

NURSING FACILITY SERVICES**17.11 ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS AND THE MEDICAL NECESSITY FOR NURSING FACILITY CARE****A. ESTABLISHING MEDICAID CATEGORICAL RELATEDNESS**

When the applicant for nursing facility services is not a recipient of Medicaid under a full Medicaid coverage group, categorical Medicaid eligibility, as well as financial eligibility, must be established.

Incapacity, disability or blindness, when not already established by the receipt of RSDI or Railroad Retirement benefits based on disability, must be established by MRT.

All procedures in Chapter 12 for a MRT referral for the appropriate coverage group are applicable, and a presumptive approval may be made according to the guidelines in that Chapter.

NOTE: The PAS does not establish incapacity or disability. However, a copy of the PAS may be submitted to MRT as medical information.

B. ESTABLISHING MEDICAL NECESSITY, THE PAS**1. When The PAS Is Completed**

Before payment for nursing facility services can be made, medical necessity must be established. The PAS is used for this purpose. The PAS is signed by a physician and is evaluated by a medical professional of the State's contracted level of care evaluator. The PAS is valid for 60 days from the date the physician signs the form. The 60-day validity period applies, regardless of the reason for completion, i.e., new admission, transfer to a different facility. See item C below for situations when a PAS is not completed and payment for nursing facility care is requested for a prior period.

NOTE: There is no requirement that the name of the facility in which the individual resides appear on the PAS.

NOTE: The date the PAS is completed for the purpose of establishing medical necessity is the date the physician signs the form, not the date of any other determination made using the PAS.

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The PAS is completed when:

- The individual enters a Medicaid certified facility.
- The individual transfers from one facility to another. Each facility, i.e., building, must have an original approved PAS even when the client moves from one facility to another governed by the same corporation, and even when 60 days has not passed since the completion of the PAS for the first facility.
- The individual is admitted to an acute care facility and returns to the same facility, after 60 days.
- The individual's condition changes to the extent that he no longer requires nursing facility services.

When a nursing facility resident is admitted to an acute care facility, moves to a distinct part of the facility which provides nursing facility services, and returns to the original nursing facility, special PAS procedures apply, depending on individual circumstances. Distinct part, as used in the following, means the part of the acute facility which provides nursing facility services. The special PAS procedures are:

- The individual moves from the acute care facility to a Medicare-only distinct part. No new PAS is required for the distinct part. However, a new PAS is required when the individual returns to the original nursing facility.
- The individual moves from the acute care facility to a distinct part which is dually certified for Medicare and Medicaid. Two PAS's are required, one when the client enters a distinct part and another when he returns to the original nursing facility.

When nursing facility care is approved for a limited time, a new PAS must be submitted by the facility before the end of the approved period, or the payment for nursing facility services cannot continue beyond that period.

When a private-pay patient applies for Medicaid, a new approved PAS must be obtained prior to payment for services, unless an approved PAS was completed within 60 days prior to the application.

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This applies even if a PAS certifying medical need was completed at the time of admission to an approved facility. This also applies if a PAS was completed any other time up to 60 days prior to the application. The new PAS certifies current need for nursing facility services. However, a previously approved PAS may be used for backdated eligibility and payment for nursing facility services, so long as the client has remained in the same facility since completion of the previously approved form.

EXAMPLE: Mr. A enters a nursing facility as a private pay patient on 10/18/96 and a PAS, which certifies his need for nursing care, is completed on that date. On 2/1/97, he is still in the same nursing facility, and his family applies for Medicaid for his nursing facility care. Because the PAS completed at admission is more than 60 days old on 2/1/97, a new PAS must be completed. If otherwise eligible, payment for services begins 2/1/97.

EXAMPLE: Mr. B enters a nursing facility on 9/2/96 and a PAS which certifies his need for nursing facility care is completed on that date. On 9/30/96, his family takes him home to care for him. On 10/16/97, his family places him in another facility and applies for Medicaid for his nursing care. A new PAS is required because he left the nursing facility for which the PAS was originally completed, and the new facility must have an original approved PAS.

EXAMPLE: Mr. C enters a nursing facility on 3/7/96 and a PAS, which certifies his need for nursing care, is completed on that date. On 9/9/97, he is still in the same facility, and his family applies for Medicaid for his nursing care. They request payment for his care beginning 6/1/97. Because the admission PAS, although approved, was completed more than 60 days prior to 9/9/97, a new PAS must be completed. The approved PAS, completed 3/7/96, is used to certify his need for nursing facility care from 6/1/97 until the date of the newly approved PAS.

When the PAS indicates the client is not in need of nursing facility care, the application for Medicaid, unless withdrawn, is processed for any other coverage group for which the person qualifies, and all client notification procedures apply.

When the client no longer has medical necessity for long-term care services, the nursing facility must notify the Worker.

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2. Procedures Related To The PAS

a. Who Originates the PAS

The originating provider of the PAS may include, but is not limited to, a hospital, physician, nursing facility or waiver agency.

b. Responsibilities of the Originating Provider

- To submit the PAS to the level of care evaluator
- To submit the original, reviewed PAS, with the admission documentation, to the provider of nursing facility services

c. Responsibilities of the Level of Care Evaluator

- To determine the client's need for and level of care, and to evaluate for the presence of mental illness/retardation
- To return the original form, with the review determination, to the originating provider
 - Review results
 - A = Nursing care needed
 - B = Personal care needed
 - C = No services needed
- Forward the original PAS to the appropriate agency for the Level II evaluation when the presence of mental illness/retardation is indicated. See item e.

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d. Responsibilities of the Worker

- Forward the original PAS to the level of care evaluator when the PAS is sent to the county office instead of the level of care evaluator.
- Obtain a signed copy of the current, approved PAS as verification of medical necessity at application and redetermination.

NOTE: A new PAS is only required in the situations described above. A new PAS is not required at each redetermination. However, the Worker must verify the individual remains medically eligible with a copy of the current PAS on file with the nursing facility.

EXAMPLE: Mrs. G completes a redetermination in June 2012. The Worker requests a copy of the current approved PAS on file with the nursing facility. The PAS is dated May 21, 2011, approved for over 6 months and Mrs. G has not left the facility since admission. The Worker has verified medical necessity at redetermination.

e. Level II PASARR

Any individual who applies for nursing facility services in a Medicaid-certified facility must be evaluated for the presence of mental illness/retardation or related conditions, as well as for the need for specialized services to address the individual's mental health needs. The level of care evaluator, after making the Level I decision of medical necessity, forwards the PAS to the mental health evaluator, if appropriate.

The date of the Level II evaluation has no bearing on the date that medical necessity for nursing care is established. See item A above.

C. ESTABLISHING MEDICAL NECESSITY, PHYSICIAN'S PROGRESS NOTES OR ORDERS

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In certain circumstances, which may be beyond the control of the client or his representative, an individual may be admitted to a Medicaid certified nursing facility without the completion of a PAS. When this occurs and the client applies for Medicaid and payment of nursing facility services for a prior period, the Worker may obtain and use the physician's progress notes or orders in the client's medical records to establish medical need. A valid PAS for current eligibility must still be obtained.

This information is obtained from the nursing facility and the facility may request that the physician add such notes to the client's records. This method may also be used when application is made and payment requested for a deceased individual when no valid PAS was completed.

This procedure is used only for backdating eligibility for nursing facility care when no PAS exists for the period for which payment of services is requested. The progress notes or orders cannot be used to change an existing PAS which does not certify need for nursing facility care. Eligibility may only be backdated up to 3 months prior to the month of application.

The Worker must record the reason for the use of the progress notes or orders in Case Comments.