

**NEW YORK STATE
MEDICAID PROGRAM**

RESIDENTIAL HEALTH SERVICES

POLICY GUIDELINES

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Section I - Requirements for Participation in Medicaid

In-State Facility Care

To participate in the Medicaid Program, a skilled nursing facility (SNF) or a health related facility (HRF) must hold a current operating certificate issued by the State Department of Health (DOH) under Article 28 of the Public Health Law.

The facility must also be certified to participate in Title 18 of the Federal Social Security Act and have a current effective provider agreement with the DOH.

Out-of-State Facility Care

An out-of-state SNF/HRF rendering care to a New York State Medicaid beneficiary must comply with applicable licensing or approval requirements established by the officially designated standard-setting authority in the state where the care is received.

The facility must also be certified to participate in Title 18 of the Federal Social Security Act and meet the Federal requirements under Title 19. The SNF/HRF must also have a current provider agreement with the respective Title 19 state agency in its own state.

Certain out-of-state facilities have been assigned enhanced rates to provide rehabilitation services to New York State Medicaid beneficiaries with Traumatic Brain Injury or other significant behavioral or developmental issues. Two levels of care, High Level and Special Level, are subject to prior approval.

Treatment of Medicaid Beneficiaries

In accordance with Federal and State regulations, each SNF/HRF must, in consultation with Medicaid beneficiaries, establish written policies regarding rights and responsibilities.

These policies must be given to beneficiaries or their guardians, next of kin, sponsoring agency or agencies or lawful representative and each member of the facility's staff and must be made available to the public and posted conspicuously in a public place in the facility.

Facility staff must be trained and involved in the implementation of these policies and accompanying procedures.

The facility's policies must ensure that each Medicaid beneficiary is:

- Fully informed, as evidenced by a written acknowledgment, of his/her rights prior to or upon admission and during his/her stay;
- Given a statement of the facility's rules and regulations along with an explanation of his responsibility to observe all reasonable regulations of the facility and to respect the personal rights and private property of other residents;

- Fully informed and given a written statement prior to or upon admission and during stay:
 - of services available in the facility, and
 - of related charges for services not covered by sources of third-party payments and not covered by the facility's basic per diem rate;
- Assured of adequate and appropriate medical care and fully informed by a physician of his/her medical condition unless medically contraindicated (as documented, by a physician, in his/her record), afforded the opportunity to participate in the planning of his/her medical treatment, to refuse to participate in experimental research, and to refuse medication and treatment after being fully informed of and understanding the consequences of such actions;
- Discharged only for medical reasons, for his/her welfare and that of other patients, or for non-payment of his/her stay (except as prohibited by sources of third-party payment), given reasonable advance notice to ensure orderly discharge, and (as is his/her representative) provided an interpretation of the content of his/her medical record by a physician of his/her choosing in instances where adverse utilization review continued stay decisions are pending and such actions are documented in his/her medical record;
- Encouraged and assisted, throughout his/her period of stay, to exercise his/her rights as a resident and citizen including to this end:
 - the right to voice grievances,
 - the right of action for damages or order relief for deprivations or infringements of his/her right to adequate and proper treatment and care established by any applicable statutes, rules and regulations, or contract, and
 - the right to recommend changes in policies and services to facility staff and/or to outside representatives of his/her choice, free from restraint, interference, coercion, discrimination, or reprisal
- Free to manage his/her personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his/her behalf, if the facility has accepted his/her written delegation of this responsibility to the facility for any period of time in conformance with State law;
- Assured security in storing personal possessions and confidential treatment of his/her personal and medical records with the right to approve or refuse their release to any individual outside the facility, except in the case of transfer to another health care institution, or as required by law or third-party payment contract;
- Treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs;

