

**DEPARTMENT OF HUMAN SERVICES
POLICY ISSUANCE**

PI-09-21

To: Regional DD Program Administrators,
Licensed DD Service Providers, Barb Murray

From: Division of Developmental Disabilities

Date: December 10, 2009

Subject: Revised Program Absences Policy

The following Policy is effective December 1, 2009, and replaces the former Program Absences Policy, DDD-PI-098/PI-09-13. The revisions are highlighted for your convenience.

CMS reimbursement regulations require that payments cannot be made for services not provided or that are duplicative of other services provided through the Medicaid program. In order to maintain continuity of services for individuals, the following exceptions are available as provided by NDAC 75-04-05-10.3.g.(1) for reimbursement for 'bed-hold' days in which individuals are absent from the service setting. No other exceptions are available.

Type of Service: Intermittent (ISLA, FCO III)

Exceptions Allowed: Two options are available. Census records must identify which option is being utilized for an individual.

1. Unplanned Absences / Shared Staffing - 30 days. An *absence* is hospitalization or absence from the service setting to the extent the individual is not available to receive direct service from the provider, or is receiving from another source, support that would normally be the responsibility of the provider. "**Not available**" means a day in which the individual does not stay in their own residence overnight. If staff are called and respond to assist the individual due to an emergency at their actual location on a day which otherwise would be an absence, that day

will not be counted as an absence. Any absences in excess of 30 days are not billable.

2. Planned Absences – None. If an individual routinely is expected to be out of the service setting for periods of time, the authorization may be developed as if the individual will not be routinely absent from the service setting. The increased daily rate will offset basing rates on only actual service and excluding payment for absence days not included in the rate determination. The authorization should identify this procedure and the additional hours added for this purpose. If this option is utilized, no absences are billed. For example:

An individual is authorized for 50 hours of direct service per month. The individual, however, spends 2 days a week away from the service setting with family. The authorization has previously been adjusted down to account for this time. The individual receives services 21.5 days per month (5×4.3) at 2.3 hours per day ($50 \div 21.5$). The authorization is then written for 30 days per month at 2.3 hours per day, a total of 69 hours. With this option only actual days of service are billable. Any absence day is non-billable.

A change in options can only be made at the time an initial authorization for service is developed or at the expiration of an existing authorization. When changing options, the allowed absences under Option 1 will be prorated for the provider fiscal year according to the amount of time Option 1 is in effect during that fiscal year.

Type of Service: SLA

Exceptions Allowed: 30 days for hospitalization or absence from the service setting to the extent the individual is not available to receive direct service from the provider, or is receiving from another source, support that would normally be the responsibility of the provider. “*Not available*” means a day in which the individual does not stay in their own residence overnight. If staff are called and respond to assist the individual due to an emergency at their actual location on a day which otherwise would be an absence, that day will not be counted as an absence.

Type of Service: Intermittent (Infant Development)

Exceptions Allowed: 20 days total per provider fiscal year for absences due to hospitalization. Since Infant Development rates are based on 5 days per week, only hospitalization days occurring from Monday through Friday are considered absences.

Type of Service: Facility based residential waiver (Congregate Care, TCLF, MSLA, Specialized Placement)

Exceptions Allowed: 30 days total per provider fiscal year for all days in which the individual is not in overnight residence in the facility as defined in DDD-PI-066 (attached).

Type of Service: Non-daily rates (Day Supports, In-Home Support, FCO, Extended Services, Self Directed Services, Extended Home Health)

Exceptions Allowed: None. Billing allowed only for actual service units delivered.

Type of Service: ICF/MR

Exceptions Allowed: 30 days total per calendar year for all days in which the individual is not in overnight residence in the facility as defined in DDD-PI-066 (attached), and up to 15 days per hospitalization are allowed. The Regional DD Program Administrator must assure that the requested exceptions are for hospitalization before approving the request.

