8.312.2-UR LONG TERM CARE SERVICES UTILIZATION REVIEW INSTRUCTIONS FOR NURSING FACILITIES

This material has been prepared to assist providers in understanding and complying with utilization review requirements for the New Mexico Medicaid Nursing Facility (NF) program (Medicaid). General utilization review program policy is contained in Section 705 [8.302.5 NMAC], Utilization Review, of the New Mexico Medical Assistance Program Manual.

The applicable policy sections for this service are:

8.302.1 NMAC	**General Provider Policies**
8.302.2 NMAC	**Billing for Medicaid Services**
8.302.3 NMAC	**Third Party Liability Responsibilities**
8.302.5 NMAC	**Utilization Review**
MAD-731 [8.312.2 NMAC]	**Nursing Facilities**
MAD-953 [8.350.2 NMAC]	**Reconsideration of Utilization Review Decisions**
MAD-954 [8.350.3 NMAC]	**Abstract Submission for Level of Care Determinations**
8.351.2 NMAC	**Remedies and Sanctions**
8.353.2 NMAC	**Provider Hearings**

Medicaid program policy sections and Billing Instructions may be obtained from the Medical Assistance Division (MAD) or its Claims Processing Contractor. Utilization Review (UR) Instructions may be obtained from the MAD. These Utilization Review Instructions do not supersede or replace the applicable policy manual sections or manual revisions. The Utilization Review Instructions serve only to quantify specific documentation requirements and utilization review processes. Providers must use correct codes, give accurate and applicable information, and supply clarifications, as requested.

Please address any questions concerning these instructions to the MAD Program Manager for Institutional Care Services. For questions concerning utilization review, (e.g., prior approval, denials, Request for Additional Information form, please contact the MAD Utilization Review Contractor (UR Contractor).

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8.312.2 UR LONG TERM CARE UTILIZATION REVIEW FOR NURSING FACILITIES

8.312.2.1-UR PRIOR APPROVAL REVIEW: Prior approval is required for all types of NF stays including, but not limited to, initial admission, continued stays, transfers, and retrospective review. This section will provide general information and discuss the method, forms and procedures for prior approval reviews. The second section discusses specific situations requiring prior approval, (e.g., initial reviews, continued stays, Medicaid Pending). The third section provides information on processes to follow when a NF disagrees with a UR decision. The last section will discuss Pre-Admission Screening and Resident Review (PASRR).

A. **Review Agency:** The following agency is the UR Contractor for the State of New Mexico and conducts all prior approval reviews for NFs:

New Mexico Medicaid Utilization Review (NMMUR)
Blue Cross/Blue Shield of New Mexico (BCBSNM)
P.O. Box 27950
Albuquerque, New Mexico 87125-7950

Telephone: (800) 392-9019 – Customer Service

B. **Nursing Facility Prior Approvals:** Prior approval reviews for NFs are complicated by the following:

(1) There are two levels of care (LOC), High NF (HNF) and Low NF (LNF);

(2) Many NF residents have Medicare coverage; and,

(3) Some NF residents become acute, are admitted to an acute care hospital, and are readmitted to the NF.

Additionally, federal law requires NFs to perform a Pre-Admission Screening and Resident Review (PASRR) that screens for mental illness, mental retardation and related conditions. In spite of these considerations, there are procedures and information that are applicable to all situations requiring prior approval.

C. **Method of Review:** The Long Term Care Assessment Abstract (Abstract), ISD 379 Form (Attachment 1), is the form used for all prior approval reviews. The Abstract is used to:

(1) Determine the appropriateness of the LOC requested by the resident's attending physician, nurse practitioner or physician assistant; and,

(2) Indicate the certified (approved) dates of service (DOS).

Supplemental documentation may be required to support information on the Abstract.

Reviews (except Reconsideration reviews) are completed or returned for additional information within six (6) working days of receipt by the UR Contractor.

The Abstract form can be obtained upon request from the UR Contractor.

D. **Nursing Facility Medical Eligibility Criteria:** The UR Contractor uses specific criteria to determine the LOC for all the reviews conducted by the UR Contractor for every NF resident. See Attachment 2, *Medical Eligibility Criteria for Nursing Facility (NF) Level of Care,* for a copy of the NF criteria.

E. **Nursing Facility's Procedures for Requests for Prior Approval**

(1) All requests for prior approval will be submitted on the Abstract. An Abstract and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.

(2) All locator fields must be clearly marked on the Abstract.

(3) When the resident goes off Medicare Co-Pay to straight Medicaid, the NF submits an Initial Abstract that begins the UR process for the resident.

(4) The NF should write what type of review is being requested at the top of the Abstract:

- Initial
- Continued Stay
- Medicaid Pending
- Transfer
- Re-admit
- Re-review
- Reconsideration
- Level of Care Change

(5) Appropriate documentation must accompany the Abstract. Section 8.312.2.2-UR, of this document, outlines specific documentation requirements for each review situation. Generally, appropriate documentation includes:

(a) Valid Physician's, Nurse Practitioner's or Physician Assistant's

Orders for Medicaid LOC.

(b) Resident's Level I PASRR Screen;

(c) A current History and Physical (H&P) examination completed within six (6) months of the assessment date for a new admission or new Medicaid recipient; and,

(d) Reason for placement in the NF.

(6) The Abstract and other documentation is forwarded to the UR Contractor for review.

F. **Physician's, Nurse Practitioner's, or Physician Assistant's Orders**

(1) A valid order must:

(a) Be signed by a Physician, Nurse Practitioner or Physician Assistant;

(b) Be dated; and,

(c) Indicate the LOC – either HNF or LNF.

Once an order is signed and dated, it cannot be changed. If a change is required, a new order must be written, signed, and dated by the Physician, Nurse Practitioner or Physician Assistant.

(2) Verbal or telephone orders are permitted. The order must be taken by a RN or LPN who must also sign and date the order. It must be clearly indicated that the order is a telephone or verbal order with the name of the Physician, nurse practitioner or physician assistant who gave the order and LOC. The date of the call or verbal communication is the date of the order.

G. **UR Contractor's Procedures for Prior Approval**

(1) The UR Contractor reviews the Abstract and accompanying documentation.

(2) If all of the documentation is in order, the UR Contractor approves the documentation and makes a LOC determination. The Abstract is completed and days are certified (approved) according to the LOC requested.

(3) When required documentation is missing for any type of Abstract, one (1)

"Request for Information" (buck back) sheet will be generated by the UR Contractor and sent to the provider. If the required documentation is not provided to the UR Contractor when the NF re-submits the "Request for Information", the Abstract will be technically denied.

(4) If upon receipt of additional information, the UR nurse is unable to make a LOC determination, it is forwarded to a physician consultant for a decision.

(5) The UR Contractor mails copies of the Abstract to the NF, the appropriate Income Support Division (ISD) office and the Medicaid Claims Processing Contractor. The Claims Processing Contractor also electronically receives a daily Long Term Care tape from the UR Contractor.

