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LONG TERM CARE

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Chapter 10 Long Term Care

Rule No. 560-X-10-.01. Definitions

(1) Nursing Facility - An institution which is primarily engaged in providing nursing care and related services for residents who require medical and nursing care, rehabilitation services for the rehabilitation of injured, disabled or sick persons, or on a regular basis health related care and services to individuals who because of their mental or physical condition require care and services which may be made available to them only through institutional facilities. A facility may not include any institution that is for the care and treatment of mental disease except for services furnished to individuals age 65 and over.

(2) Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) - An institution that is primarily for the diagnosis, treatment or rehabilitation of the intellectually disabled or persons with related conditions and provides in a protected residential setting, ongoing evaluations, planning, 24 hour supervision, coordination and integration of health or rehabilitative services to help each individual function at their greatest ability.

(3) Institution for Mental Disease (IMD) –
(a) An institution that is licensed as a mental institution; or
(b) More than fifty percent (50%) of the patients are receiving care because of disability in functioning resulting from a mental disease. Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and Statistical Manual of Mental Disorders, Current Edition, International Classification of Diseases, adopted for use in the United States (ICD 9) or its successors, except for intellectual disability.

Author: Robin Arrington, Associate Director, LTC Provider Recipient/Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 431.1, et seq., Section 483.5 and Section 435.1009.

History: Rule effective October 1, 1982. Rule amended December 18, 1986. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.02 Long Term Care Program – General

(1) The Medical Assistance (Title XIX) Plan for Alabama provides for medically necessary nursing facility services, rendered in a facility which meet the licensure requirements of the Department of Public Health and the certification requirements of Title XIX and XVIII of the Social Security Act and complies with all other applicable state and federal laws and regulations and with accepted professional standards and principles that apply to professionals providing services.

(2) Nursing facilities must be administered in a manner that enables them to use their resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(3) Nursing facilities must comply with Title VI of the Civil Rights Act of 1964, the Federal Age Discrimination Act, Section 504 of the Rehabilitation Act of 1973 and with the Disabilities Act of 1990.

(4) Nursing facilities must maintain identical policies and practices regarding transfer, discharge and covered services for all residents regardless of source of payment.

(5) Nursing facilities must have all beds in operation certified for Medicaid participation.

(6) Nursing facilities must be certified for Medicare Title XVIII as a condition of participation in the Alabama Medicaid Program.

(7) For nursing facilities participating in Medicaid two agreements must be made by representatives of the nursing facilities. These agreements outline the methods by which nursing facility care is rendered to Medicaid patients. These two documents are entitled Provider Agreement and Nursing Facility/Resident Agreement.

(a) The Provider Agreement is executed between the nursing facility and the Alabama Medicaid Agency and details the requirements imposed on each party to the agreement. It is also the document which requires the execution of the Nursing Facility/Resident Agreement.

(b) The Nursing Facility/Resident Agreement is executed between the nursing facility representative and the patient or his personal representative and details the requirements imposed on each party to the agreement. This agreement must be executed for each resident on admission and annually thereafter. If the liability amount changes for the resident or if there are policy changes, the agreement must be signed and dated as these changes occur. Two copies of the agreement will be prepared; one shall be given to the resident or personal representative and one shall be retained by the nursing facility.

(8) Nursing facilities shall accept as payment in full, those amounts paid for covered services in accordance with the State Plan.

(9) Nursing facilities must not require a third party guarantee of payment to the facility as a condition of admission, or expedited admission, or continued stay in the facility. Nursing facilities may require an individual who has legal access to a resident's income or resources available to pay for nursing facility care, to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(10) To the extent allowed by state law and the respective licensure boards, and pursuant to 42 C.F.R. § 483.40(f), for purposes of this chapter of the Administrative Code, any required physician task in a Nursing Facility may also be satisfied when performed by a nurse practitioner or physician assistant who is not employed by the facility but who is working in collaboration with a physician.

(11) Nothing in Paragraph 10 shall be interpreted to limit nurse practitioners or physician assistants employed by the facility from performing other medically necessary visits

and orders which are not considered the initial comprehensive visit or other required visits found in 42 C.F.R. Section 483.40.

Author: Robin Arrington, Administrator, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq., Section 483.75, Section 483.40.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003 **Amended:** Filed November 12, 2014; effective December 17, 2014.

Rule No. 560-X-10-.03 Enrollment and Participation

(1) All nursing facilities that desire to enroll and participate in the Alabama Title XIX Medicaid nursing facility program and to receive Medicaid payment for services provided for Medicaid residents must meet the following requirements:

(a) Possess certification for Medicare Title XVIII.

(b) Submit a budget to the Alabama Medicaid Agency Provider Reimbursement Division for the purpose of establishing a per diem rate.

(2) Execute a Provider Agreement with Medicaid.

(3) Execute a Nursing Facility/Resident Agreement with Medicaid residents.

Author: Dittra S. Graham, Administrator, LTC Program Management.

Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq., Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360).

History: Rule effective October 1, 1982. Rule amended June 16, 1989. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.04 Covered and Noncovered Services

(1) Services included in basic (covered) nursing facility charges.

(a) All nursing services to meet the total needs of the resident including treatment and administration of medications ordered by the physician.

(b) Personal services and supplies for the comfort and cleanliness of the resident. These include assistance with eating, dressing, toilet functions, baths, brushing teeth, combing hair, shaving and other services and supplies necessary to permit the resident to maintain a clean, well-kept personal appearance such as hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razors, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleanser, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, hair and nail hygiene services, bathing, basic personal laundry and incontinence care.

(c) Room (semiprivate or ward accommodations) and board, including special diets and tubal feeding necessary to provide proper nutrition. This service includes feeding residents unable to feed themselves.

(d) All services and supplies for incontinent residents, including linen savers and diapers.

(e) Bed and bath linens.

(f) Nursing and treatment supplies as ordered by the resident's physician or as required for quality nursing care. These include, but are not limited to, needles, syringes, catheters, catheter trays, drainage bags, indwelling catheters, enema bags, normal dressing, special dressings (such as ABD pads and pressure dressings), intravenous administration sets, and normal intravenous fluids (such as glucose, D5W, D10W).

