#08-25-03

Bulletin

May 29, 2008

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Tribal Health Directors
- Long -Term Care Consultation Contacts
- Nursing Facility Providers
- Hospital Discharge Planners
- Managed Care Organizations

ACTION/DUE DATE

Complete Preadmission Screening as required for all people admitted to Minnesota certified nursing and boarding care facilities, and "swing beds".

EXPIRATION DATE

May 29, 2010

Preadmission Screening: Required Activity for Nursing Facility Admission and Medical Assistance Payment

TOPIC

Preadmission screening activity establishes the need for nursing facility (NF) level of care and screens people for mental illness or developmental disability before admission. State and federal requirements prohibit medical assistance payments for NF services provided prior to completion of required preadmission screening.

PURPOSE

Summarize policy and practice related to preadmission screening requirements for *all* NF admissions. Outline MMIS editing related to preadmission screening that is applied to NF claims under medical assistance. Replace previous and obsolete bulletins related to preadmission screening.

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I. Background

Federal and state laws require that ALL individuals entering a certified NF, a certified boarding care facility, or a hospital "swing" bed[1] receive preadmission screening (PAS), regardless of the payor source for facility services. For purposes of PAS policy and requirements, the term "facility" or "NF" refers to all three settings throughout this bulletin.

PAS policy includes:

- Timelines for completion of PAS activities
- Additional evaluations for people who may have developmental disability or severe and persistent mental illness
- Additional requirements for people under age 65 admitted to facilities
- Certain exemptions from PAS requirements

All PAS policies, including federal policy, are contained in Minnesota Statutes, section 256B.0911 governing the Long Term Care Consultation (LTCC) program, formerly known as the Preadmission Screening program. This bulletin outlines these policies, exemptions, timelines, and additional requirements, as well as Minnesota Medicaid Information System (MMIS) documentation required to ensure fee-for-service NF payment for people participating in Minnesota Health Care programs.

This bulletin does not contain new policy or requirements but summarizes and organizes all related information previously published in several bulletins. This bulletin replaces all previous bulletins issued related to PAS and reiterates policy and requirements. Please see Section XIII of this bulletin for a list of replaced and obsolete bulletins related to PAS.

II. Purpose of Preadmission Screening

PAS is completed to:

- Determine and document the need for NF services in MMIS
- "Screen" people for mental illness or developmental disabilities or related conditions (referred to as OBRA Level I screening) in order to refer them to other professionals for additional diagnosis and evaluation of the need for specialized mental health or

1 A "swing" bed is one that has been certified as both an acute hospital and NF bed. A swing bed is a bed in a hospital that, under special circumstances, may be used for Medicare skilled nursing facility days. In addition, in seven hospitals in northeastern Minnesota designated as "Sole Community Providers," MA nursing facility room and board days may be provided as "swing bed" days. Requirements for use of swing beds are outlined in Chapter 27 of the Minnesota Health Care Programs Provider Manual. All other requirements for the use of these beds must be met, regardless of payor source, including claims processing procedures and Minnesota Department of Health approval for stays as needed.

developmental disability services as required under federal law. These diagnostic and evaluation activities are referred to as OBRA Level II activities[2]

- Avoid unnecessary facility admissions by identifying people whose needs might be met in the community and connecting them to community-based services

- Provide assistance after facility admission to support transition back to community life.

Unless an admission meets one of the PAS exemptions outlined in Section VI or VII below, PAS must be completed, whether by telephone or in person, PRIOR to admission.

III. Lead Agency Responsibility for Preadmission Screening

Statewide responsibility for PAS is assigned to county Long Term Care Consultation (LTCC) units made up of public health nurses, registered nurses[3], and social workers. The county responsible to perform PAS is the **county where the person is located** when admission is requested, as outlined below:

- A hospital discharge planner seeking admission of a person to a NF must contact **the county where the hospital is located.**

- A family member seeking admission of an individual living in the community must contact **the county where the individual currently lives.**

- A NF that discovers or is notified that a resident did not have PAS completed appropriately must contact the county where the hospital is located if that was the admission source, or **the county where the facility is located for all other admissions.**

A listing of statewide administrative and intake **LTCC contacts for all counties** can be found at http://www.dhs.state.mn.us/id_006098

PAS for People Enrolled in Prepaid Medical Assistance Programs ("Managed Care")

County LTCC units are responsible to perform PAS for all individuals *except* those enrolled in the following prepaid medical assistance programs:

- Minnesota Senior Health Options
- Minnesota Senior Care Plus
- Minnesota Disability Health Options

2 OBRA Level II activities and requirements are not included in this bulletin. Please see Section XIII for resource information related to OBRA Level II.

3 County LTCC administrators can request the use of a registered nurse with at least one year of home care experience to provide additional staffing to the LTCC unit at the county. This request is submitted to the DHS LTCC coordinator in writing, and approval is granted based on information provided in the request.

