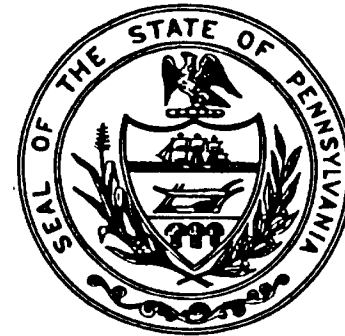


Commonwealth of Pennsylvania  
**Pennsylvania Code**

**Title 55. Public Welfare**

Department of Public Welfare

Chapter 6210. Participation Requirements for the Intermediate  
Care Facilities for the Mentally Retarded Program



Current through 24 Pa.B. 5956 (November 26, 1994)

**CHAPTER 6210. PARTICIPATION REQUIREMENTS FOR THE  
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY  
RETARDED PROGRAM**

**GENERAL PROVISIONS**

- Sec.  
6210.1. Purpose.  
6210.2. Applicability.  
6210.3. Definitions.

**GENERAL REQUIREMENTS**

- 6210.11. Payment.  
6210.12. Applicable statutes and regulations.  
6210.13. Licensure.  
6210.14. Time extensions.

**SCOPE OF BENEFITS**

- 6210.21. Categorically needy and medically needy recipients.  
6210.22. State Blind Pension recipients.

**PROVIDER PARTICIPATION**

- 6210.31. Provider agreement.  
6210.32. Budgets and cost reports for State operated facilities.  
6210.33. Budgets and cost reports for nonState operated facilities.  
6210.34. Approved funding level.  
6210.35. Ongoing provider responsibilities.

**PAYMENT CONDITIONS**

- 6210.41. Payment available from other sources.  
6210.42. Certification of initial need for care.  
6210.43. Recertification of continued need for care.  
6210.44. Evaluations.  
6210.45. Payment authorization.  
6210.46. Plan of care.  
6210.47. Continued review of plan of care.  
6210.48. Reviews by the utilization review committee.  
6210.49. Adverse decisions by the Inspection of Care Team.  
6210.50. Recipient notice of adverse decisions.  
6210.51. Attending physician decision on level of care.  
6210.52. Payment pending appeal.

6210-1

**ASSESSMENT**

- 6210.61. Eligibility for an ICF/MR level of care.
- 6210.62. Level of care criteria.
- 6210.63. Diagnosis of mental retardation.
- 6210.64. Medical evaluation.
- 6210.65. Recertification.

**PAYMENT LIMITATIONS**

- 6210.71. Limitations on payment for reserved bed days.
- 6210.72. Limitations on payment for prescription drugs.
- 6210.73. Limitations on payment during strike or disaster situations requiring recipient evacuation.
- 6210.74. Services included in the interim per diem rate.
- 6210.75. Noncompensable services.
- 6210.76. Cost reporting.
- 6210.77. Cost finding.
- 6210.78. Allowable costs.
- 6210.79. Setting interim per diem rates.
- 6210.80. Maximum rate of payment.
- 6210.81. Upper limits of payment.
- 6210.82. Annual adjustment.

**REPORTING AND AUDITING**

- 6210.91. Annual reporting.
- 6210.92. Final reporting.
- 6210.93. Auditing requirements related to cost reports.
- 6210.94. Auditing requirements related to recipient fund management.

**UTILIZATION CONTROL**

- 6210.101. Scope of claims review procedures.
- 6210.102. Review of need for admission.
- 6210.103. Inspections of care.
- 6210.104. Content of inspections of care.
- 6210.105. Inspection of care summary report.
- 6210.106. Facility course of action.
- 6210.107. Recipient right of appeal of alternate care determinations.
- 6210.108. Facility utilization review.
- 6210.109. Provider misutilization.

**ADMINISTRATIVE SANCTIONS**

- 6210.111. Failure to file a cost report.
- 6210.112. Failure to maintain adequate records.
- 6210.113. Failure to correct deficiencies.
- 6210.114. Failure to adhere to certification requirements.
- 6210.115. Failure to adhere to medical evaluation requirements.
- 6210.116. Failure to comply with requirements of maintaining recipient's funds.

**RIGHT OF APPEAL**

- 6210.121. Decisions that may be appealed.
- 6210.122. Additional appeal requirements.
- 6210.123. Time limit for submission of appeal.
- 6210.124. Submission of appeal.
- 6210.125. Right to reopen audit.

**Authority**

The provisions of this Chapter 6210 issued under section 443.1(2) and (3) of the act of June 13, 1967 (P. L. 31, No. 21) (62 P. S. § 443.1(2) and (3)), unless otherwise noted.

**Source**

The provisions of this Chapter 6210 adopted October 28, 1994, effective immediately and apply retroactively to July 1, 1994, 24 Pa.B. 5523, unless otherwise noted.

**Cross References**

The provisions of this chapter cited in 55 Pa. Code § 6211.2 (relating to applicability).

**GENERAL PROVISIONS**

**§ 6210.1. Purpose.**

The purpose of this chapter is to specify the requirements for State operated and nonState operated ICFs/MR to receive payment for services through the MA Program.

**§ 6210.2. Applicability.**

(a) This chapter applies to State operated and nonState operated ICFs/MR.

(b) This chapter applies to nonState operated ICFs/ORC.

(c) Section 6210.63(1) (relating to diagnosis of mental retardation) does not apply to ICFs/ORC.

(d) If a provision specified in Chapter 1101 (relating to general provisions) is inconsistent with this chapter, this chapter prevails.

(c) If a provision specified in this chapter is inconsistent with Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded), Chapter 6211 prevails.

