Medicaid Managed Care:
Using the New Nursing Facility Stay Review Form
Webinar Questions & Answers

Q: What is the purpose of the Nursing Facility Stay Review Form?
A: The purpose of the Nursing Facility Stay Review Form is to provide assistance to all skilled nursing facilities on what Medicaid Managed Care Plans will need to determine an enrollee’s eligibility for nursing facility care. In addition, the form provides guidance for medical necessity authorization, whereby an enrollee must achieve at minimum, an intermediate level of care, as defined in Ohio Administrative Code 5101:3-3-06 for nursing facility approval.

Q: Are all nursing facilities required to use this form?
A: No. This form is not a mandated documentation tool. Rather, all Ohio Medicaid Managed Care Plans are encouraging their nursing facility partners to utilize this form in an effort to streamline the documentation needed to determine eligibility for nursing facility.

Q: How will this form be presented?
A: Each Medicaid Managed Care Plan will work independently with their nursing facility partners to distribute the form. Plans have the ability to distribute the form electronically in its original, Microsoft Excel format so columns can easily expand as more information is needed. Some Plans also have the ability to receive this form back from the facility through a secure email connection.

Upon admission, Plans will inform their nursing facility partners how many days are covered and when the first continued stay review is needed. Subsequent reviews will be dictated by the Plans. OHCA encourages all members to inquire about this form upon receiving any Medicaid Managed Care admission.

Q: What if a patient receives a denial for a nursing facility continued stay, what occurs and what is the process for appeals?
A: A denial to the nursing facility benefit is something that should not come as a complete surprise. Plans and providers should be working cooperatively to move individuals to the least restrictive, most cost-effective setting to meet their needs. However, if a Medicaid Managed Care patient does receive a denial for continued stay while residing in the nursing facility, both the nursing facility and the patient will receive written notice of that denial. Included in that denial notice are the appeal rights back to the Plan and back to Medicaid. All coverage decisions made by the Plan, up through the maximum 62 days of coverage, is the responsibility of the Plan. Seeking a level of care from the Area Agencies on Aging is not an option until the Medicaid Managed Care patient approaches terminations from the Plan and returns to fee-for-service Medicaid, which according to law is the last day of the month following the month of the patient’s nursing facility admission, for a period not to exceed 62 days.
All the Medicaid Managed Care Plans in attendance during the webinar communicated that it is not their desire to issue denials. When there is a discrepancy over a denial, often it is due to lack of information needed by the Plan. In those cases, Plans highly encourage physician-to-physician communication, whereby the attending physician at the nursing facility communicates directly with the Medical Director of Plan, as an effective strategy to resolve most situations.

Q: **If you use MNS, are you completing the required forms?**
A: Some Plans do work with MNS. In those cases, the Plans would work directly with MNS to ensure they have this form. Since MNS plays a vital role in helping some Plans do discharge planning, they are involved with continued stay reviews. So, if you are a facility that works with MNS and continued stay reviews are done by MNS, then yes, that would be where the form would start. An MNS representative on the call indicated that they would then follow-up with the individual facilities to make sure they too are using the new Nursing Facility Stay Review Form.

Q: **Does the Nursing Facility Stay Review Form need to be completed for authorization prior to a patient’s admission to a nursing facility?**
A: Ideally this form should be used upon admission and the Plans will be working with their Provider Relations representatives to educate everyone, including their hospital partners, on completing this form. However, from a process standpoint, nursing facility admissions most often come from the hospital and therefore the Plans will work with the hospital to get the initial information needed to approve the initial length of stay in the nursing facility. Once the patient is in the nursing facility, the Nursing Facility Review Form can be used for concurrent reviews. It is advisable to work closely with the Plans to determine when the first concurrent review is needed. Based on the information obtain from the hospitals, it could be just a few days to more than a week. Just like with all Managed Care admissions, thorough screening of the pending admission, authorization for the stay, and clear communication with the Plan as to their expectations are vital to ensure success in serving Managed Care patients.