- Not required to perform services for the facility that are not included for therapeutic purposes in his/her plan of care;
- Able to associate and communicate privately with persons of his/her choice, to join other individuals within or outside of the facility to work for improvements in resident care, and to send and receive personal mail unopened, unless medically contraindicated (as documented by his/her physician in his/her medical record);
- Able to meet with, and participate in activities of social, religious, and community groups at his/her discretion, unless medically contraindicated (as documented by his/her physician in his/her medical record);
- Able to retain and use his/her personal clothing and possessions as space permits, unless to do so would infringe upon the rights of other residents, and unless medically contraindicated (as documented by his/her physician in his/her medical record);
- If married, assured privacy for visits by his/her spouse. If both are residents in the facility, they are permitted to share a room, unless medically contraindicated (as documented by the attending physician in the medical record); and
- Assured of exercising his/her civil and religious liberties including the right to independent personal decisions and knowledge of available choices with the facility's encouragement and assistance in the fullest possible exercise of these rights.

Restraints

A Medicaid beneficiary must be free from mental and physical abuse and from chemical and physical restraints except those:

- authorized in writing by a physician for a specified and limited period of time,
- necessary to protect the resident from injury to himself/herself or to others, and/or
- necessitated by an emergency.

In the case of an emergency, restraint may only be applied by a licensed nurse who shall set forth in writing the circumstances requiring the use of restraint, with a physician consulted within 24 hours if any chemical restraint is used.

Utilization Review

Each facility must have a utilization review (UR) plan developed and implemented in accordance with regulations and standards of the DOH.

DOH guidelines at [Title 10, Section 455.0](#) outline requirements for the composition of the UR Committee, medical care evaluation studies, admission and continued stay reviews, and discharge planning. By complying with DOH requirements, a facility will also meet Federal UR standards for the Medicaid Program.

Title 10 guidelines are available online at:

<http://www.health.state.ny.us/nysdoh/phforum/nycrr10.htm>.

If a facility is certified to provide both SNF and HRF care at the same location, that facility may adopt SNF UR requirements for use in the HRF in order to operate a single UR program throughout the facility.

Independent Professional Review

This program is an annual review of the care rendered to Medicaid beneficiaries of all residential health care facilities in New York State which is being conducted on a demonstration basis in New York State to test a new method to evaluate quality of care.

Periodic Medical Reviews

This program is an annual review of the care rendered to patients/residents in all residential health care facilities in New York State which is currently being conducted on a demonstration basis in New York State to test a new method to evaluate quality of care.

Non-Occupant Care Programs Registrant Review Plan

In order to periodically assess the total needs of each registrant and to plan for the individual's future care, the operator must provide, or arrange for, a written registrant review and evaluation plan.

Such review must include, but is not be limited to, review of:

- The appropriateness of the registrant's placement in the program;
- The necessity and suitability of professional and other services provided;
- The potential for discharging registrants to more appropriate levels of care; and
- The efficient use of the facility's registrant care program in relation to the use of other health facilities and services in or near the community.

Registrant reviews must include review and evaluation no less than yearly and more often as indicated by changes in the conditions or circumstances of the registrant, for all registrants who receive Medicaid benefits.

The review and evaluation of registrant services must be conducted in part by a review committee. The committee must be composed of:

- one or more licensed physicians other than one professionally involved in the care of the specific registrant being reviewed;
- representatives of other health professions participating in the registrant services program; and

- other professional personnel, including but not limited to health and social service personnel.

The SNF's UR plan for inpatient care that has been approved by the DOH Office of Health Systems Management will satisfy requirements for review of the non-occupant population. The SNF must integrate its general review patterns and policies for inpatient and non-occupant populations.

Record Keeping Requirements

A SNF/HRF is required to meet the general record-keeping requirements outlined in this manual and the New York Health Code, as well as Federal Medicare Standards.

In accordance with Federal regulations, records must be adequately safeguarded against loss, unauthorized use, or destruction. Additionally, the facility must have in effect written policies which govern access to duplication and dissemination of information from resident records.

All information concerning the resident's current medical condition and needs must be available for review by the Local Professional Director (or the Commissioner's Designee, if applicable). This assures the Director's or the Designee's ability to make informed decisions on the resident's need for continued care.