For people who receive their health care services under one of the programs listed above, the individual's managed care organization (MCO) is responsible to perform determinations of the need for NF level of care, OBRA Level I Screening, and to provide relocation assistance to all of their enrolled members. Qualified professionals as defined in the contract between the MCOs and the Department of Human Services (DHS), or the MCO's qualified designee (which may include county staff under contract with a MCO to perform PAS), follow the same PAS timelines, procedures, and MMIS documentation requirements as outlined in this bulletin.

For people in other prepaid medical assistance programs:

- Minnesota Senior Care: The managed care organization can opt to perform PAS or allow the county to retain responsibility for preadmission screening activity.

- Special Needs Basic Care: A voluntary managed care program for people with disabilities. See bulletin 08-21-02 at http://www.dhs.state.mn.us/dhs16_140037

Facility services providers can access information about an individual's enrollment in these managed care programs in the Eligibility Verification System (EVS). County PAS staff can access this information in MMIS in the Recipient subsystem on the RPPH screen.

Contact information for each MCO can be found at http://www.dhs.state.mn.us/id_058984

Section XI describes the documentation requirements for both county and MCO staff who perform preadmission screening and related LTCC activity.

IV. DHS Approval is Required for All Admissions of Persons Aged 20 or Younger, and for All Persons with Developmental Disability or Related Conditions

Regardless of the exemptions outlined in Sections VI and VII below, DHS must approve all admissions of people age 20 or younger, and all admissions of people with developmental disability or a related condition. DHS approval is required regardless of the source of admission or payor for facility services.

- **Individuals Aged 20 or Younger:** For all individuals aged 20 or younger, face-to-face assessment must occur before admission, regardless of projected length of stay or admission source. This requirement is intended to prevent admission of this population whenever possible by developing community-based support and care plans that will meet the individual's needs in a less restrictive environment.

  At the face-to-face assessment, all community alternatives must be explored and presented to the person, his/her family, and/or the person's legal representative. If a NF admission cannot be prevented, the admission must be approved by DHS by calling **651-431-2441.**

- **Individuals with Developmental Disability or Related Conditions:** Admission to a NF of a person with developmental disability or a related condition must also be approved by the

DHS, and will include an approved length of stay. A county or MCO case manager must obtain this approval by completing the following tasks:

- Complete a full team Developmental Disabilities (DD) Screening
- Complete an OBRA Level II Evaluative Report based on the outcome of the DD Screening
- Record the final disposition under Sections I-III of the Evaluative Report in the case manager comment section of the DD Screening
- Submit the completed full team DD Screening (Action Type 01) to DHS via MMIS to override location 500 Queue PWDAR25 for review and approval immediately after the Evaluative Report and the DD Screening are completed
- Once the DD Screening is in "Approved" status in MMIS, record the Document Control Number and the date on which the DD Screening was authorized by DHS on the bottom of the OBRA Level II Evaluative Report.

Please go to
http://www.dhs.state.mn.us/id_008530 for complete information about DD Screening and DD Screening Document completion described above.

V. Methods for Completing Preadmission Screening

- **Telephone-Based Preadmission Screening:** PAS may be completed by telephone **only** when a health care professional seeking admission can provide the county or MCO PAS staff with sufficient information to determine the need for NF level of care, and to complete OBRA Level I screening for mental illness and developmental disability.

Telephone screening is most typically used for hospital discharges to facility-based service. Telephone screening cannot be used to admit people from the community unless the request for admission is made by a qualified health care professional and sufficient information is available to determine the need for NF services and complete OBRA Level I screening.

If a county or MCO PAS staff cannot determine the need for facility care or complete OBRA Level I via a telephone contact, a face-to-to face assessment must be completed in order to determine the need for care and complete OBRA Level I. This face-to-face PAS must be completed within 10 working days of the initial request for screening, and *prior to admission.*

- **Face-to-Face Preadmission Screening:** It is preferred that PAS, completed as part of a face-to-face LTCC assessment, occur prior to admission for any individual seeking admission from the community. This will allow the PAS/LTCC staff to determine whether community-based supports, including caregiver supports, could delay or prevent admission. Face-to-face assessment and community-based services planning are available under the Long Term Care Consultation program for all people with long term or chronic care needs, regardless of eligibility for publicly-funded long term care services.

A face-to-face assessment and support planning visit must be made within 10 working days of a request or referral, and is provided free of charge. OBRA Level I screening and level of care determination are included in this visit.

The county where the individual resides is responsible to provide this assistance. For medical assistance participants enrolled in any of the managed care programs listed in Section III above, the enrollee's care coordinator is responsible to provide this assistance.

