4 NURSING FACILITY LEVEL OF CARE DETERMINATIONS

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Effective Date: January 1, 2014

GENERAL INFORMATION

This policy establishes guidelines and restrictions for all MCOs regarding nursing facility services. The Nursing Facility (NF) Medical Eligibility Criteria can be found at~~: See~~ 8.312.2UR.

NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL

All requests for prior approval shall contain appropriate documentation and must be completed for each resident for every situation requiring prior approval. ~~(See the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria for documentation requirements.)~~ All requests for prior authorization are submitted to the resident's MCO by fax.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability and related conditions. There are procedures and information that are applicable to all situations requiring prior approval.

1. Purpose of PASRR is as follows:
    a. To determine whether a resident requires a specific level of nursing care;
    b. To determine if there is suspicion of serious mental illness (MI) or intellectual disability/related condition (ID/RC);
    c. To assess persons suspected of having serious MI or ID/RC;
    d. To assess whether specialized services for MI or ID/RC are needed; and,
    e. To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program for those with MI or ID/RC.
2. Organization of the PASRR: PASRR is divided into two levels: Level 1 Screen and Level II Evaluation.
    a. Level I Screen: A Level I Screen must be completed prior to admission on every NF applicant. If, during the Level I Screen, it is determined that the individual is suspected of having either MI or ID/RC, a Level II Evaluation or PASRR waiver must occur prior to admission. A Level I Screen must also be done if there has been a significant change in the physical or mental condition of a resident who is suspected of having, or previously determined to have MI or ID/RC. "Significant change" for PASRR purposes can be tied to the already existing regulatory definition for significant change that prompts an alteration in a resident's Minimum Data Set (MDS). Significant change referrals must be made to the PASRR Unit no later than twenty one (21) business days after the occurrence of the significant change. The PASRR Unit is required to review the completed Level I Screen packet within seven (7) to nine (9) business days of receipt of the completed packet from the NF. Notification of the review decision must be submitted to the NF by phone or in writing within that time period.

b. Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having MI or ID/RC, a Level II Evaluation or a PASRR waiver must be completed prior to the admission of the resident. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident.

3. PASRR Waiver:
   a. If an individual falls within one of the following categories, a complete Level II Evaluation may not be performed. A PASRR Waiver is granted on a case-by-case basis.
      i. The resident has a primary diagnosis of dementia.
      ii. The resident is being discharged from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed thirty (30) business days.
      iii. The resident is suspected of having MI or ID/RC but is certified to be terminally ill with a life expectancy of six (6) months or less and is in need of continuous nursing care and/or medical supervision and treatment due to a physical condition.
      iv. The severity of the resident's medical condition and medical treatment needs are so extensive that specialized MI or ID/RC services are not likely to be beneficial.
      v. The resident who is suspected of having MI or ID/RC and is admitted directly to a NF from a home for very brief and finite stay (up to 14 days) for the purpose of providing respite to in-home caregivers.
4. Level I Screen Process
   a. A NF is required to submit copies of the Level I Screen for each resident with the MDS to the MCO/UR Contractor. The Screen and other necessary documentation must be sent with the MDS to avoid delays in the review process.
   b. The MCO/UR Contractor logs in the date on the recipient screen when the MDS, Level I Screen, and other documentation is received.
   c. The MCO/UR Contractor scans the Level I Screen. If the resident passes the Screen, the MCO/UR Contractor determines the NF LOC. If the resident fails the Screen, no further NF LOC action is to be taken by the MCO/UR Contractor. The MDS Screen, and other documentation, is submitted to the PASRR Unit.
   d. The MCO/UR Contractor then sends a notice to the NF that the MDS and other documentation have been sent to the PASRR Unit for a Level II Evaluation determination.
   e. The PASRR Unit reviews the Level I Screen, determines the NF LOC and sends a copy of the NF LOC, Screen, MDS and other documentation to the MCO/UR Contractor.
5. Level II Evaluation Process: The PASRR Program completes an evaluation and makes the Level II and NF LOC determination on the review portion of the MDS and returns the MDS to the MCO/UR Contractor. All subsequent reviews are performed by the PASRR Unit unless waived by the PASRR Unit.
   a. If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews are performed by the PASRR Unit instead of the MCO/UR Contractor.

b. If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for a NF LOC determination.