H. **Denial of Requests for Prior Approval:** If a LOC criteria is not met and the request for placement is denied, the UR Contractor will mail the referring parties a denial letter in a timely manner with the reason for denial as determined by the physician consultant. The requesting parties then have an opportunity to request a re-review, reconsideration, or an administrative hearing of the UR Contractor's decision.

I. **Reserve Bed Days** Medicaid pays to hold or reserve a bed for a resident in a nursing facility to allow for the residents to make a brief home visit, for acclimation to a new environment or for hospitalization according to the limits and conditions outlined below.

(1) Medicaid covers six reserve bed days per calendar year for every long term care resident for hospitalization **without prior approval**. Medicaid covers three reserve bed days per calendar year for a brief home visit **without prior approval**.

(2) Medicaid covers an additional six reserve bed days per calendar year **with prior approval** to enable residents to adjust to a new environment, as part of the discharge plan.

(a) A resident's discharge plan must clearly state the objectives, including how the home visits or visits to alternative placement relate to discharge implementation.

(b) The prior approval request must include the resident's name, medicaid number, requested approval dates, copy of the discharge plan, name and address for individuals who will care for the resident during the visit or placement and a written physician order for trial placement.

(3) Nursing facilities use the following procedures for prior approval for

additional discharge reserve bed days. The NF must submit the request for prior approval for additional discharge reserve bed days to the Coordination of Long Term Services (CoLTS) Managed Care Organization (MCO) in which the resident is enrolled. The NF follows the written process of the CoLTS MCO for submission of the request, and receipt of documentation of the approval. The written process of the CoLTS MCOs must also indicate if any documentation or procedures are required of the NF to assure payment of claims for approved discharge reserve bed days.

8.312.2.2-UR INITIAL, CONTINUED STAY, MEDICAID PENDING AND OTHER SITUATIONS REQUIRING PRIOR APPROVAL

A. **Initial Abstract Review Process:** All services furnished by Medicaid NF providers must be medically necessary. The medical necessity decision is made during the Initial Abstract prior approval review. The procedures described in Subsections E., F., and G. of 8.312.2.1-UR above, should be referred to when preparing documents for all reviews requiring prior approval.

(1) **Required Documentation**

(a) Current H&P completed within six (6) months of the assessment date;

(b) Valid order for Medicaid LOC (HNF or LNF) signed and dated by a Physician, Nurse Practitioner or Physician Assistant; and,

(c) PASRR Level 1 screening document.

(2) **Timeliness Requirements:** The Abstract, any accompanying documentation and PASRR Level I screening document must be postmarked and mailed to the UR Contractor within thirty (30) calendar days of the individual's date of admission to the NF. Upon receipt and approval of this documentation, the UR Contractor will make a LOC determination and assign a length of stay (certify days).

(3) **Length of Stay Time Periods**

(a) The length of stay for an Initial Abstract for a HNF resident is not to exceed thirty (30) days (approximately); however, a shorter length of stay can be assigned based on the needs of the resident.

(b) The length of stay for an Initial Abstract for a LNF resident cannot exceed ninety (90) days (approximately); however, a shorter length of stay can be assigned based on the needs of the resident.

(4) **Review for Hospitalized Individuals Seeking First Time Placement in a Nursing Facility:** For individuals seeking first time placement in a NF after being hospitalized, an Abstract and all appropriate documentation used in the review process must be completed by the NF and submitted to the UR Contractor within thirty (30) calendar days of the individuals admission to the NF. The documentation and timeliness requirements are the same as for an Initial Abstract.

B. **Continued Stay Abstract Review:** Prior approval reviews are required for all requests for the continued stay of a resident in a NF. These reviews are based on the medical necessity of NF services being continually provided to the resident. The medical necessity decision is made during the Continued Stay Abstract prior approval review. Before the expiration of the current certification, a request for continued stay must be received by the UR Contractor. The procedures described in Subsections E., F., and G. of 8.312.2.1-UR should be referred to when preparing documents for all reviews requiring prior approval.

The UR Contractor reviews the Abstract and assigns a re-certification date if approved for additional lengths of stay.

(1) **Required Documentation**

(a) Valid order for Medicaid LOC (HNF or LNF) signed by a Physician, Nurse Practitioner or Physician Assistant dated within 60 days prior to the start date of the continued stay; and,

(b) Current signed and dated progress notes.

(2) **Timeliness Requirements**

(a) The Abstract and any accompanying documentation must be postmarked and received by the UR Contractor prior to the start date of the new certification period.

(b) **Length of Stay Periods**

(i) The UR Contractor can certify up to 90 days (approximately) of HNF based on the medical needs and stability of the resident.

(ii) The UR Contractor can certify up to 365 days (approximately) of LNF based on the medical needs and stability of the resident.

C. **Pending Medicaid Eligibility:** Prior approval reviews can be done when the

service is furnished before the determination of the effective date of the resident's financial eligibility for Medicaid. If the resident is applying for both Medicaid financial and medical eligibility at the same time, please write **"MEDICAID PENDING"** across the top of the Abstract. **Please Note: A resident on Supplemental Security Income (SSI) is not Medicaid Pending.**

(1) When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed Abstract with required documentation and a Physician's, Nurse Practitioner's or Physician Assistant's order for LOC. The Abstract should have **"MEDICAID PENDING"** written across the top.

(2) The UR Contractor will review the information submitted and determine the LOC.

(3) A Level of Care Notice, MAD 385 Form, will be completed by the UR Contractor and sent to the NF, the Claims Processing Contractor and the appropriate ISD office. **The MAD 385 Form will identify the LOC only. Billable days are not certified (approved) on the MAD 385 Form.**

(4) The UR Contractor will hold the Abstract. The MAD 385 Form is valid for only ninety (90) calendar days. NFs are responsible for submitting additional Continued Stay Abstracts to the UR Contractor if the resident's financial eligibility has not been determined in the original ninety (90) day time frame.

(5) When the NF receives notification from the ISD office confirming Medicaid financial eligibility, the NF will call the UR Contractor and provide the resident's Medicaid number and effective date of eligibility.

(6) The UR Contractor will pull the original Abstract(s) and complete the information certifying (approving) days and dates. Copies will be sent to the NF, the appropriate ISD office and the claims processing contractor.

D. **Retroactive Medicaid Eligibility:** Requests for prior approval based on a resident's retroactive financial eligibility must be reviewed in writing by the UR Contractor within thirty (30) calendar days of the date of the eligibility determination. The NF must submit a copy of the Initial Abstract and a copy of the retroactive eligibility form as received from the ISD office to the UR Contractor.

E. **Re-admission Reviews**

(1) A Re-admission review is required when the resident has left the NF and then returns, after three (3) midnights, to a different LOC.

(2) **Required Documentation and Timeliness Requirements:** If the resident is out of the facility for more the three (3) midnights and is re-admitted to the NF at a different LOC, the NF has to submit a Re-admit Abstract within thirty (30) calendar days with the following accompanying documentation:

(a) A new valid LOC (HNF or LNF) for readmission signed and dated by the Physician, Nurse Practitioner or Physician Assistant.

