

6—NURSING FACILITIES LEVEL OF CARE (NF LOC) DETERMINATIONS REVIEWS

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GENERAL INFORMATION This policy establishes guidelines ~~and restrictions~~ for ~~the~~ MCOs regarding nursing facilities ~~and services~~. The Nursing Facility (NF) Medical Eligibility Criteria can be found at 8.312.2UR.

NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL

All requests for prior approval shall contain appropriate documentation and must be completed for each resident for every situation requiring prior approval. All requests for prior authorization are submitted to the resident's MCO by fax.

PRE-ADMISSION SCREENING AND RESIDENT REVIEW (PASRR)

Federal law requires NFs to perform PASRR screens for mental illness, intellectual disability and related conditions. There are procedures and information that are applicable to all situations requiring prior approval.

1. Purpose of PASRR is as follows:
 - A. To determine whether a resident requires a specific level of nursing care;
 - B. To determine if there is suspicion of serious mental illness (MI) or intellectual disability/related condition (ID/RC);
 - C. To assess persons suspected of having serious MI or ID/RC;
 - D. To assess whether specialized services for MI or ID/RC are needed; and,
 - E. To prevent inappropriate placement in a NF by determining whether the resident is more appropriately served in a specialized program for those with MI or ID/RC.
2. Organization of the PASRR: PASRR is divided into two levels: Level I Screen and Level II Evaluation.
 - A. Level I Screen: A Level I Screen must be completed prior to admission on every NF applicant. If, during the Level I Screen, it is determined that the individual is suspected of having either MI or ID/RC, a Level II Evaluation or PASRR waiver must occur prior to admission. A Level I Screen must also be done if there has been a significant change in the physical or mental condition of a resident who is suspected of having, or previously determined to have MI or ID/RC. "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 the PASRR Unit no later than twenty one (21) business 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) business 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.

- B. Level II Evaluation: If the Level I Screen identifies a resident who is diagnosed with or suspected of having MI or ID/RC, a Level II Evaluation or a PASRR waiver must be completed prior to the admission of the resident. The Level II Evaluation includes a comprehensive evaluation of the needs of the resident.
3. PASRR Waiver:
- A. If an individual falls within one of the following categories, a complete Level II Evaluation may not be performed. A PASRR Waiver is granted on a case-by-case basis.
- The resident has a primary diagnosis of dementia.
 - The resident is being discharged from an acute care hospital for the purpose of convalescent care medically prescribed for recovery, not to exceed thirty (30) business days.
 - The resident is suspected of having MI or ID/RC but is certified to be terminally ill with a life expectancy of six (6) months or less and is in need of continuous nursing care and/or medical supervision and treatment due to a physical condition.
 - The severity of the resident's medical condition and medical treatment needs are so extensive that specialized MI or ID/RC services are not likely to be beneficial.
 - The resident who is suspected of having MI or ID/RC and is admitted directly to a NF from a home for very brief and finite stay (up to 14 days) for the purpose of providing respite to in-home caregivers.

If Adult Protective Services (APS) directly admits an individual to a nursing facility because the individual is in harm's way, the PASRR Unit is required to complete the Level II assessment within 10 business days.

4. Level I Screen Process
- A. A NF is required to submit copies of the Level I Screen for each resident with the MDS to the MCO/UR Contractor. The Screen and other necessary documentation must be sent with the MDS to avoid delays in the review process.
- B. The MCO/UR Contractor logs in the date on the recipient screen when the MDS, Level I Screen, and other documentation is received.
- C. The MCO/UR Contractor scans the Level I Screen. If the resident passes the Screen, the MCO/UR Contractor determines the NF LOC. If the resident fails the

Screen, no further NF LOC action is to be taken by the MCO/UR Contractor. The MDS Screen, and other documentation, ~~is~~ must be submitted to the PASRR Unit for a Level II determination.

D. The MCO/UR Contractor then sends a notice to the NF that the MDS and other documentation have been sent to the PASRR Unit for a Level II Evaluation determination.

