

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.



Director, Program Policy Division
Bureau of Medicaid Policy and Actuarial Services

Project Number:	0913-NF	Comments Due:	August 6, 2009	Proposed Effective Date:	October 1, 2009
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Policy Subject: Complex Care Prior Authorization and Annual Pulmonary Evaluation Processes

Affected Programs: Medicaid

Distribution: Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospice

Policy Summary: NF requests for additional reimbursement to provide special care to beneficiaries with complex care needs were previously processed using a Memorandum of Understanding (MOU). Pursuant to this bulletin, additional reimbursement for complex care needs will no longer be processed using a MOU. NFs will complete a Complex Care Prior Approval - Request/Authorization for Nursing Facilities form (MSA-1576) using the Prior Authorization (PA) process. An annual pulmonary exam is required after two consecutive years of increased reimbursement for vent care in a NF not recognized as a vent dependent care unit (VDCU). The pulmonary evaluation aims to assure the non-specialized NF providing vent care is appropriate placement for the beneficiary.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: Nursing Facilities, County Medical Care Facilities, Hospital Long Term Care Units, Hospice

Issued: September 1, 2009 (proposed)

Subject: Complex Care Prior Authorization and Annual Pulmonary Evaluation Processes

Effective: October 1, 2009 (proposed)

Programs Affected: Medicaid

This bulletin revises policy for nursing facilities requesting additional reimbursement for Medicaid residents with complex care needs. This bulletin also explains the revised "Request for Prior Authorization for a Complex Care Memorandum of Understanding (MOU) Nursing Facility and Michigan Department of Community Health" (MSA-1576) form for complex care requests and renewal processes. It establishes an annual pulmonary evaluation requirement for vent patients in a nursing facility after a two year stay.

Previous Complex Care Needs Request Overview

Previously, requests for additional reimbursement to provide special care needs were submitted on a MSA-1576 form. A beneficiary residing in or entering a nursing facility with special care needs not covered by the nursing facility per diem and not reimbursed through ancillary services could submit a MSA-1576 to request increased reimbursement for the cost of the special care.

New Complex Care Needs Request Process

Michigan Medicaid has revised and renamed the form necessary to obtain additional funding for beneficiaries with special care needs in a nursing facility. Effective for dates of service on or after September 1, 2009, the "Complex Care Prior Approval - Request/Authorization for Nursing Facilities" (MSA-1576) form will be used for beneficiaries with special care needs entering a nursing facility. The Nursing Facility Coverages Chapter of the Medicaid Provider Manual provides for additional reimbursement to nursing facilities for special care services not covered by the usual Medicaid per diem rate. The payment rate for complex care residents is a prospective rate per resident day. However, if an acute care facility does not alert or adequately relay a beneficiary's special care needs to the nursing facility prior to the beneficiary's admission, the nursing facility has 30 days to request additional reimbursement for complex care. If approved, the complex care rate is retroactive to the date of admission to the nursing facility. The complex care rate and authorization period is included on the approved form.

To complete the MSA-1576, providers will need to provide:

- Section I: Provider and Beneficiary information;
- Section II: Staffing type (RN, LPN, CNA), medical supplies and costs outside of the per diem and ancillary coverage; and
- Section III: Any additional information or details relevant to the case evaluation.

Renewal Process for Complex Care Needs

Nursing facilities that have a current complex care MOU will continue to receive reimbursement until the MOU ends. To continue providing previously authorized special care services, the provider must request to renew the authorization prior to the MOU's end date. Currently, policy indicates that providers should submit requests three weeks before the effective date. This policy will define the time period as 15 business days prior to the effective date. To request a renewal, the provider submits a "Complex Care Prior Approval - Request/Authorization for Nursing Facilities" (MSA-1576) with the current MOU prior authorization number listed in the prior authorization box on the revised MSA-1576. For example, if the current MOU authorization period ends on May 31, 2009, and a provider aims to renew the authorization, a renewal request must be submitted no later than May 8, 2009. The provider will receive a response to the renewal request before June 1, 2009. The authorization period is included on the approved form.

Pulmonary Evaluation Requirement

When a beneficiary in a nursing facility has an active Complex Care Prior Authorization for vent care for two consecutive years, the beneficiary must receive a pulmonary evaluation at the beginning of the third year and annually thereafter. A beneficiary may be exempt from the annual pulmonary evaluation if, at the time the scheduled evaluation is due, the beneficiary elects not to have the evaluation, the physician indicates the patient's condition prohibits the evaluation, or the beneficiary has received a pulmonary evaluation within the current year such as during a hospital stay. The nursing facility must notify the beneficiary's physician of the beneficiary's decision. Documentation of the beneficiary's or physician's decision to decline the evaluation must be in the beneficiary's medical record.

Michigan Department of Community Health
**COMPLEX CARE PRIOR APPROVAL – REQUEST/AUTHORIZATION
 FOR NURSING FACILITIES**

PRIOR AUTHORIZATION NUMBER

Fax: MDCH Program Review Division (517) 241-7813

0913-NF - Attachment

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

SECTION I:

Provider's Name (Last, First, Middle Initial)	NPI Number	Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)		Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date
		mihealth Card Number

SECTION II: CARE STAFFING AND SUPPLIES

List the average number of nursing hours and supplies, vent, etc. required for this beneficiary's care that EXCEED the standard level of care and the corresponding rate of pay. *Attach additional information if necessary.*

Excess Nursing Hours	Charges Per Hour/Day	Total
RN _____ Hours Per Day	\$ _____ Per hour	\$ _____
LPN _____ Hours Per Day	\$ _____ Per hour	\$ _____
Aide _____ Hours Per Day	\$ _____ Per hour	\$ _____
Excess Daily Supplies		
Medical Supplies (e.g., vent)		
1. _____	\$ _____ Per day	\$ _____
2. _____	\$ _____ Per day	\$ _____
3. _____	\$ _____ Per day	\$ _____
4. _____	\$ _____ Per day	\$ _____
TOTAL		\$ _____

SECTION III: ADDITIONAL COMMENTS

(250-Character Limit).

SECTION IV: PROVIDER CERTIFICATION

The patient named above (parent or guardian if applicable) understands the necessity to request prior approval for the services indicated. I understand that services requested herein require prior approval and, if approved and submitted on the appropriate invoice, payment and satisfaction of approved services will be from Federal and State funds. I understand that any false claims, statements or documents or concealment of a material fact may lead to prosecution under applicable Federal or State law.

 Provider Signature

 Date

MDCH USE ONLY

Review action: APPROVED <input type="checkbox"/> INSUFFICIENT DATA <input type="checkbox"/> DENIED <input type="checkbox"/> NO ACTION <input type="checkbox"/> APPROVED AS AMENDED <input type="checkbox"/>	Consultant remarks
Start Date	End Date
	Units – Number of Days
	Total Daily Rate
	\$ _____

 Consultant Signature

 Date