

APA-1

TRANSMITTAL SHEET FOR  
NOTICE OF INTENDED ACTION

Control No: 560. Department or Agency: Alabama Medicaid Agency

Rule No: 560-X-10-.11

Rule Title: Establishment of Medical Need

         New Rule;   X   Amend;          Repeal;          Adoption by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?         No        

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?         Yes        

Is there another, less restrictive method of regulation available that could adequately protect the public?         No        

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?         No        

Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?         No        

Are all facets of the rulemaking process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?         Yes        

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Does the proposed rule have any economic impact?         No        

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

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Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975 and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of certifying officer: Stephanie Lindsay

Date: 9-20-12

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**ALABAMA MEDICAID AGENCY**

**NOTICE OF INTENDED ACTION**

**RULE NO. & TITLE:** 560-X-10-.11 – Establishment of Medical Need

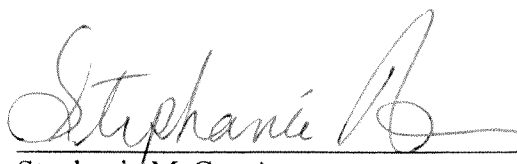
**INTENDED ACTION:** Amend 560-X-10-.11

**SUBSTANCE OF PROPOSED ACTION:** The above-referenced rule is being amended to change the name from Medicaid Long Term Care Division to Clinical Services & Support Division and to clarify the process for a prior determination for nursing home facility admission.

**TIME, PLACE, MANNER OF PRESENTING VIEWS:** Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

**FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:**  
Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than November 2, 2012.

**CONTACT PERSON AT AGENCY:** Stephanie Lindsay, Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624.



Stephanie McGee Azar  
Acting Commissioner

**Rule No. 560-X-10-.11. Establishment of Medical Need.**

(1) Application of Medicare Coverage:

- (a) Nursing facility residents, either through age or disability, may be eligible for Medicare coverage up to 100 days.
- (b) Nursing facilities must apply for eligible Medicare coverage prior to Medicaid coverage.
- (c) Nursing facilities cannot apply for Medicaid eligibility for a resident until Medicare coverage is discontinued.

(2) Periods of Entitlement.

(a) The earliest date of entitlement for Medicaid is the first day of the month of application for assistance when the applicant meets all requirements for medical and financial eligibility.

(b) An exception to (a) above, is retroactive Medicaid coverage. An individual who has been living in the nursing facility prior to application and has unpaid medical expenses during that time can seek retroactive Medicaid coverage for up to three months prior to financial application if the individual meets all financial and medical eligibility requirements during each of the three prior months.

(c) For retroactive Medicaid coverage the determination of level of care will be made by the nursing facility's RN. The nursing facility should furnish the ~~Long~~ Clinical Term Care Division Services and Support Division, Medical & Quality Review Unit or its designee, a Form 161B, a Form 161, and the financial award letter for the retro period of time.

(3) The Medicaid Agency has delegated authority for the initial level of care determination to long term care providers. Medicaid maintains ultimate authority and oversight of this process.

(a) The process to establish medical need includes medical and financial eligibility determination.

1. The determination of level of care will be made by an RN of the nursing facility staff.

2. Upon determination of financial eligibility the provider will submit required data electronically to Medicaid's fiscal agent to document dates of service to be added to the Level of Care file.

(b) All Medicaid certified nursing facilities are required to accurately complete and maintain the following documents in their files for Medicaid retrospective reviews.

1. New Admissions

(i) Form XIX LTC-9 (Form 161). If criterion unstable medical condition is one of the established medical needs the provider must maintain supporting documentation of the unstable condition requiring active treatment in the 60 days preceding admission.

(ii) A fully completed Minimum Data Set. However, the entire MDS does not have to be submitted for a retrospective review. Only the sections of the

MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.

(iii) PASRR screening information, including the Level I screening and Level I determination and Level II screening and Level II determination, if applicable.

2. Readmissions

(i) Form XIX LTC-9 (Form 161).

(ii) Updated PASRR screening information as required.

(c) All Medicaid certified nursing facilities for individuals with a diagnosis of MI are required to maintain the following documents in their files. These documents support the medical need for admission or continued stay.

1. New Admissions

(i) Form XIX LTC-9 (Form 161).

(ii) PASRR screening information, including the Level I screening and Level I determination and Level II, if applicable.

(d) All Medicaid certified ICF/MR facilities are required to complete and maintain the following documents in their files for Medicaid retrospective reviews. These documents support the ICF/MR level of care needs.

1. New Admissions

(i) A fully completed Medicaid Patient Status Notification (Form 199).

(ii) A fully completed ICF/MR Admission and Evaluation Data (Form XIX-LTC-18-22).

(iii) The resident's physical history.