~~The PASRR Unit reviews the Level I Screen, determines the NF LOC and sends a copy of the NF LOC, Screen, MDS and other documentation to the MCO/UR Contractor.~~

5. Level II Evaluation Process: There are two types of Level II PASRR reviews.

A. Mental Illness PASRR II screens are completed by the Behavioral Health Services Division (BHSD) contractor for residents living in a NF or individuals being admitted from a hospital or home to a NF.

- The PASRR Unit sends the documents to the BHSD contractor to complete an evaluation and makes the Level II determination on the review portion of the MDS and the NF LOC determination, then returns to the PASRR Unit. The PASRR Unit sends the NF LOC determination and MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation with the NF LOC determination if a waiver was not granted.
- Within 24 hours of the MCO/UR Contractor receiving the NF LOC determination from the NF determined by the BHSD contractor, the MCO/UR Contractor transmits the NF LOC determination via the ASPEN interface file.
- If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews follow the process above ~~are performed~~ by the PASRR Unit instead of the MCO/UR Contractor.
- If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for a NF LOC determination.

B. ID and RC PASRR II screens are completed by tThe PASRR Program Unit for residents living in a nursing facility or individuals being admitted from a hospital or from home to a NF.

- The PASRR Unit completes an evaluation and makes the Level II ~~and NF LOC~~ determination on the review portion of the MDS and returns the MDS to the NF. The NF then sends the MCO/UR Contractor the MDS and other documentation for a NF LOC determination if a waiver was not granted.
- All subsequent PASRR Level II reviews are performed by the PASRR Unit unless waived by the PASRR Unit.

- All subsequent NF LOC determinations are made by the MCO/UR contractor.

~~If a subsequent specified review or significant change review is required, the review portion of the MDS must be completed by the PASRR Unit. All subsequent reviews are performed by the PASRR Unit instead of the MCO/UR Contractor.~~

~~If a subsequent specified review or significant change review is not required, the MDS is returned to the MCO/UR Contractor for a NF LOC determination.~~

6. PASRR and Re-admission from a Hospital: The NF contacts the PASRR Program Unit if the hospitalization of a resident results in a change in the Level I Screen. If an individual is hospitalized from the NF, the hospital will complete a new Level I screen.

7. PASRR and Medicaid Eligibility Pending: If a resident is in a “Pending Medicaid” status at the time of MDS submission and the resident fails the Level I Screen, the MDS is forwarded to the PASRR Unit as notification while the following actions occur:

- ~~The NF LOC determination is made by the MCO/UR Contractor.~~
- ~~The MAD 385 Form is completed and sent to the MCO/UR Contractor. The MCO/UR Contractor transmits the NF LOC determination via the ASPEN interface within 24 hours of making the NF LOC determination. The information on this form is processed by the MCO/UR Contractor and submitted to the the appropriate ISD office once received, and to the NF. The MCO also sends the NF Notification form to the NF with the NF LOC effective dates and prior authorization information.~~
- Once eligibility is established, the ISD office notifies the NF and the MCO.
- The NF must notify the PASRR Unit of the status of the resident’s eligibility.
- The MDS which includes the Medicaid number and the certified length of stay is completed by the PASRR Unit.
- Upon completion, the MDS is submitted to the MCO/UR Contractor.

LEVEL OF CARE PACKET FOR NURSING FACILITES INCLUDES:

- PASRR
- NF LOC Notification Form - ~~is the form~~ used for all prior approval reviews.
 - All requests for prior approval will be submitted on the NF LOC Notification Form.
 - The NF should document what type of review is being requested at the top of the NF LOC Notification Form:
 - Initial
 - Continued Stay
 - Medicaid Pending
 - Transfer
 - Re-admit
 - Reconsideration

g. All other required fields must be completed.

3. MDS

- A. A# MDS and all other appropriate documentation must be completed for each resident for every situation requiring prior approval.
- B. All locator fields must be clearly marked on the MDS.
- C. When the resident goes from Medicare Co-Pay to Medicaid, the NF submits an Internal MDS that begins the UR process for the resident.
- D. Appropriate documentation must accompany the MDS. Generally, appropriate documentation includes a valid order and must:
 - a. Be signed by a Physician, Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant;
 - b. Be dated; and
 - c. Indicate the LOC – either high NF (HNF) or low NF (LNF).

