

Rule No. 560-X-10-.11. Establishment of Medical Need

- (1) Application of Medicare Coverage:
 - (a) Nursing facility residents, either through age or disability, may be eligible for Medicare coverage up to 100 days.
 - (b) Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.
 - (c) Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

- (2) Periods of Entitlement.
 - (a) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.
 - (b) An exception to (a) above, is retroactive Medicaid coverage. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.
 - (c) For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the Clinical Services and Support Division, Medical & Quality Review Unit or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

- (3) The Medicaid Agency has delegated authority for the initial level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.
 - (a) The process to establish medical need includes medical and financial eligibility determination.
 1. The determination of level of care will be made by an RN of the nursing facility staff.
 2. Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.
 - (b) All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.
 1. New Admissions
 - (i) Admission and Evaluation Data (Form 161). The provider must maintain supporting documentation for the admission criteria required by Rule 560-X-10-.10 listed on the Form 161.
 - (ii) A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.
 - (iii) Records of PASRR evaluations and determinations including the Level I screening and Level I determination and Level II screening and Level II determination if applicable.

2. Readmissions
 - (i) Admission and Evaluation Data (Form 161).
 - (ii) Updated PASRR screening information for a significant

change as required.

(c) All Medicaid certified ICF/IID nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

1. New Admissions
 - (i) Form XIX LTC-9 Admission and Evaluation Data

(Form 161).

(ii) Records of PASRR evaluations and determinations including the Level I screening and Level I determination and Level II if applicable.

(d) All Medicaid certified ICF/ IID facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/IID level of care needs.

1. New Admissions
 - (i) A fully completed Medicaid Patient Status
 - (ii) A fully completed ICF/IID Level of Care Evaluation for
 - (iii) The resident's physical history.
 - (iv) The resident's psychological history.
 - (v) The resident's interim rehabilitation plan.
 - (vi) A social evaluation of the resident.

Notification (Form 199).

Institutional Care (Form 361).

2. Readmissions
 - (i) Medicaid Patient Status Notification (Form 199).
 - (ii) ICF/IID Admission and Evaluation Data (Form 361).

3. A total evaluation of the resident must be made before admission to the intermediate care facility or prior to authorize of payment. An interdisciplinary team of health professionals, which must include the resident's attending physician must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings; (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the XIX LTC-9 (Form 161) on new admissions.

(e). All Medicaid certified nursing facilities will have a period of one year from the date of service in which to bill for services. There is no timeliness penalty for submission of information to establish service delivery dates.

(f). Authorization of eligibility by Medicaid physician or its designee:

1. For all applications for which a medical eligibility cannot be determined, the application should be submitted to the Clinical Services & Support Division, Medical & Quality Review Unit or its designee. The nurse reviewer will review and assess the

documentation submitted and make a determination based on the total condition of the applicant. If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency physician or its designee will approve or deny medical eligibility.

2. The Clinical Services & Support Division, Medical & Quality Review Unit or its designee will issue a notice of denial for applications which result in an adverse decision. This notice will include the applicant's right to an informal conference and/or a fair hearing.

3. The informal conference is a process which allows the recipient, sponsor, and/or provider the opportunity to present additional information to the Medicaid physician for a review.

4. If the review results in an adverse decision, the patient and/or sponsor will be advised of the patient's right to a fair hearing (See Chapter 3). If the reconsideration determination results in a favorable decision, the application will be processed.

(g). Authorization of level of care by nursing facility

1. The Alabama Medicaid Agency or its designee will conduct a retrospective review on a monthly basis of a 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

2. A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Clinical Services & Support Division, Medical & Quality Review Unit or its designee within ten working days from receipt of the faxed letter(s) requesting such documentation or additional information ~~shall~~ may be charged a penalty after the established due date as follows: day one through day seven – a rate of one hundred dollars per recipient record; day eight through day fourteen – a rate of two hundred dollars per recipient record; per day for each calendar day after the established due date unless an extension request has been received and granted. If the requested record/records have not been submitted by the fifteenth day after the established due date, the recipient's LTC segment will be end-dated until the record is received and the provider may be charged a rate of three hundred dollars per recipient record. The penalty will not be a reimbursable Medicaid cost. The Clinical Services & Support Division, Medical & Quality Review Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Clinical Services & Support Division, Medical & Quality Review Unit with supporting documentation.

3. The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

4. The Alabama Medicaid Agency may seek recoupment from the nursing facility for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for nursing facility care or Medicaid eligibility but for the certification of medical eligibility by the nursing facility.

(4) Signature Requirement

Unless otherwise specified, signatures (including handwritten, electronic and digital signatures) shall be provided in accordance with Rule 560-X-1-.18- ~~and 560-X-1-.21~~. The Form 161 shall have the required signatures prior to the nursing facility submitting any claims for a recipient.

(5) Please see Chapter Sixty-Three regarding ventilator dependent and qualified tracheostomy care.

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Statutory Authority: State Plan; Title XIX, Social Security Act; 42 CFR Section 401.101-401.625, 42 CFR Section 435.900-435.1011, et seq.

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