VI. Exemptions from Preadmission Screening Requirements Based on Type of Admission

There are two types of admission that are exempt from *both* NF level of care determination, and OBRA Level I screening for mental illness or developmental disability, as allowed under federal and state laws related to PAS requirements. These exemptions apply regardless of payor source for facility-based services, including admissions of people participating in the prepaid medical assistance programs listed in Section III above.

- **Preadmission Screening is Not Required for Qualifying Inter-facility Transfers**

  - NF to NF transfer: A person does not need PAS if they are transferring from one certified nursing or certified boarding care facility in Minnesota to another certified nursing or certified boarding care facility in Minnesota.

  - NF to acute hospital to NF transfer: PAS is not required when a person has transferred from a certified NF or certified boarding care in Minnesota to an acute (not psychiatric) hospital and then back to the same or another certified NF or certified boarding care in Minnesota, as long as the person does not return to the community between these transfers.

These are the ONLY types of transfers that are exempt from PAS requirements. These types of inter-facility transfers are exempt because it is assumed that appropriate PAS occurred at the first facility admission.

Facilities are responsible to ensure that documentation of previous OBRA Level I screening results accompany other records forwarded when residents transfer to another facility, including those transfers that occur with an intervening acute hospital admission.

- **Preadmission Screening is Not Required for Qualifying Short-Term Admissions to a Facility from an Acute Hospital**

Some admissions to a facility from an acute hospital are also exempt from PAS requirements. The short-term stay exemption is intended to create administrative efficiency when facility-based services are clearly indicated as needed for a very short period of time after a person has received acute inpatient care. It is not intended to shift PAS responsibility from hospital discharge planners to NF staff. PAS must be completed *before* admission by the hospital

discharge planner and the county where the hospital is located (or by the hospital discharge planner and the MCO) unless all of the conditions listed below are met.

In addition to an admission from a hospital as a qualifying transfer as described above, certain short-term facility admissions from a hospital are exempt from PAS. ALL of the following conditions of a short-term NF admission from an acute hospital admission must be met in order to be considered exempt from PAS:

- The person is entering a certified NF directly from an acute care hospital after receiving acute inpatient care at the hospital

AND

- The person requires NF services for the SAME condition for which he or she received care in the hospital

AND

- The attending physician has indicated in the hospital discharge care plan that the individual is likely to receive LESS THAN 30 DAYS of NF care.

If the discharge plan of care would typically require more than 30 days of facility-based care, or any other condition listed above is not met, it is the hospital discharge planner's responsibility to ensure PAS occurs prior to discharge to the facility.

The hospital discharge planner is responsible to provide to the facility admitting the person complete documentation that the requested admission meets all of the short-term stay criteria listed above. If these criteria are not met, the facility must require documentation that PAS has been completed *before* admission.

If the person admitted under a qualifying 30 day exemption remains in the facility on the 30th day after admission, PAS must be completed by (and documented in MMIS as outlined in Section XI below) the 40th day of admission, including completion of OBRA Level II activity if indicated.

VII. Exemption from Level of Care Determinations for Certain People

In addition to certain types of admissions that are exempt from both level of care determination and OBRA Level I Screening as outlined above, certain people are not required to have level of care determinations completed by the county or MCO before admission to a facility. These exemptions are outlined in Minnesota Statutes, section 256B.0911, subdivision 4b.

Unless previously completed, OBRA Level I screening for mental illness or developmental disability or related conditions, and OBRA Level II activity if indicated, **must still be completed** for the following types of admission by the county or the MCO; a copy of DHS Form 3426, *OBRA Level I Screening*, must be forwarded to the admitting facility. See Section XIII for information about OBRA Level II forms and OBRA Level II processes.

- **Individuals age 21 or older who have been receiving home and community-based services funded through a NF level of care waiver or Alternative Care program up to the date of facility admission do not require NF level of care determination prior to admission:**

This exemption applies to people participating in the Elderly Waiver (EW) and the state-funded Alternative Care (AC) program for people aged 65 and older, and to people age 21 or older participating in the Community Alternatives for Disabled Individuals (CADI), Community Alternative Care (CAC), or the Traumatic Brain Injury-NF (TBI-NF) programs. As noted in Section IV, people age 20 or younger and all people with developmental disability or related conditions must always receive a face-to-face Long Term Care Consultation and DHS approval prior to an admission to a NF, regardless of current participation in a waiver program, any other Minnesota Health Care Program, or other medical insurance.

PAS is completed to determine the need for NF care and screen for mental illness or developmental disability or related conditions (OBRA Level I screening). These same activities are also part of the eligibility determination process for NF level of care waiver programs funded under medical assistance, and for the state-funded AC program. Because these activities were already performed to complete the waiver or AC eligibility process, it would be redundant to require this same activity upon admission to a facility. In addition, under federal waiver program requirements, a person must be allowed to freely choose between institutional and community-based long term care when they meet NF level of care criteria.