### § 6210.3. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

*CAO*—County Assistance Office.

*Department*—The Department of Public Welfare of the Commonwealth.

*HIM-15*—The Medicare Provider Reimbursement Manual, Health Insurance Manual-15.

*ICF/MR*—*Intermediate care facility for the mentally retarded (facility)*—A State operated or nonState operated facility, licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for the mentally retarded), to provide a level of care specially designed to meet the needs of persons who are mentally retarded, or persons with related conditions, who require specialized health and rehabilitative services; that is, active treatment.

*ICF/ORC*—*Intermediate care facility for persons with other related conditions (facility)*—A nonState operated facility, licensed by the Department in accordance with Chapter 6600, to provide a level of care specially designed to meet the needs of persons with other related conditions who require specialized health and rehabilitative services; that is, active treatment. Persons with other related conditions are persons with severe physical disabilities, such as cerebral palsy, spina bifida, epilepsy or other similar conditions which are diagnosed prior to age 22 and result in at least three substantial limitations to activities of daily living.

*Interim per diem rate*—The rate established by the Department for the purpose of making interim payments to the facility pending a year-end cost settlement.

*MA*—Medical Assistance.

*Reserve bed day*—A day counted in the facility census, subject to limits, during which a recipient is temporarily absent from the facility for more than a continuous 24-hour period either for hospitalization or therapeutic leave.

## GENERAL REQUIREMENTS

### § 6210.11. Payment.

(a) The MA Program provides payment for intermediate care for the mentally retarded provided to eligible recipients by providers enrolled in the MA Program.

(b) Payment for services is made in accordance with this chapter, Chapter 1101 (relating to general provisions), HIM-15, the Medicaid State Plan, Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) and the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" for State operated ICFs/MR.

### § 6210.12. Applicable statutes and regulations.

The facility shall comply with applicable Federal, State and local statutes and regulations, including Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396u) and the regulations promulgated thereunder, and sections 443.1—443.6 of the Public Welfare Code (62 P. S. §§ 443.1—443.6).

### § 6210.13. Licensure.

ICFs/MR shall be licensed by the Department in accordance with Chapter 6600 (relating to intermediate care facilities for the mentally retarded).

### § 6210.14. Time extensions.

(a) The time limits specified in this chapter for the filing of an application, cost report, waiver request or appeal cannot be extended, except as provided in this section.

(b) Extensions of time in addition to the time otherwise specified for providers in this chapter with respect to the filing of an application, cost report, waiver request or appeal may be permitted only if required because of a breakdown in Department procedures justifying relief or because of an intervening natural disaster making timely compliance impossible or unsafe.

(c) This section supersedes 1 Pa. Code § 31.15 (relating to extensions of time).

### SCOPE OF BENEFITS

#### § 6210.21. Categorically needy and medically needy recipients.

Categorically needy and medically needy recipients are eligible for ICF/MR subject to the conditions specified in this chapter, Chapters 1101 and 6211 (relating to general provisions; and allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

#### § 6210.22. State Blind Pension recipients.

State Blind Pension recipients are not eligible for ICF/MR under the MA Program. Blind and visually impaired individuals are eligible for ICF/MR services if they qualify as categorically or medically needy recipients.

### PROVIDER PARTICIPATION

#### § 6210.31. Provider agreement.

The facility shall enter into a written provider agreement with the Department's Office of Medical Assistance Programs.

#### § 6210.32. Budgets and cost reports for State operated facilities.

(a) State operated ICFs/MR shall submit budgets to the Department's Office of Mental Retardation.

(b) State operated ICFs/MR shall submit cost reports to the Department's Bureau of Financial Operations.

#### § 6210.33. Budgets and cost reports for nonState operated facilities.

(a) NonState operated ICFs/MR shall submit cost reports or a budget, if a waiver is granted in accordance with Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded), to the Department's Office of Mental Retardation.

(b) Cost reports and budgets shall be submitted on forms and by deadlines specified by the Department.

#### § 6210.34. Approved funding level.

The Department's Office of Mental Retardation is responsible for establishing an approved funding level for nonState operated ICFs/MR.

#### § 6210.35. Ongoing provider responsibilities.

(a) A utilization review plan shall be submitted to the Department's Office of Medical Assistance Programs.

(b) A system for managing recipients' funds that is in compliance with 42 CFR 483.420 (relating to conditions of participation: client protections) shall be in operation. If a recipient dies and there is no will, and if no relative or friend takes responsibility for burial, the following requirements apply:

(1) The facility may make payment of funds for burial expenses, if funds remain in the decedent's personal care account.

(2) Payment may be made only to a person licensed as a funeral director by the Department of State for a debt due and owing and may not exceed \$1,000.

(3) The payment may be made whether or not a personal representative has been appointed.

(4) Under 20 Pa.C.S. § 3101 (relating to payments to family and funeral directors), a facility making the payment is released from responsibility to the same extent as if payment had been made to an appointed personal representative of the decedent. The facility is not required to oversee the manner in which the funeral director applies the payment.

(c) A cost report shall be filed with the Department's Office of Mental Retardation for nonState operated ICFs/MR and with the Department's Bureau of Financial Operations for State operated ICFs/MR within the time limit specified in § 6210.77 (relating to cost finding) if the facility is continuing its participation in the MA Program or within the time limit specified in § 6210.92 (relating to final reporting) if the facility is sold, transferred by merger or consolidation, terminated or withdraws from participation in the MA Program.

(d) Cost reports shall meet the requirements specified in § 6210.79 (relating to setting interim per diem rates).