6. PASRR and Re-admission from a Hospital: The NF contacts the PASRR Program if the hospitalization of a resident results in a change in the Level I Screen.
7. PASRR and Medicaid Eligibility Pending: If a resident is in a "Pending Medicaid" status at the time of MDS submission and the resident fails the Level I Screen, the MDS is forwarded to the PASRR Unit as notification while the following actions occur:
   a. The NF LOC determination is made.
   b. The MAD 385 Form is completed and sent to the MCO/UR Contractor. The information on this form is processed by the MCO/UR Contractor and submitted to the appropriate ISD office and to the NF.
   c. Once eligibility is established, the ISD office notifies the NF.
   d. The NF must notify the PASRR Unit of the status of the resident's eligibility.
   e. The MDS which includes the Medicaid number and the certified length of stay is completed by the PASRR Unit.
   f. Upon completion, the MDS is submitted to the MCO/UR Contractor.

LEVEL OF CARE PACKET FOR NURSING FACILITES INCLUDES:

1. PASRR
2. MDS - is the form used for all prior approval reviews.
   a. All requests for prior approval will be submitted on the MDS. An MDS and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.
   b. All locator fields must be clearly marked on the MDS.
   c. When the resident goes off Medicare Co-Pay to straight Medicaid, the NF submits an Internal MDS that begins the UR process for the resident.
   d. The NF should write what type of review is being requested at the top of the MDS:
      i. Initial
      ii. Continued Stay
      iii. Medicaid Pending
      iv. Transfer
      v. Re-admit
      vi. Re-review
      vii. Reconsideration
      viii. Level of Care Change
3. Appropriate documentation must accompany the MDS. Generally, appropriate documentation includes a valid order and must:

~~a. Physician's, Nurse Practitioner's, Clinical Nurse Specialist's or Physician Assistant's Orders. A valid order must:~~

~~b.~~a. Be signed by a Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant~~.~~;

~~c.~~b. Be dated; and~~.~~

~~d.~~c. Indicate the LOC – either high NF (HNF) or low NF (LNF).

Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the Physician, Nurse Practitioner or Physician Assistant.

Verbal or telephone orders are permitted. The order must be taken by a RN or LPN who must also sign and date the order. It must be clearly indicated that the order is a telephone or verbal order with the name of the Physician, Nurse Practitioner or Physician Assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order.

The MCO approves the documentation and makes a LOC determination following the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria within five (5) business days of receiving a completed packet. The MCO shall review the documentation provided to determine the appropriate NFLOC. A packet that requests LNF but meets HNF criteria shall be upgraded to HNF; a packet that requests HNF but only meets LNF criteria shall be downgraded to LNF. A new doctor's order is not required.

When required documentation is missing, a "Request for Information" (RFI) sheet will be generated by the MCO and sent to the provider. If the required documentation is not provided to the MCO within fourteen (14) business days the request, it will be technically denied. The MCO will make three (3) attempts during the fourteen (14) business day period to contact the NF to obtain information.

NOTE: A formal Request for Information (RFI) to the provider to justify the HNF request is not required when reviewing and processing HNF requests that clearly do not meet HNF criteria but do meet Low NF (LNF) criteria; however, the MCO will continue to use the RFI process for requests reflecting that the individual may be eligible for HNF LOC. In the event that a determination is upgraded or downgraded from the physician's order, the MCO shall give the NF technical assistance to educate the NF on determination criteria.

The MCO faxes the notification form with authorization and date span to the NF.

DENIAL OF REQUESTS FOR PRIOR APPROVAL

If the LOC criteria are not met and the request for placement is denied, the MCO will send the referring party and the member a denial letter within five (5) business days of a completed packet, with the reason for denial as determined by the physician. The requesting parties then have an opportunity to request reconsideration or appeal. After the parties have exhausted the MCO appeal process, the member may request an administrative hearing of the MCO decision.

RESERVE BED DAYS

Medicaid pays to hold or reserve a bed for a resident in a Nursing Facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below.

1. Medicaid covers six (6) reserve bed days per calendar year for every long term care resident for hospitalization without prior approval. Medicaid covers three reserve bed days per calendar year for a brief home visit without prior approval.

2. Medicaid covers an additional six (6) reserve bed days per calendar year with prior approval to enable residents to adjust to a new environment, as part of the discharge plan.
    a. Resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.
    b. The prior approval request must include the resident's name, Medicaid number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the resident during the visit or placement and a written physician order for trial placement.

Nursing facilities use the following procedures for prior approval for additional discharge reserve bed days. The NF must submit the request for prior approval for additional discharge reserve bed days to the MCO in which the resident is enrolled. The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days.

