives/interventions/supports identified as being medically necessary.
- Evidence of QIDP monitoring on all objectives/interventions/supports outlined in the IPP.
- Evidence the IPP is being revised when there is lack of progress on an intervention, or when new needs are identified, or when objectives are accomplished.
- The plan of care is current and health care needs are being monitored closely.
- The recipient is receiving specialized medical care when medically necessary.
- Professional staff is involved in the recipient's care when medically necessary, i.e. dietitian, therapists. etc.

If continued stay is medically necessary, but there are findings that need to be addressed, the UR committee will document those findings and review them with the facility that is responsible for coordinating appropriate corrective action. The UR committee will assign a new continued stay review date.

If the UR committee determines that continued stay is not medically necessary, it will notify the attending physician or the QIDP within one working day of the finding. The attending physician or QIDP has two working days from the notification to provide additional information before the UR committee makes a final decision regarding continued stay.
If upon review of the additional information, continued stay is determined to be medically necessary, the UR committee will document its recommendation and plan for continued stay and assign a new continued stay review date.

If additional information is not received, or upon review of the additional information, continued stay is determined not to be medically necessary, the decision is final. Notification of final adverse decisions will be given in writing and sent to the facility administrator, the attending physician, the QIDP, Agency for Health Care Administration, the recipient, and his or her family or guardian. The notice will be issued within two days of the final adverse decision.

ADMINISTRATOR COMPLETING UTILIZATION REVIEW PLAN

Name of Qualified Health Professional	Title
Signature	Date

*The Agency for Persons with Disabilities is responsible to conduct the recipient level utilization review and continued stay review.