HUMAN SERVICES
DEPARTMENT

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Letter of Direction #6

Date: **March 21, 2019**

To: **Centennial Care Managed Care Organizations**

From: **Nicole Comeaux, Director, Medical Assistance Division**

Subject: **Compilation of Nursing Facility Level of Care (NF LOC) Criteria and Instructions effective January 1, 2019 to the Policy Manual to include other supplements and other NMAC Rules under one document**

Title: **(NF LOC) Policy Manual Compilation Reference**

Purpose

The purpose of this Letter of Direction (LOD) is to consolidate sections from several documents and provide one set of comprehensive direction for NF LOC. Items incorporated are from the New Mexico Administrative Code (NMAC), Medicaid Managed Care Services Agreements and the Systems Manual. The areas for consideration in this LOD include:

a) Denial, Re-review Method and Timelines,
b) Reconsideration Review and 14 Day Extension,
c) Reconsideration Language,
d) HNF and LNF Length of Stay Language and
e) Clarification Language Regarding Medicaid Pending Applications.

A. Denial, Re-review Method and Timelines

If a LOC criterion is not met and the request for placement is denied, the MCO will mail the referring parties a denial letter in a timely manner with the reason for denial as determined by the physician consultant. The requesting parties then have an opportunity to request a Re-review, Reconsideration, or an Administrative Hearing of the MCO's decision.

Providers who disagree with the initial review decision must request a Re-review of the decision(s) before requesting a Reconsideration. The Re-review must be requested within ten (10) calendar days after the date on the written notification of the MCO decision or action. Requests for a Re-review must be submitted in writing directly to the MCO. The MCO completes and submits a written Re-review decision to the NF within six (6) working days from receipt of a written request for a Re-review. The decision notice from the MCO contains information on the Reconsideration process.

B. Reconsideration Review and 14 Day Filing Extension

Providers who disagree with a Re-review determination may request a Reconsideration. Requests for Reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the Re-review decision notice. The MCO performs the Reconsideration and notifies the NF in writing of a decision within ten (10) business days of receipt of the Reconsideration request. The written notice also includes information on the MCO Appeals and/or HSD Administrative Hearing process, as appropriate.

The MCO will accept a request for Reconsideration filed up to 14 calendar days past the 30 calendar day limit if the MCO finds that there was good cause for the provider's or the eligible recipient's failure to file a timely request. The provider or the eligible recipient must furnish written documentation of good cause. Good cause includes a death in the family, a disabling personal illness or another significant emergency or other exceptional circumstance.

C. Reconsideration Language

The request for Reconsideration must include the following:

- reference to the challenged decision or action;
- basis for the challenge;
- copies of any document(s) pertinent to the challenged decision or action;
- copies of the claim form(s) if the challenge involves a claim for payment which is denied due to an UR decision; and
- statement that a Reconsideration of the decision is requested.

Individuals employed with the MCO, who were not participants in the initial decision, conduct the Reconsideration review.

The MCO reviews the information and findings upon which the initial action was based and any additional information submitted to, or otherwise obtained by the MCO. The information can include the following:

- case records and other applicable documents submitted to the MCO by the provider when the request for services was initially submitted;
- findings of the reviewer resulting in the initial decision;
- complete record of the service(s) provided, including hospital or medical records; and
- additional documents submitted by the provider to support a Reconsideration review.

The MCO performs the Reconsideration and furnishes the Reconsideration decision within ten (10) business days of receipt of the Reconsideration request.

The MCO gives the provider and the eligible recipient written notice of the reconsideration determination. If the decision is adverse to the eligible recipient, the notice also includes information on the eligible recipient's right to an MCO appeal and/or HSD Administrative Hearing and timeframes to file an appeal or a hearing, and request for a continuation of his or her current benefit, as appropriate.

D. High NF (HNF) and Low NF (LNF) Length of Stays

All services furnished by Medicaid NF providers must be medically necessary. The medical necessity decision is made during the Initial Review.

The length of stays for HNF:

- Initial HNF is not to exceed thirty (30) days; however, a shorter length of stay can be assigned based on the needs of the resident;
- HNF continued stay reviews can be certified by the MCO for up to 90 days based on the medical needs and stability of the resident.

The length of stays for LNF:

- Initial LNF cannot exceed ninety (90) days; however, a shorter length of stay can be assigned based on the needs of the resident.
- LNF continued stay reviews can be certified by the MCO up to 365 days based on the medical needs and stability of the resident.

Prior approval reviews are required for all requests for the continued stay of a resident in a NF. These reviews are based on the medical necessity of NF services being continually provided to the resident. The medical necessity decision is made during the continued stay review. Thirty days before the expiration of the current certification, a request for continued stay must be received by the MCO.

E. Clarification Language Regarding Medicaid Pending Applications.

When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed Minimum Data Set (MDS) with required documentation and a Physician's, Nurse Practitioner's or Physician Assistant's order for LOC. The Notification Form - Section I. Nursing Facility Prior Authorization Request - should have **"MEDICAID PENDING"** selected for **Type of Request (Choose an item from the drop down menu).**

The MCO will review the information submitted and determine the LOC.

The MCO will issue NF LOC, if appropriate but will only issue a prior authorization to the NF for the authorized bed days, and after eligibility is established.

F. Clarification Language Regarding Skilled Services vs. High NF LOC

The updated NF LOC criteria published on 01/01/19 includes General Eligibility Requirements under Section V. This section explains the minimum requirements for LOC and also includes information on when the MCO should not assign a LOC, but rather issue a skilled authorization. Below is HSD's additional clarification to this section.

"Not appropriate for NF care: The member's needs are too complex or inappropriate for NF, such that:

- The member requires acute level of care for adequate diagnosis, monitoring and treatment or requires inpatient based acute rehabilitation services."

MAD clarification:

- Members who reside in a NF long term and have a clinical episode which requires hospitalization, should be evaluated for skilled services once readmitted to the facility to determine if the member requires acute therapy related to the hospitalization.
- Members who reside in a NF long term and have a clinical episode which does not require hospitalization, but may indicate a change in LOC, should be evaluated for HNF.
- Members who do not reside in the NF but have been hospitalized and require inpatient based acute rehabilitation services should be evaluated for skilled services.

Resources

Several documents provide rule, criteria, instructions and guidance for HSD, MCO and Nursing Facilities in which to provide oversight and management of Centennial Care Medicaid Programs. The Managed Care Policy Manual (PM), New Mexico Administrative Code (NMAC), Medicaid Managed Care Services Agreement and Systems Manual plus additional Supplementals or Letters of Direction all provide direction resulting in perusal of multiple resources.

Documents referenced include:

- Managed Care Policy Manual – Section 6 Nursing Facilities; Effective 01/01/2014, Revised 01/01/2019
- 8.350.2 NMAC Reconsideration of Utilization Review Decisions; EFF: 08/01/2014
- 8.350.2.10 NMAC; Rp, 8.350.2.10 NMAC, 08/01/2014
- 8.312.2-UR Long Term Care Services Utilization Review Instructions for Nursing Facilities; EFF 06/15/2010
- A Medical Assistance Program Manual Supplement 18 -12 dated December 12, 2018 provided revised "Nursing Facility Level of Care (NF LOC) Criteria and Instructions" effective January 1, 2019 to replace "Nursing Facility Level of Care Criteria and Instructions" effective November 1, 2014.

Questions related to this LOD should be directed to Crystal Hodges at CrystalA.Hodges@state.nm.us.

This LOD will sunset once all language has been incorporated in the Policy Manual.