Healthcare Compensation Solutions

Playing by the Rules for the Medicaid Nursing Home Program

Medicaid Representatives

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Alabama Medicaid Agency

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State of Alabama Medicaid Agency

- **MISSION:** To provide a system of financing health care for eligible Alabamians in accordance with established statues and Executive Orders.
- **VISION:** To play a key leadership role in ensuring availability and access to appropriate health care for all Alabamians.

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Long Term Care Division

The Alabama Medicaid Agency administers a comprehensive program of Long Term Care services that offers eligible recipients a wide range of care choices as well as increased opportunities to receive services at home, in the community, or in a facility. The Long Term Care Division consists of the following programs:

- Home Health Program
- Hospice Program
- Intermediate Care Facility for the Mentally Retarded (ICF/MR) Program
- Nursing Home Program
- Ombudsman Program
- Ventilator Dependent and Qualified Tracheostomy Care (Nursing Home Vent)
- Money Follows the Person (MFTP) Program
- Private Duty Nursing (PDN) Program
- Prosthetics and Orthotics Program

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Long Term Care Division

Long Term Care services also include waiver programs to provide alternatives to institutional care. Long Term Care waiver services include:

- Alabama Community Transition (ACT) Waiver
- Elderly and Disabled Waiver
- HIV/AIDS Waiver
- Intellectual Disabilities (ID) Waiver
- Living at Home (LAH) Waiver
- State of Alabama Independent Living (SAIL) Waiver
- Technology Assisted (TA) Waiver

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Topics of Discussion

- Tips for an Efficient Medical Review
- An Overview of Transfer and Discharge Appeal Process
- Long Term Care Bed Hold Policy
- Therapeutic Leave Policy
- Hospice Care
- Alabama Home and Community-Based Waiver Services

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Tips for an Efficient Medical Review

- Please accurately complete the Admission and Evaluation Data (Form 161) in its entirety. This includes documenting the **Name, Medicaid Number, and Date on pages 2 and 3of the form.** If the recipient is a spend down, please check spend down on the form and give the dates of the spend down status
- Please ensure that the Medicaid date is documented correctly on the Form 161 since when the physician signs the form he/she is stating that "I certify this resident requires nursing facility care effective on the admission date appearing on this form"
- The Form 161 should be signed appropriately by the physician and the RN
- Submit medical records pertinent to the criteria selected. Understand the criteria
- The facility is not required to send the entire medical record, only information that supports the request for LTC
- Initial audit requests and requests for additional information **must** be submitted timely to avoid any penalties as referenced in the Administrative Code **Rule No. 560-X-.07. Review of Medicaid Residents**

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Tips for an Efficient Medical Review (Continue)

- If unstable medical condition is the qualifying criterion (criterion G) then the medical record must contain information to support the condition and the active treatment rendered within 60 days prior to admission
- PRN Oxygen is not covered; must submit MAR showing regular usage
- Multiple criteria under K will count as one criterion
- When criteria K is checked on Form 161, please submit at least 1 week of nurse's notes or ADLS flow sheets, approximately 1 week prior to the Medicaid admission date if transferring from Medicare to Medicaid. This information can also be documented on Form 161 under the section of Diagnosis and Pertinent Medical Information.
- Submit the full MDS prior to and closest to the Medicaid admission date
- Cannot mark A and K, MUST BE ONE OR THE OTHER
- Cannot mark G and K9, MUST BE ONE OR THE OTHER
- If the recipient is out in the community greater than 30 days, then the recipient will be a new admission and must meet at least two criteria

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AN OVERVIEW

Transfer and Discharge Appeal Process For Nursing Facility Residents

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Definition

- Transfer and discharge includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not.

- Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

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Reasons for Transfer or Discharge

The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless one of the following conditions exist:

- The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
- The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
- The safety of individuals in the facility is endangered;
- The health of individuals in the facility would otherwise be endangered;
- The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicaid or Medicare) a stay at the facility;
- The facility ceases to operate.

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Questions Regarding Transfer or Discharge

- **WHO HAS THE RIGHT TO APPEAL A TRANSFER OR DISCHARGE?**

  ~All individuals in a Medicaid certified nursing facility regardless of payment source.

- **WHAT IS THE AUTHORITY GOVERNING TRANSFER OR DISCHARGE APPEALS?**

  ~The Code of Federal Regulations (CFR) Section 483.12. "Admission, Transfer, and Discharge Rights."