(e) An onsite inspection shall be conducted at least annually by the Department's Office of Medical Assistance Programs Inspection of Care Team to determine compliance with the regulations at 42 CFR 456.600 (relating to purpose).

(f) Within 30 days of receipt of the inspection of care team report, the facility shall submit a written response, if required by the Department.

(g) The facility shall submit changes in ownership of persons having a direct or indirect interest of 5% or more in the facility to the Department's Office of Medical Assistance Programs.

(h) If the facility is a corporation, the facility shall submit changes in the name or address of corporate officers to the Department's Office of Medical Assistance Programs.

(i) The facility shall have a written transfer agreement with one or more general hospitals to provide needed diagnostic and other medical services to recipients, and under which acutely ill recipients may be transferred to ensure timely admission. Facilities that are based in hospitals are exempt from this subsection.

(j) If the facility changes ownership and the new owner wishes the facility to participate in MA, the facility shall submit a written request for participation to the Department's Office of Medical Assistance Programs. The agreement in effect at the time of the ownership change shall be assigned to the new owner subject to applicable statutes and regulations and to the terms and conditions under which it was originally issued.

#### PAYMENT CONDITIONS

##### § 6210.41. Payment available from other sources.

Payment will not be made by the Department if full payment, at the MA interim per diem rate, is available from another public agency, another insurance or health program, or the recipient's resources.

##### § 6210.42. Certification of initial need for care.

(a) A physician shall certify in writing in the medical record that the applicant or recipient needs intermediate care for the mentally retarded.

(b) A nurse practitioner or clinical nurse specialist, who is not an employe of the facility, but who is working in collaboration with a physician, may complete the certification specified in subsection (a).

(c) The certification specified in subsections (a) and (b) shall be signed and dated not more than 30 days prior to either the admission of an applicant or recipient to a facility, or, if an individual applies for assistance while in a facility before the Department authorizes payment for intermediate care for the mentally retarded.

#### Cross References

This section cited in 55 Pa. Code § 6210.114 (relating to failure to adhere to certification requirements); and 55 Pa. Code § 6210.115 (relating to failure to adhere to medical evaluation requirements).

##### § 6210.43. Recertification of continued need for care.

(a) A physician, a physician's assistant under the supervision of a physician or a nurse practitioner, or clinical nurse specialist shall enter into the recipient's medical record a signed and dated statement that the recipient continued to need intermediate care for the mentally retarded.

(b) In a nonState operated ICF/MR, the person who certifies the need for continued care specified in subsection (a), may not be an employe of the facility but shall work in collaboration with the recipient's physician.

(c) The recertification specified in subsection (a) shall be completed at least once every 365 days after initial certification.

#### Cross References

This section cited in 55 Pa. Code § 6210.114 (relating to failure to adhere to certification requirements).

##### § 6210.44. Evaluations.

(a) Before admission to a facility, or before authorization for payment, an interdisciplinary team of health professionals shall make a comprehensive medical, social and psychological evaluation of each applicant's or recipient's need for intermediate care for the mentally retarded. The psychological evaluation shall be completed within 3 months prior to admission.

(b) If a recipient moves from one facility to another facility, this is not considered a new admission and new evaluations as required in subsection (a) are not required, if the prior evaluations are transferred with the recipient.

(c) Medical, social and psychological evaluations shall be recorded in the recipient's medical record and if applicable on forms specified by the Department.

##### § 6210.45. Payment authorization.

(a) The Department will send a written notice of the authorization or denial of payment to the recipient and the facility.

(b) The notice from the Department will indicate the effective date of coverage and the amount of money the recipient has available to contribute toward the interim per diem rate.

(c) Obtaining the recipient's share of the interim per diem rate is the responsibility of the facility.

##### § 6210.46. Plan of care.

Before admission to an ICF/MR, or before authorization for payment, the attending physician shall establish a written plan of care for each applicant or recipient. The plan of care shall indicate time-limited and measurable care objectives and goals to be accomplished and who is to give each element of care.

##### § 6210.47. Continued review of plan of care.

The interdisciplinary team shall review each plan of care at least every 90 days and document the date of the review in the record of the recipient.

**§ 6210.48. Reviews by the utilization review committee.**

(a) The utilization review committee of a facility shall document in the medical record of the recipient the continued stay review date and need determination of the committee.

(b) If the utilization review committee recommends that a recipient's level of care be changed, the committee shall notify the Department of the committee's recommendation on the Utilization Review Request for Change Summary Form. A copy of the form shall be kept in the recipient's medical record.

**§ 6210.49. Adverse decisions by the Inspection of Care Team.**

If the Department's Inspection of Care Team determines that a recipient no longer needs the level of care for which payment is authorized, the Inspection of Care team shall direct the Department to take action to authorize payment for alternate care.

**§ 6210.50. Recipient notice of adverse decisions.**

Upon notification of the recommended change in level of care, the Department will notify the recipient and facility of its decision. If the recipient or the representative of the recipient appeals the decision within 10 calendar days from the date the notice is mailed, payment for the present level of care will continue pending the outcome of the hearing. If the recipient does not respond to the notice within 10 calendar days, the Department will deny payment in a case where care is no longer needed or authorize payment for the appropriate level of care no earlier than 10 calendar days from the date the notice was mailed to the recipient.

**§ 6210.51. Attending physician decision on level of care.**

(a) In response to changes in the recipient's medical condition, the attending physician may order a change in the recipient's level of care which is different from the level of care for which payment is authorized.