INITIAL DETERMINATION, REDETERMINATION, AND PENDING MEDICAID ELIGIBILITY

1. Initial Determination: ~~See 8.312.2UR.~~All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the section *NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL* above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission.
2. Redetermination: See 8.312.2UR. The medical documentation must be faxed and received by the MCO a minimum of sixty (60) calendar days prior to the start date of the new certification period for LNF and thirty (30) calendar days prior for HNF.
3. Length of Stay Periods: See 8.312.2UR.
4. Pending Medicaid Eligibility: Prior approval reviews can be done when the service is furnished before the determination of the effective date of the resident's financial eligibility for Medicaid. If the resident is applying for Medicaid, both financial and medical eligibility at the same time, please write "MEDICAID PENDING" in the type of request box on the Notification form. Please Note: A resident on Supplemental Security Income (SSI) is not Medicaid Pending.
    a. When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed packet of required documentation. The Prior Authorization form should have "MEDICAID PENDING" in the type of request box on the Notification form.
    b. The MCO will review the information submitted and determine the LOC.
5. The Prior Authorization form will be completed by the MCO and sent to the NF.

RETROACTIVE MEDICAID ELIGIBILITY

Written requests for prior approval based on a resident's retroactive financial eligibility must be reviewed by the MCO within thirty (30) calendar days of the date of the eligibility determination. The NF must submit medical documentation to the MCO.

RE-ADMISSION REVIEWS

A re-admission review is required when the resident has left the NF and then returns, after three (3) midnights in a hospital, to a different LOC.

The NF has to submit a re-admit MCO approval request form within thirty (30) calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF.

1. When the resident is re-admitted to the NF and has more than thirty (30) calendar days left on his/her certification, days will be assigned from the re-admit date. The NF sends the notification form to the MCO along with supporting documentation.
2. If the resident has less than thirty (30) calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit redetermination (annual or continued stay) request on the notification form along with supporting documentation.

RETROSPECTIVE REVIEWS

Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the NF. Medicaid pending reviews are never considered late.

A request for retrospective review for initial, redetermination or re-admit reviews is considered in the following situations only:

1. Unexcused late reviews:
    a. For the first six (6) months of Centennial Care (ending June 30th, 2014), the MCOs shall not impose unexcused late penalties to NFs.
    b. Starting July 1st, 2014, the NF may lose payment for each day that the NF LOC review is submitted late.

Excused Late Reviews: Prior authorization forms not submitted timely due to reasons beyond the control of the NF must be submitted with a detailed written explanation and documentation that supports the request for excusable late review.

Reimbursement and retrospective reviews:

1. If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO.
2. Medicaid will not reimburse NFs for dates of service (DOS) not covered by the MCO prior authorization form. In addition, the Medicaid member cannot be billed for the service.

TRANSFER FROM ANOTHER NF

If a resident is admitted to one NF from another NF, the following procedures apply:

1. The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO.
    a. If there are more than thirty (30) calendar days on the resident's current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span.
    b. If there are less than thirty (30) calendar days remaining on the resident's current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write "TRANSFER" in the type of request box on the notification form.
2. The NF receiving the resident receives the status of resident's reserve bed days from the MCO through the notification form. This includes the number of days used during a calendar year and the reason for the use of these days. This information is placed in the resident's NF records.

CHANGED IN THE LEVEL OF CARE (LOC)

All changes in LOC require a new notification form that should be submitted within thirty (30) calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write "LEVEL OF CARE CHANGE" in the type of request box on the notification form. The NF must provide a signed and dated order from the Physician, Nurse Practitioner or Physician Assistant as well as any documentation to support the LOC request (see New Mexico Nursing Facility Level of Care Instructions and Criteria). The date the LOC change occurred must be clearly stated.

DISCHARGE STATUS

Discharge status occurs when a resident no longer meets the level of care that qualifies for nursing home placement, but there is no option for community placement of the resident at that time. Individuals are often already residing in a nursing facility at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in a nursing facility may clinically improve to the point that they no longer meet nursing facility LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the nursing facility. Community based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the nursing facility. Physically discharging the resident under such circumstances may put the resident's health at risk.

To accommodate this health care issue the New Mexico Medicaid program allows for temporary continuation of coverage at Low NF level of reimbursement while the NF and the MCO address the development of community placement resources on an ongoing basis to meet the resident's lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident is termed "Discharge Status;" however, Discharge Status does not mean that the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility.

1. ***Initial Discharge Status*** is authorized at Low NF for a maximum of ninety (90) calendar days, based upon the MCO physician determination.
2. ***Continued Stay Discharge Status*** is authorized at Low NF for not less than one hundred eighty (180) calendar days and up to three hundred sixty-five (365) calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility staff's and MCO care coordinator's ongoing attempts to find and develop appropriate community placement options for the resident. The facility should document why the resident must remain in a nursing home environment if the resident is at risk for failure to thrive upon discharge to a community placement. Failure to submit sufficient documentation specifying the facility's discharge planning efforts could result in the denial of prior authorization. The resident's inability to afford assisted living services may be a consideration in discharge planning.