Q: **On the MDS, is the patient treated as a skilled patient?**
A: During the call, there was some confusion around the intent of this written question. To attempt to best answer the question that was written in the question area by caller, the following should be noted:

1) The documentation needed to certify a Medicaid Managed Care patient’s stay in a nursing facility should be the new Nursing Facility Review Form. A completed MDS is more information than Plans need to render that decision. Providing a complete MDS to a Plan to determine nursing facility continued eligibility certainly slows down the process and the Nursing Facility Review Form was designed to streamline the documentation that is needed.

2) On the MDS, it is advisable to code Medicaid Managed Care patients as Medicaid and not Managed Care.
Q: Is a RUG score needed?
A: From a utilization management process, no. However, it should be noted that some Medicaid Managed Care Plans utilize a RUG-based form of reimbursement, so for those Plans, a RUG score would be needed for reimbursement, but not for nursing facility eligibility.

Q: Will MCP's work with hospitals to allow us the time (1-3 days) to get the authorization?
A: Plans are certainly reviewing requests for nursing facility placement as expeditiously as possible. And there are times that Plans do not have all the information needed to make a final determination. We are hoping that by utilizing the information on the form, it will help speed up the process. Sometimes the hospitals don’t provide enough information to authorize the stay in a nursing facility and therefore we have to approve one more day at the hospital to accommodate our need for more information. It is all done on a case by case basis. We also often state to our hospitals that there is no emergency discharge. We often know a couple days before hand that a member is going to a nursing facility. So we always encourage our hospitals and our physicians to let us know when they are even thinking about a nursing facility so we can start that review process. Again please note, that from a process standpoint, the Plans will work with the hospitals to get the initial information needed to approve the initial length of stay in the nursing facility. Once the patient is in the nursing facility, the Nursing Facility Review Form can be used by the nursing facility for concurrent reviews.

Q: Who is responsible for filling out the prior authorization?
A: If the Medicaid Managed Care patient is coming from a hospital, the hospital is responsible for securing the prior authorization for the nursing facility benefit. Plans will work with the hospitals to get the initial information needed to approve the initial length of stay in the nursing facility. Once the patient arrives at the nursing facility, the Nursing Facility Review Form will be utilized for concurrent reviews based on the schedule requested by the individual patient’s Plan. If the patient is coming from the community, Plans will work cooperatively with the nursing facility to secure the prior authorization for the nursing facility benefit. It should be noted that no nursing facility should ever take a Medicaid Managed Care patient until authorization is given from the Plan.

Q: How much notices does a managed care plan need to give if they deny continued stay in a nursing facility before the maximum 62nd day?
A: I think we probably want to invert that question a little because this is very different than fee-for-service benefit. The fee-for-service assumption is that the facility would be authorized for payment upon admission until the patient no longer has a nursing facility need. In the case of a managed care admission, you want to think differently in that the Plan will authorize a number of days of care and, at the end of that authorization, there is no more payment available unless the facility asks for another authorization of care. So if you believe a patient needs continued nursing facility care beyond the authorization period, you need to think ahead and request continued stay be authorized. The cycle of continued stay authorization continued until such time the patient is discharged back to the community or returns to fee-for-service Medicaid.
Q: Can you please define the difference between the Protective Level of Care and Intermediate Level of Care?

A: We are not expert on this, but basically the protective level of care is more residential and does not qualify for nursing facility placement. For complete rules defining Intermediate Level of Care and Protective Level of Care, please reference OAC 5101:3-3-06 and 5101:3-3-08 respectively. For a quick synopsis, see below:

**Intermediate Level of Care (Excerpt from OAC 5101:3-3-06)**

An individual may be determined to require an intermediate level of care (ILOC) only if both of the following conditions are met:

(1) The individual’s physical and mental condition and resulting service needs have been evaluated and compared to all of the possible levels of care (in accordance with rule 5101:3-3-15 of the Administrative Code) and it has been determined that:

(a) The individual requires services beyond the minimum required for a protective level of care (set forth in rule 5101:3-3-08 of the Administrative Code); but,

