

# Alabama Medicaid Medical and Quality Review Services and Qualis Health Long Term Care Review Services May 30, 2014

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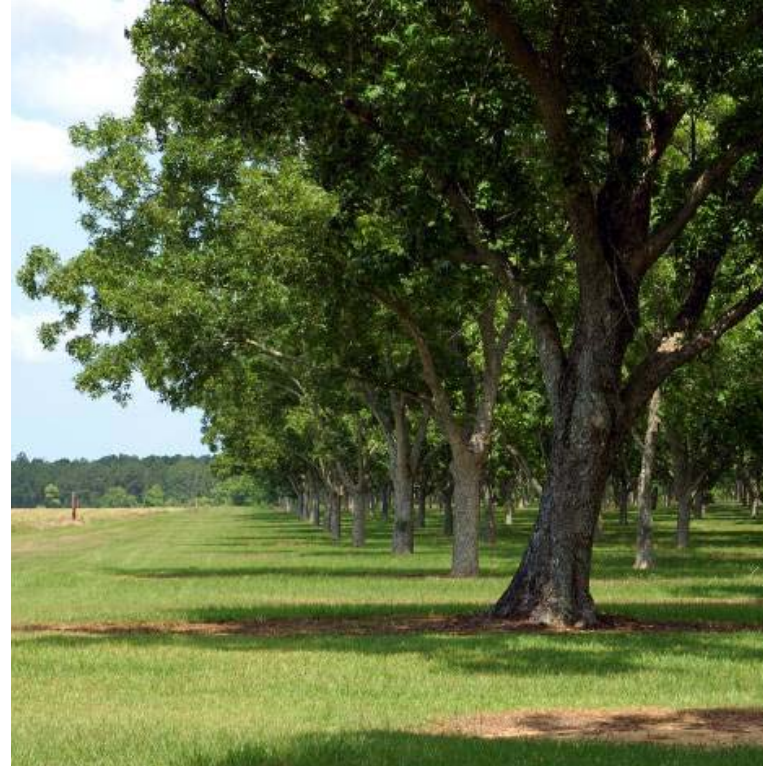


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**[www.qualishealth.org](http://www.qualishealth.org)**

# Qualis Health

- A private nonprofit organization established in 1974.
- Regional office located in Birmingham, AL.
- Have provided care management to Alabama since 2011.



# Who We Are

- We are clinicians.
- We respect your clinical judgment.
- We want your clients to receive the necessary and appropriate services.



# What We Do

- Contract with Alabama Medicaid for utilization management and quality review of healthcare services, equipment and supplies provided to Medicaid recipients.
- Review 10% sample of LTC admissions retrospectively according Administrative Code Chapter 10.
- Answer clinical and technical questions related to utilization management services and processes.
- Offer telephonic and onsite provider education.
- Provide review support resource accessibility on our webpage.



# What We Don't Do

We do not receive financial incentives  
to deny or limit services

# Presentation Objectives

The purpose of this training is to discuss:

- Qualis Health's role and responsibilities related to Long Term Care (LTC) retrospective reviews.
- Documents required to submit for retrospective reviews.
- Alabama Medicaid LTC New Admission, Readmission and Transfer Admission criteria.
- Briefly review Minimum Data Set(MDS).





# Qualis Health's Role

Our Alabama-based staff will retrospectively review records submitted by Alabama LTC facilities in order to determine medical necessity for Medicaid recipients.





# Important Points to understand regarding Alabama LTC Admission Criteria

- The principal aspect of covered care relates to the care rendered.
- The controlling factor in determining whether a person is receiving covered care is the medical supervision that the resident requires.
- Nursing facility care provides physician and nursing services on a continuing basis.



# Important Points to understand regarding Alabama LTC Admission Criteria Cont'd

- The nursing services are provided under the general supervision of a licensed registered nurse.
- It is mandatory that the physician state "I certify" need for admission by signing and dating the Form 161.
- Once the physician signs the Form 161, he is attesting to the certification date to be the Medicaid admission date on the first page of the Form 161.
- The physician signature can not be a stamped signature or a stand alone CRNP signature.



