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 the 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 monthly spenddown amount is equal to or less than the facility's monthly Medicaid 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 monthly spenddown is presumed to be met when the cost of his nursing facility care at the Medicaid rate 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 Medicaid-certified nursing facility; and

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

  Section 17.11 contains specific information about the PAS 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.

NOTE: If a Medicaid recipient loses eligibility and does not receive payment for long-term care services for one month, he must reapply and is subject to the current application requirements unless the loss of eligibility or payment was due to a delay or error caused by the department.

EXAMPLE: An individual is a patient in a hospital. The physician recommends nursing facility care to the patient's family and completes a PAS dated 6/5/05. 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 8/16/05 which is the date the client enters the nursing facility. Medicaid eligibility is established beginning 8/1/05, but the PAS has expired. A new PAS is not completed until 8/22/05. Medicaid nursing care payments begin 8/22/05.

EXAMPLE: Same situation as above except that the PAS is dated 6/25/05. A new PAS is not required, but nursing facility payments cannot begin until 8/16/05, which is the date he entered the nursing facility.

EXAMPLE: An individual enters a nursing facility on 8/16/05 and the PAS is signed 8/16/05. However, the client does not become Medicaid eligible until 9/1/05 due to excess assets. Payment for nursing facility services begins 9/1/05.

EXAMPLE: An individual enters a nursing facility on 10/10/05 and a PAS is signed on that date. On 11/25/05 his family applies for Medicaid to pay for his nursing care costs. Medicaid eligibility is backdated to 8/1/05 to cover the cost of his recent hospitalization. Payment for nursing facility services begins on 10/10/05.

NOTE: If an individual transfers to a nursing facility in WV, his eligibility must be evaluated as any other applicant.

3. Content Of The Interview

No interview is required but when an interview is conducted, the interview requirement in Section 1.2 are applicable.

In addition to the requirements in Chapter 1, the Worker must screen the client according to the priorities listed in Section 17.9 and evaluate certain individuals for the Long-Term-Care Asset Disregard. See Section 17.10.

The Worker must also explain the applicability of Estate Recovery, which is outlined on forms DFA-NH-RR-1 and DFA-RR-1. Questions about the Estate Recovery process must be referred to the current contract agency. Information about this agency is in Chapter 17, Appendix I.

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 redetermination is completed once a year, and **no** interview is required. The Worker receives an alert in RAPIDS when a redetermination is due.

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

1. 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, **a** nursing facility staff member who has knowledge of the client's financial circumstances **may choose to be interviewed.**

2. Representative Lives in Another County

Every effort must be made to accommodate an authorized representative who **chooses** to complete the interview. 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 must send an electronic message to the county office in which the representative lives. The following information is included:

- 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

- The Worker who receives the information, completes the interview**, if applicable,** 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 DFA-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, RAPIDS is changed to reflect current circumstances and appropriate notification is sent.