The NF must submit the initial NF LOC packet to the MCO no later than 30 days after admission, which includes all of the above documentation and the physician's order. The MCO may assign unexcused late days if the NF submits the LOC packet later than 30 days. Please refer the CURRENT/RETROSPECTIVE REVIEWS section for more information about assignment of late days.

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.

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.

The MCO approves the documentation and makes a LOC determination following the New Mexico Medicaid Nursing Facility Level of Care Instructions and Criteria within five (5) business days of receiving a completed packet. The MCO shall review the documentation provided to determine the appropriate NF LOC and transmits the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. A packet that requests LNF but meets HNF criteria shall be upgraded to HNF; a packet that requests HNF but only meets LNF criteria shall be downgraded to LNF. A new doctor's order is not required.

When required documentation is missing, a "Request for Information" (RFI) sheet will be generated by the MCO and sent to the NF provider. If the required documentation is not provided to the MCO within fourteen (14) business days of the request, it will be technically denied. The MCO will make three (3) attempts during the fourteen (14) business day period to contact the NF to obtain the information. The MCO will transmit a technical denial via the ASPEN interface file within 24 hours of no response from the NF. Please see CURRENT/RETROSPECTIVE REVIEWS for more information on assignment of late days.

NOTE: A formal ~~Request for Information (RFI)~~ to the NF provider to justify the HNF request is not required when reviewing and processing HNF requests that clearly do not meet HNF criteria but do meet Low NF (LNF) criteria or vice versa. ~~; however, the MCO will continue to use the RFI process for requests reflecting that the individual may be eligible for HNF LOC.~~ In the event that a determination is upgraded or downgraded from the physician's order, the MCO shall will assign the level of care and the MCO shall provide give the NF with technical assistance to educate the NF on determination criteria.

The MCO faxes the NF notification form with authorization and date spans to the NF.

For short-term stays (90 days or less) the MCO will provide ISD with a NF LOC determination dates, but will only issue a Prior Authorization to the NF for the authorized bed days.

DENIAL OF REQUESTS FOR PRIOR APPROVAL

If the NF LOC criteria ~~are~~ not met and the request for initial NF placement or Medicaid pending is denied, the MCO will send the referring party and the ~~member applicant~~ a denial letter within five (5) business days of a completed packet, with the reason for denial as determined by the physician. The requesting provider may request a reconsideration to the MCO. If no reconsideration is requested, the MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. The applicant will receive a Notice of Case Action (NOCA) from the ISD office, which explains the right to request an administrative hearing. The requesting parties then have an opportunity to request reconsideration or appeal. After the parties have exhausted the MCO appeal process, the member may request an administrative hearing of the MCO decision.

If the NF LOC criteria is not met for an existing resident, the MCO will send the referring NF party and the member a denial letter with information regarding the right to appeal to the MCO before requesting an administrative hearing. The MCO will not transmit the denial via the ASPEN until a final appeal decision has been made or until after the allowed time to request an appeal has lapsed, whichever is later.

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 (6) 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 (6) 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. 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.

~~Nursing facilities use the following procedures~~ Requests for prior approval for additional discharge reserve bed days. ~~The NF must be submitted by the NF the request to the MCO that the resident is enrolled with for prior approval. for additional discharge reserve bed days to the MCO in which the resident is enrolled.~~ The NF follows the written process of the MCO for submission of the request, and receipt of documentation of the approval. The written process of the 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.

INITIAL DETERMINATION, REDETERMINATION, AND PENDING MEDICAID ELIGIBILITY

1. Initial Determination: All services furnished by Medicaid NF providers must be medically necessary. The procedures described in the section *NURSING FACILITY'S PROCEDURES FOR REQUESTS FOR PRIOR APPROVAL* above, should be referred to when preparing documents for all initial reviews. Documents must be completed and submitted within 30 calendar days of admission.
2. Redetermination: See 8.312.2UR. The medical documentation must be faxed and received by the MCO a minimum of sixty (60) calendar days prior to the start date of the new certification period for LNF and thirty (30) calendar days prior for HNF.
3. Length of Stay Periods: See 8.312.2UR.
4. 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 Medicaid, both financial and medical eligibility at the same time, please write "MEDICAID PENDING" in the type of request box on the Notification form. Please Note: A resident on Supplemental Security Income (SSI) is not considered Medicaid Pending.
 - A. When an individual is admitted to a NF pending Medicaid financial eligibility, the NF submits a completed packet of required documentation. The Prior Authorization form should have "MEDICAID PENDING" in the type of request box on the Notification form.
 - B. The MCO will review the information submitted and determine the NF LOC.
5. The Prior Authorization form will be completed by the MCO and sent to the NF.

