MSA MEDICAL SERVICES ADMINISTRATION

Bulletin

Michigan Department of Community Health

Bulletin: MSA 10-05

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

Issued: April 1, 2010

Subject: Complex Care Prior Authorization and Annual Pulmonary Evaluation Processes

Effective: May 1, 2010

Programs Affected: Medicaid

This bulletin revises policy for nursing facilities requesting additional reimbursement for Medicaid residents with complex care needs. It also establishes the complex care agreement as a prior authorization (PA) function and removes it from the Memorandum of Understanding (MOU) contract process. The bulletin explains that the MSA-1576 form, previously used for complex care MOU requests, will now be used for complex care PA requests for additional reimbursement. The form has been re-titled to "Complex Care Prior Approval - Request/Authorization for Nursing Facilities." Finally, this bulletin establishes an annual pulmonary evaluation requirement for complex care vent patients in a nursing facility after a two-year stay.

Effective for dates of service on or after May 1, 2010, nursing facilities must submit the revised MSA-1576 "Complex Care Prior Approval - Request/Authorization for Nursing Facilities" form to request additional reimbursement for Medicaid beneficiaries with special care needs residing in or entering a nursing facility. The payment rate determined for complex care residents is a prospective rate per resident day.

If an acute care facility does not alert or adequately relay a beneficiary's special care needs to the receiving nursing facility prior to the beneficiary's admission, the receiving nursing facility has 30 calendar days to request additional reimbursement for the cost to provide the complex care. If approved by MDCH, the complex care reimbursement rate is retroactive to the date of the beneficiary's admission to the nursing facility. If a beneficiary develops the need for complex care during an ongoing nursing facility stay, the provider may submit a PA request at that time. All requests are reviewed and a letter of response is returned to the provider. An approved request details the nursing facility per diem including the additional complex care costs for the beneficiary, the procedure codes with their descriptions, the quantity of approved days, and the authorization period.

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;
- Section III: Any additional information or details relevant to the case evaluation; and
- Section IV: Provider Certification.

Renewal Process for Complex Care Needs

Nursing facilities that have a current complex care MOU will continue to receive reimbursement through the approved time period. To request a renewal, providers must submit a "Complex Care Prior Approval - Request/Authorization for Nursing Facilities" (MSA-1576). Providers must submit the request 15 business days prior to the expiration/end date. For example, if the current authorized period ends on January 29, 2010, and continued complex care is anticipated, MDCH must receive the renewal request on or before January 11, 2010.

The provider will receive a response to the renewal request on or before January 29, 2010. If the request is approved, the reimbursement rate and the authorized period will be indicated on the approved form.

Pulmonary Evaluation Requirement

A beneficiary residing in a nursing facility with an active Complex Care Prior Authorization for vent care for two consecutive years 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 documents a medical reason to not perform it, or the beneficiary has received a pulmonary evaluation within the current year, such as during a hospital stay. If the beneficiary chooses not to have the evaluation, the nursing facility must notify the beneficiary's physician of that decision. Documentation of the decision to decline the evaluation by either the beneficiary or the physician must be in the beneficiary's medical record.

Manual Maintenance

Retain this bulletin until the information has been incorporated into the Michigan Medicaid Provider Manual.

Questions

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

APPROVED

Stephen Fitton, Director
Medical Services Administration

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

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

SECTION I:

Provider's Name	NPI Number		Phone Number
Provider's Address (Number, Street, Ste., City, State, Zip)			Fax Number
Beneficiary's Name (Last, First, Middle Initial)	Sex ☐ M ☐ 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:	Consultant remarks		
APPROVED ☐ INSUFFICIENT DATA ☐ DENIED ☐ NO ACTION ☐ APPROVED AS AMENDED ☐			
Start Date	**End Date**	**Units – Number of Days**	**Total Daily Rate**
			$

_____ _____

Consultant Signature Date

Authority: Title XIX of the Social Security Act.
Completion: Completion is required for Medicaid reimbursement.
MSA-1576 (2/10) - Previous editiions are obsolete.

Attachment - MSA 10-05