Long Term Care Patient Assessment Forms

Each SNF/HRF must keep completed *Long Term Care Patient Assessment Forms (DMS-1)* on file for review by facility staff involved with patient care, DOH Personnel and other authorized individuals.

The patient's current *Form* should be kept on his/her medical chart.

It is recommended that a permanent file of the patient's *Form* be maintained separately from his/her medical record.

If properly completed and scored *DMS-1* forms are not maintained by the facility in support of Medicaid claims, Medicaid payments may be affected.

Non-Occupant Care Programs

Each SNF which operates a non-occupant care program must maintain a health record for each registrant. Entries in that record must be current with all health reports and information pertaining to registrant care and planning promptly entered, dated, and signed by the individual providing the information or prescribing the service. It should be kept in a place convenient for use by authorized staff.

Facilities must record and report reserved bed days and overnight absences on all financial and statistical reports which call for patient day information.

Records, adequate to enable Federal and State auditors to verify the number and nature of reservations must be available to such auditors and other authorized officials.

SNF must initiate and maintain a *Medicaid Patient/Resident Absence Register (DSS-2818)* for each Medicaid patient who is absent overnight (i.e., beyond the facility's normal census taking hour).

All overnight absences must be recorded in the *Register* with an annotation made as to whether the patient's bed was reserved.

When a Medicaid beneficiary is a patient in more than one medical institution within any 12-month period, it is the responsibility of the new facility to determine the number of leave of absence days that have been allowed for payments by the previous facility/facilities during the previous 12-month period, so that the total authorized number of leave days does not exceed 18 (unless an exception to the 18-day limitation has been granted).

If a beneficiary is discharged to another medical inpatient facility, a copy of his *Absence Register* must be included in his discharge records.

The *Medicaid Patient/Resident Absence Register* must be used as a source document to prepare billings submitted for bed reservation fees.

SNF must enter prior approval number on the Claim Form when requesting reimbursement for which prior approval is necessary.

Section II – Residential Health Services

In accordance with requirements outlined in the New York State Health Code for basic services to be provided to all nursing home patients, Medicaid nursing home patients are to be provided a full range of services including, but not limited to:

- board, including therapeutic or modified diets prescribed by a physician;
- lodging, a clean, healthful, sheltered environment, properly outfitted;
- around-the-clock 24-hour-per-day nursing care;
- the use of all equipment, medical supplies and modalities notwithstanding the quantity usually used in everyday care of nursing home patients, including but not limited to catheters, hypodermic syringes and needles, irrigation outfits, dressings and pads, and so forth;
- fresh bed linen, as required, changed at least twice weekly, including sufficient quantities of necessary bed linen or appropriate substitutes changed as often as required for incontinent patients;
- hospital gowns or pajamas as required by the clinical condition of the patient, unless the patient, next of kin or sponsor elects to furnish them, and laundry services for these and other launderable personal clothing items;
- general household medicine chest supplies, including but not limited to non-prescription medications, materials for routine skin care, oral hygiene, care of hair, and so forth;
- assistance and/or supervision, when required, with activities of daily living, including but not limited to toilet, bathing, feeding, and ambulation assistance;
- services, in the daily performance of their assigned duties, by members of the nursing home staff concerned with patient care;
- use of customarily stocked equipment, including but not limited to crutches, walkers, wheelchairs, or other supportive equipment, including training in their use when necessary, unless such item is custom-made, i.e., fabricated solely for a specific patient from mainly raw materials which cannot be readily changed to conform to another patient's needs;
- activities programs including but not limited to a planned schedule of diverse, meaningful activities to meet the needs and interests of each patient together with the necessary equipment and supplies;
- physical therapy, on either a staff or contract basis, as prescribed by a physician, administered by or under the direct supervision of a licensed and currently registered physical therapist;

- occupational therapy, on either a staff or contract basis, as prescribed by a physician, administered by or under the supervision of a qualified occupational therapist;
- speech-language pathology services, on either a staff or contract basis, as prescribed by a physician, administered by a qualified speech pathologist;
- replacement of lost dentures. A facility is generally not liable for the cost of replacement except when the dentures had been accepted from the Recipient for safekeeping or in cases of negligence on the part of the facility.