(b) If the attending physician recommends that a recipient's level of care be changed, the attending physician shall document the change in the recipient's medical record and notify the Department of the level of care recommendation on the Attending Physician Request for Change Summary Form. A copy of the form shall be kept in the recipient's medical record.

(c) If the recipient's level of care is changed as a result of a determination by the Department's Inspection of Care Team, the attending physician may order a change in the recipient's level of care only if the recipient's medical condition changes subsequent to the date of the Inspection of Care Team's determination and the change in the recipient's medical condition warrants another level of care.

(d) The physician shall date and sign the documentation of the change in the recipient's medical condition and state the alternate care recommendation in the recipient's record.

**§ 6210.52. Payment pending appeal.**

If the recipient or the facility acting on behalf of the recipient appeals an action of the Department to change the level of care for which payment is authorized within 10 calendar days from the date the notice is mailed, the Department will make payment to the facility for the level of care the recipient is presently receiving pending the outcome of the hearing. If the Department is sustained in its action, the Department will recover from the facility payment in excess of the amount that would have been made if the action of the Department had not been appealed. The period for which the Department will recover excess payment runs from 10 calendar days from the date the notice is mailed, to the date that the appropriate change in the level of care for which payment is authorized is made.

**Cross References**

This section cited in 55 Pa. Code § 6210.107 (relating to recipient right of appeal of alternate care determinations).

**ASSESSMENT****§ 6210.61. Eligibility for an ICF/MR level of care.**

An applicant or recipient shall receive active treatment to be determined eligible for an ICF/MR level of care. The ICF/MR Program shall have only one level of care. The level of care determination is based upon the developmental needs of each applicant or recipient.

**§ 6210.62. Level of care criteria.**

(a) There are three fundamental criteria which shall be met prior to an applicant or recipient qualifying for an ICF/MR level of care. The ICF/MR level of care shall be indicated only when the applicant or recipient:

- (1) Requires active treatment.
- (2) Has a diagnosis of mental retardation.
- (3) Has been recommended for an ICF/MR level of care based on a medical evaluation.

(b) A physician shall certify the ICF/MR level of care on a form specified by the Department and that ICF/MR services are needed, for each applicant and current ICF/MR resident. Before the facility requests payment from MA, the certification shall have been made at the time of admission, or at the time a resident applied for assistance while in an ICF/MR.

(c) For purposes of an ICF/ORC, subsection (a)(2) means a diagnosis of other related condition.

### § 6210.63. Diagnosis of mental retardation.

The facility shall document the applicant's or recipient's diagnosis of mental retardation by meeting the following requirements:

(1) A licensed psychologist, certified school psychologist or a licensed physician who practices psychiatry shall certify that the applicant or recipient has significantly subaverage intellectual functioning which is documented by one of the following:

(i) Performance that is more than two standard deviations below the mean as measurable on a standardized general intelligence test.

(ii) Performance that is slightly higher than two standard deviations below the mean of a standardized general intelligence test during a period when the person manifests serious impairments of adaptive behavior.

(2) A qualified mental retardation professional as defined in 42 CFR 483.430 (relating to condition of participation: facility staffing) shall certify that the applicant or recipient has impairments in adaptive behavior as provided by a standardized assessment of adaptive functioning which shows that the applicant or recipient has one of the following:

(i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of his age and cultural group.

(ii) Substantial functional limitation in three or more of the following areas of major life activity:

- (A) Self-care.
- (B) Receptive and expressive language.
- (C) Learning.
- (D) Mobility.
- (E) Self-direction.
- (F) Capacity for independent living.
- (G) Economic self-sufficiency.

(3) It has been certified that documentation to substantiate that the applicant's or recipient's conditions were manifest before the applicant's or recipient's 22nd birthday, as established in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. § 6001).

#### Cross References

This section cited in 55 Pa. Code § 6210.1 (relating to applicability).

### § 6210.64. Medical evaluation.

Applicants or recipients meeting the criteria for ICF/MR level of care shall have a medical evaluation completed by a licensed physician not more than 60 days prior to admission to an ICF/MR or before authorization for payment. The physician shall recommend the applicant or recipient for an ICF/MR level of care based on the medical evaluation.

### § 6210.65. Recertification.

(a) Recertification shall be on a form specified by the Department and based on the applicant's or recipient's continuing need for an ICF/MR level of care, progress toward meeting plan objectives, the appropriateness of the plan of care and consideration of alternate methods of care.

(b) Recertification of need for an ICF/MR level of care shall be made at least once every 365 days after the initial certification.

## PAYMENT LIMITATIONS

### § 6210.71. Limitations on payment for reserved bed days.

(a) Hospital leave is a reserve bed day, limited in number, during which a client is temporarily absent from the facility for hospitalization.

(b) For each hospitalization, a recipient receiving intermediate care for the mentally retarded, except for a recipient in a State operated ICF/MR, is eligible for a maximum 15 consecutive reserve bed days for hospital leave. The Department will pay a facility at the interim per diem rate on file with the Department for a hospital reserve bed day. Subject to this limit, a facility may include hospital reserve bed days in its census as client days, and costs associated with hospital reserve bed days shall be included in the facility's cost report. A reserve bed will be available for the recipient upon the recipient's return to the facility.

(c) Therapeutic leave is a reserve bed day, subject to limits, during which the recipient is temporarily absent from the facility due to the need to obtain a component of the recipient's individual program plan which cannot be provided directly by the facility. Therapeutic leave is included in the recipient's individual program plan, and the facility is required to

monitor and document therapeutic leave. Therapeutic leave is primarily intended to maintain and further enhance relationships between the recipient and his family. Therapeutic leave includes leave for camp or other special programs.

