NURSING FACILITY SERVICES

17.2 APPLICATION/REDETERMINATION

A. THE APPLICATION PROCESS

The application process for payment for nursing facility services is the same as the application process for the appropriate coverage group outlined in Chapter 1 with the following exceptions:

1. When Department Participates in Payment

The Department participates in the payment of nursing facility services when it is established that:

- The patient is Medicaid eligible or, if he must meet a spenddown, the spenddown amount is equal to or less than the facility rate.

- Nursing facility care is medically necessary.

- He is receiving care in a certified and Department-approved nursing facility.

2. Date of Eligibility

Payment for nursing facility services begins on the earliest date the three following conditions are met simultaneously:

- The client is eligible for Medicaid; and

NOTE: If the client is eligible as an SSI-Related Medicaid client, his spenddown is presumed to be met when the cost of his nursing facility care exceeds his spenddown amount. Thus, his Medicaid eligibility begins the first day of the month of application or the first day of the month, up to 3 months prior to the month of application, when coverage is backdated.

- The client resides in a nursing facility; and

There is a valid PAS-2000 or for backdating purposes only, physician’s progress notes or orders in the client’s medical records.

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Section 17.11 contains specific information about the PAS-2000 and details specific situations in which the progress notes or orders are used. Additional examples are also found in Section 17.11.

Payment for nursing facility services may be backdated for up to 3 months prior to the month of application, provided all of the conditions described above are met for that period.

EXAMPLE: An individual is a patient in a hospital. The physician recommends nursing facility care to the patient's family and completes a PAS-2000 dated 6/5/95. The family is undecided about placing the individual in a nursing facility and takes the patient home to provide care. They do not apply for Medicaid until 8/16/95 which is the date the client enters the nursing facility. Medicaid eligibility is established beginning 8/1/95, but the PAS-2000 has expired. A new PAS-2000 is not completed until 8/22/95. Medicaid nursing care payments begin 8/22/95.

EXAMPLE: Same situation as above except that the PAS-2000 is dated 6/25/95. A new PAS-2000 is not required, but nursing facility payments cannot begin until 8/16/95, which is the date he entered the nursing facility.

EXAMPLE: An individual enters a nursing facility on 8/16/95 and the PAS-2000 is signed 8/16/95. However, the client does not become Medicaid eligible until 9/1/95 due to excess assets. Payment for nursing facility services begins 9/1/95.

EXAMPLE: An individual enters a nursing facility on 10/10/95 and a PAS-2000 is signed on that date. On 11/25/95 his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to 8/1/95 to cover the cost of his recent hospitalization. Payment for nursing facility services begins on 10/10/95.

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3. Content Of The Interview

In addition to the requirements in Chapter 1, the Worker must screen the client according to the priorities listed in Section 17.9,C.

The Worker must also explain the applicability of Estate Recovery, using the OFS-LTC-4. The client or his representative must be asked to sign the OFS-LTC-4, but a signature cannot be required and is not a condition of eligibility. The signed OFS-LTC-4 is filed in the case record and a copy is provided to the client or representative. When the client or representative does not sign the form, an unsigned copy is provided to him. A recording is made in the record or in RAPIDS that Estate Recovery was explained, but the client or representative declined to sign the form. Questions about the Estate Recovery process must be referred to the toll-free number, 1-888-378-2836.

The Worker must explain to the client that the QMB approval is approval of a nursing facility case when Medicare is participating in the cost of nursing facility care. The Worker must also explain the asset policy so he is aware that his accumulated income, which he would normally pay for his care, may result in ineligibility due to excess assets.

B. REDETERMINATION PROCESS

Redeterminations are the same for nursing facility cases as they are for SSI-Related Medicaid, except that a full-scale redetermination is completed once a year, and a desk redetermination is alternated with a full-scale one.

NOTE: Because completion of an application is not required, when a recipient of a combination of SSI and another income source is eligible for nursing facility services, the first redetermination must be a full-scale one. Subsequent to the first redetermination, desk reviews are alternated with full scale redeterminations.

1. Full-Scale Redeterminations

The redetermination is completed with the individual who is responsible for handling the client's affairs.

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a. Representative Lives in Another State

If there is no one living in the State who handles the client's income and/or is knowledgeable about his affairs, the interview is conducted with the nursing facility staff member who has knowledge of the client's financial circumstances.

When the person handling the finances of a client lives too far to commute to a face-to-face interview, the Worker interviews the responsible person by telephone. The original ES-2 is mailed to the responsible person with a cover letter explaining the procedure for signing the form on the client's behalf. A copy is retained in the case record.

b. Representative Lives in Another County

When the representative to be interviewed lives in another county, the interview may be conducted in the office of the county in which he lives, at the nursing facility or in the office of the county in which the nursing facility is located. When the office in the county in which he lives agrees to conduct the interview, the procedure is as follows:

- The Worker sends the ES-23 to the county office in which the representative lives. The following information is included on the ES-23:
  - The month the redetermination is due
  - The amounts and sources of the patient's income as shown in the case record
  - The amount of the client's resource and his total contribution
  - Type and amount of the client's assets
  - Amount of the CSMA and FMA

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- The Worker who receives the ES-23 completes the interview with the representative and obtains required verification. He must explore all financial aspects of the case. See Sections 17.9 and 17.10.

- When the ES-2 is completed, the Worker in the county in which the representative lives records all pertinent information and returns the form to the originating county.

- The Worker in the originating county completes the redetermination. If the client is no longer eligible for Medicaid, the case is closed. If the client remains eligible for nursing care services, the data system is changed to reflect current circumstances and appropriate notification is sent.

2. Desk Redetermination

Form IM-LTC-3, LTC Desk Redetermination, is used to complete and transmit the redetermination.

The IM-LTC-3 is a checklist of items which are considered in completing the redetermination. Using information from the case record, the Worker reviews each item and determines if action is required. If so, he checks yes in Action Required column and completes the action prior to completion of the redetermination. The form is self-explanatory.

Space for additional narrative recording is provided.

Identifying information is entered at the top of the first page. When the redetermination is completed, the Worker signs and dates the form.