67:16:04:33. Definitions. Terms used in this chapter mean:

(1) "Administration costs," costs defined in the statistical and cost summary report ~~which include~~ that relate to patient care and includes the administrator's and assistant administrator's salaries, administrative travel, office salaries, office supplies and expenses, central office and home office expenses, dues, fees, subscriptions, professional license fees, and legal and accounting expense~~ if these costs are related to patient care~~;

(2) "Capital costs," costs associated with building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and preoperating costs, mortgage interest, rent on the facility and grounds, equipment rent, and return on net equity;

(3) "Case mix," the mixture of residents of different classifications within a nursing facility;

(4) "Case mix score," the average of the~~ M3PI classification~~ Patient Driven Payment Model nursing case mix group weights for residents in a facility over a particular time period;

(5) "Chain organization," a group of two or more health care facilities that are owned, leased, or otherwise controlled by one organization;

(6) "Desk audit," a review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements before establishing a database from which per diem rates are established;

(7) "Field audit," a comprehensive, on-site review of the statistical and cost reports to determine omissions, erroneous calculations, reasonableness of selected cost items, and compliance with other reporting requirements before establishing a database from which per diem rates are established;

(8) "Hospital-affiliated nursing facility," a licensed nursing facility that is under common ownership with ~~and~~, is operated by the same administrative authority as, and shares on a daily basis common services areas with, the licensed hospital ~~and shares on a daily basis common service areas such as nursing, dietary, housekeeping, laundry, plant operations, and administrative services~~, and ~~which~~ that is required to use the stepdown method of allocation required by Medicare if the stepdown results in part of the cost of the shared areas being allocated between the hospital and the nursing facility, and ~~if~~ the stepdown numbers are the numbers used for Medicare reimbursement;

~~(9) "M3PI," the relative ratio of resources required to care for one class of residents when compared to another class of residents as measured by the resident assessment;~~

~~(10)~~ "Nursing facility," any facility that is licensed, maintained, and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician ~~24~~ twenty-four hours a day;

~~(11)~~(10) "Over-the-counter medications," medications that can be purchased by the general public without a physician or other licensed practitioner's prescription;

(11) "Patient Driven Payment Model," the relative ratio of resources required to care for one class of residents when compared to another class of residents as measured by the resident assessment using the nursing case mix group;

(12) "Related-party transaction," a business transaction between parties having a common ownership or control interest;

(13) "Resident assessment," a comprehensive assessment ~~of the functional, medical, mental, nursing, and psychosocial needs~~ of a nursing facility resident completed under § 44:73:06:10;

(14) "Routine services," services and items ~~which are~~ necessary ~~to meet~~ for the care, treatment, and comfort of a resident;

(15) "Salvage value," the estimated value of a depreciable asset at the end of its useful life. The ~~amount~~ value is estimated at the time of acquisition or construction and is deducted from the cost of the depreciable property to arrive at the basis for depreciation;

(16) "Stepdown method of allocation," an accounting methodology in which costs flow from nonrevenue-producing cost centers to revenue-producing cost centers. On ledgers showing this allocation, the lists of numbers take on a visual tiering appearance from the left of the page to the right;

(17) "Straight-line depreciation method," a procedure followed in depreciation computations that assigns equal segments of the cost of an item to the benefits to be yielded by the item, often over a period of time; and

(18) "Swing-bed hospital," an acute care general hospital that has been approved by the Department of Health to provide short-term nursing facility services in a portion of its licensed hospital beds pending the availability of a nursing facility bed.

Source: SL 1975, ch 16, § 1; 1 SDR 30, effective October 13, 1974; 2 SDR 16, effective September 4, 1975; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:01, 21

SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 35 SDR 312, effective July 6, 2009; 44 SDR 94, effective December 4, 2017.

General Authority: SDCL 28-6-1~~(1)(2)(4)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~(4).