- **Individuals for whom the Veteran's Administration has unlimited responsibility for NF services.**

The Veteran's Administration provides varying degrees of health and long term care coverage for veterans based on when, where, and how they served in branches of the military. The Veteran's Administration may have contracts with some nursing facilities to provide institutional care to covered veterans. These individuals are exempt from PAS requirements related to level of care determinations, but should still have OBRA Level I screening completed, since they are not exempt under federal requirements for screening for mental illness, or developmental disability or related conditions.

Meeting OBRA Requirements for Admission to a Facility

If a person participating in a home and community-based waiver program did not complete an OBRA Level I screening as part of the community assessment, this portion of PAS must be completed and documented before admission, since this type of admission is not exempt from federal screening requirements for mental illness or developmental disabilities or related conditions, and any indicated OBRA Level II activity must also be completed.

Regardless of exemption from level of care determination for current home and community-based waiver participants, any indicated OBRA Level II diagnosis and evaluation of the need for specialized services must be complete prior to or within 10 days of admission. See Section XIII for information related to OBRA Level II requirements and activities.

In addition, certain tasks must still be completed in MMIS in the Long Term Care Screening Document (LTC SDOC) subsystem to ensure payment to the NF and document the person's admission. See DHS 4625, the manual *"Instructions for Completing and Entering the LTCC Screening Documents and Service Agreements into MMIS"* for further information about the LTC SDOC subsystem and required documentation when a person participating in the EW, AC, CADI, CAC or TBI-NF program enters a facility; both county and MCO staff complete this documentation.

VIII. Facilities Providing Home and Community-Based Respite Service

Neither level of care determination nor OBRA Level I screening is required when an individual is receiving out-of-home respite in a nursing facility IF:

- The facility has enrolled as a waiver or AC respite provider under Minnesota Health Care Programs Provider Enrollment requirements[4].
- The facility has been authorized by the case manager or service or care coordinator to provide respite service for the individual as indicated on the Service Agreement produced by MMIS, or by the MCO.
- The facility is not providing nor billing for NF services for the individual.
- The facility has a contract with the lead agency (MCO or county or tribe[5]) to provide out-of-home respite care.

IX. Additional Activities Required for People Under Age 65

In order to support the state's goal of reducing the number of people whose long term care needs are met in institutional rather than in community settings, face-to-face Long Term Care Consultation visits are required for all individuals under age 65, either before admission or <u>within 40 days of admission if the person was admitted via telephone screening.</u>

This requirement also applies to people under 65 who were admitted at hospital discharge under a qualifying short term stay exemption who subsequently remains in the facility beyond 30 days. The in-person visit must occur within 40 days of the *admission* date. This requirement applies to admissions to certified boarding care facilities, as well as hospital "swing" beds and certified nursing facilities.

If OBRA Level II diagnosis and evaluation of the need for specialized services is indicated by the OBRA Level I screening, Level II activities must also be completed by the 40th day of admission. In addition to this initial follow-up visit, the person must be visited at least annually if they remain

4 Managed care organizations may have contracted waiver service providers in their home and community-based services networks that must meet all provider standards and qualifications, but are not required by the MCO to enroll in Minnesota Health Care Programs. Provider enrollment requirements must be met to receive fee-for-service payments.
5 Counties, and tribes and managed care organizations under contract with DHS manage the home and community-based waiver and AC programs. A NF may have a respite contract with any or all of these types of lead agencies.

in the facility.[6] These visits must be documented in MMIS in order to continue medical assistance fee-for-service payments to the facility.

Counties receive two reports each quarter which identify those persons, under the age of 65, that are residing in nursing facilities. One report identifies all people under the age of 65 that are residing in an NF which is located within that particular county. The second report identifies those persons under the age of 65 that are the financial responsibility of that particular county, regardless of where the NF is located.

Please go to the Disabilities Services Program manual at http://www.dhs.state.mn.us/id_000813 for additional information about Long Term Care Consultation service requirements for people under age 65, including billing and payment information for face-to-face visits.

Given the various exemptions and requirements, please see Attachment A for a summary of the various PAS requirements as outlined in all previous sections.

X. Additional Policy Information

- **Lead agency staff, including tribes, managed care organizations and county PAS staff, must communicate about the admission of persons whose care will be, or may be, purchased under Minnesota Health Care Programs using DHS Form 5181. In addition, medical assistance program participants must apply specifically for long term care services using DHS Form 3543; new applicants may complete a combined application DHS Form 3531.** See bulletins 07-21-09 and 07-21-12 for information about roles, responsibilities, scenarios, and forms.

- **Facilities are required to provide each person admitted with information about assistance available to return to the community.** As a requirement under Minnesota Statutes, section 256B.0911 governing Long Term Care Consultation, facilities must provide each person admitted with information about assistance available to help the person return to community living. Facilities provide this information using DHS Brochure 2497, *"Promoting and Supporting Independent Community Living"*.