(b) The hospital discharge summary and/or resident's admission note back to the NF.

(i) When the resident is re-admitted to the NF and has **more than thirty (30) days left on his/her certification**, days will be assigned from the re-admit date.

(ii) If the resident has **less than thirty (30) days left on his/her certification**, the NF will not submit a Re-admit Abstract. Instead the NF should submit a Continued Stay Abstract. Any days remaining on the current certification will be added to the continued stay request. The Continued Stay Abstract must be received before the current Abstract expires.

F. **Retrospective Reviews:** Abstracts for Initial, Continued Stay, Re-admit and changes in LOC reviews can be considered late and a Retrospective review may be requested by the NF. Medicaid Pending reviews are never late. A request for Retrospective review of an Abstract for Initial, Continued Stay or Re-admit reviews is considered in the following situations only:

(1) **Unexcused Late Reviews**

(a) A NF is allowed ten (10) unexcused late reviews per calendar year for the first ten (10) Abstracts that are not submitted on time due to reasons within the control of the NF.

(b) The UR Contractor logs unexcused Retrospective reviews.

(c) The UR Contractor will notify the NF when the NF has reached ten (10) late reviews for the calendar year.

(d) After a NF has ten (10) late reviews, days will be denied on an Abstract.

(2) **Excused Late Reviews:** Requests for Abstracts not submitted timely due to reasons beyond the control of the NF, must be submitted with a detailed written explanation and documentation that supports the request for excusable late review.

(3) **Reimbursement and Retrospective Reviews**

(a) If the reason for the delay in Abstract submission was within the control of the NF, reimbursement is effective back to the start date of requested certification only for the first ten (10) Abstracts per calendar year.

(b) For additional Abstracts that are submitted late due to reasons within the control of the NF, the effective date for reimbursement is the date the Abstract was received by the UR Contractor.

(c) Medicaid will not reimburse NFs for DOS not covered by an Abstract. In addition, the Medicaid recipient cannot be billed for the service.

G. **Transfer from Another NF:** If a resident is admitted to one NF from another NF, the following procedures apply:

(1) The receiving NF must notify the UR Contractor by telephone that a transfer to their NF is to occur. The receiving NF will provide the UR Contractor with the date of the transfer and the end of the resident's current certification. Without this information, claims submitted by the receiving NF will not be paid by the MAD Claims Processing Contractor.

(a) If there are more than thirty (30) days on the resident's current certification, the UR Contractor will complete a MAD 385 Form which will indicate the LOC and certification period remaining for the receiving NF. The MAD 385 Form will be sent to the NF, the appropriate ISD office and the Claims Processing Contractor. This can be done by telephone.

(b) If there are less than thirty (30) days remaining on the resident's current certification, the receiving NF will be requested to send a Continued Stay Abstract to the UR Contractor. The days remaining on the current certification will be added to the Continued Stay. Please write **"TRANSFER"** across the top of the Abstract .

(2) The NF receiving the resident, with the assistance of the Claims Processing Contractor must determine the status of resident's reserve bed days. This

includes the number of days used during a calendar year [~~and the reason for the use of these days~~]. This information is placed in the resident's NF records.

H. **Change in Level of Care (LOC):** All changes in LOC require a new Abstract that should be submitted within thirty (30) calendar days of the change in LOC. If an Abstract is being submitted for a change in LOC, please write **"LEVEL OF CARE CHANGE"** across the top of the Abstract. The NF must provide a signed and dated order from the Physician, Nurse Practitioner or Physician Assistant as well as any documentation to support the LOC request. The date the LOC occurs must be clearly stated.

I. **Discharge Status:** Discharge Status occurs when a resident no longer meets the level of care that qualifies for nursing home placement, but there is no option for community placement of the resident at that time. Discharge Status does not mean the resident is being discharged from the facility.

Individuals are often already residing in a nursing facility at the time of initial application for Medicaid. In addition, Medicaid eligible individuals residing in a nursing facility may clinically improve to the point that they no longer meet nursing facility LOC. Such individuals may lack the personal or family resources to provide for their own ongoing care in the community if discharged from the nursing facility. Community based health care and support services may be limited or unavailable. Residents may be at risk for failure to thrive outside the supportive structured environment of the nursing facility. Physically discharging the resident under such circumstances may put the resident's health at risk.

To accommodate this health care issue the New Mexico Medicaid program allows for **temporary** continuation of coverage at Low NF level of reimbursement while the facility addresses the development of community placement resources **on an ongoing basis** to meet the resident's lower level of need. The temporary continuation of coverage while discharge planning is taking place for a resident who does not meet Low NF or High NF Level of Care is termed **"Discharge Status".** Discharge Status does not mean the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility.

(1) **Initial Discharge Status** is authorized at Low NF for a maximum of 90 days, based upon the Peer Consultant physician determination.

(2) **Continued Stay Discharge Status** is authorized at Low NF for not less than 180 days and up to 365 days. **Submission of a Continued Stay abstract for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility's ongoing attempts to find and develop appropriate community placement**

options for the resident. The facility should document why the resident must remain in a nursing home environment if the resident is at risk for failure to thrive upon discharge to a community placement. Failure to submit sufficient documentation specifying the facility's discharge planning efforts could result in the denial of the abstract. The resident's inability to afford assisted living services may be a consideration in discharge planning.

8.312.2.3-UR RE-REVIEW, RECONSIDERATION AND ADMINISTRATIVE HEARINGS OF REVIEW DECISIONS: Providers who are dissatisfied with the UR Contractor's medical necessity decision(s) may request a Re-review and Reconsideration. See 8.350.2 NMAC.

A. **Re-review:** Providers who disagree with review decisions must request a Re-review of the decision(s) before requesting a Reconsideration. The Re-review must be requested with ten (10) calendar days after the date on the written notification of the UR decision or action. Requests for Re-review must be submitted in writing directly to the UR Contractor. The UR Contractor completes and submits a written re-review decision to the NF within six (6) working days from receipt of a written request for a Re-Review. The decision notice from the UR Contractor contains information on the Re-consideration process.

B. **Reconsideration:** Providers who disagree with a Re-review determination may request a Reconsideration. Requests for Reconsideration must be in writing and received by the UR Contractor within thirty (30) calendar days after the date on the Re-review decision notice. The UR Contractor performs the Reconsideration and notifies the NF in writing of a decision within eleven (11) working days of receipt of the Reconsideration request. The written notice also includes information on Administrative Hearing process.

The request for a Reconsideration must include the following:

(1) Statement that a Reconsideration of a Re-review is requested.

(2) Reference to the challenged decision or action;

(3) Basis for the challenge;

(4) Copies of any document(s) pertinent to the challenged decision or action; and,

(5) Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a UR decision.

C. **Administrative Hearings:** Providers who disagree with the Reconsideration

determination made by the UR Contractor can request an Administrative Hearing within thirty (30) calendar days of the UR Reconsideration decision. See Section 8.353.2 NMAC, Provider Hearing.