67:16:04:46. Depreciation. The department calculates depreciation ~~according to the following~~ as follows:

(1) Masonry buildings ~~—~~ are calculated ~~on~~ using the straight-line depreciation method not to exceed three percent of the capital cost basis of the building. The capital cost basis for depreciation of new construction, major renovations, and facilities acquired through purchase is subject to a salvage value computation of at least ~~15~~ fifteen percent;

(2) Frame buildings ~~—~~ are calculated ~~on~~ using the straight-line depreciation method not to exceed four percent of the capital cost basis of the building. The capital cost basis for depreciation of new construction, major renovations, and facilities acquired through purchase is subject to a salvage value computation of at least ~~15~~ fifteen percent;

(3) Fixed equipment ~~—~~ is calculated based on the useful life of the item as determined according to the ~~"~~Estimated Useful Lives of Depreciable Hospital Assets, ~~2004~~ 2018 Edition~~"~~; and

(4) Major movable equipment, furniture, automobiles, and specialized equipment ~~—~~ is calculated ~~on~~ using the straight-line depreciation method~~;~~ and

~~(5) Movable equipment, furniture, automobiles,specialized equipment -~~ the useful life of the item ~~as~~ is determined according to the ~~"~~Estimated Useful Lives of Depreciable Hospital Assets, ~~2004~~ 2018 Edition.~~"~~

~~The department may allow a facility to~~ A facility may deviate from a determination based on the ~~"~~Estimated Useful Lives of Depreciable Hospital Assets~~"~~ if the facility ~~can provide~~ provides the department with documented historical proof of the asset's useful life.

Source: 16 SDR 26, effective August 13, 1989; transferred from § 67:16:04:08.07, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 35 SDR 312, effective July 6, 2009.

General Authority: SDCL 28-6-1~~(2)~~.

Law Implemented: SDCL 28-6-1~~(2)~~.

Reference: Estimated Useful Lives of Depreciable Hospital Assets, ~~2004~~ 2018 edition, published by the American Hospital ~~Publishing, Inc.~~ Association, ~~211 East Chicago Avenue~~ 155 North Wacker Drive, Chicago, Illinois ~~60611~~ 60606, https://www.aha.org/; ~~$45~~ $88.

67:16:04:49. Occupancy. ~~When determining a facility's direct and~~ To determine the nondirect care per diem rate of a facility, the department shall use the facility's actual occupancy, or three percent less than the statewide average of all nursing facilities, whichever is greater.

The department shall waive this provision for the first ~~12~~ twelve months of operation of a newly constructed facility that does not replace an existing facility. For the second ~~12~~ twelve months, the occupancy factor used to establish the facility's per diem rate is three percent less than the statewide average of all nursing facilities, or the facility's actual occupancy for the last quarter of the first ~~12~~ twelve months prorated to ~~12~~ twelve months, whichever is greater.

Source: 15 SDR 68, effective November 7, 1988, effective July 1, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:06.04, 21 SDR 8, effective July 25, 1994; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:04:51. Ceilings. Ceilings are established using allowable costs as follows:

(1) ~~Case mix adjusted direct care costs -- The department shall use two ceiling calculations when determining a facility's case mix adjusted direct care costs~~ To determine the case mix adjusted direct care costs of a facility, the department shall use two ceiling caluculations. The first ceiling is ~~established at 115~~ one hundred and fifteen percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. The department ~~will~~ shall recognize ~~100~~ one hundred percent of the facility's allowable costs up to the ~~115~~ one hundred and fifteen percent ceiling. The ~~department shall establish a~~ second ceiling ~~at 125~~ is one hundred and twenty-five percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. Payment for the case mix adjusted direct care costs ~~which~~ that exceed the ~~115~~ one hundred and fifteen percent ceiling and are up to the ~~125~~ one hundred and twenty-five percent ceiling is calculated according to § 67:16:04:54.01;