6. The MCO will transmit the NF LOC determination via the ASPEN interface within 24 hours of making the determination.

CARE PLAN AND EMERGENCY PREPAREDNESS

Care Plan

The NF must develop a care plan, per CFR 483.21, for each resident within 48 hours of admission, to include instructions needed to provide effective and person-centered care that meets professional standards of quality of care. The care plan must include all specialized or rehabilitation services the NF will provide as a result of PASRR recommendations.

Emergency Preparedness

The NF must be in compliance with CFR 483.73 including, but not limited to:

1. Self-Assessment and Planning:
 - A. Develop an emergency plan based on a risk assessment;
 - B. Perform risk assessment using an “all-hazards” approach, focusing on capacities and capabilities; and
 - C. Update emergency plan at least annually.
2. Policies and Procedures:
 - A. Develop and implement policies and procedures based on the emergency plan and risk assessment.
 - B. Policies and procedures must address a range of issues including subsistence needs, evacuation plans, procedures for sheltering in place, tracking patients and staff during an emergency.
 - C. Review and update policies and procedures at least annually.
3. Communication Plan
 - A. Develop a communication plan that complies with both Federal and State laws;
 - B. Coordinate patient care within the facility, across health care providers, and with state and local public health departments and emergency management systems;
 - C. Review and update plan annually.
 - D. Share information from the emergency plan with residents and family members or representatives.
4. Training & Testing Requirements
 - A. Develop and maintain training and testing programs, including initial training in policies and procedures;
 - B. Demonstrate knowledge of emergency procedures and provide training at least annually; and
 - C. Conduct drills and exercises to test the emergency plan.

RETROACTIVE MEDICAID ELIGIBILITY

Written requests for prior approval based on a resident's retroactive financial eligibility must be reviewed by the MCO within thirty (30) calendar days of the date of the eligibility determination. The NF must submit all appropriate medical documentation to the MCO for the NF LOC determination. The MCO will transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination. Requests for retroactive eligibility will not be accepted after 180 days of the Medicaid eligibility determination date. Please see NMAC 8.281.600.13

RE-ADMISSION REVIEWS

~~A re-admission review is required w~~When the resident ~~has left~~leaves the NF ~~and then returns,~~ after for three (3) or more midnights for an inpatient in a hospital stay, ~~to a different LOC,~~ a readmission review is required.

The NF ~~has~~must ~~to~~ submit a re-admit MCO approval request form within thirty (30) calendar days together with the following accompanying documentation – the hospital discharge summary and/or resident's admission note back to the NF.

1. When the resident is re-admitted to the NF and has more than thirty (30) calendar days left on his/her certification, days will be assigned from the re-admit date. The NF sends the notification form to the MCO along with supporting documentation.
2. If the resident has less than thirty (30) calendar days left on his/her certification, the NF will not submit a re-admit notification form. Instead the NF should submit a redetermination (annual or continued stay) request on the notification form along with supporting documentation.

CURRENT/RETROSPECTIVE REVIEWS

Medical documentation for initial, redetermination, re-admit and changes in LOC reviews can be reviewed retrospectively if requested by the ~~NF~~NF provider. ~~Medicaid pending reviews are never considered late.~~

A request for a current or a retrospective review for initial (including medicaid pending), redetermination or re-admit reviews will be considered; however, the below outlines the procedure policy for unexcused and excused assignment of late days by the MCO: ~~in the following situations only:~~

Unexcused late reviews:

~~A. For the first six (6) months of Centennial Care (ending June 30th, 2014), the MCOs shall not impose unexcused late penalties to NFs.~~

Starting July 1st, 2014, the NF may lose payment for each day that the NF LOC review is submitted late.

