ND Department of Human Services

ICF/IID Medically Intensive Rate Policy

General Information

If a client has one of the following conditions and resides in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), they may qualify for the ICF/IID Medically Intensive Rate. The condition must pose an additional program support cost, as identified in the rate matrix.

Additional program support costs include extraordinary nursing consult, assessment, and intervention need that is separate from direct support hours and cannot be delegated to direct support staff. This does not include standard nursing care that would be provided in an ICF/IID setting. Program support costs may also include extraordinary expense related to equipment and supplies that are not covered by the client's Medicaid and are allowable through state and federal regulations. This request is not be used for requesting additional direct support staff intervention.

Medical qualifiers:

Client must qualify under one of these categories and require the additional program support costs to qualify for the ICF/IID Medically Intensive Rate.

- Uncontrolled seizure disorder
  - Definition: Frequent, typically daily seizures, uncontrolled by medication and requiring nursing/medical intervention such as airway support, oxygen use, or medications that must be administered by nursing staff (such as IV medications). The person must be supervised at all times to prevent injury due to the frequency and severity of seizure activity and potential for status epilepticus. The person also requires frequent nursing observation or intervention.
  - This does not include medication administration, typical observation, or monitoring of seizure activity which can be done by direct support staff.
- Respiratory (trach care, vent care)
  - Definition: Daily need for respiratory care (trach, vent care) and use of life sustaining equipment and/or respiratory treatment, such as deep suctioning, that is required either scheduled or on an as needed basis requiring frequent close monitoring by nursing or respiratory therapy and ongoing staff training.
  - Trach care: Frequent changes, more than once every two weeks.
  - Oxygen: Needs are unstable, individual's oxygen setting is constantly monitored, and staff assist a client with frequent adjustment of oxygen.
  - This does not include equipment covered by the client's Medicaid or interventions/supervision that can be done by direct support staff.
- Gastrointestinal (IV fluids, rectal tube and enteral port flushing, feeding entry port)
  - Definition: Gastrointestinal (IV fluids) for a condition that is not stable and requires frequent nursing observation and ongoing staff training, and has excess formula needs not covered by Medicaid.
  - Rectal Tube and Port Flushing: Regular, direct flushing of bowels via port or rectal tube by nursing staff or requiring nursing assistance/observation during flushing.
  - Feeding/Enteral Access: Frequent unscheduled changing of feeding entry port by nursing staff or requiring nursing assistance/observation of feeding/enteral access. Supplies would be covered for scheduled changing more frequent than quarterly.
  - Does not include regular established tube feedings (G or J) with bolus feeding to a stable individual.

- This does not include equipment covered by the client's Medicaid or interventions/supervision that can be done by direct support staff.

- Genitourinary (catheter care with sterile catheterization)
  - Definition: Genitourinary (sterile catheter care) for a condition that is not stable and requires frequent nursing observation and ongoing staff training.
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  - Sterile Catheterization: Presence of sterile catheterization site(s) requiring changing by nursing staff or requiring nursing assistance/observation.
  - Does not include regular catheter care for a stable client such as cleaning the area, draining the catheter, recording input/output etc.
  - This does not include equipment covered by the client's Medicaid or interventions/supervision that can be done by direct support staff.
- Infection (active infection or IV Antibiotic)
  - Definition: A contagious disease or serious immune deficiency condition for which basic universal precautions will not maintain health and safety for the individual or his/her sharing partner. Frequent nursing observation/intervention (greater than once per day) or specialized equipment not covered by Medicaid is required to maintain health and safety (use of gown, mask, and/or gloves is not sufficient criterion on its own to qualify).
  - Sterile Dressing/Wound Care: A client has a wound requiring a wound vac with frequent (greater than once per day) nursing intervention, an infected wound(s) requiring sterile dressing and frequent (greater than once per day) sterile dressing changes by nursing staff, has a sterile dressing change less than once per day but greater than once per week of a large area (or multiple areas covering 10% or more of the body, or decubitus wounds) that all require sterile dressings or with frequent nursing assistance/observation with sterile dressing changes.
  - IV Antibiotic: Requires IV antibiotic at least once per day, anticipated to be provided for greater than two weeks and associated additional short-term nursing that may be provided by home health in an alternate setting.
  - Infection: A client has an Infection (active infection) with need for frequent nursing intervention and ongoing staff training.
  - This does not include equipment and supplies covered by the client's Medicaid or interventions/supervision that can be done by direct support staff.
- Multiple system involvement: A client that exhibits multiple of the above sections that may not on their own meet the requirements of this policy but between all may meet the severity and nursing intervention required. They must have a need for frequent nursing intervention/observation of tasks that are not able to be delegated. This does not include equipment and supplies covered by the client's Medicaid or interventions/supervision that can be done by direct support staff.