(d) The Department will make payment to a facility for a reserved bed day when the recipient is absent from the facility for a continuous 24-hour period because of therapeutic leave. Each reserved bed day for therapeutic leave shall be recorded on the facility's daily census record and invoice. A reserved bed shall be available for the recipient upon the recipient's return to the facility.

(e) A recipient receiving intermediate care for the mentally retarded is eligible for a maximum of 75 days per calendar year for therapeutic leave outside the facility.

(f) For each continuous 24-hour period the recipient is absent from the facility, the facility shall bill the Department for a therapeutic leave day, under the limitations in this chapter. When the continuous 24-hour period is broken, this will not count as a reserved bed day.

#### Cross References

This section cited in 55 Pa. Code § 6210.75 (relating to noncompensable services).

### § 6210.72. Limitations on payment for prescription drugs.

The Department's interim per diem rate for nonState operated ICFs/MR does not include prescription drugs. Prescribed drugs for categorically needy recipients are reimbursable directly to a licensed pharmacy according to regulations contained in Chapter 1121 (relating to pharmaceutical services).

### § 6210.73. Limitations on payment during strike or disaster situations requiring recipient evacuation.

(a) Payment may continue to be made to a facility that has temporarily transferred recipients, as the result or threat of a strike or disaster situation, to the closest medical institution able to meet the recipients' needs, if the institution receiving the recipients is licensed and certified to provide the required level of care.

(b) If the facility transferring the recipients can demonstrate that there is no certified facility available for the safe and orderly transfer of the recipients, the payments may be made so long as the institution receiving the recipients is certifiable and licensed to provide the required level of care.

(c) If the facility to which the recipients are transferred has a different interim per diem rate, the transferring facility will be reimbursed at the lower rate.

(d) The facility shall immediately notify the Department, Office of Medical Assistance Programs, in writing of an impending strike or a disaster situation and shall include a listing of MA recipients and the facility to which they will be or were transferred.

### § 6210.74. Services included in the interim per diem rate.

The Department's interim per diem rate of reimbursement includes allowable costs for routine services. Services include the following:

(1) Regular room, habilitation services, personal care services, social services, therapeutic services, dietary services, general nursing services, other services required to implement the recipient's plan of care and to meet certification standards, medical supplies and the use of equipment and facilities.

(2) Items furnished routinely and relatively uniformly to recipients, such as personal clothing, furniture and recreational equipment.

(3) Items furnished, distributed or used individually in small quantities such as personal hygiene supplies, health care supplies and nonprescription drugs ordinarily kept on hand.

(4) Items used by recipients but which are reusable and expected to be available, such as household furniture, therapeutic equipment and durable medical equipment.

(5) Special dietary supplements used for tube feeding or oral feeding, such as an elemental high nitrogen diet, even if written as a prescription item by a physician.

(6) Laundry services including the laundering of the recipient's personal clothing.

(7) Other special medical services of a rehabilitative, restorative or maintenance nature, designed to restore or sustain the recipient's physical and social capacities.

### § 6210.75. Noncompensable services.

Payment will not be made for:

(1) Services provided to a recipient who no longer requires the level of care for which payment is authorized by the CAO.

(2) Reserved bed days that exceed the limits specified in § 6210.71 (relating to limitations on payment for reserved bed days).

(3) Services provided to a recipient occupying a bed which is not certified for the level of care for which payment is authorized by the CAO.

(4) Services covered but disallowed by Medicare.

(5) Services rendered by a provider that do not meet the conditions for payment established by this chapter. Chapters 1101 and 6211 (relating to general provisions; and allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

(6) Services directly reimbursable under the MA Program.

#### § 6210.76. Cost reporting.

(a) Each facility shall submit a cost report to the Department within 90 days following the close of each fiscal year as designated by the facility in accordance with § 6210.91 (relating to annual reporting).

(b) The time frame for submission of cost reports may be extended for an additional 30 days with written approval from the Department's Office of Mental Retardation for nonState operated ICFs/MR and from the Department's Bureau of Financial Operations for State operated ICFs/MR.

(c) Cost reports shall be submitted on Department form MA-11.

(d) The cost report shall be prepared using the accrual basis of accounting and shall cover a fiscal period of 12 consecutive months.

(e) Facilities beginning operations during a fiscal period shall prepare a cost report from the date of approval for participation to the end of the facility's fiscal year.

(f) The cost report shall identify costs of services, facilities and supplies furnished by organizations related to the provider by common ownership or control.

#### Cross References

This section cited in 55 Pa. Code § 6210.111 (relating to failure to file a cost report).

#### § 6210.77. Cost finding.

(a) The direct allocation method of cost finding shall be used.

(b) The costs of ancillary and administrative services shall be apportioned directly to the appropriate level of care based on appropriate statistical data.

(c) A facility's direct or indirect allowable costs related to care shall be considered in the finding and allocation of costs to the MA Program for its eligible recipients. Total allowable costs of a facility shall be apportioned between third-party payors and other recipients so that the share borne by MA is based upon actual services and costs related to MA recipients. For purposes of MA reimbursement, the return on net equity and net worth is not reimbursable.

#### Cross References

This section cited in 55 Pa. Code § 6210.35 (relating to ongoing provider responsibilities).

#### § 6210.78. Allowable costs.

(a) For State operated ICFs/MR, allowable costs shall be determined by the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" and HIM-15.

(b) For nonState operated ICFs/MR, allowable costs shall be determined based on Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) and HIM-15.

(c) State operated ICFs/MR shall be reimbursed actual allowable costs under the Statewide Cost Allocation Plan and Medicare principles, subject to MA regulations.