(2) ~~Nondirect care costs of health and subsistence, plant/operational, and other operating -- The department shall use two ceiling calculations when determining a facility's nondirect care costs of health and subsistence, plant/operational, and other operating~~ To determine the nondirect care costs of health and subsistence, plant, plant operations, and other operating costs of a facility, the department shall use two ceiling calculations. The first ceiling is ~~established at 105~~ one hundred and five percent of the median cost of all nursing facilities that have an average case mix score of 1.00 or more for the reporting period. The department ~~will~~ shall recognize ~~100~~ one hundred percent of the facility's allowable costs up to the ~~105~~ one hundred and five percent ceiling. The ~~department shall establish a~~ second ceiling is established at ~~110~~ one hundred and ten percent of the median cost of all nursing facilities that

have an average case mix score of 1.00 or more for the reporting period. Payment for these nondirect care costs ~~which~~ that exceed the ~~105~~ one hundred and five percent ceiling and are up to the ~~110~~ one hundred and ten percent ceiling is calculated according to § 67:16:04:54.02;

(3) ~~Nondirect care costs of administration -- The department shall use two ceiling calculations when determining a facility's nondirect care costs of administration~~ To determine the nondirect care costs of administration of a facility, the department shall use two ceiling caluculations. The first ceiling is ~~established at 105~~ one hundred and five percent of the median cost of all freestanding nonchain organization affiliated nursing facilities. The department ~~will~~ shall recognize ~~100~~ one hundred percent of the facility's allowable costs up to the ~~105~~ one hundred and five percent ceiling. The ~~department shall establish a~~ second ceiling is at ~~110~~ one hundred and ten percent of the median cost of all freestanding nonchain organization affiliated nursing facilities. Payment for the nondirect care costs of administration ~~which~~ that exceed the ~~105~~ one hundred and five percent ceiling and are up to the ~~110~~ one hundred and ten percent ceiling is calculated according to § 67:16:04:54.03; and

(4) ~~Capital costs -- For state fiscal year 2008~~ Beginning July 1, 2023, capital costs are ~~$12.42~~ limited to a ceiling of twenty dollars and ninety-five cents per resident day ~~to be increased each July 1 by one-half of the annual percentage of cost change from the previous year to the current year, calculated by using the median square foot unit cost for nursing homes from the **2007 Means Building Construction Cost Data**. For state fiscal year 2009, capital costs are $12.65 per resident day to be increased each July 1 by one-half of the annual percentage of cost change from the previous year to the current year, calculated by using the median square foot unit cost for nursing homes from the 2008 Means Building Construction Cost Data~~.

Source: 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 24 SDR 185, effective July 6, 1998; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009.

General Authority: SDCL 28-6-1~~(2)~~.

Law Implemented: SDCL 28-6-1~~(2)~~.

~~**References: 2007 Means Building Construction Cost Data**, published by the R. S. Means Company, Inc., Construction Consultants and Publishers, 63 Smiths Lane, P.O. Box 800, Kingston, MA 02364-0800; (781) 422-5000; $136.95.~~

~~**2008 Means Building Construction Cost Data**, published by the R.S. Means Company, Inc., Construction Consultants and Publishers, 63 Smiths Lane, P.O. Box 800, Kingston, MA 02364-0800; (781) 422-5000; $149.95~~

Cross-References:

Method of establishing per diem rates, § 67:16:04:54~~;~~.

State fiscal year, SDCL 4-10-10.

67:16:04:52. Maximum capital cost for leased facility. The maximum capital cost for leased facilities is limited to the lower of actual costs or the total capital costs per resident day established in § 67:16:04:51.

The capital cost items for computing the above limit consist of rent, building insurance, building depreciation, furniture and equipment depreciation, amortization of organization and preoperating costs, capital related interest, and return on net equity. The capital cost items are allowable only if incurred and paid by the lessee. Capital costs incurred by the lessor and passed on to the lessee ~~will not be recognized~~ are not allowed in any other manner than as outlined in this section. No reimbursement is allowed for additional costs related to subleases.