Process and Documentation Requirements:

If it is deemed that the client needs the ICF/IID Medically Intensive Rate and the client meets all criteria outlined in the section above, the provider agency is to complete the ICF/IID Medically Intensive Request Form. If the form is not completed and submitted with the required information in its entirety, the request will be determined incomplete and sent back to the provider for the required information. The provider will have 15 business days from the date of the notification to submit the required information to the DD Program Administrator (DDPA). If the required information is not submitted within

the timeline, the request will be considered withdrawn. If the need is still present, a new request will need to be submitted.

The information in the request must include information related to the specific request and reason for the request. The person-centered plan should contain evidence of the medical need and provide supporting documentation.

Link to ICF/IID Medically Intensive Rate Request Form https://www.nd.gov/eforms/Doc/sfn01797.pdf

If there is additional information supporting the request, the provider must indicate the location of the information on the form and if it is not in the web-based case management system, include it with the request. The information, including a summary, should be included from the timeframe when the medical needs began and how long since the last occurrence. Examples may include, but are not limited to:

- Seizure logs
- Data tracking
- Program support costs
- Medical assessments
- Nursing care plans
- Psychiatric assessments
- Behavior support plans
- GER's
- RMAP
- Person Centered Service Plans
- Team meeting minutes
- Medication lists
- QDDP monitoring
- Staffing schedules/documentation
- Any other information and data related to the request

The ICF/IID Medically Intensive Rate Checklist must be completed by the provider, DDPA, and the DD Division to track if the request is complete.

Submission and Approval of the Request:

The provider agency is responsible for completing the request. The team may be included in the completion of the request but is not required. The provider agency CEO will sign the completed ICF/IID Medically Intensive Rate Request Form. The following Department timelines will be effective when a completely executed request and documentations are received. All requests must be typed and submitted to the DDPA. The DDPA may consult with the DDPM and make a recommendation of approval or denial to the DD Division within 10 business days.

The ICF/IID Medically Intensive Rate Request will be reviewed by the DD Division where an approval or denial decision will be made within 15 business days and the DDPA is notified of the decision. The DDPA will notify the provider of the decision within 5 business days including the reason for the approval or denial. If the ICF/IID Medically Intensive Rate Request is approved, the DDPM will complete and approve the request in the web base case management system.

If an ICF/IID Medically Intensive Rate Request is denied, it can only be re-submitted if there is new information and documentation for review that wasn't included in the previous request. If no new

information is submitted, the original decision will be upheld.

ICF/IID Medically Intensive Rates will be approved for 12 months, however the timeframe may be shorter to align with the person-centered service plan date or to align with the timeframe identified as needed in the request. ICF/IID Medically Intensive Rates do not automatically renew. If the need continues, the provider agency will need to submit an updated ICF/IID Medically Intensive Rate Request with the timeframes in this policy to ensure continuity of program support costs.

The effective date of the approved ICF/IID Medically Intensive Rate Request will be one of the following:

- The date the request was received by the DDPA. This would be applicable for a new ICF/IID Medically Intensive Rate Request.
- Start date of a newly enrolled ICF/IID authorized service in the ISP. This would be applicable to align the ICF/IID Medically Intensive Rate with the start date of the new ICF/IID service.
- The day following the end date of a previously approved ICF/IID Medically Intensive Rate to maintain continuity of the ICF/IID Medically Intensive Rate. The request would need to be received by the DDPA prior to the end date of the previously approved ICF/IID Medically Intensive Rate, otherwise the effective start date, if approved, would be the date the DDPA received the request.

The provider will be reimbursed beginning on the identified effective start date of the approved ICF/IID Medically Intensive Rate. If the request is denied, payment will not occur after the end date of the prior approved ICF/IID Medically Intensive Rate Request.