# Form 161

- The form 161 is on the Agency's website:
- Resources – Forms Library – Long Term Care Forms
- [http://medicaid.alabama.gov/documents/5.0\\_Resources/5.4\\_Forms\\_Library/5.4.3\\_LT\\_C\\_Services/5.4.3\\_LTC\\_Admission\\_&\\_Evaluation\\_Data\\_Form161\\_Revised\\_1-30-12.pdf](http://medicaid.alabama.gov/documents/5.0_Resources/5.4_Forms_Library/5.4.3_LT_C_Services/5.4.3_LTC_Admission_&_Evaluation_Data_Form161_Revised_1-30-12.pdf)



# Where to send requested documents

- The policy of Alabama Medicaid Agency (AMA) is to provide the opportunity to submit information timely. Administrative Code Rule Number 560-X-10-10.
  - Mail HP Long Term Care Records Cover Sheet, Form 161 and medical records to:  
HP Enterprise Services  
PO Box 244032  
Montgomery, AL 36124-4032



# Where to send requested documents

## Cont'd

- Information must be received within 10 working days from receipt of the series of faxed audit request letters  
*-Administrative Code Chapter 10, Rule 560-X-10-.07.*
- Send only what is being requested and not the entire medical record. Please send copies, and **not** original documents.
- Failure to send information timely may result in financial penalties of \$100.00 per day.
- If the information is not received timely, Qualis Health may proceed with the penalty process.
- **Please mail and do not fax the record.**



# Where to send requested documents Cont'd

## RECORDS MUST BE MAILED NOT FAXED

- These records will be scanned into the (FEITH) system by HP for access electronically.
- You **must** include a LTC coversheet to ensure that the records are added to the correct site electronically.
- Remember you must add the 13<sup>th</sup> digit unique identifier to the recipient ID. This 13<sup>th</sup> digit can be located on the members eligibility screen as the check digit.



# Where to send requested documents

## Cont'd

- The receipt date will be the date the information is received at HP with a complete and **CORRECT HP** cover sheet.
- If you have questions regarding the review, contact Qualis Health at **(888) 213-7576**.
- If you have questions regarding the medical records being received, contact HP at **(800) 688-7989**.





# New Admissions

- Must meet a minimum of two medical criteria as per the Administrative Code Rule Number 560-X-10-.10.
- **Exception:** Individuals admitted to a nursing facility in a spend down status for more than 30 days, must meet only one of the criteria to transfer from private pay to a Medicaid admission.



# Transfer Admissions

- Must meet a minimum of one medical criteria as per the Administrative Code Rule Number 560-X-10-.10.
- **Exceptions:** Must meet a minimum of two criteria as follows:
  - Transfers from out of state nursing facilities.
  - Transfers from Assisted Living Facility(ALF) or other non-Medicaid certified facilities.



# What Documents to submit for Review?

## Documents to submit for New Admissions and/or Transfers:

- Form 161 for the **requested Medicaid admission date, signed by the** physician and RN.
- Please ensure the Form 161 indicates the Medicare admission date, if applicable, and if the recipient was in a **spend down status. The date span of the spend down must be included on the Form 161.**
- Please ensure the Form 161 is complete in its entirety, including the NPI and Medicaid number. The Form 161 is now 3 pages, so ensure each page is complete, including the name, Medicaid number, and date at the top of each page.



# What Documents to submit for Review Cont'd

- Physician orders including medication list for the **requested Medicaid admission date.**
- OBRA Level I Screening and Level I Determination Letter.
- Clinical Review or Level II if appropriate.
- MDS - Please submit a fully completed Minimum Data Set (MDS). However, the entire MDS does not have to be submitted for a retrospective review. Only the section of the MDS which the facility deems necessary to establish medical need should be sent for a retrospective review.