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Nursing Facility Responsibilities in the Transfer or Discharge Process

Before a facility transfers or discharges a resident, the facility must:

- Notify the resident and a family member or legal representative of the transfer or discharge and the reasons for the move;
- Record the reasons in the resident's clinical record; and

Be sure to include the following information when submitting the notice:

- The reason for transfer or discharge;
- The effective date of transfer or discharge;
- The location to which the resident is to be transferred or discharged;
- A statement that the resident has the right to appeal the action by filing a written request within 30 days of the notice or transfer or discharge to the Medicaid Agency at the following address:

Ozenia G. Patterson, LTC Director
Alabama Medicaid Agency
P.O Box 5624
Montgomery, AL 36130

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Nursing Facility Responsibilities in the Transfer or Discharge Process (Continue)

State Long Term Care Ombudsman Contact Information:

Alabama Department of Senior Services
Virginia Moore-Bell
770 Washington Avenue, Suite 470
Montgomery, AL 36130
(877) 425-2243 or (334) 242-5753

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Nursing Facility Responsibilities in the Transfer or Discharge Process (Continue)

For nursing facility residents with developmental disabilities, the protection and advocacy of developmentally disabled individuals under Part C of the Developmental Disabilities Assistance and Bill of Rights Act:

Alabama Disabilities Advocacy Program (ADAP)
P.O. Box 870395
Tuscaloosa, AL 35487
(800) 826-1675 or (205) 348-4928

For nursing facility residents who are mentally ill, the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act:

Alabama Disabilities Advocacy Program (ADAP)
P.O. Box 870395
Tuscaloosa, AL 35487
(800) 826-1675 or (205) 348-4928

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Nursing Facility Responsibilities in the Transfer or Discharge Process (Continue)

- When a nursing facility resident appeals a proposed discharge, the documentation submitted by the nursing facility to Medicaid in support of the discharge must meet all requirements of Alabama Administrative Code 560-X-10-.26 including but not limited to, those outlined above as well as a physician statement indicating that the resident is appropriate for discharge.
- CFR 483.20(l)(3): *Discharge Summary* – When the facility anticipates discharge, a resident must have a discharge summary that includes:
  - A recapitulation of the resident's stay;
  - A final summary of the resident's status at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative; and
  - A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

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Most Common Reasons for Denial

- Insufficient discharge notification
- Insufficient documentation of reasons for discharge in the clinical record for review
- Clinical records not submitted
- Physician statement not submitted
- No post-discharge plan of care has been developed

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Who makes the final decision on an appealed discharge or transfer?

The Alabama Medicaid Agency has a Discharge Appeal Committee composed of the following individuals:

- Director, Long Term Care Division –Chairperson
- Director, Provider Audit
- Medicaid, Office of General Counsel
- Associate Medical Director
- Associate Director, Medical & Quality Review Unit
- Associate Director, Long Term Care Provider/Recipient Services Unit

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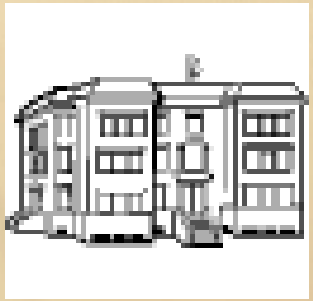
When should the resident, family member, or legal representative be notified?

The facility must notify the resident, family member, or legal representative at least 30 days before the resident is transferred or discharged.



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Can a notice be issued in less than 30 days?

Notice may be made as soon as practicable before transfer or discharge when:

- The health and safety of individuals in the facility would be endangered;
- The resident's health improves sufficiently to allow a more immediate transfer or discharge;
- An immediate transfer or discharge is required by the resident's urgent medical needs; or
- A resident has not resided in the facility for 30 days.

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Refusal of Certain Transfers

An individual has the right to refuse a transfer to another room within the institution, if the purpose of the transfer is to relocate:

- **A resident of a SNF from the distinct part of the institution that is a SNF to a part of the institution that is not a SNF.**
- **A resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is a SNF.**
- **A resident's exercise of the right to refuse transfers as indicated does not affect the individual's eligibility or entitlement to Medicare or Medicaid benefits.**

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What Are Appropriate and Inappropriate Discharges or Transfers?

APPROPRIATE:

- Health and safety issues
- Payment issues

INAPPROPRIATE:

- Discharges to hospital without notice of intended discharge and not allowing residents to return
- Any discharge without proper notice as referenced in CFR 483.12

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Long Term Care Bed Hold Policy

- Effective September 1, 2000, neither Medicaid patients, nor their families, nor their sponsor, may be charged for reservation of a bed for the first four days of any period during which a Medicaid patient is temporarily absent due to admission to a hospital.
- Nursing facilities must allow residents to return to their facility before the bed hold period expires provided the resident is an appropriate placement for nursing facility care and the nursing facility provides the type of services that meets the needs of the resident.
- The nursing facility must have documented verifiable evidence in the resident's medical record to indicate that there has been a significant change in the resident's condition, either prior to or during the hospital stay making re-admission to the nursing facility inappropriate because the nursing facility can no longer meet the needs of the resident.
- When such a significant change in a resident's condition occurs prior to discharge to the hospital, the nursing facility should use reasonable efforts to begin to arrange for appropriate placement for the resident prior to transferring the resident to the hospital.

