MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Distribution: Hospitals 04-12
Hospice 04-03
Medicaid Health Plans 04-09
Nursing Facilities 04-05

Issued: September 17, 2004

Subject: Ventilator Dependent Beneficiaries; Ventilator Dependent Care Unit Prior Authorization Forms; Memorandums of Understanding

Effective: October 17, 2004

Programs Affected: Medicaid

PURPOSE

The purpose of this bulletin is to instruct hospitals and nursing facilities on the process for admission of Medicaid beneficiaries to Medicaid Ventilator Dependent Care Units and Memorandums of Understanding for Complex Care in the Nursing Facility. There are two distinct processes contained in this bulletin.

MEDICAID VENTILATOR DEPENDENT CARE

There may be occasions when a beneficiary no longer requires acute hospital care but does require specialized care in a Ventilator Dependent Care Unit (VDCU). The Michigan Department of Community Health (MDCH) prior authorizes admission of ventilator dependent Medicaid beneficiaries to hospital and nursing facility (NF) ventilator units with which it has agreements to provide VDCU services. A hospital initiates the request for placement to a VDCU by submitting to MDCH, Long Term Care (LTC) Services Section, the completed Medicaid Ventilator Dependent Care Assessment form (MSA-1634) and Medicaid Ventilator Dependent Care Authorization form (MSA-1635) (copies attached). The MDCH reviewer may request additional information before a decision is made to approve or deny the special placement request.

A request for placement must show that:

- The beneficiary is dependent on life-supporting mechanical ventilating equipment for at least six hours per day.
- The beneficiary stay **normally** meets or exceeds the hospital outlier threshold for DRG 475.

Approval for admission to a VDCU will not be given for a beneficiary who is only on CPAP or BiPAP.
If a beneficiary has weaning potential or requires other rehabilitative services (in addition to the respiratory care) and is enrolled in a Medicaid Health Plan (MHP), the MHP is responsible for the first 45 days reimbursement in the post acute setting. If there is no weaning potential and the beneficiary requires only custodial care needs, disenrollment from the MHP may occur at the time the beneficiary is discharged from the hospital.

In situations where a beneficiary cannot immediately be placed in a Medicaid Nursing Facility (NF) or hospital VDCU, MDCH will cover nursing days in the inpatient hospital. When the beneficiary is in a hospital setting because a LTC placement is not available, Medicaid will cover the ancillary services provided by the hospital.

The hospital cannot charge a beneficiary the difference between the hospital's charge and MDCH's payment for nursing days.

If a beneficiary refuses an appropriate placement to a VDCU, the beneficiary is responsible for all hospital charges incurred after the date of referral.

Obtaining Authorization For VDCU Placement

To begin the prior authorization process, the hospital discharge planner, case manager, or social worker must complete and submit forms MSA-1634 and MSA-1635. Electronic copies of the forms are available on the MDCH website at www.michigan.gov/mdch, click on Providers, Information for Medicaid Providers, Medicaid Forms and Other Resources. Fax completed forms to the LTC Services Section at (517) 241-8995.

The beneficiary's physician must sign the MSA-1635 Medicaid Ventilator Dependent Care Authorization form and, by doing so, attests to the medical necessity of the patient transfer from an acute care setting to a long-term care setting. Physician assistant, medical assistant, or nurse practitioner signatures may not be substituted for the physician's signature.

The VDCU must complete and submit the MSA-1634 and the MSA-1635 when the resident has exhausted other resources of reimbursement.

Questions related to completion of the forms should be directed to the LTC Services Section at (517) 241-4293.

MEMORANDUM OF UNDERSTANDING

Prior Authorization for a Complex Care Memorandum of Understanding (MSA-1576) provides prior approval for the placement of a Medicaid beneficiary for whom placement from a hospital has been, or could be, hindered due to the cost and/or complexity of nursing care or special needs. The prior authorization covers an individually negotiated reimbursement rate for the placement. Special individualized placement requests and payment arrangements are based on medical necessity and/or service/supply needs exceeding those already covered by the usual and customary Medicaid reimbursement for routine nursing facility long-term care.

Examples include, but are not limited to:

- Ventilator dependent care (for NFs not contracted with MDCH to provide ventilator dependent care)
- Multiple skin decubiti utilizing several treatment modalities
- Tracheostomy with frequent suctioning needs
- Beneficiaries who require intensive nursing care or treatment

Program Requirements:

- Referrals may come from either the acute care hospital or the NF.
- Hospitals must document that at least ten (10) Medicaid certified NFs within a fifty (50) mile radius of the hospital refused to admit the beneficiary due to the complexity of the patient's care needs.
- NFs may request a MOU after admitting a beneficiary if the hospital failed to accurately document the beneficiary's condition and needs prior to transfer to the NF. The NF must request the MOU within 30 days from the date of admission to the NF.