8.312.2.4-UR PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR): All individuals seeking or receiving services in a NF must be screened for mental illness, mental retardation and related conditions prior to admission to a Medicaid certified NF regardless of the type of payment for these services. This function is accomplished by administration of the Pre-Admission Screening and Resident Review (PASRR). See Federal Nursing Home Reform Legislation of 1987; 42 CFR §§ 405, 431, 433, and 483; and, P.L. 104-315 that amends Title XIX of the Social Security Act effective in 1996. The PASRR function is conducted by the PASRR Unit of the Department of Health (DOH) and is done in conjunction with and the approval of the MAD.

A. The purpose of PASRR is as follows:

(1) To determine whether the resident requires a specific level of nursing care;

(2) To determine if there is, in fact, a diagnosis of serious mental illness or mental retardation;

(3) To assess whether specialized services for mental illness or mental retardation are needed; and,

(4) To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in an institution for those with conditions of mental retardation or mental illness.

B. **Organization of the PASRR:** PASRR is divided into two levels: Level 1 Screen and Level II Evaluation.

(1) **Level I Screen:** A Level I Screen must be completed on every NF applicant. If, during the Level I Screen, it is determined that the individual has a condition of serious mental illness or mental retardation, a Level II Evaluation must occur prior to admission. In the case of a current resident in the NF, a Level I Screen is required to confirm the appropriateness of continued placement in a NF.

The Level I Screen must be done if there has been a significant change in the physical or mental condition of a resident who is mentally ill or mentally retarded. "Significant change" for PASRR purposes can be tied to the already existing regulatory definition for significant change that prompts an alteration in a resident's Minimum Data Set (MDS). Significant change referrals must be made to PASRR no later than twenty one (21) days after the occurrence of the significant change. The PASRR Unit is required to

review the completed Level I Screen packet within seven (7) to nine (9) days of receipt of the completed packet from the NF. Notification of the review decision must be submitted to the NF by phone or in writing within that time period.

(2) Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having mental illness, mental retardation, or a related condition a Level II Evaluation must be completed unless exclusions apply. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident, including psychosocial, psychiatric and developmental assessments, resident's medical status, and drug history.

C. **Exclusions to PASRR**

(1) If an individual falls within one of the following categories, a Level II Evaluation need not be performed. Exclusions are granted on a case-by-case basis.

(a) The resident has a primary diagnosis of dementia, Alzheimer's disease, a related disorder, or an adjustment disorder with anxiety or depression as documented by the attending physician.

"Dementia", as a diagnosis, must have objective documentation. This involves a scored mini-mental status examination or a brain scan showing cerebral atrophy.

(b) The resident is not considered a danger to self or others and has been released from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed thirty (30) days. There is no primary diagnosis of mental illness or mental retardation.

(c) The resident has a diagnosis of mental illness or mental retardation but is certified to be terminally ill with a life expectancy of six (6) months or less and is need of continuous nursing care and/or medical supervision and treatment due to a physical condition.

(d) The resident is comatose, ventilator dependent, functions at a brain stem level or has a diagnosis of:

(i) Chronic Obstructive Pulmonary Disease Oxygen Dependent

(ii) Parkinson's Disease

(iii) Huntington's Disease

(iv) Amyotrophic Lateral Sclerosis

(2) **Psychotropic Drugs:** It is not necessary to submit psychotropic drug references to the PASRR Unit if there is no major psychiatric diagnosis or the individual is regularly receiving the drug for dementia/related conditions.

D. **Level I Screen Process**

(1) A NF is required to submit copies of the Level I Screen for each resident with the Abstract to the UR Contractor. The Screen and other necessary documentation must be sent with the Abstract to avoid delays in the review process.

(2) The UR Contractor logs in the date on the recipient screen when the Abstract, Level I Screen, and other documentation is received.

(3) The UR Contractor scans the Level I Screen. If the resident passes the Screen, the UR Contractor determines the LOC. If the resident fails the Screen, no further action is to be taken by the UR Contractor. The Abstract, Screen, and other documentation is submitted to the PASRR Unit.

(4) The UR Contractor then sends a notice to the NF that the Abstract and other documentation has been sent to the PASRR Unit for a Level II Evaluation determination.

(5) The PASRR Unit reviews the Level I Screen, determines the LOC and sends a copy of the LOC, Screen, Abstract and other documentation to the UR Contractor for data entering.

E. **Level II Evaluation Process:** The PASRR Unit completes an evaluation and makes the Level II and LOC determination on the review portion of the Abstract and returns the Abstract to the UR Contractor. All subsequent reviews are performed by the PASRR Unit unless waived by the PASRR unit.

(1) If a subsequent specified review or significant change review is required, the review portion of the Abstract must be completed by the PASRR unit. All subsequent reviews are performed by the PASRR unit instead of the UR Contractor.

(2) If a subsequent specified review or significant change review is not required, the Abstract is returned to the UR Contractor for a LOC determination. The UR Contractor enters the data that shows the approved

LOC into their system and transmits this information to the Claims Processing Contractor.

F. **PASRR and Re-admission from a Hospital:** The NF contacts the PASRR unit if the hospitalization of a resident results in a change in the Level 1 screen.

G. **PASRR and Medicaid Eligibility Pending:** If a resident is in a "Pending Medicaid" status at the time of Abstract submission and the resident fails the Level I Screen, the Abstract is forwarded to the PASRR Unit where the following action occurs:

(1) The LOC determination is made.

(2) The MAD 385 Form is completed and sent to the UR Contractor. The information on this form is processed by the UR Contractor and submitted to the appropriate ISD office and to the NF.

(3) Once eligibility is established, the ISD office notifies the NF.

(4) The NF must notify the PASRR Unit of the status of the resident's eligibility.

(5) The Abstract which includes the Medicaid number and the certified length of stay is completed by the PASRR unit.

(6) Upon completion, the Abstract is submitted to the UR Contractor who must notify the Claims Processing Contractor of the results of the determination.

ATTACHMENT II

New Mexico Medicaid Utilization Review
Medical Eligibility Criteria for Nursing Facility (NF) Level of Care

Current Version Date: 11/04/02

Background: The Omnibus Reconciliation Act of 1987 eliminated a previous distinction between Medicaid Skilled and Intermediate care facilities and revised a baseline set of requirements for facilities providing long-term care to Medicaid recipients. Facilities which provide this level of care are termed Nursing facilities (NF). (Note: For purposes of the Medicare program, there are still facilities designated as "Medicare Skilled." This issue is separate from Medicaid issues.) To recognize that the clinical severity and resource utilization of recipients who require NF placement spans a considerable spectrum, New Mexico Medicaid has established two payment categories. These categories are termed "High NF" and "Low NF." They are constructs for payment methodologies and do not constitute different types of facilities. All NF's are required to be able to provide adequate services across the spectrum of severity/intensity encompassed by High NF and Low NF.