(g) Safety and treatment equipment such as bed rails, standard walkers, standard wheelchairs, intravenous administration stands, suction apparatus, oxygen concentrators and other items generally provided by nursing facilities for the general use of all residents.

(h) Materials for prevention and treatment of bed sores.

(i) Medically necessary over-the-counter (non-legend) drug products ordered by a physician, with the exception of over-the-counter insulin covered under the Pharmacy program. Generic brands are required unless brand name is specified in writing by the attending physician.

(j) Laundry services of personal apparel.

(2) Special (noncovered) services not ordinarily included in basic nursing facility charges. These services, drugs, or supplies may be provided by the nursing facility or by arrangement with other vendors by mutual agreement between the resident, or their personal representative and the nursing facility.

(a) Prosthetic devices, splints, crutches, and traction apparatus for individual residents.

(b) If payment is not made by Medicare or Medicaid, the facility must inform the resident/personal representative that there will be a charge, and the amount of the charge. Listed below are general categories and examples of items:

1. Telephone;
2. Television/radio for personal use;
3. Personal comfort items, including smoking materials, notions and novelties, and confections;
4. Cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;
5. Personal clothing;
6. Personal reading matter;
7. Gifts purchased on behalf of a resident;
8. Flowers and plants;
9. Social events and entertainment offered outside the scope of the required activities program;
10. Noncovered special care services such as privately hired nurses or aides;

11. Private room, except when therapeutically required (for example: isolation for infection control).
 12. Specially prepared or alternative foods request instead of the food generally prepared by the facility;
 13. Beauty and barber services provided by professional barbers and beauticians.
 - (c) Services of licensed professional physical therapist.
 - (d) Routine dental services and supplies.
 - (e) Tanks of oxygen.
- (3) Other services are provided by Medicaid under separate programs, including prescription drugs as listed in the Alabama Drug Code Index, hospitalization, laboratory and x-ray services, and physician services.

Author: Laura Walcott, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 C.F.R. Section 401, et seq.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Effective date of this amendment February 13, 1991. Emergency rule effective September 6, 1991.

Amended: December 12, 1991 and April 14, 1994. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed April 20, 2005; effective July 15, 2005.

Rule No. 560-X-10-.05. Reservation of Beds

- (1) Payment for Reservation of Beds in Long Term Care Facilities.
 - (a) Neither Medicaid patients, nor their families, nor their sponsor, may be charged for reservation of a bed for the first four days of any period during which a Medicaid patient is temporarily absent due to admission to a hospital. Prior to discharge of the patient to the hospital, the patient, the family of the patient or the sponsor of the patient is responsible for making arrangements with the nursing home for the reservation of a bed and any costs associated with reserving a bed for the patient beyond the covered four day hospital stay reservation period. The covered four day hospital stay reservation policy does not apply to:
 1. Medicaid-eligible patients who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
 2. Any non-Medicaid patients;
 3. A patient who has applied for Medicaid but has not yet been approved; provided that if such a patient is later retroactively approved for Medicaid and the approval period includes some or all of the hospital stay, then the nursing home shall refund that portion of the bed hold reservation charge it actually received from the patient, family of the patient or sponsor of the patient for the period that would have been within the four covered days policy; or
 4. Medicaid patients who have received a notice of discharge for non-payment of service.

(2) Upon entering the hospital or the resident being placed on therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy. The bed-hold policy specifies when a resident is permitted to return and resume residence in the nursing facility.

(3) When a nursing facility is contacted by the hospital notifying them that the resident is ready for release, within the four day bed-hold period, the nursing facility must allow the resident to return to their facility before the bed-hold period expires provided the resident is an appropriate placement for nursing facility care and the nursing facility provides the type of services that meets the needs of the resident. The nursing facility must have documented verifiable evidence in the resident's medical record to indicate that there has been a significant change in the resident's condition, either prior to or during the hospital stay, making re-admission to the nursing facility inappropriate because the nursing facility can no longer meet the needs of the resident. When such a significant change in a resident's condition occurs prior to discharge to the hospital, the nursing facility should use reasonable efforts to begin to arrange for appropriate placement for the resident prior to transferring the resident to the hospital. If there is documented evidence in the medical record that the nursing facility is refusing to re-admit a resident without valid cause as determined by the Alabama Medicaid Agency, the Alabama Medicaid Agency shall notify the Division of Health Care Facilities, Alabama Department of Public Health, for appropriate enforcement action. If enforcement action ensues and results in program termination, any loss of nursing facility payment during the time that the nursing facility contract is terminated will not be considered a reimbursable Medicaid cost.

(4) A nursing facility or ICF/IID must establish and follow a written policy under which a resident who has been hospitalized or who exceeds therapeutic leave or bed-hold policy is readmitted to the facility immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

(5) Four day bed-hold. If a nursing facility refuses to take a resident back who has been released from the hospital during the four day bed-hold period, provided the resident is an appropriate placement for nursing facility care and the nursing facility provides the type of services capable of meeting the resident's needs, Medicaid may terminate the facility's provider agreement for failing to adhere to the rules set forth in the federal and state bed-hold policy until an acceptable plan of correction is received from the nursing facility. If the Alabama Medicaid Agency determines that the nursing facility has failed to follow the rules set forth in the federal and state bed-hold policies, the Alabama Medicaid Agency shall notify the Division of Health Care Facilities, Alabama Department of Public Health, for appropriate enforcement action. If enforcement action ensues and results in program termination, any loss of nursing facility payment during the time that the nursing facility contract is terminated will not be considered a reimbursable Medicaid cost.

Author: Robin Arrington, Associate Director, LTC Provider Recipient/Services Unit.

Statutory Authority: State Plan Attachment 4.19-C; Title XIX, Social Security Act; and 42 CFR Section 483.12.

History: Rule effective October 1, 1982. Amended October 1, 1990, and February 13, 1991. **Amended:** Filed July 20, 1999; effective October 12, 1999. **Amended:** Filed May 22, 2000; effective August 11, 2000. **Amended:** Filed December 17, 2001; effective March 15, 2002. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.06. Therapeutic Leave

(1) Payments to nursing facilities may be made for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter. A therapeutic leave visit may not exceed three days. Visits may not be combined to exceed the three day limit.

(2) Payments to ICF/IID facilities for therapeutic visits are limited to 14 days per calendar month.