See Section XIII for the web link to this brochure, to DHS Brochure 4789, *"Take the Road to Independence"*, a consumer guidebook for people under age 65 years living in a nursing facility but interested in moving to the community, and to all other DHS forms cited in this bulletin.

- **When a person is seeking admission to a certified Minnesota nursing or boarding care facility, or swing bed, and resides in a different state, e.g., North Dakota resident coming to a Minnesota facility:** If a person does not meet the 30 day hospital exemption, the Minnesota county where the facility is located must perform PAS for all persons seeking admission to a certified NF, certified boarding care facility, or hospital "swing bed" in Minnesota, regardless of the person's state of residence. In this case, the health care

6 A person may choose to receive an LTCC assessment every 36 months instead of every 12 months after the initial face to face visit. This choice must be documented on the first line of the "Case Manager Comments" screen in the Screening Document subsystem in MMIS.

professional seeking admission (e.g. North Dakota hospital discharge planner) must contact the county where the Minnesota facility is located to complete PAS prior to admission.

- **When a Minnesota resident is seeking admission to a NF in another state:** The statute governing PAS and LTCC does not require a Minnesota county to perform PAS or LTCC for a Minnesota resident that is being admitted to an out-of-state NF. In this case, the Minnesota hospital, or other health care professional seeking admission should follow the PAS requirements of the state where the facility is located. However, if Minnesota medical assistance is going to be the payor for the out-of-state NF care, documentation of the out-of-state PAS must be forwarded by the facility to the county of Minnesota residence for entry into MMIS.

- **When a person is transferring from an out-of-state facility to a Minnesota facility:** A person who is currently a resident of an out-of-state NF and is seeking a "transfer" to a NF in Minnesota is NOT exempt from PAS. The definition of an exempt transfer specifies that the transfer must occur between one Minnesota certified facility and another Minnesota certified facility.

- **When a county or MCO is not notified of a NF admission:** Minnesota Statutes, section 256B.0911 prohibits medical assistance payments for NF services provided prior to the completion of required PAS. If the admission is subject to PAS requirements, the first day payment will occur will be the date PAS is completed. If the person is not exempt from PAS, the NF will not be paid until either a face-to-face or telephone screening has been performed and entered into MMIS. PAS staff cannot back-date completion of PAS in MMIS.

- **For people admitted under the 30-day exemption who stay longer, and the NF does not notify the lead agency that PAS must be completed:** The NF will not be paid for services provided after the 40th day UNLESS the county or MCO performs the required screening within the required time lines (by the 40th day). Payments to the NF will be resumed on the date either a face-to-face or telephone screening has been performed and entered into MMIS. PAS staff cannot back-date completion of PAS in MMIS. For example, if PAS is not completed until the 48th day after admission, days 41-47 will not be paid.

- **Preadmission screening is valid for 60 calendar days:** If a person received PAS either by telephone or through a face-to-face LTCC assessment, that PAS is good for 60 calendar days. Sometimes, a person's admission is delayed after PAS is completed and documented in MMIS. If the screener determined NF level of care was needed, and Level I was completed, and the screening document was entered, re-screening is not needed if the date of admission occurs within 60 calendar days of the date of the PAS. If the person is under 65 and is admitted via telephone screening, the in-person follow-up LTCC visit is still due within 40 calendar days after admission.

- **Emergency Admission to a Certified NF, Boarding Care, or "Swing" Bed:** An "emergency admission" is defined in Minnesota Statute, section 256B.0911 governing Long Term Care Consultation. Emergency admission from the community to a certified nursing

facility prior to screening is permitted during county nonworking hours when **all** of the following criteria are met:

- A physician has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety.
- There is a recent precipitating event that no longer enables the client to live safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver is unable to continue to provide care.
- The attending physician must authorize the emergency placement and document the reason that emergency placement is recommended.
- The county or MCO must be contacted on the **first working day following the emergency admission.**

Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation (e.g., stabilization of medications), or for care in an emergency room without hospital admission, or following hospital 24-hour bed care. County LTCC staff will use the admission date for the Activity Type (screening) Date for emergency or acute hospital discharge admissions when the criteria above are met. If these criteria are not met, the date of actual screening is entered.

Persons admitted to the certified nursing facility from an acute care facility on a county nonworking day must be screened **the first working day after admission.**

XI. Documentation of Preadmission Screening Activity in MMIS

County LTCC staff and MCO care coordinators document PAS activities in the Minnesota Medicaid Information System (MMIS) using the Long Term Care Screening Document (LTC SDOC) subsystem. Data to be entered into MMIS is captured in DHS Form 3427 or 3427T (for telephone screening). For some individuals, a Developmental Disabilities (DD) Screening Document (DHS 3067) is also completed and entered into MMIS by county or MCO staff. Staff must enter this information into MMIS in a timely manner to prevent delays in medical assistance fee-for-service payments for NF services, and in capitation payment rate changes for people enrolled in managed care under Minnesota Health Care programs.