# What Documents to submit for Review Cont'd

- If admitted from the hospital, please submit this information: Hospital History and Physical and/or Discharge Summary. Additionally, any nursing documentation at the time of the Medicaid admission.
- If criterion (G) or (K)9 is checked, supporting documentation of an unstable medical condition with acute illness and active treatment within the past 60 days must be attached.



# Readmissions

- Must meet a minimum of one medical criterion as per the Administrative Code Rule Number 560-X-10-.10.
- A readmission is a resident that has had no break in institutional care since discharge from a nursing home, and was previously a new **Medicaid** admission.



# What Documents to submit for Review

## **Documents to submit for Readmission:**

- Form 161 for the requested Medicaid admission date, signed by the physician and RN.
- Please ensure the Form 161 indicates the Medicare admission date, if applicable.
- Hospital History and Physical and or Discharge Summary.





# What Documents to submit for Review Cont'd

## **Documents to submit for Readmission Cont'd:**

- Physician orders including medication list for the requested Medicaid admission date.
- An updated OBRA Level I Screening and Determination letter if a significant change is identified.



# Brief Overview of Minimum Data Set (MDS) Requirement

- The MDS assessment identifies each resident's functional capabilities and health problems to assist in providing appropriate care.
- All residents in certified LTC facilities are assessed at admission and the assessment must be completed by the 14<sup>th</sup> day of the resident's stay.
- Three quarterly reviews and one full assessment are required within a 12 month period on an ongoing basis.



# Important Points

- Do not submit admission notifications to HP until medical and financial eligibility has been established.
- Form 161 should be completed in its entirety, signed by a RN and physician before submitting dates through the LTC notification software for claims processing.



# Overview of Criteria A-K

To locate the detailed information for Alabama Medicaid Criteria A-K go to [www.medicaid.alabama.gov](http://www.medicaid.alabama.gov), then click on Resources, then Administrative Code, then Chapter 10, Long Term Care.



# Review of Criterion A

Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment.

## **Tips for Discussion:**

- A diagnosis code must be present in the recipient's medical record to support the use of a medication. This documentation should support the name, frequency and the dosage of the injectable medication and/or IV medication. Also any solution and/or oral medication administered on a daily basis.

Examples: Lasix 40 mg IM everyday, Lasix 40 mg IV everyday, Lasix 40 mg by mouth every day



# Review of Criterion A Cont'd

- Medications ordered on a routine basis will be acceptable, such as QOD, 1X W, 1X Month.
- If the medication is an eye drop or some type of ointment, the frequency and dosage documented in the medical record should support administration on a daily basis.
- Ointments may be prescribed for ophthalmic conditions or skin conditions.



# Review of Criterion A Cont'd

- The facility must submit the physicians orders for the MEDICAID ADMISSION DATE.
- Criterion (A) and criterion (K)7 are the same as they both involve medication administration - **Only one may be used.** Therefore, if an individual meets criterion (A), criterion (K)7 may not be used as the second qualifying criterion.
- The medical record should support a diagnosis for each medication prescribed. Another example: if a multivitamin is prescribed, there should be a documented diagnosis such as anemia, malnutrition or malabsorption diagnosis.





# Review of Criterion A Cont'd

- If Aspirin (ASA), one by mouth-every day is prescribed, there should be documentation in the medical record, such as a history of Cerebral Vascular Accident (CVA) or Coronary Artery Disease (CAD) to support this medication.
- Medications administered through a gastrostomy tube will also be accepted.
- The list of medications can be written on the Form 161. If written on the Form 161, all other criteria apply, for example, the frequency, dosage, etc.



# Review of Criterion B

Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.

## **Tips for Discussion:**

- The medical record documentation must include:
- Must have Physician orders.



# Review of Criterion B Cont'd

- A documented diagnosis to support the need for restorative nursing.