(d) NonState operated ICFs/MR shall be reimbursed actual, allowable reasonable costs under Chapter 6211 and other applicable MA regulations.

#### Cross References

This section cited in 55 Pa. Code § 6210.92 (relating to final reporting); and 55 Pa. Code § 6210.93 (relating to auditing requirements related to cost reports).

#### § 6210.79. Setting interim per diem rates.

(a) For State operated ICFs/MR, interim per diem rates shall be established by the Department based on the latest adjusted reported costs and approved budgets.

(b) For nonState operated ICFs/MR, interim per diem rates shall be established by the Department based on the latest adjusted cost report plus an inflationary factor, or a submitted budget if a waiver is granted in accordance with Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).

#### Cross References

This section cited in 55 Pa. Code § 6210.35 (relating to ongoing provider responsibilities).

#### § 6210.80. Maximum rate of payment.

Except as provided in this section, the Department's maximum rate of payment to an enrolled facility will be the lower of the following:

(1) The facility's lowest charge to private pay recipients for the same level of care.

(2) The facility's final interim per diem rate.

#### Cross References

This section cited in 55 Pa. Code § 6210.111 (relating to failure to file a cost report).

**§ 6210.81. Upper limits of payment.**

(a) The upper limits of payment for State operated ICFs/MR are the full allowable costs as specified in the Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" and HIM-15.

(b) The upper limits of payment for nonState operated ICFs/MR are the lower of costs or the total projected operating cost or if a waiver is granted under Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded) an approved budget level as specified in Chapter 6211.

**Cross References**

This section cited in 55 Pa. Code § 6210.111 (relating to failure to file a cost report).

**§ 6210.82. Annual adjustment.**

(a) An annual payment adjustment shall be made by the Department or facility based on total audited costs related to the total Department interim claims for services for the fiscal year.

(b) For cost reporting periods ending on or after October 1, 1985, if the total amount of MA payment for interim claims for services during the fiscal year exceeds the total audited costs, the Department will recover the overpaid amount from the provider in accordance with Chapter 1101 (relating to general provisions).

**REPORTING AND AUDITING****§ 6210.91. Annual reporting.**

The fiscal year, for purposes of MA payments, is July 1 through June 30.

**Cross References**

This section cited in 55 Pa. Code § 6210.76 (relating to cost reporting).

**§ 6210.92. Final reporting.**

A facility that enters into a termination agreement or an agreement of sale, or is withdrawing or being terminated as a provider, or is otherwise undergoing a change of ownership shall file an acceptable final cost report and outstanding annual cost reports with the Department within 45 days of the effective date of the termination, transfer, withdrawal or change of ownership and is required to provide financial records to the Department for auditing. An acceptable cost report is one that meets the requirements of § 6210.78 (relating to allowable costs).

**Cross References**

This section cited in 55 Pa. Code § 6210.35 (relating to ongoing provider responsibilities); and 55 Pa. Code § 6210.111 (relating to failure to file a cost report).

**§ 6210.93. Auditing requirements related to cost reports.**

(a) Except in cases of provider delay or delay requested by State or Federal agencies investigating possible criminal or civil fraud, the Department will conduct either a field audit or desk review of each cost report within 1 year of the latter of its receipt in acceptable form, as defined in § 6210.78 (relating to allowable costs) or, if the facility participates in Medicare and has reported home office costs to the Department on its cost report, the Department's receipt of the facility's Medicare home office audit, to verify, to the extent possible, that the facility has complied with:

- (1) This chapter.
- (2) Chapter 1101 (relating to general provisions).
- (3) The limits established in Chapter 6211 (relating to allowable cost reimbursement for nonState operated intermediate care facilities for the mentally retarded).
- (4) The Department's "Cost Apportionment Manual for State Mental Hospitals and Mental Retardation Centers" for State operated ICFs/MR.
- (5) HIM-15.
- (6) The Department's cost allocation plan for State operated ICFs/MR.

(b) An onsite field audit will be performed on a periodic basis at reporting facilities. Participating facilities will receive a field audit or a desk audit each year. Full scope field audits will be conducted in accordance with auditing requirements in Federal regulations and generally accepted auditing standards.

(c) An auditor may validate the costs and statistics of the annual report by an onsite visit to the facility. The auditors will then certify to the Department the allowable cost for the facility as a basis for calculating a per diem and an annual adjustment. Based on the certification and total interim payments received by the facility, the Department will compute adjustments due the facility or due the Department for the fiscal year. The Department will notify the facility of the annual adjustment due after the annual cost report is audited.

(d) Financial and statistical records to support cost reports shall be available to State and Federal agents upon request.

**§ 6210.94. Auditing requirements related to recipient fund management.**

(a) Records relating to the facility's management of MA recipients' personal funds shall be maintained for at least 4 years.

(b) Records relating to the facility's management of MA recipients' personal funds shall be available to Federal and State representatives upon request.

(c) MA recipients' fund accounts shall be audited at the time the annual cost reports are validated for a facility.

(d) If discrepancies are proven and the facility is found to be at fault, the facility shall make restitution to the recipients for funds improperly handled, accounted for or disbursed.

(e) The facility has the right of appeal in accordance with §§ 6210.121—6210.125 (relating to right of appeal).

**UTILIZATION CONTROL.****§ 6210.101. Scope of claims review procedures.**

Claims submitted for payment under the MA Program are subject to the utilization review procedures established in Chapter 1101 (relating to general provisions). In addition, the Department will perform the reviews specified in this section and §§ 6210.102—6210.109 for controlling the utilization of ICF/MR services.