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Long Term Care Bed Hold Policy (Continue)

- If the Alabama Medicaid Agency determines that the nursing facility has failed to follow the rules set forth in the federal and state bed hold policies, the Alabama Medicaid Agency shall notify the Division of Health Care Facilities, Alabama Department of Public Health, for appropriate enforcement action.
- Medicaid may terminate the facility's provider agreement for failing to adhere to the rules set forth in the federal and state bed-hold policy until an acceptable plan of correction is received from the nursing facility.
- If the therapeutic leave or bed hold period has expired, the resident must be readmitted to the facility immediately upon the first available bed in a semi-private room if the resident requires the services provided by the facility.

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Long Term Care Bed Hold Policy (Continue)

The covered four day hospital stay reservation policy does not apply to:

- Medicaid eligible patients who are discharged to a hospital while their nursing home stay is being paid by Medicare or another payment source other than Medicaid;
- Any non Medicaid patient;
- A patient who has applied for Medicaid but has not yet been approved;
- Medicaid patients who have received a notice of discharge for non-payment of service.

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Long Term Care Bed Hold Policy (Continue)

Providers will not receive payment for bed hold days prospectively but should be included on the NF cost reports.

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Therapeutic Leave Policy

Payments to nursing facilities may be for therapeutic leave visits to home, relatives, and friends for up to six days per calendar quarter.

A therapeutic leave visit may not exceed three days per visit.

A resident may have a therapeutic visit that is one, two, or three days in duration as long as the visit does not exceed three days per visit or six days per quarter.

Visits may not be combined to exceed the three-day limit.

The facility must obtain physician orders for therapeutic leave.

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Third Party Guarantee of Payment

The facility must not require a third party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility.

The facility may require an individual who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the residents income or resources.

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REMINDER: ALERT Message Submitted to Medicaid Certified Nursing Facilities (Publication Date via Website: 8/22/12)

Attention: **Medicaid Certified Nursing Facilities**

RE: **Coverage for Ventilator-Dependent and Qualified Tracheostomy Care Residents**

Effective January 16, 2012, the Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment for care provided to ventilator-dependent residents and/or qualified tracheostomy residents who are eligible for Medicaid benefits and meet specific medical criteria established by Medicaid.

The Alabama Medicaid Agency will pay nursing facilities a supplemental fee-for-service payment in addition to the daily nursing facility rate for care provided to ventilator-dependent and/or qualified tracheostomy residents who are eligible for Medicaid benefits.

The nursing facility must meet specific provider requirements and the ventilator-dependent/tracheostomy care resident must meet specific medical criteria established by the Alabama Medical Agency.

Information regarding the required documentation for the nursing facility and the resident is included in Alabama Medicaid Administrative Code Chapter 63. Nursing facilities must mail all documentation for the facility and resident to HP with a correctly completed Long Term Care Records coversheet. The coversheet is located on the Medicaid website at: http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LTC_Services/5.4.3_LTC%20Records%20Coversheet_6-11.pdf

The records should be mailed to the following address:

HP ENTERPRISES SERVICES
P. O. BOX 224032
MONTGOMERY, AL 36124-4032

An incorrectly completed coversheet will result in the record being returned to the provider. Please denote, "VENT/TRACH" on the coversheet. To facilitate review of the record, please send an e-mail to theresa.carlos@medicaid.alabama.gov with ONLY the Medicaid ID, stating, "the record is ready for review." Do not send any PHI in the e-mail.

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Hospice Care

- Hospice Care is a comprehensive home care program which primarily provides medical and support services for terminally ill patients.

- Medicaid patients who voluntarily choose to end any treatment designed to cure their disease are eligible to receive services, supplies, and care to provide necessary relief of pain or other symptoms.

- All Alabama hospice providers are now required to use the Medicaid approved criteria when determining medical necessity for Medicaid recipients electing the hospice benefit when Alabama Medicaid is the primary payor.

- Hospice Room & Board: Medicaid pays the hospice 95% of the Nursing Home rate applicable for that year for the room and board that would have been paid to the nursing facility for that individual under the State Plan.

- Hospice reimburses the nursing home based on the contract between the two providers.