(3) The nursing facility must ensure that each therapeutically indicated visit by a patient to home, relatives, or friends is authorized and certified by a physician.

(4) Medicaid shall not be responsible for the record keeping process involving therapeutic leave.

(5) A nursing facility must provide written notice to the resident and a family member or legal representative of the above specifying the Medicaid policy upon a resident taking therapeutic leave and at the time of transfer of a resident to a hospital.

Author: Robin Arrington, Associate Director, LTC Provider Recipient/ Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; and 42 CFR Section 401, et seq., Section 483.12.

History: New Rule: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-. 07 Review of Medicaid Residents

(1) The Alabama Medicaid Agency or its designated agent will perform a retrospective review of Medicaid nursing home or ICF/IID facility residents' records to determine appropriateness of admission.

(2) A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Division or its designee within ten working days from receipt of the series of faxed audit request letters shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Agency may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Agency with supporting documentation.

Author: Robin Arrington, Administrator, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401, et seq., Section 435.1009 and Section 456.1.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed August 21, 2006; effective December 13, 2006. **Amended:** Filed June 20, 2011; effective September 15, 2011. **Amended:** Filed November 9, 2012; effective December 14, 2012. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.08 Physician Certification

(1) A physician must perform the specific physician services required by state and federal law.

(2) A physician is defined in Section 1861R of the Social Security Act as a doctor of medicine or osteopathy legally authorized to practice medicine and surgery in the state in which he is performing services.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Section 1861R and Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 491.2.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.09 Reimbursement and Payment Limitations

(1) Reimbursement will be made in accordance with Chapter 22, Alabama Medicaid Administrative Code.

(2) Each nursing facility shall have a payment rate assigned by Medicaid. The patient's available monthly income minus an amount designated for personal maintenance (and in some cases amounts for needy dependents and health insurance premiums) is first applied against this payment rate and Medicaid then pays the balance.

(a) The nursing facility may bill the resident for services not included in the per diem rate (noncovered charges) as explained in this chapter.

(b) Actual payment to the facility for services rendered is made by the fiscal agent for Medicaid in accordance with the fiscal agent billing manual.

(3) Residents with Medicare Part A.

(a) Medicaid may pay the Part A coinsurance for the 21st through the 100th day for Medicare/Medicaid eligible recipients who qualify under Medicare rules for skilled level of care.

(b) An amount equal to that applicable to Medicare Part A coinsurance, but not greater than the facility's Medicaid rate will be paid for the 21st through the 100th day. No

payment will be made by Medicaid for nursing care in a nursing facility for the first 20 days of care for recipients qualified under Medicare rules.

(c) Nursing facilities must assure that Medicaid recipients eligible for Medicare Part A benefits first utilize Medicare benefits prior to accepting a Medicare/Medicaid recipient as a Medicaid resident.

(d) Residents who do not agree with adverse decisions regarding level of care determinations by Medicare should contact the Medicare fiscal intermediary.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 442.1, et seq., Section 431.151, et seq. and Section 481.1, et seq.

History: Rule effective October 1, 1982. Emergency rule effective July 22, 1988. Amended October 12, 1988. Emergency rule effective October 1, 1990. Amended February 13, 1991; March 13, 1992. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.10 Admission Criteria

(1) Guidelines for nursing facility admission criteria: The principal aspect of covered care relates to the care rendered. The controlling factor in determining whether a person is receiving covered care is the medical supervision that the resident requires. Nursing facility care provides physician and nursing services on a continuing basis. The nursing services are provided under the general supervision of a licensed registered nurse. An individual may be eligible for care under the following circumstances:

(a) The physician must state "I certify" need for admission and continuing stay.

(b) Nursing care is required on a daily basis.

(c) Nursing services are required that as a practical matter can only be provided in a nursing facility on an inpatient basis.

(d) Nursing service must be furnished by or under the supervision of a RN and under the general direction of a physician.

(2) Listed below, but not limited to, are specific services that a resident requires on a regular basis: (Resident must meet at least two criteria for initial admissions.)

(a) Administration of a potent and dangerous injectable medication and intravenous medications and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.

(b) Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis.

(c) Nasopharyngeal aspiration required for the maintenance of a clear airway.

(d) Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.

(e) Administration of tube feedings by naso-gastric tube.

(f) Care of extensive pressure ulcers or other widespread skin disorders.

- (g) Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.
- (h) Use of oxygen on a regular or continuing basis.
- (i) Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, post operative, or chronic conditions.
- (j) Comatose patient receiving routine medical treatment.
- (k) Assistance with at least one of the activities of daily living below on an ongoing basis:

1. Transfer- The individual is incapable of transfer to and from bed, chair, or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).

2. Mobility - The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch, or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane, or other mobility aid shall not by itself be considered to meet this requirement.

3. Eating - The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up, and assistance in cutting up foods shall not be considered to meet this requirement.

4. Toileting - The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care, or indwelling catheter care on an ongoing basis (daily or multiple times per week).

5. Expressive and Receptive Communication - The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.

6. Orientation - The individual is disoriented to person (e.g., fails to remember own name, or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).

7. Medication Administration - The individual is not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual, and reassurance of the correct dose.

8. Behavior- The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing, or repetitive elopement attempts).

9. Skilled Nursing or Rehabilitative Services - The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration, or intensity than, for practical purposes, would be provided through a daily home health visit.

The above criteria should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional, or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.

Admission to a certified nursing facility still requires that the patient meet two or more criteria listed on Form 161 (a-k). As a result, an individual who meets one or more ADL deficits under (k) must also meet an additional criterion from the list (a-j). All applications for admission to a nursing facility must include supporting documentation.

Four exceptions are noted:

- Criterion (a) and Criterion (k) (7) are the same as they both involve medication administration. Only one may be used. Therefore, if an individual meets criterion (a), criterion (k) (7) may not be used as the second qualifying criterion.
- Criterion (g) and Criterion (k) (9) are the same as they both involve direction by a registered nurse. Only one may be used. Therefore, if an individual meets criterion (g), Criterion (k) (9) may not be used as the second qualifying criterion.
- Criterion (k) (3) cannot be used as a second criterion if used in conjunction with criterion (d) if the ONLY stoma (opening) is Gastrostomy or PEG tube.
- Criterion (k) (4) cannot be counted as a second criterion if used in conjunction with criterion (d) if used for colostomy, ileostomy, or urostomy.