When required documentation from the NF is missing, a “Request for Information” (RFI) sheet is generated by the MCO and sent to the provider. If the required documentation is not provided to the MCO within fourteen (14) business days of the RFI request, it will be administratively denied by the MCO. The MCO will make three (3) attempts during the fourteen (14) business day period to contact the NF to obtain the missing information. If no response is received, the MCO will transmit an administrative denial via the ASPEN interface file within 24 hours of no response from the NF.

If the provider responds after the 14 business day period, the MCO will assign “unexcused late days” for every day the NF did not respond to the RFI and will begin the NF LOC effective date the date the RFI response was received from the provider. The MCO shall transmit the determination via the ASPEN interface file within 24 hours of making the NF LOC determination.

Excused Late Reviews: Prior authorization forms not submitted timely due to reasons beyond the control of the NF must be submitted to the MCO with a detailed written explanation and documentation that supports the request for an excusable late review. If the MCO approves the excused late review and does not assign late days, the MCO must notify the NF program manager in Long-Term Services and Supports Bureau (LTSSB), via email, before transmitting the NF LOC determination via the ASPEN interface file. The program manager will work with the ISD to ensure the ASPEN interface file can be received and accepted for the resident.

Reimbursement and retrospective reviews:

1. If the reason for the delay in documentation submission was within the control of the NF, the effective date for reimbursement is the date the packet was received by the MCO.
2. Medicaid will not reimburse NFs for dates of service (DOS) not covered by the MCO prior authorization form. In addition, the Medicaid member and ~~not~~ his/ her family member(s) cannot be billed for the services provided by the NF. The NF will not discharge the resident due to assignment of late days by the MCO.

TRANSFER FROM ANOTHER NF

If a resident ~~is admitted to~~ transfers from one NF from another NF, the following procedures apply:

1. The receiving NF must notify the MCO by telephone that a transfer to its NF is to occur. The receiving NF will provide the MCO with the date of the transfer. Without this information, claims submitted by the receiving NF will not be paid by the MCO.
 - A. If there are more than thirty (30) calendar days on the resident's current authorization, the MCO will fax the receiving NF the completed notification form which will include the prior authorization and date span.
 - B. If there are less than thirty (30) calendar days remaining on the resident's current authorization, the receiving NF shall request a continued stay on the notification form to the MCO. The MCO shall make a new NF LOC determination; the days remaining on the current certification will be added to the continued stay. Please write "TRANSFER" in the type of request box on the notification form.
2. The NF receiving the resident receives the status of resident's reserve bed days from the MCO through the notification form. 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.

CHANGED IN THE LEVEL OF CARE (LOC)

All changes in LOC require a new notification form that should be submitted within thirty (30) calendar days of the change in LOC. If a prior authorization form is being submitted for a change in LOC, please write "LEVEL OF CARE CHANGE" in the type of request box on the notification form. 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 (see New Mexico Nursing Facility Level of Care Instructions and Criteria). The date the LOC change occurred must be clearly stated.

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. 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 ~~a nursing facility~~ NF 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 NF and the MCO actively address 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 is termed "Discharge Status;" however, Discharge Status does not mean that the resident is being discharged from the facility. Families and residents should not be told that the resident is being discharged from the facility. The MCO care coordinator, family, resident and NF will work together to develop a transition plan to safely transition the resident to an alternate setting of care per Section 5 of the Medicaid Managed Care Policy Manual.

1. **Initial Discharge Status** is authorized at Low NF for a maximum of ninety (90) calendar days, based upon the MCO physician determination.
2. **Continued Stay Discharge Status** is authorized at Low NF for not less than one hundred eighty (180) calendar days and up to three hundred sixty-five (365) calendar days. Submission of a continued stay on a prior authorization form for a resident in Discharge Status must acknowledge the resident's Discharge Status and document the facility staff's and MCO care coordinator'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 prior authorization. The resident's inability to afford assisted living services may be a consideration in discharge planning.

