Nebraska Medicaid Level of Care Evaluation Requirements
Questions and Answers

1. **Is a level of care (LOC) evaluation required for a Medicaid client who has been determined eligible for nursing facility (NF) admission as a result of a Preadmission Screening and Resident Review Level II (PASRR) screen?**

   No, a LOC Evaluation is not required if NF admission criteria is met based on PASRR Level II screen results.

2. **Who is authorized to perform the PASRR? If League of Human Dignity (LHD) and Area Agency on Aging (AAA) staff are performing the PASRR, are they adequately staffed to perform a PASRR?**

   AAA and LHD staff do not perform PASRR evaluations. All involved parties eligible to conduct the Level I screens include NFs or an independent entity such as a discharging hospital. Level I assessments of possible indication or evidence of mental illness or intellectual disability (MI/ID) must be made by qualified professionals such as hospital discharge planners, community health nurses, social workers, nursing facility staff, etc. The PASRR is completed on everyone upon admission to a Medicaid-certified NF.

3. **How does 471 Chapter 12-005.04B “Minimum Referral Information” relate to the language located in Provider Bulletin 15-31?**

   It does not relate. Hospitals have no role in making referrals for LOC Evaluations or performing a LOC Evaluation.

4. **What criteria will be used to determine the LOC?**

   The criteria can be found in 471 NAC 12-003.

5. **If we do not agree with the LOC determination, what steps should be taken?**

   The client, NF, or the managed care organization (MCO) can appeal the LOC decision by submitting a request for fair hearing to the Department of Health and Human Services (DHHS) Legal Services within ninety (90) days of the date the notice of the LOC determination was mailed or delivered in accordance with the procedures outlined in 465 NAC 2-001, 471 NAC 2-003, and 465 NAC 6-004.

6. What credentialing or qualifications do the persons conducting LOC Evaluations possess?

LOC evaluations will be performed by individuals who meet the minimum qualifications contained in Nebraska's approved aged and disabled waiver application:

- *Education:*
  - *Baccalaureate or graduate degree in the following fields: Human Services, Education or Health/Medicaid: OR*
  - *Registered Nurse, currently licensed in Nebraska.*
- *Experience:*
  - *At least (2) years of professional experience in one of the following fields:*
    - *Long-term care,*
    - *Gerontology,*
    - *Rehabilitation,*
    - *Health/disability case management,*
    - *Children with special health needs. or*
    - *Health/medical.*

7. What is the timeframe for the agencies to complete their evaluations?

Senior Care Options (SCO) staff at the AAA have 48 hours to complete the evaluation. LOC staff at the LHD have six calendar days to complete the evaluation. If the evaluation is not completed within the timeline, the applicant is determined appropriate for admission until a LOC evaluation is completed and the required notice is given.

8. I was under the impression that if a resident had previously been at another Skilled Nursing Facility that the LOC Evaluation did not need to be completed. Is this true? PASRR Level II?

If a resident had previously been at another NF, it would be in your best interest to get copies of any LOC Evaluation documentation issued by the AAA or LHD from that facility. If a LOC Evaluation was done AND if the transfer to your facility was a direct transfer, you would not need another determination. If the resident went in between facilities to a lower LOC, another LOC Evaluation would be needed. If the stay at the transferring nursing facility was entirely covered by Medicare Part A, a LOC determination may not have been completed. If not, then the current nursing facility will need to make a referral for a LOC Evaluation. The same circumstances would apply for a PASRR Level II, unless the resident experienced significant change in his/her clinical status or was admitted for inpatient psychiatric treatment. Always obtain any documentation concerning either of these determinations when admitting a resident.

The only change to the LOC referral requirements is the additional requirement to make a LOC referral at the point in time when the facility is notified that a resident is being dis-enrolled from Medicaid Managed Care.

9. What organizations conduct the LOC Evaluation and the PASRR?

The LOC staff at the LHD (residents 18-64) and AAA (residents 65 or older) conduct the LOC Evaluations based on the NF LOC criteria identified in 471 NAC 12-003 and 12-005 as well as Provider Bulletin 13-37. DHHS has a contract with Ascend to perform the PASRR Level I evaluation and Level II PASRR assessments.

10. What is the difference between the LOC Evaluation and the PASRR?

The PASRR is a federal requirement to evaluate appropriateness of NF services in relation to mental illness, intellectual disability or a related condition and the client's needs and is performed on everyone at admittance to any nursing facility with Medicaid-certified beds. The LOC Evaluation applies to Nebraska Medicaid's criteria for medical necessity for the need for NF services.

