PROCEDURES FOR DETERMINATION OF MEDICAL NEED FOR

NURSING HOME SERVICES

I. MEDICAL NEED ASSESSMENTS

Each Medicaid certified Nursing Facility will evaluate each nursing home applicant's need for nursing home services using the Form DMS-703. A thorough and complete evaluation must be conducted to ensure that individuals who do not require nursing home services are not admitted to nursing facilities.

For Medicaid eligible recipients, the Office of Long Term Care cannot guarantee Medicaid reimbursement for any applicant admitted prior to approval by the Office of Long Term Care Medical Needs Determination section. No applicant with diagnoses or other indicators of mental illness and/or mental retardation may be admitted to nursing home care prior to evaluation and approval by the Office of Long Term Care.

A. Nursing Facility Procedures for Medical Need Assessments

1. Complete the Form DHS-703 for each applicant. Be sure to mark the appropriate box for application, ensure that all areas are completed and that the applicant's degree of incapacity is reflected accurately. Use the Nurse's Comments section on page 2 to provide other information related to the individual's need for nursing home care.

2. Complete Form DMS-787 (Pre-Admission Screening for Mental Illness/Mental Retardation, Level I Identification Screen) for all applicants. If the completed form indicates that the individual has a diagnosis or other indicators of mental illness and/or mental retardation/developmental disability follow the procedures outlined under Section II below.

3. If the completed Form DMS-787 indicates the presence of MI/MR, complete the Pre-Admission Screening Annual Resident Review Client Consent form with the applicant and/or his/her guardian or legal representative. Attach the signed, dated and witnessed consent form to the DMS-787.

4. If the individual has a diagnosis of dementia (including Alzheimer's Disease or other related disorders), complete form DMS-780 (Dementia Diagnosis Substantiation). Attach the signed and dated form to the DHS-703. Refer to the section on Dementia below.

5. If the individual does not have a diagnosis or other indicators of mental illness and/or mental retardation/developmental disability, forward copies of the DHS-703 and the DMS-787, and if applicable, the DMS-780, to:

Medical Need Determination
PO Box 8059, S406
Little Rock, AR 72203
501 682 1920 (Telephone)
501 682 8540 (FAX)

Keep a copy of all forms for the facility's files.

Whenever possible, the application packet should be submitted to OLTC prior to the individual's admission to the Nursing Facility. Otherwise, the packet must be submitted within 48 hours of the individual's admission to the facility.

For private pay (Medicare, VA contract, private insurance, etc.) applicants who are applying for Medicaid coverage, the facility must submit the packet as soon as facility staff is made aware that the application will be made.

5. IF the individual does have a diagnosis or other indicators of mental illness and/or mental retardation/developmental disability follow procedures outlined in Section II.

6. Send a copy of the EMS-702, Notice of Admission, Discharge, or Transfer from Nursing Home to the local County DHS office.

7. Ensure that an individual acting on behalf of the applicant applies or has applied for nursing home care at the DHS County Office.

B. OLTC Procedures for Medical Need Assessments

1. On receipt of a complete medical need assessment packet (Forms DHS-703, DMS-787, and if applicable the DMS-780, and any other necessary documentation), the information received will be reviewed by OLTC, and OLTC will make a determination as to the individual's need for nursing home placement.

2. OLTC determines that the individual meets medical criteria for nursing home placement, and recommends placement. OLTC will determine the level of care and a date to be reviewed when applicable. The Office of Long Term Care will then forward the determination (Form EMS-704) to the Nursing Facility and to the County DHS Office for completion of the financial eligibility and routing of applicable forms.

3. If OLTC determines, based on the information submitted, that the individual does not meet medical criteria for nursing home placement, and recommends that placement be denied, OLTC will then notify the Nursing Facility and the DHS County Office. Once the Nursing Facility is notified of the denial the facility may send any additional information/comments that might impact OLTC's decision and recommendation. Any additional comments must be received by OLTC within 10 days of the date of the request for reconsideration. Upon receipt of the information, OLTC will determine, based on the information submitted, whether the individual meets medical criteria for nursing home placement, and recommend whether placement be approved or denied. The Office of Long Term Care will then notify the Nursing Facility, and will notify the DHS County Office only if the determination changes as a result of the reconsideration.

a. If additional information is received and results in approval for NF placement, notification will be sent to the Nursing Facility.

b. If additional information is not received or is not sufficient to indicate a medical necessity for nursing home placement, the local DHS County Office and the Nursing Facility will be notified of the denial on the EMS-704.