RECONSIDERATION, APPEAL, ADMINISTRATIVE HEARING

1. Reconsideration: Providers who disagree with a NF LOC determination can request reconsideration. Members who disagree with a NF LOC determination may request the provider to pursue reconsideration on his or her behalf. Requests for reconsideration must be in writing and received by the MCO within thirty (30) calendar days after the date on the re-review decision notice. The MCO performs the reconsideration and notifies the NF and Member in writing of a decision within eleven (11) business days of receipt of the reconsideration request. The written notice also includes information on a Member's right to request an HSD administrative hearing after the Member has exhausted his or her MCO's appeal process.
2. The request for reconsideration must include the following:
 - A. Statement that reconsideration is requested.
 - B. Reference to the challenged decision or action.
 - C. Basis for the challenge.
 - D. Copies of any document(s) pertinent to the challenged decision or action; and
 - E. Copies of claim form(s) if the challenge involves a claim for payment which is denied due to a decision.
3. Appeal: If a reconsideration determination is adverse to the Member, the Member may request an appeal with his or her MCO in accordance with ~~8.305.12~~ 8.308.15 NMAC.

4. HSD Administrative Hearings: After the Member has exhausted the MCO appeal process, the Member may request an HSD administrative hearing in accordance with 8.352.2 NMAC.
5. State Administrative Hearing: After the parties have exhausted the MCO appeal process, the parties may request an administrative hearing according to State administrative rule 8.352.2 NMAC. The MCO/UR Contractor is responsible for the development of the Summary of Evidence (SOE) to ISD and for the testimony of the NF LOC denial during the fair hearing, including denied NF LOCs for Medicaid Pending residents.

COMMUNICATION FORMS

The MCO shall use the approved HSD forms for communication and notification with the NFs.

EXTERNAL AUDITS OF NF LOC DETERMINATIONS

HSD or its designee will sample and audit each MCO's quarterly NF LOC denial determinations to assure that the LOC criteria are being appropriately applied by the MCOs. Each MCO will submit a universe of all high-NF and Community Benefit requests that were reviewed and denied due to not meeting NF LOC. The denial universe will be submitted to HSD by the 7th day of the month following the end of the quarter. The naming convention for the universe file is MCO, quarter, year, denial universe. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCO-name.Q1.18.denial universe." The universe will be broken out by high-NF denials and CB denials in separate tabs in an Excel file and will include the following information: member name, Medicaid identification number, and member's date of birth. The MCO shall submit the universe file to HSD via the DMZ (NF LOC review folder).

HSD or its designee will perform a random selection of the universe and notify the MCO of selected members' files to be audited. HSD or its designee will submit a list of members selected to the MCO via the DMZ. Upon receipt of the member selection list, the MCO will have five (5) business days to send the complete information for the selected members. The naming convention for the member selection is MCO-name, quarter, year, member file. For example, if the MCO is reporting first quarter member files, the file shall be named "MCO-name.Q1.18.member file." The MCO shall submit the following information below to HSD via DMZ (NF LOC review folder).

The MCO shall include the following information in the member's file for high-NF denials:

- a) Member Name;
- b) Medicaid Identification Number;

c) All NF documentation sent to MCO to make determination; and

d) Utilization review noted related to the determination, including medical director review.

The MCO shall include the following information in the member's file for Community Benefit denials:

a) Member Name;

b) Medicaid Identification Number;

c) Copy of completed CNA for member;

d) Any utilization notes pertaining to the denial;

e) Allocation tool;

f) Name of care coordinator;

g) Comprehensive Care Plan, if applicable; and

h) Any additional information such as functional assessment, NF LOC, community supports and plans developed for services authorized for the member, including medication management plans.

Member file documents shall be bookmarked and/or highlighted, and text boxed to identify all elements in the file that indicate why the member received a denial.

MCO INTERNAL AUDITS OF NF LOC DETERMINATIONS

Each MCO will conduct internal random sample audits of both facility and community benefit NF LOC determinations based on HSD NF LOC instructions and tool guidelines each quarter.

The audit will include, at a minimum: accuracy, timeliness, training documentation of reviewers, and consistency of reviewers. The results and findings will be reported to HSD by the 7th day of the month following the end of the quarter along with any Quality Performance Improvement Plan via DMZ (NF LOC reviews folder). The naming convention for the results and findings file is MCO, quarter, year, internal audit results. For example, if the MCO is submitting first quarter reviews, the file shall be named "MCO-name.Q1.18.internal audit results."