**§ 6210.102. Review of need for admission.**

The Department's Inspection of Care Team will evaluate each applicant's or recipient's need for admission by reviewing and assessing the appropriate Departmental form completed by the attending physician or interdisciplinary team as required for the specifically prescribed level of care needed. The facility and recipient shall be notified of the decision on forms designated by the Department.

**Cross References**

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

**§ 6210.103. Inspections of care.**

(a) The Department's Inspection of Care Team will inspect the care and services provided to each recipient in a participating facility at least annually.

(b) The Department will not give the facility more than 48 hours notice of the time and date of the schedule arrival of the team.

(c) The facility shall make available to the team, in a readily reviewable format, the recipient's complete medical records for the year since the last review of the team.

**Cross References**

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

**§ 6210.104. Content of inspections of care.**

(a) The inspection by the Inspection of Care Team shall include:

(1) Personal contact with and observation of each recipient.

(2) Review of each recipient's medical record. The record shall include timely certification and recertifications by the physician that the services are needed and a written individual plan of care developed either by an interdisciplinary team or the attending or staff physician, whichever is applicable. The plan of care shall indicate time limits and measurable care objectives and goals to be accomplished and who is to give each element of care.

(b) The team shall determine in its inspection if:

(1) The services are available and adequate to meet the recipient's physical, mental and psychosocial needs.

(2) It is necessary for the recipient to remain in the facility.

(3) Each recipient is receiving active treatment.

(4) The recipient's medical and social evaluations and the plan of care are complete and current, are followed, and ordered services are provided and recorded.

(5) The recipient receives adequate services based on personal observations of the Inspection of Care Team.

(6) Service needs are met by the facility or by outside arrangements.

(7) The recipient needs continued placement in the facility or there is an appropriate plan to discharge the recipient to an alternative living arrangement.

**Cross References**

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

**§ 6210.105. Inspection of care summary report.**

(a) The Inspection of Care Team shall develop a summary report at the conclusion of its inspection of each facility. The report shall include:

(1) The alternate care determinations.

(2) Findings of the adequacy and quality of care rendered by the facility. The findings will specify that the care rendered is acceptable or in need of improvement.

(b) Within 45 days following the conclusion of the inspection, two copies of the summary report shall be forwarded to the administrator of the facility. The administrator shall forward one copy of the summary report to the utilization review committee chairperson. On the second copy of the summary report, the administrator shall give written responses to each area identified as deficient and to narrative recommendations.

(c) In advance of forwarding the summary report to the facility, the Inspection of Care Team shall notify the CAO and the facility of alternate care determinations made by the team.

#### Cross References

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

### § 6210.106. Facility course of action.

(a) The facility shall return a copy of the summary report with appropriate corrective actions written thereon to the Department within 30 days of the control date indicated on the summary report. The facility's planned course of corrective action shall include proposed time frames for correcting findings of deficient care or services and narrative recommendations.

(b) The Inspection of Care Team may conduct a followup visit to determine if the deficiencies and recommendations are corrected.

#### Cross References

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

### § 6210.107. Recipient right of appeal of alternate care determinations.

(a) The recipient or the person or the facility acting on the behalf of the recipient, in accordance with Chapter 275 (relating to appeal and fair hearing), has 30 days in which to appeal the Inspection of Care Team's alternate care determination.

(b) Neither the facility, the facility's utilization review committee, nor the recipient's attending physician has the right to appeal the alternate care determination on its own behalf.

(c) If the recipient or the person or the facility acting on behalf of the recipient appeals the decision within 10 calendar days from the date the CAO issues the advance notice, payment for the present level of care will continue pending the outcome of the hearing subject to § 6210.52 (relating to payment pending appeal).

#### Cross References

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

### § 6210.108. Facility utilization review.

(a) Each facility furnishing services to eligible MA recipients shall have in effect a written utilization review plan that provides for review of each recipient's need for the services.

(b) If the utilization review committee of a facility finds that the continued stay of a recipient at a specific level of care is not needed, the committee shall, within 1 working day of its decision, request additional information from the recipient's qualified mental retardation professional, who shall respond within 2 working days. A physician member of the committee, in cases involving a medical determination, or the utilization review committee, in cases not involving a medical determination, shall review the additional information and make the final recommendation. If the additional information is not received within 2 working days, the committee's decision will be deemed final.

(c) The utilization review committee shall send written notice of adverse final decisions on the need for continued stay to:

- (1) The facility administrator.
- (2) The qualified mental retardation professional of the recipient.
- (3) The CAO.

(d) The CAO shall notify the recipient or the person acting on behalf of the recipient and the facility of the recommended change in the level of care. The recipient has the right of appeal in accordance with Chapter 275 (relating to appeal and fair hearing). Neither the facility nor the attending physician may appeal the decision of the utilization review committee on its own behalf.

#### Cross References

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

### § 6210.109. Provider misutilization.

Facilities determined to have billed for services inconsistent with MA Program regulations, to have provided services outside the scope of customary standards of practice or to have otherwise violated the standards set forth in the provider agreement, are subject to the sanctions described in this chapter and Chapter 1101 (relating to general provisions).

**Cross References**

This section cited in 55 Pa. Code § 6210.101 (relating to scope of claims review procedures).