Determinations that individual applicants do not meet medical criteria for nursing home placement are subject to the Appeals and Fair Hearings process. Appropriate forms and information regarding appeal timeframes may be obtained from the local County DHS Office.

II. PRE-ADMISSION SCREENING FOR MENTAL ILLNESS AND/OR MENTAL RETARDATION/DEVELOPMENTAL DISABILITY

Under current Federal regulations, all nursing home applicants, including private pay applicants, must be screened for diagnoses or other indicators of mental illness and/or mental retardation/developmental disability (MI/MR) prior to admission to a Medicaid certified Nursing Facility.

Applicants whose initial screening (Level I) indicates the presence of MI/MR must be referred to Level II for a full psychosocial evaluation to determine whether or not they need specialized services for the MI/MR and whether or not a nursing facility is the most appropriate placement for them. The State has seven (7) to nine (9) workdays from the time the MI/MR is identified under the initial screening to complete the Level II assessment. Since conducting the Level II assessment requires that a qualified evaluator be located, the information regarding the applicant forwarded, an appointment for the assessment made with the individual/hospital staff, the assessment conducted, the completed assessment returned to the contractor, then sent for psychiatric review and sign-off, then sent to the Divisions of Developmental Disabilities Services and/or Mental Health Services, as appropriate, it is imperative that these packets be forwarded to OLTC-PASRR immediately.

The Office of Long Term Care has a contract with Bock Associates, Inc. to conduct the Level II assessments at State expense and OLTC handles all arrangements for the Level II.

Under current Federal regulations failure to conduct the full Pre-Admission Screening of persons identified as potentially MI or MR (Level I and Level II) prior to the applicant's admission to the Nursing Facility will result in denial of Medicaid coverage until the PASRR determination date is established. The Nursing Facility may not bill the resident or the resident's family for services received by the resident during this denial time period.

A. Nursing Facility Procedures for Pre-Admission Screening for Mental Illness and/or Mental Retardation

1. Complete the Form DMS-787 for all applicants (including private pay) to the Nursing Facility. This is the Level I Identification phase of the Pre-Admission Screening.

2. Determine whether or not there is a diagnosis or other indication of MI/MR. Any "Yes" answer on the Mental Retardation/Developmental Disabilities or Mental Illness sections of the DMS-787 require referral to Level II.

3. If there is no indication of MI/MR, then forward the Forms DMS-787 and DHS-703, and Form DMS-780 if applicable, to the Medical Needs Determination Unit of the Office of Long Term Care, as specified in Section I(A)(5) of these regulations for Medicaid applicants.

For private pay applicants file the DMS-787 with the applicant's other facility records.

4. If the completed Form DMS-787 indicates the Presence of MI/MR (any "Yes" answer in the MR/DD or MI sections), the Forms DMS-787, DHS-703, and DMS-780 if applicable, and any other necessary documentation must be forwarded to Bock Associates. The forms should be FAXED to:

Carol Wilson, Director
or
Sandy Tankersley
FAX Number (501) 375-2541
Telephone Number (501) 375-2559

The facility should keep a copy of the packet in the applicant's file.

5. When there is an indication of mental illness and/or mental retardation DO NOT ADMIT THE APPLICANT. If there is evidence that the individual would be in danger if not immediately admitted to the nursing facility, facility staff may contact Sherri Proffer, RN or Dorothy Ukegbu, RN at 682-8480 to discuss the situation.

B. OLTC-PASRR Procedures for Pre-Admission Screening for Mental Illness and/or Mental Retardation

1. On receipt of a complete assessment packet (Forms DHS-703, DMS-787, and form DMS-780 if applicable) OLTC-PASRR will refer the individual to Bock Associates, Inc. for psychosocial assessment.