For NF care to be covered by New Mexico Medicaid, a recipient must be financially eligible and medically eligible. The criteria which follow address the second eligibility issue: medical eligibility. To be medically eligible, a recipient must meet the criteria for either Low NF or High NF. Note that a recipient may require substantial services, but if that array of services can be provided at a lower level of care (example: assisted living, shelter care, boarding home) the recipient would not meet medical eligibility requirements for NF coverage. Recipients who require skilled services on a time limited basis due to temporary self-limiting decline from a baseline functional level would not meet medical eligibility requirements for NF coverage. Also, if a recipient requires a level of care of higher intensity/resources than can be provided at a NF (example: acute care, acute rehabilitation, the Recipient would not meet medical eligibility requirements for NF coverage. In the past, there has been confusions about the relationship of skilled services to payment status. Note that a recipient certified at the Low NF rate may need and receive some degree of skilled level of care services. The mere provision of skilled level of care services to a Medicaid recipient does not per se constitute qualification for the High NF payment level.

Review decisions are based solely on documentation. The sources eligible for review are the Medicaid Long Term Care abstract, the clinical record or portions thereof, the Minimum Data Set (MDS), or facility written responses to requests for additional information. What follows are a set of review factors which are used to establish whether a recipient's clinical condition meets criteria for Low NF or High NF eligibility. If the clinical information available for review indicates the recipient meets criteria for a given level, the nurse reviewer may certify medical eligibility. (The nurse is <u>not</u> obligated to do so, however, if in his or her judgement criteria are "met" on their face, but not in their intent. In that case the nurse reviewer may refer the case for physician

review.) If the information does not substantiate that the recipient's condition meets criteria for the level being sought, the nurse reviewer is obligated to refer the case to physician review.

Definitions:

Skilled: For purposes of New Mexico Medicaid, the term "skilled" services may carry a different meaning than used in other programs, such as Medicare. Medicaid skilled services are direct ("hands-on") which can only be provided by a licensed professional acting within a defined scope of practice and in accordance with professional standards. Skilled services are those provided by registered nurses (RN), licensed practical nurses (LPN), licensed respiratory therapists (RT), licensed physical therapists (PT), licensed occupational therapists (OT), and licensed speech language pathologists (SLP or "speech therapists"). Skilled services are highly individualized and directed toward the evaluation, monitoring, treatment, or amelioration of specific clinical conditions. Skilled services are provided under direction of a licensed physician (MD or DO) and in accordance with a plan of treatment that is individualized and medically necessary.

Intermediate: Intermediate services are direct ("hands-on") services which can only be provided by certified (or similarly officially qualified) personnel who have received specialized training and are supervised by licensed professionals. Such services are directed toward specific needs of a resident as a result of a specific clinical condition. Examples include services provided by Certified Nurse Assistants (CNA) and Physical therapy aides.

Assistance: Assistance services are direct ("hands-on") services which are general in nature, principally independent of specific medical needs, which do not require extensive training in performance, and which require oversight by supervising professionals. Examples include food set-up and assistance with cutting food, bathing and grooming assistance, shopping assistance, money management, routine transfer assistance. (Assistance services may be provided by persons capable of providing professional or skilled services, but if the services do not require persons with that level of expertise, they remain assistance level services.)

Homemaker: Non-direct services which are general in nature and independent of specific medical needs. Examples include shopping, transportation, housekeeping.

Daily: For skilled, intermediate, and assistance services, at least once a day. For therapies, at least five times per week.

ADLs: Activities of Daily Living

- Dressing (Once clothes are accessible and fasteners appropriately modified, putting on and fastening clothes; putting on shoes.)
- Grooming (Once in front of appropriately modified sink, turning on water, washing face, shaving face, brushing teeth, combing hair.) Bathing (Once in an appropriately modified bath or shower, ability to turn on water and wash head and body.)
- Eating (Once in front of food, ability to bring food and fluid to mouth, chew and swallow.)
- Meal acquisition/preparation (Once food items appropriate to the recipient are in an appropriate, accessible location in residence, the ability to access and prepare the food in an edible state that over time meets age-appropriate nutritional needs. Includes preparation of cold foods re-heating of pre-made meals. Does not include meal planning, diet teaching, shopping, or issues of financial access. Does not include food choice or preference decisions of the recipient; the issue in question is capacity.)
- Transfer (Ability to move to and from bed and chair.)
- Mobility (Ability to move self from place to place by ambulation, wheelchair or other mechanically assisted means.)
- Toileting (Ability to properly sit on commode, adjust clothing properly, use commode, slush or empty commode, and clean perineal area.)
- Bowel/bladder control and management (Continence of urine and stool or ability to self-manage if incontinent or abnormal bladder function.)
- Taking daily, essential prescription medication (Assuming use of assistive dispensing devices and schedules as needed, the ability to recognize and properly self-administer prescription medications which are essential to maintaining life and health such that in the absence of such medication, mortality or serious morbidity would occur.)

IADLs: Instrumental Activities of Daily Living

- Answering telephone (includes use of special modifying equipment)
- Making a telephone call
- Shopping (once in store, selecting groceries and other items of necessity)
- Transportation ability (manner by which transports self from place of residence to other places beyond walking distance)
- Prepare meals (ability to prepare meals as desired, beyond simple meal acquisition/preparation; does not include meal planning)
- Laundry (ability to put clothes in washer or dryer, starting and stopping machine, removing clothes, drying clothes)
- Housekeeping (dusting, vacuuming, sweeping, routine cleaning of kitchen and bathroom)
- Heavy chores (moving furniture, yard work, windows, manually cleaning oven
- Taking non-essential medication (assuming use of assistive dispensing devices as needed, the ability to recognize and properly self-administer medications which are used for comfort or amelioration of symptoms, but which do not preserve life or avert serious morbidity)

- Handling money (ability to properly pay, count change, pay bills, balance checkbook)

Unstable: A clinical condition which requires daily skilled reassessment in order to prevent serious morbidity. Such reassessment must lead to clinical decision-making and a reasonable potential must exist that treatment goals may be modified and/or immediate skilled interventions might occur based on the results of the monitoring. The definition is broader than used in acute settings. An unstable condition does not necessarily mean that immediate death might result from lack of monitoring, only that serious morbidity might results. An unstable condition may be chronic and have no prognosis for improvement. Evolving processes for which monitoring is necessary in order to determine the seriousness of the process are also unstable conditions for the purposes of these criteria.

Medically Necessary: Medically necessary services are clinical and rehabilitative physical, mental or behavioral health services that:

- Are essential to prevent, diagnose or treat medical conditions or are essential to enable the individual to attain, maintain or regain functional capacity;
- Are delivered in the amount, duration, scope and setting that is clinically appropriate to the specific physical, mental and behavioral health care needs of the individual.
- Are provided within professionally accepted standards of practice and national guidelines;
- Are required to meet the physical, mental and behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payor.