The maximum allowed for the rental component of the capital cost items for facilities negotiating new leases and facilities renewing, assigning, selling, transferring, or otherwise changing existing leases ~~after June 30, 1999~~, is limited to the lower of actual lease costs or ~~70~~ seventy percent of the average per diem cost of the capital cost for owner-managed facilities, excluding hospital-affiliated facilities.

~~For a facility with a valid lease before July 1, 1999, the maximum allowed for the rental component of the capital cost items is limited to the cost limit recognized by the department on July 1, 1998. The rental component remains constant and is not subject to any inflation adjustment.~~

Source: 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08.09, 21 SDR 8, effective July 25, 1994; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24,

1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004; 35 SDR 312, effective July 6, 2009.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

67:16:04:54. Method of establishing per diem rates. The department shall establish a case mix adjusted direct care per diem rate and a nondirect care per diem rate for each facility prior to July ~~1~~ first of each year. These rates are based on the facility's allowable costs, the facility's ~~M3PI~~ Patient Driven Payment Model case mix score, inflation factors, cost ceilings, occupancy, and known future cost increases that have prior departmental approval.

The case mix adjusted direct care per diem rate is established on a facility-specific basis using allowable direct patient care costs and paid according to the ~~M3PI~~ Patient Driven Payment Model index under the Patient Driven Payment Model classification system on a resident-specific basis. The case mix adjusted direct care per diem rate is established by calculating the average ~~M3PI~~ Patient Driven Payment Model case mix score for the facility, determining the per diem case mix component cost for the facility by dividing the allowable cost by ~~the occupancy determined according to § 67:16:04:49~~ total resident days, and dividing the facility's per diem case mix component cost by its ~~M3PI~~ Patient Driven Payment Model average case mix score. The case mix adjusted direct care per diem cost is used to establish the case mix adjusted direct care cost ceilings established in § 67:16:04:51, and the case mix adjusted direct care per diem rate is subject to those ceilings and the payment limits established in § 67:16:04:54.01.

The nondirect care per diem rate is established on a facility-specific basis using all other allowable costs. The nondirect care per diem rate is based on cost components consisting of health and subsistence, general administrative, other operating, ~~plant/operational~~ plant, plant operations, and capital. ~~To establish the~~ The nondirect care per diem rate~~, divide~~ is established by dividing the allowable nondirect care costs, by the occupancy ~~as~~ determined according to § 67:16:04:49. The allowable nondirect care costs are used to establish the

ceilings contained in § 67:16:04:51, and the nondirect care per diem rate is subject to those ceilings and the payment limits established in § 67:16:04:54.02. The nondirect care cost is not subject to case mix adjustment.

The per diem rate for the nondirect care costs of administration is subject to the payment limits established in § 67:16:04:54.03.

~~An individual nursing facility is limited to no greater than an eight percent rate increase from one period to another in the facility's combined direct care case mix adjusted rate and the nondirect care rate. If the facility's rate exceeds this limit, the department shall amend the facility's nondirect care rate to equalize the rates to the allowable limit.~~

Source: 16 SDR 26, effective August 13, 1989; 17 SDR 50, effective October 7, 1990; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:07.05, 21 SDR 8, effective July 25, 1994; 23 SDR 42, effective September 30, 1996; 26 SDR 5, effective July 1, 1999; 26 SDR 21, effective August 24, 1999; 29 SDR 177, effective July 1, 2003; 29 SDR 177, adopted July 1, 2003, effective July 1, 2004.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1.

Cross-Reference: Payment adjustment due to review of resident assessment, § 67:45:03:08.