All PAS staff, whether county or MCO, are responsible to provide documentation to the facility that OBRA Level I was completed, using DHS Form 3426, *OBRA Level I Screening.* All PAS staff must also ensure that documentation of level of care and OBRA Level I screening are entered into MMIS via the Long Term Care Screening Document subsystem as described in Chapter 2 of DHS 4625, the manual *"Instructions for Completing and Entering the LTCC Screening Documents and Service Agreements into MMIS".* See Section XIII for the web link to this manual. The manual contains detailed information about entering screening documents, including the data fields required for completion, the valid values for those fields, and screening document edits and their resolution, for each of the types of admissions listed below.

Medical assistance fee-for-service payments will be made for NF services only when "checks" or editing performed within MMIS indicate that PAS requirements have been met. MMIS will compare claims for NF services to Long Term Care and Developmental Disabilities Screening Documents to verify that PAS was completed.

The information provided below pertains only to edits related to PAS; provider claims may still be suspended or denied based on other claims editing related to eligibility or claims errors, for examples.

- For **admissions occurring on or after January 1, 2005** MMIS claims editing verifies that:

  - PAS occurred in a timely manner;
  - the need for NF level of care is determined;
  - an OBRA Level I screening for mental illness or developmental disability was completed; and
  - DHS approval is complete for people under age 21 and for people with developmental disabilities or related conditions, and dates of services on claims match DHS-approved length of stay.

- **Payment for qualifying exempted 30 day stay when admitted after an acute hospital stay:** Payment for up to 40 days of NF service will be allowed, without MMIS verification of PAS in the LTC Screening Document subsystem for qualifying exempted admissions when:

  - the admission met all the exemption criteria; and
  - the provider prepares the claim for services using "hospital" as the admission source code; and
  - the DD screening document indicates the need for NF services and a DHS-approved length of stay for people with developmental disabilities or related conditions.

While the exemption is based on a projected length of stay of less than 30 days, an additional 10 days are allowed to complete any necessary reviews and approvals from local mental health or developmental disability professionals when referrals for OBRA Level II evaluations are indicated by the information collected in the OBRA Level I screening.

- **Payment for services provided when a qualifying exempted admission exceeds 30 days:** If, after admission, a person who initially met the criteria for a 30 day exempted stay after discharge from an acute hospital, remains in the NF beyond 30 days, MMIS will verify that required PAS activity, including the mandatory LTCC visit to a person under age 65, has occurred within 40 calendar days of admission before additional payment will be made. Editing will verify that:

  - PAS occurred within 40 calendar days of admission; and
  - the need for NF level of care is determined; and

- a face-to-face LTCC visit was completed by the 40th calendar day of admission of a person under age 65; and
- required OBRA Level II activity related to mental illness or developmental disability was completed within 7 to 9 working days of the OBRA Level I referral. This includes DHS approval of admissions of, and length of stay of, persons with developmental disability.

- **How MMIS editing "recognizes" the admission of a person who was on the waiver:** MMIS editing looks for certain criteria on a valid screening document for purposes of NF claims payment:

  - the LTCC (PAS) activity date related to the date of NF admission
  - information on the most recent LTC Screening Document indicates NF level of care
  - OBRA Level I screening was performed.

  When a person leaves a waiver or the AC program to enter a facility for more than 30 days, an "exit" document is entered by the county case manager or MCO care coordinator. MMIS recognizes this document as a valid document for purposes of PAS editing, since it contains information that matches the criteria noted above. If the person was opened to a NF level of care waiver prior to admission, and the admission is expected to be less than 30 days, the waiver may remain open[7]. The "open" screening document, if OBRA Level I was completed as part of community assessment, is recognized by MMIS for purposes of documentation for PAS and NF claims payment.

- **What date MMIS uses for PAS editing:** The facility must always use the person's actual admission date on every claim, as well as the dates of service billed on each individual claim, regardless of the payer source for any given period of time. The financial worker also uses the actual admission date in the Recipient File (not the date the person became MA eligible or any other date) to establish NF living arrangement. MMIS will look at the admission date on the claim and in the recipient file information in MMIS to edit for all PAS requirements, including the valid screening date, and the face-to-face visit timelines for people under age 65 admitted to facilities.

- **County codes used on the LTC Screening Document when doing a telephone screen or face-to-face assessment for a person who is <u>not</u> a Minnesota resident:** There are four county code fields on the screening document: County of Residence (COR), County of Service (COS), County of Financial Responsibility (CFR), and LTCC/PAS county. Use code 089 (out-of-state) for COR only. Use *your* county code in all other fields. If there happens to be information in MMIS Recipient files where CFR has been established at some previous date, MMIS will "over-write" the codes entered for CFR.