In instances where dentures are lost, an appropriate staff member should prepare a recommendation that the dentures be replaced, including an explanation of how the dentures were actually lost. This statement should be submitted to the Local Professional Director who will determine whether this will be covered under Medicaid;

- prescription drugs.

Physical therapy, occupational therapy and speech-language pathology services provided to Medicaid patients in an out-of-state SNF, which does not include these services in their rate, may be billed to the Medicaid Program on a fee-for-service basis.

Physician Services

In accordance with requirements of the New York State Health Code, each resident must be cared for by a physician who visits that patient at least once every 30 days and more often when medically indicated or at the number of days specified in an alternate schedule of patient visits approved by the utilization review committee.

Physician Certification for HRF Care

In accordance with Federal law and regulation, each resident's attending physician must certify, *at admission and at least every 60 days thereafter*, the resident's need for HRF care.

Physician Services for HRF

Each resident must be cared for by a physician as needed and in no case less often than once every 60 days, unless justified otherwise and documented by the attending physician.

Emergency medical care must be provided by the medical staff of the HRF pending the visit and orders of the personal physician or his alternate.

Unless medically contraindicated, each resident is to be fully informed of and permitted to participate in the planning of his care plan. The medical rationale underlying a physician's decision not to inform a resident of his condition must be noted in the resident's record.

Nursing Services

Nursing services must be provided by the facility in accordance with the resident's needs. Restorative nursing care provided to each patient shall attempt to achieve and maintain the highest possible degree of function, self-care, and independence.

Each HRF's health services are to be under the immediate supervision on all days of each week by a registered professional nurse (RN) or licensed practical nurse (LPN) employed full time on the day shift and currently licensed in New York State.

When a LPN serves as supervisor of health services:

- Consultation must be provided by a RN, through formal contact, at regular intervals, but not less than four hours weekly, and
- The licensure must have been obtained by taking the regular licensing examination in New York State or if licensed initially in another state, received licensure in New York State on the basis of the other state's examination.

Medication

Medications administered to a patient must be ordered in writing or verbally by the individual's personal or staff physician. Verbal orders for prescription drugs may be given only to a licensed nurse, pharmacist, or physician.

All verbal orders for medication must be immediately recorded and signed by the person receiving them and countersigned by the attending physician in a manner consistent with good medical practice.

Self-administration of medication is permitted only with the written approval of the resident's attending physician. Facility personnel who administer medications must have passed a State approved program in medication administration.

The resident's medication must be reviewed monthly by a registered nurse who will notify the physician when changes are appropriate. The attending or staff physician must review the resident's medication every 90 days.

In accordance with the facility's written standards, medications not specifically limited as to time or number of doses when ordered are to be controlled by automatic stop orders or other methods. The attending physician must be notified of an automatic stop on medication.

Prescriptions and Orders

Each medication, treatment, dietary or other order written by the resident's physician must be provided only for the number of hours or days specified in the written order and, in no event, for more than 30 days or the number of days in an alternate schedule of resident visits approved by the utilization review committee at the end of which time each new order intended to be continued must be written in the resident's record by the person issuing such order.

Prescription Drugs

All New York State residential health care facilities have included in their Medicaid rates prescription drugs, non-prescription drugs and medical/surgical supplies. Residential health care facilities may:

- operate an institutional pharmacy to provide these items; or
- contract with Medicaid enrolled community pharmacies to provide these items to Medicaid residents. The pharmacy must be reimbursed by the facility for these items.

Residential health care facilities with inclusive Medicaid rates for drugs and supplies may dispense these items to Medicaid residents regardless of the refill, quantity, and prior authorization/approval limitations described in this Manual.

Only drugs specifically carved out of the Medicaid all-inclusive rate may be billed directly to the Medicaid Program. Drugs carved out and billed directly to Medicaid are subject to refill, quantity and prior authorization/approval requirements as described in this Manual. The *Medicaid Nursing Home/Child (Foster) Care Drug Carveout List* may be accessed at:

http://www.nyhealth.gov/health_care/medicaid/program/docs/carveout.pdf.