67:16:04:60. Basis of payment. Payment to participating providers of nursing facility services is made on the following basis:

(1) Payment to an in-state ~~facilities~~ facility is calculated using the per diem rates ~~that are established~~ according to § 67:16:04:54, multiplying the case mix adjusted direct care per diem rate by the resident's ~~M3PI~~ Patient Driven Payment Model weight established by the resident assessment, and adding the nondirect care rate for each day the Medicaid resident is an inpatient resident;

(2) Payment to an out-of-state ~~facilities~~ facility providing nursing facility services to residents of South Dakota is the lesser of the Medicaid rate established by the state in which the facility is located or the South Dakota statewide average Medicaid rate for all ~~instate~~ in-state facilities. Payment to an out-of-state ~~facilities~~ facility for care not available at ~~instate facilities~~ an in-state facility is the rate recognized for the facility by the Medicaid agency in the state in which the facility is located;

(3) Payment for reserved bed days is governed by the provisions of § 67:45:02:04 and is based on the resident's latest resident assessment and ~~M3PI classification~~ Patient Driven Payment Model nursing case mix group at the time of the resident's absence;

(4~~) Swing-bed hospitals are~~ A swing-bed hospital is reimbursed at a daily rate established by the department. The daily rates are located on the department's fee schedule website~~. Swing-bed hospitals are reimbursed for assisted living at the current maximum rate paid for assisted living~~; and

(5) Coinsurance under the Medicare program is payable at the Medicare coinsurance rate.

Source: SL 1975, ch 16, § 1; 2 SDR 16, effective September 4, 1975; 2 SDR 88, effective July 1, 1976; 7 SDR 23, effective September 18, 1980; 7 SDR 76, effective February 11, 1981; 7 SDR 66, 7 SDR 89, effective July 1, 1981; 8 SDR 11, effective August 13, 1981; 11 SDR 26, effective August 21, 1984; 15 SDR 68, effective November 7, 1988; 16 SDR 26, effective August 13, 1989; 18 SDR 67, effective October 13, 1991; transferred from § 67:16:04:08, 21 SDR 8, effective July 25, 1994; 24 SDR 185, effective July 6, 1998; 26 SDR 21, effective August 24, 1999; 38 SDR 224, effective July 1, 2012; 42 SDR 51, effective October 13, 2015.

General Authority: SDCL 28-6-1~~(2)~~.

Law Implemented: SDCL 28-6-1(2).

Cross-Reference: Payment adjustment due to review of resident assessment, § 67:45:03:08.

67:16:04:62. Medicare Provider Reimbursement Manual. ~~For purposes of provider~~ Provider reimbursement under the provisions of this chapter and chapter 67:16:44~~,~~ is made by the department ~~uses~~ according to the Medicare Provider Reimbursement Manual (CMS Pub 15-1), ~~(May 2019)~~ (December 2021) available at ~~http://www.cms.hhs.gov/manuals/PBM/list.asp~~ https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.

Source: 21 SDR 172, effective April 3, 1995; 23 SDR 109, effective January 5, 1997; 26 SDR 21, effective August 24, 1999; 26 SDR 168, effective July 1, 2000; 28 SDR 1, effective July 18, 2001; 29 SDR 177, effective July 1, 2003; 35 SDR 312, effective July 6, 2009; 46 SDR 50, effective October 10, 2019.

General Authority: SDCL 28-6-1.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-References:

Absence of regulations -- Allowable costs based on CMS-15, § 67:16:04:40.

Costs not allowed, § 67:16:04:47.

Reference: Medicare Provider Reimbursement Manual (CMS Pub 15-1), March 31, 2023, published by the Centers for Medicare and Medicaid Services, available to download at no cost at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Paper-Based-Manuals.

CHAPTER 67:45:03

CASE MIX VALIDATION PROCESS

Section

67:45:03:01. Definitions. Terms used in this chapter mean:

(1) "Case mix," the mixture of residents of different classifications within a nursing facility;

(2) "Classification," a system of mutually exclusive categories that relate a resident's needs to the resident's cost of care;

(3) "Nurse consultant," a registered nurse employed by the department to validate resident classifications used to establish payment levels for the facility;

(4) "Nursing facility," a facility licensed as a nursing facility by the Department of Health and maintained and operated for the express or implied purpose of providing care to one or more persons, whether for consideration or not, who are not acutely ill but require nursing care and related medical services of such complexity as to require professional nursing care under the direction of a physician ~~24~~ twenty-four hours a day; and