(3) The above criteria will be applied to all initial admissions to a nursing facility with the exception of Medicaid residents who have had no break in institutional care since discharge from a nursing home and residents who are re-admitted in less than 30 days after discharge into the community. These residents need to meet only one of the above criteria in paragraph two, above.

(4) Individuals admitted to a nursing facility as a private pay resident in spend down status with no break in institutional care for more than 30 days and becomes financially eligible for Medicaid, must meet only one of the criteria to transfer from private pay to a Medicaid admission.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603 and P.L. 98-369; 42 C.F.R. 435.1009 and Section 456.1.

History: Rule effective October 1, 1982. Amended February 8, 1984 and December 6, 1984. Emergency rule effective October 1, 1990, Amended February 13, 1991, and August 12, 1993. Amended: Filed June 20, 2003; effective September 15, 2003. Amended: Filed September 20, 2011; effective September 15, 2011. Amended: Filed November 9, 2012; effective December 14, 2012.

Rule No. 560-X-10-11. Establishment of Medical Need

- (1) Application of Medicare Coverage:
 - (a) Nursing facility residents, either through age or disability, may be eligible for Medicare coverage up to 100 days.
 - (b) Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.
 - (c) Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

- (2) Periods of Entitlement.
 - (a) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.
 - (b) An exception to (a) above, is retroactive Medicaid coverage. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.
 - (c) For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the Clinical Services and Support Division, Medical & Quality Review Unit or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

- (3) The Medicaid Agency has delegated authority for the initial level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.
 - (a) The process to establish medical need includes medical and financial eligibility determination.
 1. The determination of level of care will be made by an RN of the nursing facility staff.
 2. Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.
 - (b) All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

1. New Admissions
 - (i) Admission and Evaluation Data (Form 161). The provider must maintain supporting documentation for the admission criteria required by Rule 560-X-10-.10 listed on the Form 161.
 - (ii) A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.
 - (iii) Records of PASRR evaluations and determinations including the Level I screening and Level I determination and Level II screening and Level II determination if applicable.

2. Readmissions
 - (i) Admission and Evaluation Data (Form 161).
 - (ii) Updated PASRR screening information for a significant change as required.

(c) All Medicaid certified ICF/IID nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

1. New Admissions
 - (i) Form XIX LTC-9 Admission and Evaluation Data (Form 161).
 - (ii) Records of PASRR evaluations and determinations including the Level I screening and Level I determination and Level II if applicable.

(d) All Medicaid certified ICF/ IID facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/IID level of care needs.

1. New Admissions
 - (i) A fully completed Medicaid Patient Status Notification (Form 199).
 - (ii) A fully completed ICF/IID Level of Care Evaluation for Institutional Care (Form 361).
 - (iii) The resident's physical history.
 - (iv) The resident's psychological history.
 - (v) The resident's interim rehabilitation plan.
 - (vi) A social evaluation of the resident.
2. Readmissions
 - (i) Medicaid Patient Status Notification (Form 199).
 - (ii) ICF/IID Admission and Evaluation Data (Form 361).
3. A total evaluation of the resident must be made before admission to the intermediate care facility or prior to authorize of payment. An interdisciplinary team of health professionals, which must include the resident's attending physician must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings; (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d)

mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the XIX LTC-9 (Form 161) on new admissions.

(e). All Medicaid certified nursing facilities will have a period of one year from the date of service in which to bill for services. There is no timeliness penalty for submission of information to establish service delivery dates.

(f). Authorization of eligibility by Medicaid physician:

1. For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Clinical Services & Support Division, Medical & Quality Review Unit. The nurse reviewer will review and assess the documentation submitted and make a determination based on the total condition of the applicant. If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency physician will approve or deny medical eligibility.

2. The Clinical Services & Support Division, Medical & Quality Review Unit will issue a notice of denial for applications which result in an adverse decision. This notice will include the applicant's right to an informal conference and/or a fair hearing.

3. The informal conference is a process which allows the recipient, sponsor, and/or provider the opportunity to present additional information to the Medicaid physician for a review.

4. If the review results in an adverse decision, the patient and/or sponsor will be advised of the patient's right to a fair hearing (See Chapter 3). If the reconsideration determination results in a favorable decision, the application will be processed.

(g). Authorization of level of care by nursing facility

1. The Alabama Medicaid Agency or its designee will conduct a retrospective review on a monthly basis of a 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

2. A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Clinical Services & Support Division, Medical & Quality Review Unit or its designee within ten working days from receipt of the faxed letter(s) requesting such documentation or additional information shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. The Clinical Services & Support Division, Medical & Quality Review Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.

3. The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

4. The Alabama Medicaid Agency may seek recoupment from the nursing facility for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for nursing facility care or Medicaid eligibility but for the certification of medical eligibility by the nursing facility.

(4) **Signature Requirement**

Unless otherwise specified, signatures (including handwritten, electronic and digital signatures) shall be provided in accordance with Rule 560-X-1-.18.

(5) Please see Chapter Sixty-Three regarding ventilator dependent and qualified tracheostomy care.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401.101-401.625, 42 CFR Section 435.900-435.1011, et seq.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Rule amended February 13, 1991, and August 14, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed August 21, 2006; effective December 13, 2006.

Amended: Filed September 20, 2011; effective September 15, 2011. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.12. Utilization Review for ICF/IID

(1) An ICF/IID must comply with the utilization review requirements contained in 42 C.F.R. §§456.350-456.438 (“Utilization Review Requirements”).

(2) Medicaid or its designee will conduct retrospective audits to ensure the facility complies with the Utilization Review Requirements. The ICF/IID must make available to Medicaid or its designee such documents, records, and other writings as are necessary to demonstrate compliance with the Utilization Review Requirements.

(3) If an ICF/IID fails to comply with the Utilization Review Requirements, Medicaid may take appropriate action, including but not limited to provider education, recoupment of the amount of payments made during the time which the ICF/IID did not comply with the Utilization Review Requirements, or denial of payments for the new admissions to the ICF/IID.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603; 42 C.F.R. Section 401, et seq.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Rule amended February 13, 1991, August 14, 1991, and January 14, 1994. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.13 Resident Medical Evaluation

(1) The admitting or attending physician must certify the necessity of admission of a resident to an intermediate care facility and make a comprehensive medical evaluation, as described in Rule No. 560-X-10-.11(3)(d)3. This evaluation will be maintained by the facility as part of the resident's permanent record.