- Learn more about the new Alabama Medicaid Hospice Medical Criteria by visiting: medicaid.alabama.gov

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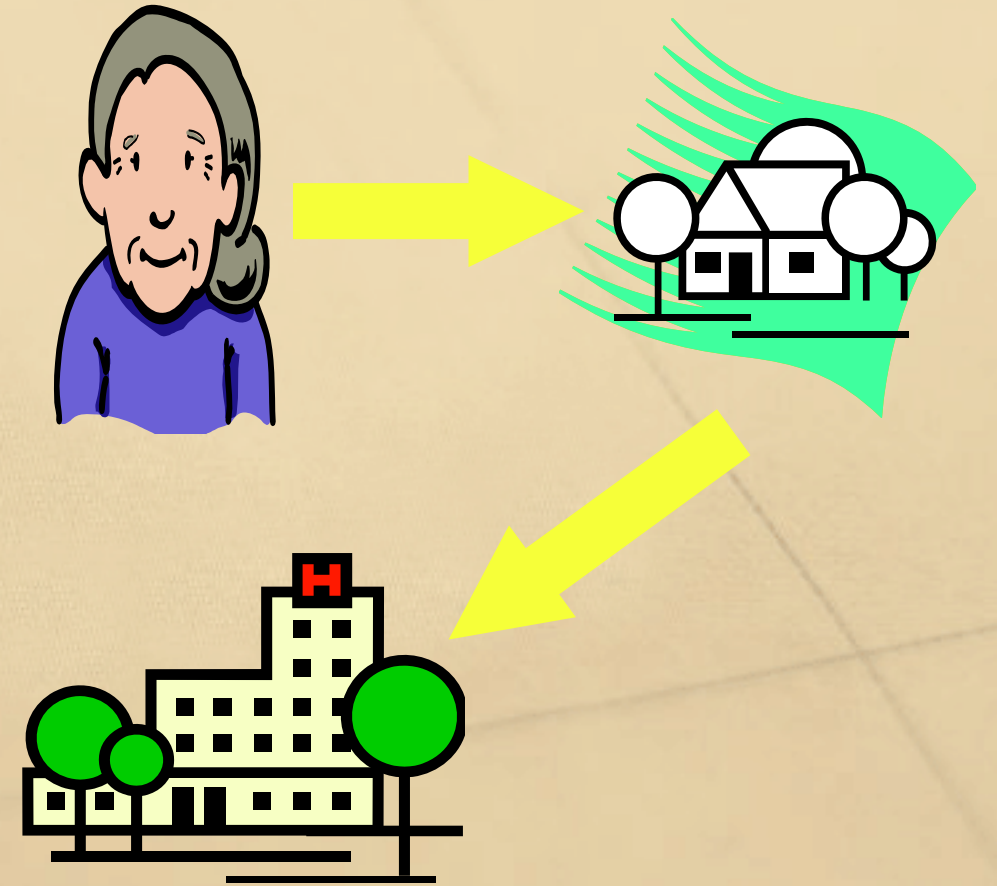
SSI Recipients Transitioning from Home to Institution

- If the recipient receives hospice in the home and transitions to a nursing home, SSA must be notified by the provider or sponsor regarding the individual's change of residence. The individual's income must be adjusted accordingly by SSA.



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Alabama Home and Community-Based Waiver Services

Medicaid is a health care program for low income Alabamians. Home and Community-Based Waiver services provide additional Medicaid benefits to specific populations who meet special eligibility criteria. The Alabama Home and Community-Based Waiver Services Chart/Matrix summarizes those benefits, criteria, and informs you on how to apply for a HCBS waiver.

Applicants must meet financial, medical, and program criteria to access waiver services. The applicant also must be at risk of nursing institutionalization (nursing facility, hospital, ICF/MR). A client who receives services through a waiver program also is eligible for all basic Medicaid covered services. Each waiver program has an enrollment limit. There may be a waiting period for any particular waiver. Applicants may apply for more than one waiver, but may only receive services through one waiver at a time. Anyone who is denied Medicaid eligibility for any reason has a right to appeal. Additional information can be found on the Alabama Medicaid Agency's website: www.medicaid.alabama.gov

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Contact Information

Policy Questions Regarding Nursing Home:

Robin Arrington, LTC Provider/Recipient Services Unit
(334) 353-4754 Robin.Arrington@medicaid.alabama.gov

Policy Questions Regarding Hospice in a Nursing Home:

Felicha Fisher, LTC Provider/Recipient Services Unit
(334) 353-5153 Felicha.Fisher@medicaid.alabama.gov

Billing Questions:

HP
(800) 688-7989

Alabama Medicaid Agency
Medicaid

Contact Information

Mailing Address:

Alabama Medicaid Agency
Long Term Care Division
501 Dexter Avenue
P.O. Box 5624
Montgomery, AL 36103-5624

Website Addresses:

www.medicaid.alabama.gov
www.cms.hhs.gov

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State of Alabama Medicaid Agency

On behalf of the State of Alabama Medicaid Agency, "Thank you" for attending the Healthcare Compensation Solutions Seminar!

Questions?

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