COMMUNICATION FORMS

~~The MCO shall use the approved HSD forms for communication and notification with the NFs.~~

6.A: NURSING FACILITY LEVEL OF CARE COMMUNICATION FORM



**Nursing Facility Level of Care
Communication Form**

***This Communication Form is intended to be used between MCO and Nursing Facilities ONLY.**

I. Requestor Information

Date of Request	Click here to enter a date.		
FROM	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.
TO	Choose an item.	Name	Click here to enter text.
Company	Click here to enter text.		
Fax	Click here to enter text.	Phone	Click here to enter text.

II. Communication:

Nursing Facility Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN#	xxx – xx – Click here to enter text.

a. Request For Information

Request for following selected information:
<input type="checkbox"/> Missing Member Demographics <input type="checkbox"/> Missing MDS Required fields: Click here to enter text. <input type="checkbox"/> MDS not within the service time frame requested <input type="checkbox"/> Need a valid physician order for: Click here to enter text. <input type="checkbox"/> Need member’s Level I PASSR <input type="checkbox"/> Need member’s Level II PASSR <input type="checkbox"/> Need current H&P <input type="checkbox"/> Need current signed and dated physician progress notes <input type="checkbox"/> Medicare COB if applying therapy as HNF criteria for dual member <input type="checkbox"/> Other: Click here to enter text.

b. Member Status Update

Request for following selected member status update:
<input type="checkbox"/> Discharge Status <input type="checkbox"/> Member Representative Info <input type="checkbox"/> Current Progress Note <input type="checkbox"/> Other: Click here to enter text.

c. Member MCO Update

Request for following selected member MCO update:
<input type="checkbox"/> Member current MCO selection: Click here to enter text. <input type="checkbox"/> Member previous MCO assignment: Click here to enter text.



Nursing Facility Level of Care

Notification Form

I. Nursing Facility Prior Authorization Request

Nursing Facility Information			
Date of Request	Click here to enter a date.	Type of Request	Choose an item.
Nursing Facility Name	Click here to enter text.		
NF Contact Name	Click here to enter text.		
Nursing Facility Fax	Click here to enter text.	Nursing Facility Phone	Click here to enter text.

Nursing Facility Resident Information:			
NF Resident Name	Click here to enter text.		
Resident DOB	Click here to enter text.	Resident SSN#	xxx - xx - Click here to enter text.
NF Admission Date	Click here to enter a date.	Selected MCO	Choose an item.
Resident Rep Name	Click here to enter text.	Rep Phone	Click here to enter text.
Resident Rep Address	Click here to enter text.		

Requesting Service			
NFLOC Type	Choose an item.		
Service Begin Date	Click here to enter a date.	Service End Date	Click here to enter a date.

Documentation Requirements:	
Initial Request: <input type="checkbox"/> MDS <input type="checkbox"/> Physician Order <input type="checkbox"/> PASRR Level I and PASRR Level II if indicated by PASRR Level I <input type="checkbox"/> History & Physical	Continuation Stay: <input type="checkbox"/> Most recent MDS <input type="checkbox"/> Physician Order <input type="checkbox"/> Physician Progress Notes <input type="checkbox"/> History & Physical

II. Utilization Management (For MCO Use Only)

Review Information			
Date of Review	Click here to enter a date.	Authorization Number	Click here to enter text.
NFLOC Begin Date	Click here to enter a date.	NFLOC End Date	Click here to enter a date.
Approved Bed Begin Date		Approved Bed End Date	

LNF Factors:		HNF Factors:	
<input type="checkbox"/> Dressing	<input type="checkbox"/> Transfer	<input type="checkbox"/> Oxygen	<input type="checkbox"/> Rehabilitation Therapy
<input type="checkbox"/> Bathing	<input type="checkbox"/> Mobility	<input type="checkbox"/> Orientation / Behavior	<input type="checkbox"/> Skilled Nursing
<input type="checkbox"/> Eating	<input type="checkbox"/> Toileting	<input type="checkbox"/> Medication Administration	<input type="checkbox"/> Feeding
<input type="checkbox"/> Meal Preparation	<input type="checkbox"/> Bowel/Bladder		<input type="checkbox"/> Mobility / Transfer
	<input type="checkbox"/> Daily Medication		

Approved NFLOC Type: Choose an item.
Comments: Click here to enter text.