(2) Each Medicaid resident in an intermediate care facility must have a written medical plan of care established by his physician and periodically reviewed and evaluated by the physician and other personnel involved in the individual's care.

(3) For nursing facilities, the resident must be seen by a physician at least once every 30 days for the first 90 days from admission, and at least once every 60 days thereafter.

(4) The physician's care plan must include:

- (a) Diagnosis.
- (b) Symptoms and treatments.
- (c) Complaints.
- (d) Activities.
- (e) Functional level.
- (f) Dietary.
- (g) Medications.
- (h) Plans for continuing care and discharge as appropriate.
- (i) Social services.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit

Statutory Authority: State Plan; Title XIX, Social Security Act; P.L. 92-603; 42 C.F.R. Section 401, et seq.

History: New Rule Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.14 Resident Rights

The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident, specified in 42 CFR 483.10.

(1) Exercise of rights.

(a) The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(b) The resident has the right to be free of interference, coercion, discrimination, or reprisal from the facility in exercising his or her rights.

(c) In the case of a resident adjudged incompetent by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.

(2) Notice of rights and services.

(a) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations

governing resident conduct and responsibilities during the stay in the facility. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

(b) The resident has the right to inspect and purchase photocopies of all records pertaining to the resident, upon written request and 48 hours' notice to the facility.

(c) The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.

(d) The resident has the right to refuse treatment, and to refuse to participate in experimental research.

(e) The facility must:

1. Inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or when the resident becomes eligible for Medicaid, of:

(i) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged.

(ii) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and

2. Inform each resident when changes are made to the items and services specified in paragraphs (e)1.(i) and (ii) of this section.

(f) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicaid and Medicare.

(g) The facility must furnish a written description of legal rights which includes:

1. A description of the manner of protecting personal funds, under paragraph (3) of this section; and

2. A statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility.

(h) The facility must inform each resident of the name, specialty and way of contacting the physician responsible for his or her care.

(i) The facility must prominently display in the facility written information, and provide to residents and potential residents oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(j) Notification of changes.

1. Except in a medical emergency or when a resident is incompetent, a facility must consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within 24 hours when there is:

(i) An accident involving the resident which results in injury.

(ii) A significant change in the resident's physical, mental, or psychosocial status.

(iii) A need to alter treatment significantly; or
(iv) A decision to transfer or discharge the resident from the facility as specified in 42 C.F.R. Section 483.12(a).

2. The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is:

(i) A change in room or roommate assignment as specified in 42 C.F.R. Section 483.15(e)(2).

(ii) A change in resident rights under Federal or State law or regulations as specified in 42 C.F.R. Section 483.10(b)(1).

3. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

(3) Protection of resident funds.

(a) The resident has the right to manage his or her financial affairs and the facility may not require residents to deposit their personal funds with the facility.

(b) Management of personal funds. Upon written authorization of a resident, the facility must hold, safeguard, manage and account for the personal funds of the resident deposited with the facility, as specified below.

(c) Deposit of funds.

1. Funds in excess of \$50. The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on the resident's account to his or her account.

2. Funds less than \$50. The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account or petty cash fund.

(d) Accounting and records. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

1. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

2. The individual financial record must be available on request to the resident or his or her legal representative.

(e) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits:

1. When the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, as specified in Section 1611(a)(3)(B) of the Social Security Act; and

2. That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(f) Conveyance upon death. Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds and a final accounting of those funds, to the individual designated on the Administrator of Estate Designation Form. If no form has been completed or no administrator has been designated by the

probate court, the funds will be conveyed in accordance with Medicaid Administrative Code 560-X-22-.25(5)(e). Pursuant to 42 C.F.R. § 433.139, the Alabama Medicaid Agency is the payer of the last resort. Upon the death of a resident, the facility must determine if a credit balance exists on the facility's financial records and promptly convey the funds to the proper source.

(g) Assurance of financial security. The facility must purchase a surety bond, or provide self-insurance to assure the security of all personal funds of residents deposited with the facility.

(h) Limitation on charges to personal funds. The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare.

(i) Refer to Alabama Medicaid Administrative Code, Chapter 22 for further details.

(4) Free choice. The resident has the right to:

(a) Choose a personal attending physician.

(b) Be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being; and

(c) Unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, participate in planning care and treatment or changes in care and treatment.

(5) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

(a) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room.

(b) The resident may approve or refuse the release of personal and clinical records to any individual outside the facility, except that the resident's right to refuse release of personal and clinical records does not apply when:

1. The resident is transferred to another health care institution; or
2. Record release is required by law or third-party payment contract.

(6) Grievances. A resident has the right to:

(a) Voice grievances with respect to treatment or care that is or fails to be furnished, without discrimination or reprisal for voicing the grievances.

(b) Prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

(7) Examination of survey results. A resident has the right to:

(a) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The results must be posted by the facility in a place accessible to residents; and

(b) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.

(8) Work. The resident has the right to:

(a) Refuse to perform services for the facility.
(b) Perform services for the facility, if he or she chooses, when:
1. The facility has documented the need or desire for work in the plan of care;
2. The plan specifies the nature of the services performed and whether the services are voluntary or paid;
3. Compensation for paid services is at or above prevailing rates; and
4. The resident agrees to the work arrangement described in the plan of care.

(9) Mail. The resident has the right to privacy in written communications, including the right to:
(a) Send and receive mail promptly that is unopened; and
(b) Have access to stationery, postage and writing implements at the resident's own expense.

(10) Access and Visitation Rights.
(a) The resident has the right and the facility must provide immediate access to any resident by the following:
1. Any representative of the Department of Health and Human Services.
2. Any representative of the State.
3. The resident's individual physician.
4. The State long term care ombudsman (established under 307(a)(12) of the Older Americans Act of 1965).
5. The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act).
6. The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act).
7. Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
8. Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.
(b) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.
(c) The facility must allow representatives of the State Long Term Care Ombudsman, to examine a resident's clinical records with the permission of the resident or the resident's legal representative, and consistent with State law.