(5) "~~Resident assessment" or "assessment~~ Assessment," a comprehensive assessment, completed using the resident assessment instrument described in § 67:73:06:10, of the functional, medical, mental, nursing, and psychosocial needs of a resident of a nursing facility and includes admission, readmission, and discharge information as applicable.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:02. Nursing facility ~~and critical access hospital~~ to submit assessments to department. A nursing facility ~~and a critical access hospital~~ participating in the Medicaid program ~~must~~ shall submit completed ~~resident~~ assessments to the department~~. The nursing facility and critical access hospital must submit the assessments~~ according to ~~the schedule established in § 44:04:06:16~~ § 44:73:06:10.

~~———~~ The nursing facility ~~and the critical access hospital must~~ shall ensure that the documentation maintained in the resident's file replicates exactly the assessment submitted to the department.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-Reference: Resident assessments, § ~~44:04:06:15~~ 44:73:06:10.

67:45:03:03. Correction to previously submitted resident assessment. If a facility finds that it submitted an inaccurate or incomplete ~~resident~~ assessment, the facility ~~may~~ shall submit a new, corrected assessment ~~to correct the previous assessment~~. The ~~facility must indicate on the new assessment that~~ new assessment must:

(1) Indicate it is a correction document. ~~Corrections are restricted to the most recently submitted resident assessment. The new assessment must be~~;

(2) Be dated with the date the new assessment is prepared; and ~~it must reflect~~

(3) Reflect the resident's status ~~of~~ on that date.

Corrections are restricted to the most recently submitted assessment.

The schedule for submitting ~~resident~~ subsequent assessments is reset according to the date the corrected document is ~~prepared~~ submitted.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-References:

Resident assessments, § ~~44:04:06:15;~~ 44:73:06:10

~~Resident assessment reviews, § 44:04:06:16~~.

67:45:03:04. ~~On-site reviews~~ Review to validate resident classifications. ~~The~~ Every fifteen months, at a minimum, a nurse consultant shall~~, at least every 15 months,~~ conduct ~~an on-site~~ a facility review to validate ~~resident~~ assessments and classifications. The nurse consultant shall notify the nursing facility of a pending review at least ~~48~~ forty-eight hours before the review is conducted. The review may encompass any resident of the nursing facility, regardless of payment source, ~~who has an~~ whose assessment ~~that~~ was completed in the last ~~45-60~~ forty-five to ninety days.

~~The validation~~ Validation of assessments and classifications is accomplished by reviewing the resident's clinical record, ~~observing and interviewing the resident,~~ interviewing staff from the nursing facility, and comparing the nurse consultant's findings with the ~~resident~~ assessment completed by the facility. If a resident to be reviewed ~~is~~ no longer ~~living~~ lives in the facility or is temporarily absent, the nurse consultant may review another resident ~~preferably~~ of the same classification. The nurse consultant may conduct the review onsite at the facility and may observe or interview the resident.

If the nurse consultant finds an error or ~~an~~ inconsistency on the ~~resident~~ assessment being reviewed, the nurse consultant may review that resident's assessments completed during the prior ~~12~~ twelve months.

If the nurse consultant identifies ~~problems such as high error rates, shifts in case mix, and unusually high or low proportions of residents~~ errors or irregularities in any one classification, the nurse consultant may expand the review to include ~~those~~ resident assessments completed for residents of the same classification. This expanded review may include residents who have since died or been discharged from the facility.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:05. Attempt to reconcile differences. In completing the review of the resident, the nurse consultant and a facility staff member shall attempt to reconcile any differences between the assessments completed by the facility and the validations completed by the nurse consultant. The nurse consultant's decision prevails if a difference cannot be resolved.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-Reference: Fair hearing, § 67:45:03:12.