2. A copy of the packet will be forwarded to the Medical Needs Determination section so that the medical need assessment may occur simultaneously with the PASRR assessment.

3. As soon as the final determinations have been made by the Divisions of Mental Health Services and/or Developmental Disabilities Services the appropriate agencies/individuals (applicant, guardian, nursing facility, hospital discharge planner) will be notified of the placement and special service decisions by mail. A copy of the complete assessment and a written notification will be sent to the nursing facility.

PASRR placement and special services determinations are subject to the Appeals and Fair Hearings process. Appropriate forms and information regarding appeal timeframes may be obtained from the local County DHS Office.

III. OTHER PROCEDURES/GUIDELINES

Prior Authorization for Out-of-State Applicants

Applicants or transfers from other states, including border areas, must receive authorization from the Office of Long Term Care - Medical Needs Determination section prior to admission to an Arkansas Nursing Facility. To request clearance on out-of-state applicants contact:

Medical Needs Determination Unit
501-682-8480

To expedite this process, please obtain as much information as possible about the applicant prior to contacting Medical Needs Determination section. This information should include: presenting diagnoses (including whether or not the individual is diagnosed or has indicators of mental illness and/or mental retardation/developmental disability), medications, locations of Arkansas relatives, level of ADLS, dementia, level of mental competence, etc.

Private Pay Applicants

All private pay (Medicare, VA contract, private insurance, etc.) applicants must be screened for mental illness and/or mental retardation/developmental disability (MI/MR) prior to admission to the nursing facility. A copy of the DMS-787 will be completed for each private pay applicant prior to admission.

- If the completed DMS-787 does not indicate that the individual has a diagnosis or other indicators of mental illness, the form should be filed in the individual's facility records for easy access.

- If the completed form indicates that the individual has a diagnosis or other indicators or MI/MR then he/she must meet the same medical necessity criteria for admission that Medicaid applicants/recipients must meet. In these cases follow procedures outlined in Section II.

Dementia

Persons with a diagnosis of Dementia (including Alzheimer's Disease or other related disorders) which is based on the criteria of the Diagnostic and Statistical Manual for Mental Disorders, 3rd Ed. (DSM-IV-R) are excluded from the definition of mental illness for purposes of the Pre-Admission Screening if the dementia is the applicant's only mental illness/mental retardation diagnosis. These admissions can therefore be expedited if written verification is provided by the physician making the diagnosis. This verification may consist of the physician's dated signature on the Dementia Diagnosis Substantiation form DMS-780. The other written verification must include the diagnosis, must state that the diagnosis was based on the criteria in the DSM-IV-R and must be signed and dated by the physician.

Placement of Hospitalized Patients

Hospital Discharge Planners should make referrals of hospitalized patients to the Nursing Facility as soon as it is anticipated that placement in a Medicaid-certified nursing facility is likely.

Hospital Discharge Planners may coordinate with Nursing Facilities by assisting in completion of the DHS-703, DMS-787, and form DMS-780 if applicable, and in providing needed information, such as a comprehensive transfer sheet listing medications, treatments, laboratory and x-ray, where appropriate, as well as functional abilities. Hospital Discharge Planners assisting with nursing home medical necessity activities would follow the same procedures specified for nursing facilities.

Forms Distribution

Nursing Facilities and hospitals can download the applicable forms from the OLTC web site at http://www.medicaid.state.ar.us/general/units/oltc.

IV. MEDICAL CRITERIA

a. To be determined a functionally disabled elderly individual, the individual must meet at least one of the following three criteria as determined by a licensed medical professional:

1. The individual is unable to perform either of the following:

A. At least one (1) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without extensive assistance from or total dependence upon another person; or,

B. At least two (2) of the three (3) activities of daily living (ADL) of transferring/locomotion, eating or toileting without limited assistance from another person; or,

2. The individual has a primary or secondary diagnosis of Alzheimer's disease or related dementia and is cognitively impaired so as to require substantial supervision from another individual because he or she engages in inappropriate behaviors which pose serious health or safety hazards to himself or others; or,

3. The individual has a diagnosed medical condition which requires monitoring or assessment at least once a day by a licensed medical professional and the condition, if untreated, would be life-threatening.