Out-of-state residential health care facilities may or may not include prescription drugs, non-prescription drugs and medical/surgical supplies in their rates.

Residents with both Medicare and Medicaid (dual-eligibles) who have met their residency requirements in a residential health care facility will receive their prescription drug coverage from their Medicare Part D Plan.

Additional information regarding the Medicare Part D Prescription Drug Program and residential health care facilities may be accessed at:

http://www.health.state.ny.us/health_care/medicaid/program/update/2006/jun2006spec.htm.

Non-Prescription Drugs, Medical/Surgical Supplies and Medical Equipment

A SNF/HRF is required to provide residents with non-prescription drugs, medical/surgical supplies, and general standard and customized medical equipment.

Pharmaceutical services for residents are to be provided and monitored in accordance with the requirements set forth in the New York State Health Code. Such requirements include:

- implementation of written SNF/HRF policies, and
- procedures and methods for obtaining, dispensing, storing and administering medications and biologicals in accordance with accepted professional practices

developed with the advice of a pharmaceutical services committee consisting of the medical director or consultant physician, the staff or consultant pharmacist and the director of nursing.

Specific items may be ordered for a resident by his/her attending physician when medically indicated and prescribed for the sole use of that resident.

Freedom of Choice

When an Out-of-State SNF/HRF does not include drugs in its all-inclusive rate, a resident is free to choose from among qualified pharmacies who participate in the NYS Medicaid Program.

If the facility has an agreement to obtain all of its drugs from a community pharmacy, each resident in the facility must be given the choice of whether or not he/she wishes to have that particular pharmacy provide his drugs.

A resident may choose not to obtain his/her drugs from the pharmacy which the SNF has chosen.

It is understood that a resident in a SNF/HRF which includes drugs in its all-inclusive rate has, in making the choice of facility, also chosen the pharmacy.

Prescribing and Dispensing Limitations for an Out-of-State SNF/HRF

In an Out-of-State SNF or HRF which does not include drugs in its all-inclusive rate and which provides for inpatient drugs through arrangement with community pharmacies, the following policies apply:

Situations Where Medicaid Reimbursement is Not Available

- Amphetamine and amphetamine-like drugs which are used for the treatment of obesity;
- Drugs whose sole clinical use is the reduction of weight;
- Any drug regularly supplied to the general public free of charge;
- Any drug not included on the [NYS List of Medicaid Reimbursable Drugs](#) unless provided by a facility which includes the cost of drugs in its rate;
- Any item stamped or preprinted on a prescription;
- Any item on a prescription or claim form bearing a stamped signature of a prescriber or pharmacist;
- Any item marked "sample" or "not for sale," etc.;
- Contrast agents, etc., used for radiological testing (these are included in the radiologist's fee), except for Iopanoic Acid; and

- Any legend drug which does not have a National Drug Code.

Drugs Requiring Prior Approval

Certain drugs obtained for residents in SNF's/HRF's through community pharmacies must be prior approved by the Local Professional Director. Without such approval, Medicaid will not cover these drugs.

The **prescriber** must obtain prior approval before writing prescriptions and/or Fiscal orders for the following:

- All food supplements or food substitutes including infant food;
- All amphetamine and amphetamine-like drugs, their salts, and combinations containing them;
- More than a fourteen day supply of any antibiotic;
- Repeated prescriptions for small quantities of Class II Controlled Substances (other than codeine);
- Codeine, or its compounds, for more than 100 doses;
- All injectables except insulin and epinephrine;
- Methadone;
- Secobarbital;
- Pentobarbital; and
- Sera, vaccines, and biologicals other than insulin;
- All non-prescription vitamins except when ordered as medically appropriate for pregnant or lactating women, children up to and including age 6, adults age 65 and older, or renal dialysis patients.