To expedite the review and authorization process, the following information must be submitted:

- A completed Prior Authorization for a Complex Care Memorandum of Understanding form (MSA-1576), including any requests for additional nursing, CENA, supplies or equipment. This form may be downloaded from the MDCH website at www.michigan.gov/mdch. (Refer to the Michigan Medicaid Nursing Facility Manual when completing the request for information to determine what is already provided to a resident of a NF under the daily per diem.)
- The beneficiary's medical background, including current medical status, treatment/nursing care plan, and justification for any additional nursing hours and/or special equipment requested. (This information should be included on the MSA-1576).
- Recent (within the past 30 days) lab, x-ray, and diagnostic/therapeutic test results and/or reports.
- A list of nursing facilities within a fifty (50) mile radius that have denied admission due to the complexity of care the beneficiary required, including:
  - Name and address of the nursing facility
  - Contact person's name and title
  - Date of contact
  - Reason for denial
- Documentation of the financial resources available to the beneficiary, including:
  - Medicaid coverage
  - Medicare Parts A and B
  - Other commercial insurance coverage.
- Name and telephone number of a contact person at the nursing facility requesting the MOU.

NOTE: It may take up to three weeks for the MOU to be processed. If it appears that a beneficiary, upon discharge, will require intensive nursing care, the hospital's discharge planning coordinator should initiate the prior authorization process for the MOU as early in the beneficiary's hospital stay as possible to ensure a smooth transition to the nursing facility.

The hospital or NF will be contacted by telephone regarding Medicaid's ability to assist with the beneficiary's placement. If approved, the NF will receive a prior authorization number to be used when billing.

CONTACT INFORMATION

MDCH LTC Services Section
CCC, 7th Floor
400 S. Pine
PO Box 30479
Lansing, Michigan 48909-7979

Phone: 517-241-4293
Fax: 517-241-8995

Manual Maintenance

This bulletin should be retained until the information is incorporated into the January 2005 version of the Medicaid Provider Manual (Discharge Planning portion of the Hospital Chapter and the Ventilator-Dependent Care Units portion of the Coverages and Limitations Chapter of the Nursing Facility Manual).

Questions

Any questions regarding this bulletin should be directed to Provider Support, P.O. Box 30731, Lansing, Michigan 48909-8231, or e-mail at ProviderSupport@michigan.gov. When you submit an e-mail, be sure to include your name, affiliation, and phone number so you may be contacted if necessary. Providers may phone toll-free 1-800-292-2550.

Approved

Paul Reinhart, Director
Medical Services Administration

Michigan Department of Community Health

MEDICAID VENTILATOR DEPENDENT CARE ASSESSMENT

Instructions:

- Type or Print Legibly
- Fax completed form to:

  (517) 241-8995

Beneficiary's Name:	Date of Birth: / /
Prospective Ventilator Unit:	Sex: ☐ Female ☐ Male
Address of Unit: (Street, Suite Number, City, State, Zip)	
Administrator:	
Admissions Coordinator:	

INSURANCE/RESOURCE SOURCE:

Medicaid ID #: Active: ☐ Yes ☐ No	Medicaid Health Plan: (Name)	Disenrollment Date / /
Medicare ID #:	Blue Cross/Blue Shield ID #:	Other Insurance: (Name)
Date Benefits Exhausted: / /	Date Benefits Exhausted: / /	Date Benefits Exhausted: / /

DISCHARGE INFORMATION:

☐ Hospital ☐ Nursing Facility	Facility Name:	Admission Date: / /

Primary Diagnosis: Secondary Diagnosis:

Medical History:

Surgeries and Dates:

RESPIRATORY STATUS:

Date Placed on Ventilator: / /	Suctioning Frequency:
Number of Hours on Vent (Out of 24 hrs.):	Secretion Description:
Weaning Potential:	Prognosis:
Weaning Attempts:	

02 Usage: Level: Frequency: Route:

NOTE: Medicaid does not reimburse for C-PAP/BI-PAP only.

Blood Gases: Labs:

Medications:

ADDITIONAL DATA:

Mental Status:	Sensory/Communication Status:
Diet Status: Type: ☐ Tube Feeding	Caloric Intake: Supplements:
Incontinence: Bowel ☐ Yes ☐ No; Bladder ☐ Yes ☐ No; Catheter ☐ Yes ☐ No	Treatment /Therapies: (Check as applicable.) ☐ OT ☐ PT ☐ ST

Wounds:

Comments:

Submitted by: Date:

Telephone Number: ( ) - Fax #: ( ) - Pager: ( ) -

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MEDICAID VENTILATOR DEPENDENT CARE AUTHORIZATION

_____ **is requesting authorization from the**
Hospital or Nursing Facility

Michigan Department of Community Health, Long Term Care Services, for the discharge of the identified beneficiary to the Medicaid Ventilator Dependent Care Unit of _____
Nursing Facility

Beneficiary's Name: _____

Date of Birth: ____/____/_____ **Medicaid I.D. Number:** _____

Medicaid Status: ☐ **Active** ☐ **Inactive** **Date:** ____/____/_____

Anticipated date of discharge to Long Term Care: _____

Diagnosis(es): _____

_____

_____

_____
Physician's Signature **Date**

MEDICAID USE ONLY

_____
MDCH Staff Signature **Date**