67:45:03:06. ~~Exit conference~~ Conference. ~~Before leaving the facility, the~~ The nurse consultant shall conduct ~~an exit~~ a conference with ~~facility staff to present a preliminary report of the on-site review. At a minimum,~~ the administrator of the facility ~~and~~ or the facility's director of nursing ~~must attend the exit conference~~ to present any finding of the review conducted pursuant to § 67:45:03:04. The ~~preliminary report shall~~ conference must address the following items, as applicable:

(1) Areas which need improvement;

(2) Assessments requiring classification and payment changes;

(3) Error patterns; and

(4) Staff education and training needs~~; and~~

~~(5) Information as to when the department will send the final report to the facility~~.

Before the ~~exit~~ conference is concluded, the department shall give the facility staff the opportunity to provide additional information or explanations about discrepancies in the coding or documentation of the ~~resident~~ assessment. If the facility staff cannot provide evidence that supports its coding of the ~~resident~~ assessment, the decision of the nurse consultant stands.

Staff from the nursing facility who attend the ~~exit~~ conference must sign the ~~exit~~ conference attendance sheet as an indication that the conference was held and that they attended.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-References:

Payment adjustment due to review of resident assessment, § 67:45:03:08~~;~~

~~Fair hearing, § 67:45:03:12~~.

67:45:03:07. Written report of ~~on-site~~ review. Within ~~15~~ fifteen calendar days following the ~~on-site review~~ conference described in § 67:45:03:06, the nurse consultant ~~must~~ shall send to the facility a written report detailing the results of the review. ~~If the facility does not agree with the written report, the facility has 10 calendar days following receipt of the written report to submit information that substantiates the coding of the resident assessment~~ The written report is the department's final decision.

~~The nurse consultant shall review the additional documentation and prepare its final decision. The final decision shall be in writing and sent to the nursing facility within seven calendar days after receiving the additional documentation.~~

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-Reference:

Payment adjustment due to review of resident assessment, § 67:45:03:08.

Fair hearing, § 67:45:03:12.

67:45:03:08. Payment adjustment due to review of ~~resident~~ assessment. The department shall adjust a facility's payment if a review of a resident results in either an increase or a decrease in the payment amount the nursing facility should have received on behalf of a resident. The payment adjustment is limited to the most recent ~~resident~~ assessment submitted. ~~The department shall adjust the nursing facility's next available payment.~~

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:09. Nursing facility to provide resident's clinical record. The nursing facility ~~must~~ shall provide the nurse consultant with the clinical record of each resident being reviewed. The resident's clinical record must include clear, concise, descriptive, and dated documentation that accurately described the resident's condition. The facility must make a resident's clinical ~~file~~ record available to the department in a format acceptable to the department and must provide the department with copies of needed documentation from the resident's clinical record on request.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:10. Record retention. The facility ~~must maintain~~ shall retain the documentation necessary to support each resident's assessment~~. The facility must retain this supporting documentation~~ for a minimum of six years.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:11. Cases of suspected fraud -- Investigation -- Restitution. If the department receives a report that suggests ~~that~~ fraud or abuse has occurred or is occurring in a facility, ~~it shall~~ the department must immediately investigate to determine the validity of the report.

Nothing contained in this chapter restricts the department's ability to collect payments made to a facility as a result of fraud committed by the facility.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

67:45:03:12. Fair hearing. A facility may appeal an adverse decision made under the provisions of this chapter. A request for a fair hearing must be made within ~~10~~ ten calendar days after the nursing facility receives the written notice of the department's final decision.

A facility ~~must~~ shall request a fair hearing in writing. A fair hearing is conducted under the provisions of chapter 67:17:02.

A decision affecting the nursing facility's payment level is applied retroactively to the assessment start date.

Source: 26 SDR 21, effective August 24, 1999.

General Authority: SDCL 28-6-1~~(1)(2)~~.

Law Implemented: SDCL 28-6-1~~(1)(2)~~.

Cross-Reference:

~~How to request a hearing~~ Hearing requests, § 67:17:02:03.