(11) Telephone. The resident has the right to have regular access to the private use of a telephone.

(12) Personal property. The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(13) Married couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

(14) Self-Administration of Drugs. Each resident has the right to self-administer drugs unless the interdisciplinary team, as defined by 42 C.F.R. Section 483.20(d)(2)(ii), has determined for each resident that this practice is unsafe.

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 442.311(A)-4 Section 405.1121 (K)-2 and Section 483.10. Omnibus Budget Reconciliation Act of 1987.

History: Rule effective October 1, 1982. Amended October 7, 1983; February 8, 1984; October 9, 1985; and May 10, 1988. Emergency rule effective January 1, 1990. Amended April 17, 1990. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed March 20, 2014; effective June 16, 2014. **Amended:** Filed January 9, 2015; effective February 13, 2015.

Rule No. 560-X-10-.15 Nursing Aide Training

(1) A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual as a nurse aide in the facility on or after October 1, 1990, for more than four (4) months unless the individual has completed a training and competency evaluation program, or a competency evaluation program, approved by the State and is competent to provide nursing or nursing related services.

(2) The Alabama Department of Public Health will be responsible for the certification of the Competency Evaluation programs and will establish and maintain a nurse aide registry.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq., Section 431, and Section 483. OBRA-87 Sections 4201(a) and 4211(a); OBRA-89 Section 6901(b).

History: Rule effective October 1, 1982. Amended September 8, 1983. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.16 Preadmission Screening and Resident Review

(1) Prior to admission, all individuals seeking admission into a nursing facility must be screened for suspected mental illness (MI), intellectual disability (ID), or a related condition (RC) to determine if the individual's care and treatment needs can most appropriately be met in the nursing facility or in some other setting.

(2) A Level I screening document (LTC-14) must be completed in its entirety and submitted to OBRA PASRR Office for a Level I Determination prior to admission. The Level I Screening can be completed by anyone who has access to the medical records excluding family members.

(3) The nursing facility is responsible for ensuring that the applicant is not admitted into the nursing facility without a Level I Screening, Level I Determination and Level II Determination, if applicable, from the Department of Mental Health. The nursing facility is responsible for ensuring that the Level I Determination is signed and dated by the RN indicating that the Level I Screening is accurate based on the available medical records.

(4) The Department of Mental Health is responsible for conducting a Level II Evaluation on all applicants and residents with a suspected diagnosis of MI/ID/RC to determine the individual's need for mental health specialized services and medical eligibility. For all residents with a primary or secondary diagnosis of MI/ID, the Department of Mental Health will make the determination of appropriate placement in a nursing facility, based on the results of the Level II Screening and the application of Medicaid medical criteria.

(5) If the nursing facility fails to obtain the Level I screening, Level I Determination and Level II Determination, if applicable, made by the Department of Mental Health prior to admitting the resident into their facility, the Alabama Medicaid Agency will recoup all Medicaid payments for nursing facility services from the date of the resident's admission and continuing until the Level I Determination or Level II Determination, if applicable, is received.

(6) If a resident is discharged into the community for more than 30 days, a new Level I Screening, Level I Determination, and Level II Determination, if applicable, is required before admission.

(7) If the nursing facility's interdisciplinary team identifies a significant change in the condition of a resident with a diagnosis of MI/ID/RC, an updated Level I Screening must be completed and submitted to the Department of Mental Health's PASRR Office within 14 days of the resident's status change to receive an updated Level II Determination to establish continued eligibility. If the nursing facility fails to update the Level I Screening for a significant change in a resident's condition, the Alabama Medicaid Agency may recoup all Medicaid payments for nursing facility services from 14 days of the resident's change in condition and continuing until the updated Level II Determination is received.

Author: Samantha McLeod, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 435.911.

History: Rule effective October 1, 1982. Amended February 8, 1984; October 9, 1985 and December 12, 1988. Emergency rule effective January 1, 1989. Amended April 14, 1989. Emergency rule effective June 1, 1989, and October 1, 1990. Amended February 13, 1991.

Amended: Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed September 21, 2009; effective December 23, 2009.

Rule No. 560-X-10-17 Medical Director

(1) The nursing facility shall retain, pursuant to a written agreement, a physician licensed under state law to practice medicine or osteopathy, to serve as medical director on a part-time or full time basis as is appropriate for the needs of the residents and the facility.

(a) If the facility has an organized medical staff, the medical director shall be designated by the medical staff with approval of the governing body.

(b) A medical director may be designated for a single facility or multiple facilities through arrangements with a group of physicians, a local medical society, a hospital medical staff, or through another similar arrangement.

(2) The medical director is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and appropriateness of the medical services provided to residents and to maintain surveillance of the health status of employees.

(a) The medical director is responsible for the development of written bylaws, rules, and regulations which are approved by the governing body and include delineation of the responsibilities of attending physicians.

(b) Coordination of medical care includes liaison with attending physicians to ensure their writing orders promptly upon admission of a patient, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services.

(c) The medical director is also responsible for surveillance of the health status of the facility's employees, and reviews incidents and accidents that occur on the premises to identify hazards to health and safety. The administrator is given appropriate information, by the medical director, to help ensure a safe and sanitary environment for residents and personnel.

(d) The medical director is responsible for the execution of resident care policies.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq., Section 405.1122, and Section 405.307, et seq.

History: Rule effective October 1, 1982. Amended February 8, 1984 and October 13, 1987. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-18 Availability of Nursing Facilities Accounting Records

(1) Availability of accounting records must be made available in compliance with chapter 22, Alabama Medicaid Administrative Code.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 483.10. Omnibus Budget Reconciliation Act of 1987.