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7 DHS Form 4625, Instructions for Completing and Entering the LTCC Screening Document and Service Agreement into MMIS" has complete information about managing exits from the waiver and AC programs for both short and longer term facility admissions.

XII. Preparation of Claims

Facilities can avoid unnecessary denials of payment for NF services by properly preparing claims.

- **Use the correct Admission Date on the claim.** MMIS will apply PAS editing only to admissions that occurred on or after January 1, 2005. In addition, PAS editing will compare the date PAS was completed to the date of admission, not the date the person became eligible for medical assistance or was enrolled in a managed care program.

- **Use the correct Admission Source code on the claim.** This is important for two different situations: transfers and the exempted 30 day stays.

  Transfers: Transfers from one Minnesota certified facility to another, or from a Minnesota certified facility to an acute hospital and back to a Minnesota certified facility are exempt from PAS requirements. Use of the appropriate code for transfers as an admission source will avoid denials of payment.

  30 Day Exempted Hospital Discharge: The facility MUST use 'Hospital' as the admission source code on the claim if payment is to be made for services provided to individuals admitted under a qualifying exemption. This is true for both qualifying admissions of less than 30 days and those initially qualifying as an exempted admission but exceeding 30 days.

In addition, facilities should make sure that they have forwarded DHS Form 1503 to the person's county financial worker if medical assistance will be the payor for facility services. Managed care organizations may also require additional documentation to be forwarded to them before NF services will be paid for by the MCO.

- **Bill the appropriate payor.** Nursing facilities can use the Eligibility Verification System (EVS) and the *Nursing Home Prepaid Health Plan Report by LTC Provider* to identify which admissions are covered under MCO benefits, and which MCO is responsible for the benefit. On EVS, information indicating cases where the health plan has responsibility for nursing facility services immediately follows the prepaid health plan information. The monthly Nursing Home Prepaid Health Plan Report by LTC Provider will include the following information:

  - Enrollee name
  - Medicaid ID number (PMI)
  - MCO name
  - Minnesota Health Care Program Product ID (M01 = PMAP, M02 = MSHO, M21=PMAP in Cass, Crow Wing, Morrison, Todd and Wadena counties)
  - NF Liability Begin Date
  - NF Liability End Date

If the NF Liability Begin and End dates are blank, this indicates that the MCO does not have responsibility for nursing facility services. If the end date contains all 9s, this indicates that the health plan still had responsibility for nursing facility services at the time the report was generated (approx. the 10th of each month). If there is a value other than 9s in the NF Liability End Date, this indicates the last day the MCO had responsibility for NF services.

See **Attachment B** for the list of MMIS edit codes related to fee-for-service payment of NF claims and PAS requirements.

XIII. Related Bulletins and Other Resources

Bulletins issued within the last two years are available on the Department of Human Services' website at www.dhs.state.mn.us (click on bulletins)

More information about the Long Term Care Consultation program, and community alternatives to facility-based services, can be found at http://www.dhs.state.mn.us/id_005990

The statute governing the Long Term Care Consultation program and preadmission screening is located at http://ros.leg.mn/ 7

DHS Forms referenced in this bulletin, as well as others that may be of interest, can be located at http://www.dhs.state.mn.us/id_007907 The specific forms listed in this bulletin include

- DHS Form 3426 OBRA Level I Screening
- DHS Form 3427T Long Term Care Screening Document-Telephone Screening
- DHS Form 3427 Long Term Care Screening Document
- DHS Form 3067 Developmental Disabilities Screening Document
- DHS Form 1503 Physician's Certification for Nursing Facility Services
- DHS Form 2497 Promoting and Supporting Independent Community Living (brochure)
- DHS Form 4625 Instructions for Completing and Entering Long Term Care Screening Documents and Service Agreements in MMIS or DHS Form 4669 for the MCO version of the same document (manuals)
- DHS Form 5181 Case Manager/Financial Worker Communication Form
- DHS Form 3543 MHCP Request for Payment of Long Term Care Services

OBRA Level II Resources

- DHS Form 3457 OBRA Level II Evaluative Report Form for people with mental illness
- DHS Form 4248 OBRA Level II Evaluative Report Form for people with developmental disabilities
- DHS Bulletin 08-53-02 Update to Adult Mental Health Preadmission Screening and Resident Review (PASRR) and new forms for Level I and II Screenings

A listing of statewide administrative and intake **PAS contacts for all counties** can be found at http://www.dhs.state.mn.us/id_006098

Contact information for each MCO can be found at http://www.dhs.state.mn.us/id_058984

http://www.dhs.state.mn.us/id_008530 for **complete information about completion of DD Screening and DD Screening Document completion** in MMIS

http://www.dhs.state.mn.us/id_000813 for complete information about **Long Term Care Consultation service requirements for people under age 65**, and for billing and payment information for these face-to-face visits.