(b) The individual’s condition and/or corresponding service needs do not meet the minimum criteria for a skilled level of care set forth in rule 5101:3-3-05 of the Administrative Code; and,

(c) The individual's condition and/or service needs do not meet the criteria for an intermediate care facility for the mentally retarded developmentally disabled level of care (ICF-MR/DD LOC) set forth in rule 5101:3-3-07 of the Administrative Code; and

(2) At least one of the following applies:

(a) The individual requires hands-on assistance with the completion of at least two activities of daily living;

(b) The individual requires hands-on assistance with the completion of at least one activity of daily living; and is unable to perform self-administration of medication and requires that medication administration be performed by another person;

(c) The individual requires one or more skilled nursing or skilled rehabilitation services (as defined in paragraphs (B)(4) and (B)(5) of rule 5101:3-3-05 of the Administrative Code) at less than a skilled care level (as defined in paragraph (B)(3) of rule 5101:3-3-05 of the Administrative Code); or

(d) Due to a cognitive impairment, including but not limited to dementia (as defined in rule 5101:3-3-15.1 of the Administrative Code), the individual requires the presence of another person, on a twenty-four-hour-a-day basis for the purpose of supervision to prevent harm.
**Protective Level of Care (Excerpt from OAC 5101:3-3-08)**

An individual may be determined to require protective care, only if both of the following conditions are met:

(1) The individual’s physical and mental condition and resulting service needs have been evaluated and compared to all of the possible levels of care, and it has been determined in accordance with rule 5101:3-3-15 of the Administrative Code that the individual’s condition and/or corresponding service needs do not meet the criteria for skilled care, intermediate care, or for an ICF-MR level of care set forth in rules 5101:3-3-05 to 5101:3-3-07 of the Administrative Code; and

(2) The individual requires either:

(a) Both of the following:
   (i) Supervision of one ADL or supervision of self-administration of medication; and
   (ii) Assistance with three IADLs; or

(b) Due to a cognitive impairment, including but not limited to dementia (as defined in rule 5101:3-3-15.1 of the Administrative Code), the individual requires the presence of another person, on less than a twenty-four-hour-a-day basis for the purpose of supervision to prevent harm.

Q: On the form, some areas allow for multiple updates while other areas allow for only one, could you tell us what we should do in those areas with only space for one update?
A: While the Nursing Facility Review Form is presented as a pdf for attendees of the webinar, it is available in its original Excel format which allows columns to expand as information is recorded. Please work with your individual Medicaid Managed Care Plan to obtain this documentation tool electronically. The excel version of the tool is also available through the Ohio Health Care Association.

Q: Who do we bill for services?
A: For Medicaid Managed Care patients, the Plans are responsible for payment of all nursing facility services up through the last day of the month following the month of the patient’s nursing facility admission, for a period not to exceed 62 days. And therefore, during that period, the facility would bill the Plan. Following that period, if the patient still requires nursing facility services, the patient would return to fee-for-service Medicaid and a level of care would need to be obtained from the facility’s local Area Agency on Aging. Following approval of a nursing facility level of care, the facility would begin billing Medicaid.

Q: Do we need a contract to serve a Medicaid Managed Care patient?
A: Not always does a facility need a contract. However, with or without a contract, authorization for care in a nursing facility must be granted by the Medicaid Managed Care Plan to serve one of their members and get paid. While Plans prefer to work with nursing facilities in their
contracted networks, they all said that they periodically work with non-network nursing facility when the need arise. If you are a non-network nursing facility working with a Medicaid Managed Care Plan, please make sure to understand the per diem payment, what is covered and not cover, and the terms for a clean claim.

Q: **Do the RUGs scores need to be on the UB claim form?**
A: If you are being reimbursed through a RUG-related contract or agreement, yes, the RUG score does need to be on the claim form. Some Medicaid Managed Care Plans pay nursing facilities based on the patient’s RUG score, while others do not. It is important to understand the payment policies of each Plan and understand what is needed to file a clean claim.