Please consult the [New York State List of Medicaid Reimbursable Drugs](#) for applicable quantities.

Unused Medication

Nursing home pharmacy services providers are required to reimburse or credit the nursing home or purchaser of such drug products for the unused medication that is restocked and redispensed (Title 10 New York Codes, Rules and Regulation (NYCRR) 415.18(f)).

Drugs listed on the [Medicaid Nursing Home Carve-Out List](#) must be credited back to the Medicaid Program.

Nursing homes and pharmacies providing pharmacy services to nursing homes are encouraged to review their protocols to assure these requirements are met:

- Drug products returned must be sealed in unopened, individually packaged, units and within the recommended period of shelf life for the purpose of redispensing.
- Drug products returned should show no obvious sign of deterioration.
- Drug products packaged in manufacturer's unit-dose packages may be returned provided that they are redispensed in time for use before the expiration date, if any, indicated on the package.

Drug products repackaged by the pharmacy into unit-dose or multiple-dose "blister packs" may be returned for redispensing provided that:

- The date on which the drug product was repackaged, its lot number and expiration date are indicated clearly on the package;
- Not more than 90 days have elapsed from the date of the repackaging;
- A repackaging log is maintained by the pharmacy;
- Partially used blister packs may be redispensed only as returned.
- Partially used blister packs may not be emptied and repackaged.
- Additional units of medication may not be added to partially used blister packs.
- No drug product dispensed in bulk in a dispensing container may be returned.
- No medication or drug product defined as a controlled substance in Section 3306 of the Public Health Law may be returned.

The vendor pharmacy to which such drug products are returned shall reimburse or credit the nursing home or purchaser of such drug products for the unused medication that is restocked and redispensed and shall not otherwise charge any individual resident or the State, if a resident is a recipient or beneficiary of a State-funded program, for unused medication or drug products returned for reimbursement or credit.

Non-Occupant Care

A SNF/HRF may provide day care to outpatients who, because of social, physical or mental conditions, require certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services but who do not require continuous 24-hour inpatient care.

Residential health care facilities may be certified by the DOH to provide registrants with non-occupant care. Such care includes:

- Clinic visits defined as care on an occasion of service of less than three hours duration; or
- Part day care, defined as clinic care extending for more than three hours, but less than five hours; or

- Full day care, defined as clinic care extending for more than five hours, but less than 24 hours; or
- Evening care, defined as clinic care provided after 5 p.m. but not including an overnight stay; or
- Night care, defined as clinic care for less than 24 hours in a day in a residential health care facility and including, as a minimum, an overnight stay in the facility.

The facility may arrange for indirect or direct provision of the following services to registrants:

- Medical services including admission and medical history, physical examinations, consultations by medical specialists when needed, and necessary orders for medication, diet, physical therapy, occupational therapy, and supportive services;
- Nursing services, under the direct supervision of a registered professional nurse, based on periodic and continuing evaluations of each registrant's need for nursing care;
- Dental care, services provided in accordance with State guidelines for dental care for inpatients of residential health care facilities;
- Rehabilitation therapy and speech-language pathology services, including the arrangement of transportation to an approved facility in the event that the skilled nursing facility does not provide these services;
- Pharmaceutical services, with supervision in taking prescribed drugs and in administering medication, as appropriate;
- Supportive services, including laboratory, X-ray, and other services provided by the skilled nursing facility or through an arrangement with an approved agency.

Registrant Care Plan

The non-occupant care program must provide for the establishment of a written comprehensive plan of care for each registrant within 30 days after registration. That plan must summarize:

- The medical, psychiatric, social, emotional, and related goals and limitations anticipated for the registrant;
- The registrant's potential for remaining in the community, for achieving or maintaining his most obtainable level of functioning by registration in the program, or for referral or transfer to another more appropriate setting;
- The forms of medical, social, health maintenance, and other services required to achieve the anticipated goals; and

- The frequency of periodic physician visits on the premises, in the registrant's home, in the physician's office, or other appropriate sites when such visits are deemed necessary by the physician.