11. Will there be any changes to the referral process to the LHD and AAA process for the LOC Evaluations?

There are no changes to the referral process.

12. What is needed for a new referral?

The NF should contact the appropriate agency (AAA/LHD) and ask them what they require. Each agency has their established procedures for requesting a referral.

13. When should a NF report a member's changes to Access Nebraska?

You can find a list of what changes must be reported to ACCESSNebraska at http://dhhs.ne.gov/children_family_services/accessnebraska/documents/accessnebraskausertips.pdf.

14. Does a NF need to request a LOC Evaluation for a current resident who has not received a LOC Evaluation?

A LOC Evaluation referral must be made to the LHD or to the AAA for any current Medicaid NF resident who does not have a LOC determination. A second LOC evaluation is not needed if a LOC Evaluation has already been performed on a Medicaid NF resident and the resident has not discharged from the NF. Provider Bulletin 15-31 and Medicaid regulations (471- NAC 12-005.01A) specify when a LOC Evaluation is NOT required.

15. How do we know that we have the correct documentation in the client's file to verify completion of this requirement?

If the facility is unsure if they have the correct documentation, review 471 NAC 12-003 and 12-005. If the situation requires a LOC, look for one of the documents listed below. If the facility does not have one of these documents, the facility should contact the appropriate agency (AAA/LHD) and submit a referral.

- *MC9NF (for the current stay with the same admit date on the MC9NF)*
- *LOC Determination Letter on letterhead from either LHD or AAA*
- *MILTC Form 47*
- *PASSR Level II*

16. What happens if a LOC Evaluation is not completed for a client residing in a NF?

Nebraska Medicaid's claim system edit will stop payment to the NF if a LOC determination has not been completed on a resident for which claims are submitted or for a needed determination to not meet NF LOC.

17. Is the MILTC Form 47 used by NF to make a referral to the LHD and AAA?

No, the MILTC Form 47 is used by the AAA and the LHD to give notice to the NF regarding the results of the LOC evaluation.

18. Does the NF base the referral on the current age of the client or the age of the client when they entered the NF?

Please base the referral on the current age of the Medicaid client.

19. Currently the LHD and AAA only issue written approval for short term and then give verbal approval for long term. Do we need to request the long term approval be documented in written form?

The LHD or AAA will provide the NF with written determination that short term approval has ended and that long term care is approved.

20. When should a facility request a LOC Evaluation for a Medicaid client with spend down status?

NF should make a LOC referral as soon as the resident is identified as "Medicaid pending", in order to lock in the referral date. The referral date is the first date of Medicaid payment for a client who meets LOC and is eligible for Medicaid.

21. How does the NF proceed for clients on waiver services?

A LOC evaluation is not required when the client is admitted to a NF and has already been determined eligible for Medicaid waiver services. Individuals receiving Medicaid waiver services are currently excluded from managed care.

22. Should a LOC Evaluation be conducted again on a client when there has been a change in condition?

No.

23. For clients on Medicare and Medicaid should a referral for a LOC Evaluation be made?

For clients currently under a Medicare Part A covered stay, a LOC Evaluation referral is necessary when the facility is notified that Medicare Part A coverage will end. The client may be eligible for both Medicare and Medicaid; however, it will depend on who is currently covering the stay.

24. Is it mandatory for all facilities to use the AAAs and LHD?

Yes. Though only the AAAs are cited in 471 NAC 12-005, Medicaid has more recently delegated this authority also to the LHD.

25. Can the hospital staff continue performing the PASRR I and PASRR II evaluations or use the hospital's contracted resource?

Yes, hospital staff can continue to do the Level I. The Level II is not done by hospital staff– it is done by the current DHHS contractor for PASRR services, which is currently Ascend.

26. When is the MCO released from liability of coverage of the basic benefit package when a member is deemed LTC? Is it the same as the current process?

The MCO will continue to provide the basic benefits package through the month a member is waived. For example, if a MCO member is waived from managed care on the 15th of September, the MCO is responsible for the basic benefits package through the 30th of September. This has not changed.

28. Is the Level of Care Evaluation by the AAA or the League of Human Dignity required for Special Needs nursing facilities?

No, the NF LOC determination is made by Medicaid staff through the prior authorization process and submitted documentation.