RECONSIDERATION, APPEAL, ADMINISTRATIVE HEARING

1. Reconsideration: Providers who disagree with a NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on his or her behalf. 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 and Member in writing of a decision within eleven (11) business days of receipt of the reconsideration request. The written notice also includes information on a Member's right to request an HSD administrative hearing after the Member has exhausted his or her MCO's appeal process.
2. The request for reconsideration must include the following:
    a. Statement that reconsideration is requested.
    b. Reference to the challenged decision or action.
    c. Basis for the challenge.
    d. Copies of any document(s) pertinent to the challenged decision or action; and
    e. Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision.
3. Appeal: If a reconsideration determination is adverse to the Member, the Member may request an appeal with his or her MCO in accordance with 8.305.12 NMAC.
4. HSD Administrative Hearings: After the Member has exhausted the MCO appeal process, the Member may request an HSD administrative hearing in accordance with 8.352.2 NMAC.
5. State Administrative Hearing: After the parties have exhausted the MCO appeal process, the parties may request an administrative hearing according to State administrative rule 8.352.2 NMAC.

COMMUNICATION FORMS

The MCO shall use the approved HSD forms for communication and notification with the NFs.

Nursing Facility Level of Care

Communication Form

***This Communication Form is intended to be used between MCO and Nursing Facilities ONLY.**

I. Requestor Information

Date of Request	Click here to enter a date.		
FROM	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.
TO	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.

II. Communication:

Nursing Facility Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN#	xxx – xx – Click here to enter text.

a. ☐ Request For Information

Request for following selected information:

- ☐ Missing Member Demographics
- ☐ Missing MDS Required fields: Click here to enter text.
- ☐ MDS not within the service time frame requested
- ☐ Need a valid physician order for: Click here to enter text.
- ☐ Need member's Level I PASSR
- ☐ Need member's Level II PASSR
- ☐ Need current H&P
- ☐ Need current signed and dated physician progress notes
- ☐ Medicare COB if applying therapy as PNFS criteria for dual member
- ☐ Other: Click here to enter text.

b. ☐Member Status Update

Request for following selected member status update:

- ☐ Discharge Status
- ☐ Member Representative Info
- ☐ Current Progress Note
- ☐ Other: Click here to enter text.

c. ☐Member MCO Update

Request for following selected member MCO update:

- ☐ Member current MCO selection: Click here to enter text.
- ☐ Member previous MCO assignment: Click here to enter text.

Nursing Facility Level of Care

Notification Form

I. Nursing Facility Prior Authorization Request

Nursing Facility Information			
Date of Request	Click here to enter a date.	Type of Request	Choose an item.
Nursing Facility Name	Click here to enter text.		
NF Contact Name	Click here to enter text.		
Nursing Facility Fax	Click here to enter text.	Nursing Facility Phone	Click here to enter text.

Nursing Facility Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN#	xxx – xx – Click here to enter text.
NF Admission Date	Click here to enter a date.	Selected MCO	Choose an item.
Resident Rep Name	Click here to enter text.	Rep Phone	Click here to enter text.
Resident Rep Address	Click here to enter text.		

Requesting Service			
NFLOC Type	Choose an item.		
Service Begin Date	Click here to enter a date.	Service End Date	Click here to enter a date.

Documentation Requirements:

Initial Request:

- ☐ MDS
- ☐ Physician Order
- ☐ PASRR Level I and PASRR Level II if indicated by PASRR Level I
- ☐ History & Physical

Continuation Stay:

- ☐ Most recent MDS
- ☐ Physician Order
- ☐ Physician Progress Notes
- ☐ History & Physical

II. Utilization Management (For MCO Use Only)

Review Information			
Date of Review	Click here to enter a date.	**Authorization Number**	Click here to enter text.
NFLOC Begin Date	Click here to enter a date.	**NFLOC End Date**	Click here to enter a date.
Approved Bed Begin Date		**Approved Bed End Date**	

LNF Factors:

- ☐ Dressing
- ☐ Bathing
- ☐ Eating
- ☐ Meal Preparation
- ☐ Transfer
- ☐ Mobility
- ☐ Toileting
- ☐ Bowel/Bladder
- ☐ Daily Medication

HNF Factors:

- ☐ Oxygen
- ☐ Orientation / Behavior
- ☐ Medication Administration
- ☐ Rehabilitation Therapy
- ☐ Skilled Nursing
- ☐ Feeding
- ☐ Mobility / Transfer

Approved NFLOC Type: Choose an item.

Comments: Click here to enter text.