History: Rule effective October 1, 1982. Amended November 10, 1983; December 18, 1986; and September 13, 1989. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-19 Administration of Medication

- (1) The facility must provide routine and emergency drugs and biologicals to its residents.
- (2) Alabama law prohibits nonlicensed personnel from administering medication.
- (3) A facility must permit residents to self-administer a drug when the facility determines, in accordance with the comprehensive assessment, that a resident is a good candidate, when the resident demonstrates that he or she can securely store, safely administer and accurately record the administration of drugs, and the facility reassesses the residents ability to self-administer drugs at least every three months.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule 560-X-10-20 Conditions Under Which Nursing Facilities are Not Classified as Mental Disease Facility Under Title XIX

- (1) Nursing facilities located on grounds of State Mental Hospitals or in the communities, must follow the required criteria to meet specific conditions in order to be eligible for Federal matching funds for care provided to all individuals eligible under the State Plan.
- (2) The Alabama Medicaid Agency is responsible for coordinating with the proper agencies concerning the mental disease classification of nursing facilities. Facilities are NOT considered institutions for mental disease if they meet the following criteria:
 - (a) The facility is established under State law as a separate institution organized to provide general medical care and does offer and provide such care.
 - (b) The facility is licensed separately under a State law governing licensing of medical institutions other than mental institutions.
 - (c) The facility is operated under standards which meet those for nursing facilities established by the responsible State authority.
 - (d) The facility is operated under policies which are clearly distinct and different from those of the mental institutions and which require admission of patients from the community who need the care it provides.
 - (e) The facility is dual certified under Title XVIII and XIX.
 - (f) The facility is not maintained primarily for the care and treatment of individuals with mental disease.
- (3) If the facility under examination meets one of the following criteria, it is deemed to be maintained primarily for the care and treatment of individuals with mental disease:
 - (a) It is licensed as a mental institution;
 - (b) It is advertised as a mental institution;

(c) More than fifty percent (50%) of the patients are receiving care because of disability in functioning resulting from a mental disease. Mental diseases are those listed under the heading of Mental Disease in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, International Classification of Diseases, adopted for use in the United States (ICD-10 or its successors), except for intellectual disability.

(4) Mental illness definition: An individual is considered to have mental illness if he or she has a current primary or secondary diagnosis of a major mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or its successors), and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

Author: Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and 483.

History: Rule effective October 1, 1982. Emergency rule effective January 1, 1989 and February 1, 1989. Amended April 14, 1989 and May 12, 1989. Emergency rule effective January 1, 1990. Amended April 17, 1990. Emergency rule effective October 1, 1990.

Amended: Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.21. Admission of Mentally Ill Residents to Nursing Facilities

(1) Nursing facilities must monitor the admission of mentally ill residents to their facilities.

(a) A nursing facility may not have more than fifty percent (50%) mentally ill residents which is based on the total population of the facility including public and private pay residents.

(b) If a facility does have more than fifty percent (50%) mentally ill residents, it will be designated as an institution for mental diseases for Medicaid payment purposes.

Author: Robin Arrington, Associate Director, LTC Recipient/Services Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. 401, et seq. and Section 483.

History: Emergency rule July 1, 1988. Amended July 12, 1988 and January 10, 1989.

Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed January 11, 2017; effective February 27, 2017.

Rule No. 560-X-10-.22 Quality of Life

(1) A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Factors to be considered include:

- (a) Dignity
- (b) Self determination and participation
- (c) Participation in resident and family groups.

- (d) Participation in other Activities
- (e) Accommodation of needs
- (f) Activities
- (g) Social Services
- (h) Environment

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.15. Omnibus Budget Reconciliation Act of 1987.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.23 Resident Assessment

(1) The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity as required by 42 C.F.R. Section 483.20 and any other applicable State and Federal requirements.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.20. Omnibus Budget Reconciliation Act of 1987.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.24 Quality of Care

(1) Each resident must receive the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status, as defined by the comprehensive assessment and plan of care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; 42 C.F.R. Section 401, et seq. and Section 483.25. Omnibus Budget Reconciliation Act of 1987.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.25 Resident Behavior and Facility Practices

(1) The resident has the right to be free from any physical restraints imposed or psychoactive drug administered for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

(2) The resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

(3) The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act; Omnibus Budget Reconciliation Act of 1987. 42 C.F.R. Section 401, et seq. and Section 483.13.

History: Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.26 Transfer and Discharge Rights

(1) Definitions.

(a) Discharge means movement from an entity that participates in Medicare as a skilled nursing facility (SNF), a Medicare certified distinct part, an entity that participates in Medicaid as a nursing facility (NF), or a Medicaid certified distinct part to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident.

(b) Resident means a resident of a SNF or NF or any legal representative of the resident.

(c) Transfer means movement from an entity that participates in Medicare as a SNF, a Medicare certified distinct part, an entity that participates in Medicaid as a NF or a Medicaid certified distinct part to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility. A transfer is not the movement from one certified bed in the facility to another certified bed in the same facility.

(2) Transfer and Discharge Requirements. The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

(a) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

(b) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

(c) The safety of individuals in the facility is endangered due to the clinical behavioral status of the resident;

(d) The health of individuals in the facility would otherwise be endangered;

(e) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Non-payment applies if the resident does not submit the necessary paperwork for third party payment or after the third party (including Medicare or Medicaid) denies the claim and the resident refuses to pay for the stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or

(f) The facility ceases to operate.

(3) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified above, the resident's clinical record must be documented. The documentation must be made by:

- (a) The resident's physician when transfer or discharge is necessary under paragraph (2)(a) or (2)(b) of this rule; and
- (b) A physician when transfer or discharge is necessary under paragraph (2)(d) of this rule.

(4) Notice Before Transfer. Before a facility transfers or discharges a resident, the facility must:

- (a) Notify the resident and, if known, a family member or legal representative of the resident of any transfer or discharge and the reasons for the move. The facility must send a copy of the notice to a representative of the Office of the State Long Term Care Ombudsman. In addition, the facility must send a copy of any non-emergency, involuntary transfer and discharge notices to the Alabama Medicaid Agency;
- (b) Record the reasons in the resident's clinical record; and
- (c) Include in the notice the items described in paragraph (6) of this rule. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the resident as soon as practicable.

(5) Timing of the Notice.

(a) Except when specified in paragraph (5)(b) of this rule, the notice of transfer or discharge required under this rule must be made by the facility at least 30 days before the resident is transferred or discharged.

(b) Notice may be made as soon as practicable before transfer or discharge when:

- 1. The safety of individuals in the facility would be endangered under paragraph (2)(c);
- 2. The health of individuals in the facility would be endangered under paragraph (2)(d);
- 3. The resident's health improves sufficiently to allow a more immediate transfer or discharge under paragraph (2)(b);
- 4. An immediate transfer or discharge is required by the resident's urgent medical needs under paragraph (2)(a); or
- 5. A resident has not resided in the facility for 30 days.