For example: fracture to right hip, new CVA, etc. When this criterion is checked, the documentation must support restorative functioning such as the individual receiving PT, OT or ST.

- A minimum frequency of five times per week.
- The Preadmission Screening Process (PASRR) requires that persons seeking convalescent are to meet the minimum of 5x a week for OT/PT/ST.
- Therapy during Medicare and HMO days does not meet Medicaid criteria .
- Flow sheets to demonstrate frequency.



# Review of Criterion B Cont'd

- Remember the recipient must have restorative potential; therefore, range of motion is an indication of good nursing care and is not considered a restorative procedure.
- If bladder and bowel is the restorative procedure, there should be documentation to support restorative functioning.
- A routine check every two hours to see if the recipient is wet is not sufficient to meet this criterion.



# Review of Criterion C

Nasopharyngeal aspiration required for the maintenance of a clear airway

## Tips for Discussion:

- Must have a written physician's order to support this criterion.
- The medical record should support a diagnosis for the need of suctioning. For examples, CVA with dysphagia, cerebral palsy, closed head trauma, respiratory distress, etc.
- The medical record should include documentation and the assessment of the individual's bedside need that indicate the appropriate equipment is present to perform this procedure, such as a suction machine.



# Review of Criterion D

Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.

## Tips for Discussion:

- Documentation in the medical record should reflect the type of tube indwelling in the body. In order to maintain the tube there should be some type of treatment involved.

Example: Give Bolus feeding of Jevity every 4 hrs, Flush G-Tube with 120cc water every 4 hrs or Trach care every day, etc.



# Review of Criterion D Cont'd

- Cannot be counted as a second criterion if used in conjunction with criterion (K)3 if the ONLY stoma (opening) is a Gastrostomy or PEG tube.
- Cannot be counted as a second criterion if used in conjunction with criterion (K)4 if used for Colostomy and Ileostomy.
- Diagnosis such as tracheostomy will support this criterion.
- Use of **Foley catheter does not** support this criterion.
- Documentation must include a physician's order.





# Review of Criterion D Cont'd

- Other types of tubes that support this criterion may be related to patients receiving dialysis with an AV fistula.
- Additionally, recipients receiving chemotherapy who may have Groshong or Hickman catheters, etc.
- Remember, all of these tubes require treatment for maintenance for which there should be supporting documentation found in the medical record.
- The medical record must include a physician order for active treatment.



# Review of Criterion E

Administration of tube feedings by naso-gastric tube.

## **Tips for Discussion:**

- If a recipient has a naso-gastric tube for administration of feedings then the medical record should include a physician's order describing the type and amount of feedings, plus the frequency of tube changes.
- This criterion is for naso-gastric tubes only and not for gastrostomy tubes.



# Review of Criterion F

Care of Extensive Decubitus Ulcers or Other Widespread Skin Disorders.

## Tips for Discussion:

- The medical record should contain documentation to support the stage of the wound and the treatment being rendered. A Stage II decubitus or greater requiring active treatment or multiple Stage I sites would be considered as an extensive decubitus ulcer.
- As a rule if a recipient meets this criteria they may also meet Criterion I specifically if wound care is involved.



# Review of Criterion F Cont'd

- Other widespread skin disorders may include psoriasis, herpes or other skin related conditions.
- Submit the Treatment Administration Record (TAR) indicating treatment.
- Please also include a list of staging and treatment of pressure ulcers.
- Admission and Evaluation Data Form 161 must include supporting diagnosis such as multiple Stage II decubitus ulcers to sacral or buttocks.



# Review of Criterion G

Observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse.

## **Tips for Discussion:**

- For this criteria, AMA adopted the same criteria to define an unstable medical condition based upon Medicare guidelines.
- An unstable medical condition must contain information to support the condition and active treatment rendered in the last 30 to 60 days prior to admission.