**ADMINISTRATIVE SANCTIONS****§ 6210.111. Failure to file a cost report.**

(a) Failure to file a cost report, other than a final cost report, may result in termination of the provider agreement and shall result in the suspension of interim payments to the provider until the reports are filed in acceptable form. If the reports are not filed by the end of the fifth month after the due date established by § 6210.76 (relating to cost reporting), including extensions of that date granted by the Department, the Department may either determine payment for the cost reporting period involved on the basis of the method established with respect to untimely final cost reports in subsection (b) or seek injunctive relief to require proper filing, as the Department may deem is in the best interest of the efficient and economic administration of the program.

(b) Failure to file a final cost report and outstanding annual cost reports, when due, under § 6210.92 (relating to final reporting) shall result in payment to the provider for the cost reporting periods involved being determined on the basis of the lowest audited rate for a provider, including a rate limited by §§ 6210.80 and 6210.81 (relating to maximum rate of payment; and upper limits of payment) for the same level of care without regard to the type of provider for services rendered during the 6 months immediately preceding the beginning of the fiscal periods involved. Payment will not be made for depreciation expenses incurred by the provider with respect to services during the 365 days preceding the effective date of the event described in § 6210.92 which required the final cost report to be filed. Interim payments or payments after audit of the depreciation expenses shall be offset against payments due to the provider or shall be repaid to the Department by the provider if no payment is due.

**§ 6210.112. Failure to maintain adequate records.**

(a) If the Department determines that the facility has not maintained financial and statistical records in accordance with the Department's regulations, thus preventing the Department from conducting an audit of the facility's records, the facility shall be notified, by certified mail, that it has 60 days to correct the problem.

(b) The facility shall be advised that for failure to comply with the Department's notice, the Department will terminate the MA Provider Agreement, unless the problem is corrected within the 60-day period.

**§ 6210.113. Failure to correct deficiencies.**

(a) If the facility fails to correct a deficiency cited by the Department's Inspection of Care Team or causes delay in the review process which results in a penalty being imposed by the United States Department of Health and Human Services on the Department, the penalty shall be imposed on the facility.

(b) Failure to correct deficiencies in recipient care and services within 6 months following the receipt of the Inspection of Care Team's review report may result in the termination of the facility's MA Provider Agreement.

**§ 6210.114. Failure to adhere to certification requirements.**

If the facility's failure to comply with the requirements that the physician certify and recertify the need for care as described under §§ 6210.42 and 6210.43 (relating to certification of initial need for care; and recertification of continued need for care) results in a penalty being imposed by the United States Department of Health and Human Services on the Department, the penalty will be imposed on the facility.

**§ 6210.115. Failure to adhere to medical evaluation requirements.**

If the facility fails to comply with the requirements that the physician perform a medical evaluation before admission or before authorization for payment, as described under § 6210.42 (relating to certification of initial need for care), which results in a penalty being imposed by the United States Department of Health and Human Services on the Department, the penalty will be imposed on the facility.

**§ 6210.116. Failure to comply with requirements of maintaining recipient's funds.**

If discrepancies are identified by audit and the facility fails to make restitution to the recipient, the Department may terminate the provider agreement for cause.

**RIGHT OF APPEAL****§ 6210.121. Decisions that may be appealed.**

(a) The facility has a right to appeal and have a hearing if dissatisfied with the Department's decision regarding:

- (1) The interim per diem rate established by the Department.
- (2) The findings of the auditors in the annual audit report.
- (3) The determination by the comptroller of the difference between the allowable costs certified by the auditors in the annual audit report, and the total allowance amount as shown on the interim billing.

(4) The denial or nonrenewal of a provider agreement.

(b) Facilities participating in Medicare and the MA Program that are denied renewal of a MA Provider Agreement or have the Agreement terminated by the Department because of termination or nonrenewal by Medicare are entitled to the review procedures specified for Medicare facilities at 42 CFR Part 498 (relating to appeals procedures for determinations that affect participation in the Medicare Program). The final decision entered as a result of the Medicare review procedures is binding for the purposes of participation in the MA Program.

**Cross References**

This section cited in 55 Pa. Code § 6210.94 (relating to auditing requirements related to recipient fund management); and 55 Pa. Code § 6210.123 (relating to time limit for submission of appeal).

**§ 6210.122. Additional appeal requirements.**

The appeal is subject to the requirements specified in § 1101.84 (relating to provider right of appeal).

**Cross References**

This section cited in 55 Pa. Code § 6210.94 (relating to auditing requirements related to recipient fund management).

**§ 6210.123. Time limit for submission of appeal.**

An appeal shall be taken within 30 days of the date that the facility is notified of the decisions specified in § 6210.121 (relating to decisions that may be appealed). Findings contained in a facility's audit report which are not appealed by the facility within the 30-day limit will not be considered as part of a subsequent appeal proceeding.

**Cross References**

This section cited in 55 Pa. Code § 6210.94 (relating to auditing requirements related to recipient fund management).

**§ 6210.124. Submission of appeal**

An appeal shall be mailed to the Director, Office of Hearings and Appeals, Department of Public Welfare, Harrisburg, PA 17120, with a copy to the Office of Legal Counsel. The appeal request shall specify the issues presented for review.

**Cross References**

This section cited in 55 Pa. Code § 6210.94 (relating to auditing requirements related to recipient fund management).

**§ 6210.125. Right to reopen audit.**

(a) The Department may reopen a prior year's audit if an appeal is filed.

(b) For cost reporting periods ending prior to October 1, 1985, if an analysis of the facility's audit report by the Office of the Comptroller discloses that an overpayment has been made to the facility, the facility shall be bound by § 1101.84(b)(4) and (5) (relating to provider right of appeal).

**Cross References**

This section cited in 55 Pa. Code § 6210.94 (relating to auditing requirements related to recipient fund management).