(c) In the case of the facility closure under paragraph (2)(f), the facility administrator must provide written notice at least 60 days prior to the impending closure to the Department of Public Health, the Office of the State Long Term Care Ombudsman, residents of the facility, and residents' representatives, as well as the plan for the transfer and adequate relocation of the residents to the most appropriate facilities.

(6) Contents of the Notice. For nursing facilities, the written notice specified in paragraph (4) of this rule must include the following:

- (a) The reason for transfer or discharge;
- (b) The effective date of transfer or discharge;

(c) The location to which the resident is transferred or discharged;

(d) The name, mailing address, e-mail address, and telephone number of the Alabama Medicaid Agency and a statement that the resident has the right to appeal the action to the Medicaid Agency by filing a written request within 30 days of the notice of transfer or discharge;

(e) The name, mailing address, e-mail address, and telephone number of the State

Long Term Care Ombudsman;

(f) For nursing facility residents with intellectual and developmental disabilities or related conditions, the mailing address, e-mail address, and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

(g) For nursing facility residents with a mental disorder or related condition, the mailing address, e-mail address, and telephone number of the agency responsible for the protection and advocacy of individuals with mental disorders established under the Protection and Advocacy for Mentally Ill Individuals Act.

(7) Orientation for Transfer or Discharge.

(a) A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(b) The resident's clinical record must be documented when the facility transfers or discharges a resident. The documentation should include a statement from the resident's physician indicating that the resident may be transferred or discharged including the level of care required for the resident.

(8) Appeal of Transfer or Discharge.

(a) A resident who is aggrieved by a facility's decision to transfer or discharge the resident may request a review of the decision by the Medicaid Agency. Such request must be in writing and received within 30 days of the date of the notice of transfer or discharge.

(b) Upon receipt of a request for review, Medicaid will promptly notify the facility and the resident of the procedures to be followed. Once the resident has requested a review of the discharge, the nursing facility must allow the resident to remain in the facility until all administrative appeals have been exhausted unless there is documented verifiable evidence in the resident's medical record indicating that the facility can no longer meet the resident's needs or he is a danger to the health and safety of other resident's in the facility and an appropriate placement for the resident has been located. Both parties will be allowed 10 days to submit any documentary information regarding the proposed transfer or discharge. If deemed desirable, Medicaid may contact one or both parties to obtain additional information, either written or oral. Properly qualified personnel will be utilized in the review process, and all decisions involving medical issues will be made by a Medicaid physician.

(c) Both parties will be notified by certified mail of the review decision. An aggrieved party may request a fair hearing by filing a written request with Medicaid within 30 days of the date of the review decision letter. Except as otherwise provided herein, hearings will be conducted in accordance with Chapter 3 of this Administrative Code. The hearing will be a de novo proceeding to review the decision to transfer or discharge. Both the facility and the

resident will be notified of the hearing date and will be entitled to participate. The hearing decision will be binding on all parties, regardless of whether a party participates in the fair hearing.

(9) 24 hour hospital stay. Resident's of nursing facilities who go to a hospital to receive outpatient services, i.e. emergency room observation, etc., do not have to be discharged from the nursing facility unless the resident is retained longer than 24 hours. After 24 hours discharge by the nursing facility is necessary. Residents who go to a hospital to receive inpatient service must be discharged. If an inpatient claim suspends as a duplicate of a nursing facility claim, the inpatient claim shall be paid and the other claim shall be denied or recouped unless the "from" and "to" dates on the hospital claim are the same. It is the nursing facilities responsibility to monitor the status of residents in hospitals to assure that discharge and readmissions to the nursing facility are properly reported.

Author: Robin Arrington, Administrator, LTC Provider/Recipient Services Unit.

Statutory Authority: State Plan Attachment 4.35-B; Title XIX, Social Security Act, Sections 1819 and 1919; 42 CFR 431.200 et seq., and 483.200 et seq.

History: Rule effective January 8, 1985. Emergency rule effective October 1, 1990. Amended February 13, 1991, and August 12, 1993. **Amended:** Filed June 20, 2003; effective September 15, 2003. **Amended:** Filed March 20, 2008; effective June 18, 2008. **Amended:** Filed October 18, 2017; effective December 4, 2017.

Rule No. 560-X-10-.27 Enforcement of Compliance for Long-Term Care Facilities with Deficiencies

The regulations of the Centers for Medicare and Medicaid Services, Department of Health and Human Services at 42 C.F.R. Section 488.400, et seq., as promulgated in 59 Federal Register 56116 (Nov. 10, 1994), and as may be subsequently amended, are adopted by reference. Copies of these regulations may be obtained from the U.S. Government Printing Office, Washington, DC 20402-9328. Copies are also available from Medicaid at a cost of \$2.50.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act, Section 1919; 42 C.F.R. Section 442.1, et seq., Section 431.151, et seq., Sections 441.11 and 489.53; Ala. Code (1975) Section 22-6-20, et seq. Section 488.400, et seq., and 498.1, et seq.

History; Rule effective October 1, 1982. Emergency Rule effective July 22, 1988. Amended October 12, 1988. Emergency rule effective October 1, 1990. Amended February 13, 1991. Emergency Rule Effective July 1, 1995. Amended August 12, 1995. **Amended:** Filed June 20, 2003; September 15, 2003.

Rule No. 560-X-10-.28 Financial Eligibility

(1) Financial eligibility will be established in accordance with Chapter 25, Alabama Medicaid Administrative Code.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan; Title XIX, Social Security Act.

History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule No. 560-X-10-.29 Claim Filing Limitations

(1) For claim filing limitations refer to Alabama Medicaid Administrative Code, Rule No. 560-X-1-.17.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Section 447.45, et seq.

History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.

Rule 560-X-10-.30 Third Party Payment Procedures

(1) Refer to Alabama Medicaid Administrative Code, Chapter 20.

Author: Dittra S. Graham, Administrator, LTC Program Management Unit.

Statutory Authority: State Plan, Title XIX, Social Security Act; 42 C.F.R. Sections 433.135, 433.138 and 433.139.

History: Emergency rule effective October 1, 1990. Amended February 13, 1991. **Amended:** Filed June 20, 2003; effective September 15, 2003.