# Review of Criterion G Cont'd

- In general, a person is considered to have a chronic condition when it has persisted for over six months and there have been no significant changes in the past 30 to 60 days. **This is not acceptable for this criterion.**
- Documentation must support an unstable medical condition such as medication changes, treatments related to abnormal labs, etc.



# Review of Criterion G Cont'd

- Dementia reviews require specific documentation which includes: description of the client's behavior, the level of care required for personal assistance, the nutritional status including weight loss and level of supervision required. Documentation in these areas gives an overall picture that reveals the necessity of care.
- Documentation is the key to support this criterion.



# Review of Criterion G Cont'd

- Criteria (G) and (K)9 are the same as they both involve directions by a registered nurse. Therefore, if an individual meets criterion (G), then criterion (K)9 cannot be used as the second qualifying criterion.





# Review of Criterion H

Use of oxygen on a regular or continuing basis.

## **Tips for Discussion:**

- The medical record should have a physician's order that document the flow and frequency for oxygen.
- The medical record should have a diagnosis supporting the need for the oxygen.
- The order for oxygen should be listed with the medications.
- PRN oxygen is not covered – consider if used continuously every night, all night then submit MAR showing regular use of PRN.



# Review of Criterion I

Application of dressing involving prescription medications and aseptic and/or changing of dressing in non-infected, postoperative or chronic conditions per physician's orders.

## **Tips for Discussion:**

- The medical record should include documentation of a wound and specific physician's orders for wound care.
- The physician's orders must include a dressing change.
- Documentation on the Admission and Evaluation Data Form 161 must include supporting diagnosis such as right total hip replacement or Stage II sacral decubitus.



# Review of Criterion J

Comatose resident receiving routine medical treatment.

## **Tips for Discussion:**

- The medical record should include documentation to support that the individual requires total care and is in a non-responsive comatose state.
- The recipient must meet medical criteria and be at risk for institutional care.



# Review of Criterion K

Assistance with at least one of the following activities on an ongoing basis.

## **Tips for Discussion:**

- Effective September 2011, Admission Criteria were revised to add criterion (K) to consolidate all ADL's under one criterion. Multiple items under (K) will only count as one criterion.
- Multiple criteria under (K) will only count as one criterion.
- The MDS assessment must be within the Medicaid Admission Date.
- If transitioning from Medicare to Medicaid, please submit nurses notes prior to the Medicaid admission date to support these criteria.



# Review of Criterion K Cont'd

1. Transfer - the individual is incapable of transfer to and from bed, chair or toilet unless physical assistance is provided by others on an ongoing basis (daily or multiple times per week).



# Review of Criterion K Cont'd

2. Mobility – The individual requires physical assistance from another person for mobility on an ongoing basis (daily or multiple times per week). Mobility is defined as the ability to walk, using mobility aids such as a walker, crutch or cane if required, or the ability to use a wheelchair if walking is not feasible. The need for a wheelchair, walker, crutch, cane or other mobility aid shall not by itself be considered to meet this requirement. The individual must have hands-on assistance from another person for mobility, in addition to the mobility aid(s). The individual cannot have mobility aids only and meet this item under criterion (k).



# Review of Criterion K Cont'd

3. Eating – The individual requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth. Food preparation, tray set-up and assistance in cutting up foods shall not be considered to meet this requirement.

**(K)3 cannot be counted as a second criterion if used in conjunction with criterion (D) if the ONLY stoma (opening) is a G tube or PEG tube.**



# Review of Criterion K Cont'd

4. Toileting – The individual requires physical assistance from another person to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care on an ongoing basis (daily or multiple times per week).

**Cannot be counted as a second criterion if used in conjunction with (D), if used for colostomy or ileostomy.**





# Review of Criterion K Cont'd

5. Expressive and Receptive Communication – The individual is incapable of reliably communicating basic needs and wants (e.g., need for assistance with toileting; presence of pain) using verbal or written language; or the individual is incapable of understanding and following very simple instructions and commands (e.g., how to perform or complete basic activities of daily living such as dressing or bathing) without continual staff intervention.