(iv) The resident's psychological history.

(v) The resident's interim rehabilitation plan.

(vi) A social evaluation of the resident.

2. Readmissions

(i) Medicaid Patient Status Notification (Form 199).

(ii) ICF/MR Admission and Evaluation Form.

(e) A total evaluation of the resident must be made before admission to the nursing facility or prior to authorization of payment.

1. An interdisciplinary team of health professionals, which must include the resident's attending physician, must make a comprehensive medical, social, and psychological evaluation of the resident's need for care. The evaluation must include each of the following medical findings; (a) diagnosis; (b) summary of present medical, social, and developmental findings; (c) medical and social family history; (d) mental and physical functional capacity; (e) prognosis; (f) kinds of services needed; (g) evaluation of the resources available in the home, family, and community; and (h) the physician's recommendation concerning admission to the nursing facility or continued care in the facility for residents who apply for Medicaid while in the facility and a plan of rehabilitation where applicable. The assessment document will be submitted with the XIX LTC-9 (Form 161) on new admissions.

(f) All Medicaid certified nursing facilities will have a period of one year from the date of service in which to bill for services. There is no timeliness penalty for submission of information to establish service delivery dates.

(g) Authorization of eligibility by Medicaid physician;

1. For all applications for which a medical eligibility cannot be determined, the application should be submitted to the ~~Medicaid Long Term Care Division~~ Clinical Services & Support Division, Medical & Quality Review Unit. The ~~nurse reviewer~~ Alabama Medicaid Agency physician will review and assess the documentation submitted and make a determination based on the total condition of the applicant. ~~If the nurse reviewer cannot make the medical determination then the Alabama Medicaid Agency~~ The physician will approve or deny medical eligibility.

2. ~~The Long Term Care Division~~ Clinical Services & Support Division, Medical & Quality Review Unit will issue a notice of denial for applications which result in an adverse decision. This notice will include the applicant's right to an informal conference and/or a fair hearing.

3. The informal conference is a process which allows the recipient, sponsor, and/or provider the opportunity to present additional information to the Medicaid physician for a review.

4. If the review results in an adverse decision, the patient and/or sponsor will be advised of the patient's right to a fair hearing (See Chapter 3). If the reconsideration determination results in a favorable decision, the application will be processed.

(h) Authorization of level of care by nursing facility

1. The Alabama Medicaid Agency or its designee will conduct a retrospective review on a monthly basis of a 10% sample of admissions, re-admissions and transfers to nursing facilities to determine the appropriateness of the admission and re-admission to the nursing facility. This review includes whether appropriate documentation is present and maintained and whether all state and federal medical necessity and eligibility requirements for the program are met.

2. A nursing facility provider that fails to provide the required documentation or additional information for audit reviews as requested by the Alabama Medicaid Agency Long Term Care Division or its designee within ten working days from receipt of the certified letter shall be charged a penalty of one hundred dollars per recipient record per day for each calendar day after the established due date unless an extension request has been received and granted. The penalty will not be a reimbursable Medicaid cost. ~~The Long Term Care Division~~ Clinical Services & Support Division, Medical & Quality Review Unit may approve an extension for good cause. Requests for an extension should be submitted in writing by the nursing facility Administrator to the Long Term Care Division with supporting documentation.

3. The Alabama Medicaid Agency will initiate recoupment of payment for services when it determines that state and federal medical necessity and eligibility requirements are not met.

4. The Alabama Medicaid Agency may seek recoupment from the nursing facility for other services reimbursed by Medicaid for those individuals whom Medicaid determines would not have been eligible for nursing facility care or Medicaid eligibility but for the certification of medical eligibility by the nursing facility.

(4) Signature Requirement

Under Alabama's Uniform Electronic Transactions Act, effective January 1, 2002, Alabama law recognizes the validity of electronic signatures. For all Medicaid Nursing Home Forms, the signature must be an original signature or an approved electronic signature of the recipient's attending physician. Provider certification is made via standardized electronic protocol.

(5) Please see Chapter Sixty-Three regarding ventilator dependent and qualified tracheostomy care.

**Author:** Robin Arrington, Associate Director, LTC Provider/Recipient Services Unit.

**Statutory Authority:** State Plan; Title XIX, Social Security Act; 42 CFR Section 401.101-401.625, 42 CFR Section 435.900-435.1011, et seq.

**History:** Rule effective October 1, 1982. Emergency rule effective October 1, 1990. Rule amended February 13, 1991, and August 14, 1991. Amended: Filed June 20, 2003; effective September 15, 2003. Amended: Filed August 21, 2006; effective December 13, 2006. Amended: Filed September 20, 2011; effective September 15, 2011.

**Amended:** Filed September 20, 2012