Application of the definition:

- A determination that a health care service is medically necessary does not mean that the health care service is a covered benefit or an amendment, modification or expansion of a covered benefit.
- The utilization review contractor is making the determination of the medical necessity of clinical, rehabilitative and supportive services consistent with the Medicaid benefit package applicable to an eligible individual shall do so by:
    1. Evaluating individual physical, mental and behavioral health information provided by qualified professionals who have personally evaluated the individual within their scope of practice, who have taken into consideration the individual's clinical history including the impact of previous treatment and service interventions and who have consulted with other qualified health care professionals with applicable specialty training as appropriate;
    2. Considering the views and choices of the individual or the individual's legal guardian, agent or surrogate decision maker regarding the proposed covered service as provided by the clinician or through independent verification of those views; and
    3. Considering the services being provided concurrently by other service delivery systems,
- Physical, mental and behavioral health services shall not be denied solely because the individual has a poor prognosis. Required services may not be arbitrarily denied or reduced in amount, duration or scope to an otherwise eligible individual solely because of the diagnosis, type of illness or condition.
- Decisions regarding benefit coverage for children shall be governed by the EPSDT coverage rules.

Medical Eligibility Criteria

Medical Eligibility for Low NF may be certified when one of the following criteria is met:

(1) The recipient's condition satisfies the General Eligibility Requirement for Low NF and one or more of Low NF Clinical Status Factors 1 - 8 are present.

OR

(2) The physician consultant determines that the recipient's condition satisfies the general Eligibility Requirement for Low NF and that there are factors present
which are equivalent to one or more of Clinical Status Factors 1 - 8.

Medical Eligibility for High NF may be certified when one of the following criteria is met:

(1) The recipient's condition satisfies the General Eligibility Requirement for High NF and one or more of High NF Clinical Status Factors 1 - 8 are present.

OR

(2) The physician consultant determines that the recipient's condition satisfies the General Eligibility Requirement for High NF and that there are factors present
which are equivalent to one or more of Clinical Status Factors 1 - 8.

Table of Clinical Status Factors

Note: Some factors from earlier versions have been incorporated into other factors. Their numbers have been left in the chart for data management purposes. They
may be ignored.

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
NF General Eligibility Requirement	The recipient's functional level must first meet the general eligibility requirement for Low NF. In addition, the recipient has at least one condition or limitation such that it is medically necessary to receive (1) daily skilled monitoring and/or (2) daily skilled interventions to maximize medical stability or achieve restoration of function.	The recipient's functional level is such that two or more ADLs cannot be accomplished without consistent, ongoing, daily provision or some or all of the following levels of service: skilled, intermediate and/or assistance. The functional limitations must be secondary to a condition for which general treatment plan oversight of a physician is medically necessary.	Needs are too complex or inappropriate for NF, such that the recipient requires acute level of care for adequate diagnosis, monitoring, and treatment or requires inpatient based acute rehabilitation services. The recipient is completing the terminal portion of an acute stay and the skilled services are only being used to complete the acute therapy. Needs do not require an institutional long-term care setting, such as those which can be adequately addressed by home health care. The recipient requires services on an intermittent basis and has a functional level which does not require daily services at the skilled, professional or assistance level in order to accomplish ADLs. Recipient requires homemaker services to accomplish one or more ADLs, but is generally functional in accomplishing ADLs most days of the week.

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
1.A Medications	Administration of intravenous solutions and/or medications on a continuous basis. (See "Feeding" for parenteral nutrition administration issues.) OR Administration of medically necessary parenteral medications (except insulin, see below) OR Administration of varying doses of subcutaneous insulin based on a physician-determined and medically necessary sliding scale when such monitoring and decision for administration (1) occurs at least two times daily, (2) cannot be managed by the recipient, and (3) is in the setting of reasonable medical efforts to establish a baseline regarding dosing of intermediate and long-acting insulin. OR Administration of routine subcutaneous insulin twice daily (or more often) when the recipient is unable to self-administer insulin and also unable to report or manifest standard signs and symptoms of hypoglycemia such that each insulin injection requires increased skilled monitoring for presence of cerebral glycopenia (i.e., neurologic sequelae of hypoglycemia). OR Initiation of insulin therapy for a recipient who has not previously been on insulin (for the first thirty days of therapy). OR Administration of medications with well-established high risk profiles of side-effects mandating skilled nursing monitoring for	Intravenous fluids administered on rare occasion and for less than a day. (See "Feeding" for parenteral nutrition administration issues.) Includes TKO, KVO, Heparin Locks. OR Administration of routine, unchanging dose of subcutaneous insulin up to twice a day when the recipient is unable to self-administer (meaning if provided with a pre-filled syringe, would not be able to understand and administer.) The recipient must be able to report or manifest signs and symptoms of cerebral glycopenia and must not have had the need for side-effect related insulin adjustment for at least the past thirty days. OR Administration of medically necessary parenteral medications (except insulin) once per day. The patient is unable to self-administer. OR Administration of oral life-preserving prescription medications daily which the recipient cannot self-administer even if medications are set-up in assisted dispensing units and schedule reminders given. The medication must be significant enough that its absence would lead to significant morbidity or mortality.	Can administer own oral life and health preserving prescription medications if given assistance in scheduling and assisted dispensing units. Can administer own subcutaneous insulin in pre-filled syringes. Can administer own subcutaneous or intramuscular medications.

	predicted adverse reactions to administration which would require prompt medical intervention to prevent serious morbidity or mortality.		