# Review of Criterion K Cont'd

6. Orientation – The individual is disoriented to person (e.g., fails to remember own name or recognize immediate family members) or is disoriented to place (e.g., does not know residence is a Nursing Facility).



# Review of Criterion K Cont'd

7. Medication Administration – The individual is not mentally or physically capable of self administering prescribed medications despite the availability of limited assistance from another person. Limited assistance includes, but is not limited to, reminding when to take medications, encouragement to take, reading medication labels, opening bottles, handing to individual and reassurance of the correct dose. (Cannot be counted as a second criterion if used in conjunction with criterion **A**.)



# Review of Criterion K Cont'd

8. Behavior – The individual requires persistent staff intervention due to an established and persistent pattern of dementia-related behavioral problems (e.g., aggressive physical behavior, disrobing or repetitive elopement attempts).
9. Skilled Nursing or Rehabilitative Services – The individual requires daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than, for practical purposes, would be provided through a daily home health visit. Cannot be counted as a second criterion if used in conjunction with criterion **G**.



# Review of Criterion K Cont'd

- If an individual meets one or more ADL deficits within criterion (K), they must also meet an additional criterion in (A) through (J), accompanied by supporting documentation as is currently required. Multiple items met under (K) will count as only one criterion.
- Criteria (A) and (K)7 are the same as they each involve Medication Administration. Therefore, if an individual meets criterion (A), then criterion (K)7 cannot be used as the second qualifying criterion.



# Review of Criterion K Cont'd

- Criteria (G) and (K)9 are the same as they both require direction by a Registered Nurse. Therefore, if an individual meets criterion (G), then criterion (K)9 cannot be used as the second qualifying criterion.
- Criterion (K) should reflect the individual's capabilities on an ongoing basis and not isolated, exceptional or infrequent limitations of function in a generally independent individual who is able to function with minimal supervision or assistance.
- **Multiple criteria selected under (K) will count as one criterion.**



# Team Approach Enhances Care



# Thank you for your participation! Any Questions?

Again, thank you for your participation in today's training presentation. In order to gauge the effectiveness and value of this meeting, will you please take a few minutes to complete the very brief survey.

<https://www.surveymonkey.com/s/MDJSH6L>





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## Alabama Medicaid Agency

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Our work advances healthcare and improves health for people in Alabama through our expertise in utilization management and quality review. From our Birmingham office, we collaborate with the Alabama Medicaid Agency (AMA). Our staff is composed of Alabamians who provide services within their own community to support the needs of Alabama residents. We are privileged to provide this vital work for the state of Alabama.

### Services We Provide for the AMA

Our current work in Alabama includes medical and quality review for the AMA for the following healthcare services, equipment and supplies provided to Medicaid recipients:

- Hospice reviews, including admission and concurrent review
- Institutional admission review, including review of nursing homes, post-extended care, swing beds and inpatient psychiatric facilities
- Prior authorization review, including review of durable medical equipment, home health, transportation, occupational and physical therapy, surgical procedures and inpatient and outpatient hospital services
- Appeal review, including informal review and fair hearings

### Announcements

- Training presentation: Institutional Review Record Request (October 2011)
- Download the current AMA Provider Manual
- AMA News and Notices

### Contact Us

Phone:  
(888) 213-7576

Fax:  
(888) 213-8548

### Contact the Alabama Medicaid Agency

Medicaid Providers Helpline:  
(800) 688-7989

[»visit the AMA website](#)

[»more contact info](#)



# Conclusion

In conclusion we have discussed the following objectives:

- Qualis Health's role and responsibilities related to LTC Retrospective reviews.
- Documents required to submit for retrospective reviews.
- Alabama Medicaid LTC New Admission, Readmission, and Transfer Admission criteria.
- Documents to submit for LTC Retrospective reviews.
- Minimum Data Set requirements.