Minnesota Health Care Providers can find additional policy and billing and payment information at http://www.dhs.state.mn.us/id_000221

This bulletin incorporates and replaces the following previously published bulletins:

- Bulletin # 97-67-1
- Bulletin #02-25-01
- Bulletin #02-25-06
- Bulletin # 04-25-13

XIV. Special Needs

This information is available in other forms to persons with disabilities by calling 651-296-2770, or contact us through the Minnesota Relay Service at 1 (800) 627-3529 (TTY) or 1 (877) 6273848 (speech-to-speech relay service).

Attachment A: Minnesota Preadmission Screening (PAS) Requirements

PAS is required under state and federal law for *all* persons entering a certified NF or certified boarding care facility, including "swing" beds, regardless of payment source for NF care. The information below provides a brief chart for use as a quick reference of tools, timelines, and agencies responsible to perform PAS activities. Requirements are the same whether county PAS staff or managed care organization PAS staff is responsible to complete and document activities.

Statutory Timelines & Process Requirements	**Forms Used**
Admission from an acute hospital: Before admission for all admissions with a projected length of NF stay of more than 30 days. ***By the 40th day of admission*** for a person admitted under a 30 day exemption from an acute hospital who has remained in the facility longer than 30 days. OBRA LEVEL I and LEVEL II are required to be completed within the 40 days as well. ***Before <u>any</u> admission from an Regional Treatment Center (RTC)***. ***Emergency admissions:*** First working day after an admission that meets criteria as an emergency admission ***Non-working day:*** First working day after a county or MCO non-working day for non-exempt hospital discharge to NF ***Admission from the community:*** Before admission for all admissions from the community. Typically requires a face-to-face visit. A telephone screening is only permitted when a health care professional (physician or clinic nurse, e.g.) is seeking admission and contacts the county LTCC staff or HMO care coordinator directly. ***NF Level of Care Waiver or Alternative Care program participants*:** PAS is not required to admit a person who has been receiving services in the community under EW, AC, CADI, TBI-NF or CAC waiver programs up to the date of admission. However, OBRA Level I must still be completed for all persons. OBRA Level II requirements must also be met for all admissions. ***All people under Age 65:*** Face-to-face visit within 40 working days of admission for persons age 21-64 if phone screening was used to admit. ***All people with developmental disabilities:*** DHS *always* must approve admission and length of stay. ***All people under age 21:*** DHS *always* must approve admission and length of stay.	***DHS Form 3361***: NF Level of Care Criteria ***DHS Form 3426***: OBRA Level I Screening Form PAS staff enters a Telephone Screening Document ***DHS Form 3427T*** for all PAS completed by phone. This form documents in MMIS that PAS was completed as required in order to make FFS payments for NF services. MCOs are required under contract to document NF admissions for enrolled members in MMIS. This information is also required to be present in MMIS in order for FFS payments to be made for NF services when a person enrolled in an MCO has exceeded their NF benefit set for days of NF service (the MCO NF benefit maximum). The LTC Screening Document ***DHS 3427*** is entered into MMIS for admissions approved during a face-to-face visit**,** as well as to document mandatory follow visits for people under age 65. **OBRA LEVEL II NOTE:** OBRA Level I screening is completed for all admissions. OBRA Level II will be coded as "Y" if a referral for completion of Level II activity is made OR if the person is known to have a current completed Level II evaluation.

Attachment B

MMIS SYSTEM EDITS FOR NF CLAIMS RELATED TO PAS

The MMIS edits that generate Status Code 9 or 21 and Remittance Advice Remark N146 are explained below:

The Status Code 21 message is "Missing or invalid information. Note: At least one other status code is required to identify the missing or invalid information".

Status Code 21 will show on MN-ITS when entering the claim if the screening document is missing or too old.

Remittance Advice Remark N146 "Missing screening document" will also show on your remittance advice form.

These messages posts for one of several reasons:

- The LTC Screening Document or DD Screening Document is missing;
- The LTC or DD Screening Document is not approved;
- The LTC Screening Document does not show the person requires NF Level of Care (Level of Care Status does not equal NF);

AND/OR

- The DD Screening Document does not indicate a full team screening;
- The DD Screening Document does not have the Medicaid Service Program as "05"

OR

- The DATE of the LTC Screening is either:
  - More than 60 days prior to the admission date;
  - More than 40 days after the admission date and the 30 day delay indicator on the screening document is "N
- The LTC Screening Document shows the OBRA LEVEL I was NOT completed
- The DD Screening Document has an Action Date that is greater than the first day of service, and this is not a short term stay.

Status Code 9 "No payment will be made for this claim" will post on MN-ITS when entering the claim for one of two reasons:

- There is no approved DD Screening Document
- The claim dates of service are outside of the DD Screening Document short-term stay approval period

Remittance Advice Remark N146 "Missing screening document" will also show on your remittance advice form.