4. No individual who is otherwise eligible for waiver services shall have his or her eligibility denied or terminated solely as the result of a disqualifying episodic medical condition or disqualifying episodic change of medical condition which is temporary and expected to last no more than twenty-one (21) days. However, that individual shall not receive waiver services or benefits when subject to a condition or change of condition which would render the individual ineligible if expected to last more than twenty-one (21) days.

b. When determining eligibility for waiver services, if an individual requires a skilled level of care as defined below, eligibility for Medicaid will be denied. Likewise, if an individual has a serious mental illness, except as specified in Section I (2) above, or has mental retardation, the individual will not be eligible for Medicaid unless the individual has medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meets the criteria set out in Section I above, provided, however, that a diagnosis of severe mental illness or mental retardation will not bar eligibility for individuals having medical needs unrelated to the diagnosis of serious mental illness or mental retardation and meeting the criteria set out in Section I above.

c. Definitions

3. EATING means the intake of nourishment and fluid, excluding tube feeding and total parenteral (outside the intestines) nutrition. This definition does not include meal preparation.

4. EXTENSIVE ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) without another person to aid in performing the complete task, by providing weight-bearing assistance.

5. LICENSED MEDICAL PROFESSIONAL means a licensed nurse, physician, physical therapist, or occupational therapist.

6. LIMITED ASSISTANCE means that the individual would not be able to perform or complete the activity of daily living (ADL) three or more times per week without another person to aid in performing the complete task by guiding or maneuvering the limbs of the individual or by other non-weight bearing assistance.

7. LOCOMOTION means the act of moving from one location to another, regardless of whether the movement is accomplished with aids or devices.

8. MENTAL RETARDATION means a level of retardation as described in the American Association on Mental Retardation's Manual on Classification on Mental Retardation. For further clarification, see 42 C.F.R. § 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

9. SERIOUS MENTAL ILLNESS OR DISORDER means schizophrenia, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; or other psychotic disorder. For further clarification, see 42 C.F.R. § 483.100 - 102, Subpart C - Preadmission Screening and Annual Review of Mentally Ill and Mentally Retarded Individuals.

10. SKILLED LEVEL OF CARE means the following services when delivered by licensed medical personnel in accordance with a medical care plan

requiring a continuing assessment of needs and monitoring of response to plan of care; and such services are required on a 24-hour/day basis. The services must be reasonable and necessary to the treatment of the individual's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, the individual's particular medical needs, accepted standards of medical practice, and in terms of duration and amount.

- Intermuscular or subcutaneous injections if the use of licensed medical professional personnel are necessary to teach an individual or the individual's caregiver the procedure.
- Intravenous injections and hypodermoclysis or intravenous feedings.
- Levin tubes and nasogastric tubes.
- Nasopharyngeal and tracheostomy aspiration.
- Application of dressings involving prescription medication and aseptic techniques.
- Treatment of Stage III or Stage IV decubitus ulcers or other widespread skin disorders which are in Stage III or Stage IV.
- Heat treatments which have been specifically ordered by a physician as a part of active treatment and which require observation by nurses to adequately evaluate the individual's progress.
- Initial phases of a regimen involving administration of medical gases.
- Rehabilitation procedures, including the related teaching and adaptive aspects of nursing/therapies, that are part of active treatment, to obtain a specific goal and not as maintenance of existing function.
- Ventilator care and maintenance.
- The insertion, removal and maintenance of gastrostomy feeding tubes.

9. SUBSTANTIAL SUPERVISION means the prompting, reminding or guidance of another person to perform the task.

10. TOILETING means the act of voiding of the individual's bowels or bladder, and includes the use of a toilet, commode, bedpan or urinal, transfers on and off a toilet, commode, bedpan or urinal, the cleansing of the individual after the act, changes of incontinence devices such as pads or diapers, management of ostomy or catheters and adjustment to clothing.

11. TOTAL DEPENDENCE means the individual needs another person to completely and totally perform the task for the individual.

12. TRANSFERRING means the act of an individual in moving from one surface to another, and includes transfers to and from bed, wheelchairs, walkers and other locomotive aids, and chairs.