The calendar year will be used for counting ICF absences and the absence policy will be applied for all ICF/MR providers effective August I, 2009. This means that provider census data beginning Aug. 1 needs to identify any absences as Therapeutic Leave or Hospitalization (Therapeutic leave being any absence except for hospitalization). The MMIS system will be changed to accept the following billing codes for ICF/MR for leave types up to the Days Allowed for each type:

ICF/MR Billing Codes

	Adult <u>ICF/MR</u>	<u>ICF Phy Hdc</u>	<u>ICF Child</u>	Days <u>Allowed</u>
In-house	110	120	160	
Therapeutic	180	183	169	30 per calendar year
Hospital	182	185	189	15 per occurrence

Therapeutic Leave and Hospitalization Leave are not interchangeable. Therapeutic Leave cannot be applied to Hospitalization Leave and Hospitalization Leave cannot be used for Therapeutic Leave.

For the period August 1 to December 31, 2009, up to 30 days Therapeutic Leave for an individual may be billed regardless of leave used prior to August 1, 2009. Beginning January 1, 2010 the limits above will apply to the full calendar year.

Providers will be notified when billing system changes have taken place. In the meantime, ICF/MR providers must keep census records and identify absences according to the above codes. However, codes used for billing will continue as is until MMIS changes are complete.

Implementation Provisions

1. The policy will be applied to each provider agency with the start of their next fiscal year after April 1, 2009.
2. Hospitalization does not include the ND State Hospital or other institutional placement. An individual will not be enrolled in community services during admission to the ND State Hospital, ND Developmental Center, or other institution (nursing facility, swing bed, etc.).
3. Providers must maintain census records which identify absent days and the reason (hospitalization, out-of-town/state, etc.).
4. An absence does not include days in which the individual is out of the service setting but is being provided direct service by the provider agency. However, absences are counted during a period of hospitalization regardless of support a provider may be giving to an individual.
5. The number of absences allowed for residential programs are based on the time enrolled in the program during the provider's fiscal year. This includes new admissions to the providership and internal transfers between residential programs.
6. A provider may elect to not bill for excess absence days for CC, MSLA, TCLF, Specialized Placement, ICF/MR, SLA, and Infant Development. Non-billed days will not be counted as an absence on audit. Census records must identify those absence days that are non-billed.

DDD-PI-066

TO: DD Service Providers
Regional DD Program Administrators

FROM: Sandi Noble, Director AP7@
Developmental Disabilities Division

DATE: March 20, 1995

SUBJECT: Definition of Residential Program Census

The following provisions will be used in determining what constitutes an absence for residential census purposes:

POLICY: An individual present in a group facility at midnight will be considered as present for the day just ended.

Intent: To provide a consistent guideline in determining when an individual should be considered as present for determination of 95% occupancy rules and the 30 day absence allowance. It is assumed the provider has had responsibility for direct care and programming for the individual for the day in which the attendance is recorded. A token return to the facility to meet a midnight "bed count" and then leaves is not to be considered present as it is an attempt to circumvent the intent of the policy.

Example:

An individual leaves at 5:30 p.m. on January 20 to spend a weekend with family. The individual returns to the residential facility at 8:30 p.m. on January 23. The person would be considered present on January 19, absent on January 20, 21, and 22 and present on the 23rd.

Example:

On January 25, Helgi and a friend leave in early evening for a dinner out and late movie. He returns at 12:45 a.m. on the 26th. Helgi is considered present for the 25th. Although he was not

present at midnight, he obviously was not residing elsewhere at the time and remained in the sphere of the provider's direct responsibility for care and programming.

POLICY: An individual will be considered present on the day of admission to a program, but not the day of discharge.

Intent: To provide a method of determining occupancy and for payment that is consistent with other Department of Human Service Programs. For the purposes of this policy, a change in screening level from an ICF/MR to Swing Bed facility is considered a discharge from the ICF/MR even though the ICF/MR provider is not discharging the individual from the agency.

Example: On the afternoon of February 2, Helga is admitted to a hospital. On February 5th in the afternoon, she is transferred to a Swing Bed facility for recovery and returns to the ICF/MR group home on the morning of February 15. The ICF/MR can count Helga as present through February 1, for 95% occupancy determination purposes and is eligible for payment through February 4. A Level of Care Determination change would be completed discharging her from the ICF/MR on the 5th and admitting her to the Swing Bed on the 5th. The ICF/MR facility would be eligible for payment for the 15th and the Swing Bed facility would not.

POLICY: Occupancy and eligibility for payment will include the date of death of an individual (assuming the individual is not screened to another level of care at the time of death).