TABLE OF CLINICAL STATUS FACTORS			
Factor	**High NF**	**Low NF**	**Not consistent with NF**
I.B. Respiratory therapy and supplemental oxygen	It is medically necessary for the recipient to receive 24-hour per day oxygen to prevent serious and potentially life threatening hypoxemia <u>at rest</u> and additionally it is medically necessary for the recipient to receive specific skilled monitoring and/or intervention on a daily basis to assure adequate oxygen delivery and/or assess respiratory depression. OR It is medically necessary for the recipient to receive respiratory therapy at least once per day such that in the absence of such therapy there is a significant risk of pulmonary compromise due to known and predictable complications of a physician-diagnosed condition. The necessary therapy cannot be self-administered by the resident. This factor includes tracheostomy suctioning.	It is medically necessary for the recipient to receive supplemental oxygen up to 24 hours per day and the administration of the oxygen requires skilled supervision and professional or assistance level care up to daily to prevent clinically predictable deterioration. The recipient must otherwise be unable to manage and self-administer supplemental oxygen. OR It is medically necessary for the recipient to receive respiratory therapy no less than three times per week to treat a condition amenable to such therapy. The therapy cannot be self-administered. This factor includes occasional or intermittent tracheostomy suctioning.	Recipient requires supplemental oxygen which can be self-administered. The oxygen needs are stable. The recipient does not require daily skilled observation. Recipient requires intermittent respiratory therapy that may be administered by family or self-administered in a non-institutional setting.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1. C. Ventilator	The recipient is ventilator dependent, but otherwise medically stable and the facility provides chronic ventilator management capability.	N/A	The recipient is ventilator dependent and has medical needs which cannot safely be met at a NF.
1.D. Ostomy care	Recipient has a new ostomy (first 30 days), requires active training, and requires skilled nurse monitoring and intervention of the ostomy site. OR Recipient has complication of an ostomy requiring daily skilled assessment and intervention.	Recipient has an uncomplicated ostomy but is unable to adequately manage and care for the ostomy site such that without at least daily assistance services, there would exist a health or hygiene risk.	Recipient is able to manage and care for ostomy site with less than daily assistance.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.E. Management of decubitus ulcers (pressure ulcers) (Excludes other lesions, such as venous stasis ulcers.)	Recipient has one or more stage III or IV decubitus ulcers requiring skilled nursing intervention and monitoring. OR Recipient requires skilled nursing intervention for two or more stage II decubitus ulcers at <u>separate</u> anatomic sites.	Recipient requires skilled care for: (a) one or more stage I or stage II decubitus ulcers at a single site (e.g., sacrum) or (b) two or more stage I ulcers at multiple sites. Recipient would not be able to self-treat or prevent progression without daily assistance level of care.	Recipient has healed or healing decubitus ulcers in the context of eradication of factors which led to the development of the decubitus ulcer and is able to manage and care for the healing ulcer with intermittent assistance.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1.F. Dressings (lesions other than pressure ulcers)	Recipient requires frequent sterile dressing changes (and/or irrigation) for significant, unstable lesions that require frequent nursing observation such as fresh, poorly healing, or infected wounds. Recipient must be unable to accomplish wound care without assistance.	Recipient requires sterile dressing changes (and/or irrigation) for significant, but stable, healing lesions. Recipient may be able to facilitate wound care, but must be unable to meaningfully accomplish wound care without assistance.	Recipient requires minimal assistance with dressing changes. Recipient is able to address wound care needs after training and mechanical assistance provided.
1.G. N/A	Incorporated into other factors	Incorporated into other factors	N/A

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
I.H. Specialized Rehabilitative / restorative Procedures by Qualified Therapists	It is medically necessary that the recipient receive one or more of the following therapies on a daily basis: speech, physical, and/or occupational therapy. Therapy must be directed toward significant treatable functional limitations, which affect ADLs. Therapy must be directed toward significant treatable functional limitations, which affect ADLs. Therapy must be individualized, goal oriewnted, and in accordance with specific treatment plan goals in order to maximize recovery. In the aggregate, such therapy must occur no less than five (5) hours per week. Goals, expectation for improvement, and duration of therapy must be medically reasonable.	It is medically necessary for the recipient to receive one or more of the following therapies on less than a daily basis: speech, physical, and/or occupational therapy. Therapy must be directed toward significant treatable functional limitations which affect ADLs. Therapy must be individualized, goal oriented, and in accordance with specific treatment plan goals to maximize recovery. Goals, expectation for improvement, and duration of therapy must be medically reasonable.	The recipient requires maintenance speech, physical, and/or occupational therapy achievable on an outpatient basis. (Transportation needs are not considered.) The recipient requires maintenance speech, physical, and/or occupational therapy which can be performed independently or with home-based assistance.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
1. I. Other NF Services Required	The recipient is comatose, in a persistent vegetative state, or is otherwise totally bed bound and totally dependent for all ADLs such that daily skilled intervention is required to prevent or treat specific, identifiable medical conditions which pose a risk to health. The recipient's ability to communicate needs, report symptoms, and participate in care is severely limited.	The recipient has physician diagnosed organic brain syndrome, dementia, or abnormal mental status such that the recipient is unable to manage ADLs independently and poses a significant, documented safety risk to self or others and such risk can only be managed in an observed, guarded, structured environment. OR Due to organic brain syndrome, dementia, spinal cord injury, or other causes, the recipient requires frequent intermediate and assistance services (such as repositioning), but the recipient does not medically require daily skilled interventions.	N/A

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
2. Feeding and Nutrition	PARENTERAL The recipient receives medically necessary parenteral nutrition (PN) solutions via non-permanent or permanent central venous catheter (Hickman, Groshong, Broviac, etc.), via peripherally inserted central catheter (PICC), or via peripheral access sites. ENTERAL The recipient receives some or all nutrition through a nasoenteric feeding tube (i.e., a tube placed through the nose) AND one or more of the permissive conditions for nasoenteric feeding at the Low NF level are not met. OR The recipient receives enteral nutrition via gastrostomy, jejunostomy, or other permanent tube feeding method and one or more of the permanent tube feeding permission conditions for Low NF and not met.	PERENTERAL N/A ETHERAL The recipient receives some or all nutrition via nasoenteric feeding tube. Tube placement and feeding must be uncomplicated. Tube feeding canot be managed by the recipient independently. All of the following permissive conditions must be met for Low NF as opposed to High NF: (a) The resident must be alert (not have a diminished sensorium); (b) The resident must have an intact gag reflex; (c) The resident must be able to be fed either upright in a chair or with a bed raised to at least 30 degrees and preferably 45 degrees. OR The recipient receives some or all nutrition via gastrostomy, jejunostomy, or other permanent tube feeding method and ALL of the following permissive conditions are met: (a) the tube placement site has been healed, mature, secure, continent, and non-infected for at least one month; (b) the recipient has been on a stable feeding solution regimen for at least one month with no complications (e.g.: tube clogging, pulmonary aspiration, uncontrollable diarrhea, dumping syndrome, glucose intolerance, hypoglycemia) which required skilled intervention.	Once fool is present in an accessible location, and reasonable accommodations made for functional limitations, the recipient is able to prepare it (open container, heat via microwave, oven, or range if necessary) and eat sufficiently to prevent protein-calorie malnutrition. OR The recipient requires a special diet for weight reduction, weight maintenance or gain, diabetes, hypertension, or other medical conditions and has no medical reason why the diet could not be followed. OR The recipient self-manages an enteral feeding tube.

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
2. Feeding and Nutrition (continued)	ORAL N/A	ORAL The recipient requires at least assistance level assistance level care with <u>every</u> meal such that in the absence of daily assistance with meals, ineffective intake leading to protein-calorie malnutrition would occur or other serious medical consequence (e.g., aspiration) would occur.	
3. A. Mobility	The recipient is totally dependent on others for mobility from one location to another and the method of such mobility is highly specialized, accommodates specific clinical conditions, and by its nature <u>requires</u> skilled attendance to assure recipient safety during <u>each</u> episode of transportation.	For more than fifteen (15) days per month on average, the recipient is dependent on at least one other person for mobility beyond short distances (up to 30 feet). (Mobility refers to ambulation, ambulation with cane or walker, or use of wheelchair or other assist device.) OR The recipient is totally dependent on others for mobility, but such mobility is accomplished through assistance or routine transport devices (such as a wheelchair or gurney) and does not require skilled attendance at each episode.	The recipient is principally independent of assistance from at least one other person in mobility.

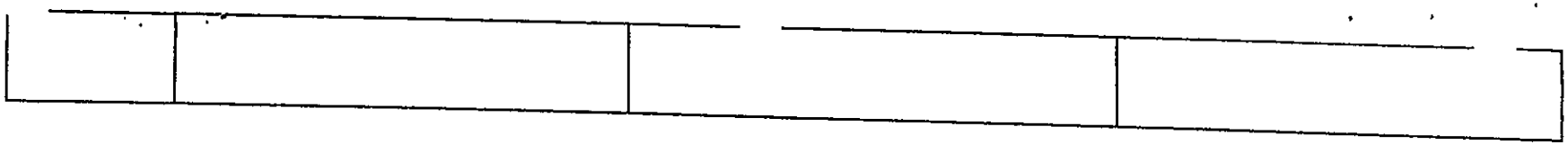

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
3.B. Transfer	The recipient is bed bound, unable to independently transfer, routinely requires transfer on a regular basis (at least three times per week), and has a clinical condition(s) such that the transfer itself is not routine, is reasonable viewed as posing unusual risks, and must be monitored by a licensed nurse to assure no clinical complications of the transfer have occurred.	The recipient cannot transfer from bed and chair without physical assistance of up to two persons. The transfers do not medically require observation by skilled personnel.	The recipient is able to transfer from bed and chair using mechanical and DME devices, technologies, and accommodations, but does not require direct physical assistance of another person for the majority of transfers.
4. N/A	This factor has been incorporated into the other factors.	This factor has been incorporated into the other factors.	This factor has been incorporated into the other factors.
5.A. Fluid intake and output	The recipient has a medical condition for which daily skilled monitoring of fluid balance is medically necessary to prevent or treat serious morbidity. The monitoring must be complete (all intake and output), must include at least weekly weights (unless contraindicated medically), and must be reviewed by the attending physician and licensed nursing staff at a frequency appropriate to the medical condition in order to specifically guide medical management of fluid balance.	The recipient has a medical condition for which skilled or intermediate observation of fluid intake no less than three times per week is medically necessary to prevent excess or insufficient intake of fluids. The results of this observation are reviewed by the attending physician and licensed nursing personnel at a frequency appropriate to the clinical condition in order to guide clinical management of fluid intake.	The recipient's fluid intake and output may require periodic assessment by nurses and/or physicians.

TABLE OF CLINIC STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
5.B. Vital Signs	The recipient has a medical condition for which daily or more frequent measurement of vital signs (pulse, blood pressure, respirations, and temperature) is medically necessary for guiding specific medical therapy. The vital signs must be reviewed for significance and used to make adjustments in the medical regimen accordingly. It must be clinically reasonable to believe that therapy will be altered by the findings and that outcomes can be meaningfully affected by the therapy.	The recipient has a medical condition for which measurement of vital signs no less than three times a week is medically necessary in an institutional setting. The findings must be used by licensed nursing personnel to guide management and/or used by a physician to guide the course of medical therapy. It must be clinically reasonable to believe that therapy will be altered by the findings and that outcomes can be meaningfully affected by the therapy. (Routine measurement of vital signs in accordance with facility policy but not directed toward specific medical needs does not meet this criteria.)	Periodic measurement of vital signs to verify continued stability.
6. Bowel and bladder function	Bladder dysfunction (such as neurogenic bladder) requiring sterile intermittent catheterizations by skilled personnel.	Chronic daily incontinence of bowel and/or bladder requiring assistance or intermediate services (including scheduled formal toileting programs), perineal care and cleansing that cannot be provided independently by the recipient.	Stress or other forms of intermittent incontinence which can be managed and cleansed by the recipient with minimal or occasional assistance.

TABLE OF CLINICAL STATUS FACTORS

Factor	High NF	Low NF	Not consistent with NF
7.A. Non-urinary catheter care	The recipient has an indwelling catheter other than a urinary catheter (e.g.: drains, t-tubes) which requires daily nursing care and observation. The recipient cannot manage the catheter independently.	N/A	The recipient has an indwelling catheter other than a urinary catheter which is planned to be short-term and managed by home-health care. The recipient is able to independently care for catheter related needs between home health visits.
7.B. Indwelling urinary catheter care	Due to unusual or unstable medical condition, daily skilled treatments (e.g.: instillation) or monitoring (e.g.: blood loss) are required in addition to routine chronic indwelling urinary catheter care (Foley or suprapubic).	The recipient requires skilled, intermediate, or assistance services with daily, routine indwelling urinary catheter care (Foley or suprapubic). The catheter requires only routine monitoring.	The recipient is able to manage daily, routine indwelling urinary catheter care with no assistance.
8. Conditions for which multiple sub-threshold conditions in the aggregate require NF level of care	There are a number of sub-threshold conditions and limitations such that the aggregate of the recipient's limitations and clinical needs requires daily skilled monitoring and/or intervention to reasonably prevent deterioration to an unstable state or to reasonable facilitate maximum restoration of function by the use of skilled techniques.	There are a number of sub-threshold conditions and limitations such that the aggregate of the recipient's limitations and clinical needs requires daily assistance, intermediate, or skilled services in order to maintain medical stability, and/or accomplish ADLs.	N/A

TABLE OF CLINICAL STATUS FACTORS			
Factor	High NF	Low NF	Not consistent with NF
9. Physician Consultant determines discharge status	For Internal Use	For Internal Use	For Internal Use
10. Physician consultant approval	For Internal Use	For Internal Use	For Internal Use
11. Physician consultant denial	For Internal Use	For Internal Use	For Internal Use
12. Administrative denial	For Internal Use	For Internal Use	For Internal Use

Explanation of Factors 8-11

- FACTOR 8: PHYSICIAN CONSULTANT DETERMINES DISCHARGE STATUS.

  THIS IS USED WHEN A NF RESIDENT WHO HAS RESIDED AT A NF FACILITY FOR A PERIOD OF TIME NO LONGER MEETS LOW NF CRITERIA AND THEY HAVE NO PLACE TO GO AND THERE IS NO ALTERNATIVE PLACEMENT IN THE COMMUNITY.

  WE APPROVE THEM A LNF LEVEL OF CARE, BUT REQUIRE THE PROVIDER TO KEEP MEDICAID U/R UPDATED ON THE AVAILABILITY OF ALTERNATIVE PLACEMENTS

- FACTOR 9: PHYSICIAN CONSULTANT APPROVAL

  THE REVIEW WAS SENT TO A PHYSICIAN PEER CONSULTANT AND IT WAS APPROVED

- FACTOR 10: PHYSICIAN CONSULTANT DENIAL

  THE REVIEW WAS SENT TO A PHYSICIAN PEER CONSULTANT AND IT WAS DENIED

- FACTOR 11: ADMINISTRATIVE DENIAL

  THIS REVIEWER WAS DENIED FOR SOME ADMINISTRATIVE REASON. THE MOST LIKELY EXAMPLE WOULD BE WHEN CMS DOESN'T ALLOW NEW ADMISSIONS TO A FACILITY BECAUSE OF A FAILED CMS SURVEY.