Non-occupant care program operators should note DOH services and items require prior approval whenever the services/items are not covered by the program's Medicaid rate. Prior approval requirements are listed in the applicable Provider Manual, available online at:

<http://www.emedny.org/ProviderManuals/index.html>.

General Admissions Restrictions

The provision of SNF services will be restricted for the following:

- Patients under 16 years of age must be admitted to a facility approved for such occupancy by the DOH and must be lodged separately and apart from adult patients;
- Prenatal, intrapartum or postpartum, and maternity patients cannot be admitted;
- Patients who manifest such degree of behavioral disorder that they are dangerous to themselves or others, or whose behavior is so unacceptable or disturbing to interfere with the adequate care or comfort of other patients, cannot be admitted or retained;
- Patients suffering from narcotic or alcohol addiction or habituation to depressant or stimulant drugs cannot be admitted or retained in the SNF unless such patients suffer from other illnesses for which such drugs have been prescribed by their physicians; and
- Patients suffering from a communicable disease must not be admitted or retained unless a physician certifies in writing that transmissibility is negligible, except in certain facilities (acceptable to the DOH) which are appropriately staffed and equipped to manage such cases.

Medical Eligibility Reviews for Placement of Patients

The following procedural requirements must be met in order to determine the medical eligibility of currently eligible Medicaid Recipients for placement into a SNF or HRF, as well as any patient identified to be in need of Medicaid financial eligibility review.

Community Based Patients

Level of care approval and certification by the Local Professional Director must be obtained before a Medicaid beneficiary or potential Medicaid beneficiary can be placed in a SNF/HRF directly from the community.

A DOH *Long Term Care Placement Form-Medical Assessment Abstract* (hereafter referred to as *DMS-1*) or an equivalent patient assessment form approved by the

Department must be properly completed and scored. It must be signed by a physician or registered nurse. The completed *DMS-1* must then be submitted to the Local Professional Director (or Commissioner's Designee, where applicable) for level of care approval.

In no instance can the patient be admitted to a SNF/HRF directly from the community without the approval of the Local Professional Director (or the Commissioner's Designee, where applicable).

The party which has referred the patient to the SNF/HRF will receive from the Director (or Commissioner's Designee), a *Local Medical Director Determination/Decision of Medical Eligibility* Form (hereafter referred to as *DMS-4*), which indicates the level of care decision. The *DMS-4* approval, the *DMS-1* assessment and other appropriate medical information must be presented to the admitting SNF/HRF.

Level of Care Approval for Community Based Recipients

Prior approval (pre-admission certification) of level of care for community based patients expires 90 days following the *DMS-1* assessment date unless appropriate placement is made within that 90 day period. If placement is not accomplished within 90 days of assessment, a new *DMS-1* assessment and prior approval is required.

Within five days of admission to a SNF/HRF, the admitting facility must complete a *DMS-1* patient assessment to verify the appropriateness of the placement. This five-day (post-admission) *DMS-1*, as well as all other *DMS-1* assessments, must be maintained as part of the patients' records.

Because pre-admission certification of the appropriateness of SNF/HRF placement will have already been issued, further *DMS-1* review and *DMS-4* approval by the Local Professional Director is not required.

Community Alternative Systems Agencies (CASAs) that have been specifically designated to function as the DOH Commissioner's Designee will issue additional, local instructions and procedures for medical eligibility review as necessary.

Hospitalized Patients Admitted to a SNF or a HRF

When a Medicaid beneficiary or potential Medicaid beneficiary is to be admitted to a SNF or to a HRF from a hospital, the discharging facility's discharge planning unit must initiate completion and scoring of a *DMS-1*. In addition, where established CASA procedures relating to hospital discharge of Medicaid patients are in effect, CASA procedures must also be followed.

As a prerequisite for final payment by Medicaid, SNFs are required to apply for and fully utilize Medicare benefits on behalf of Medicaid eligible patients who are eligible for, or reasonably appear to meet, the criteria of eligibility of Medicare.

A Medicaid patient can be **discharged to a SNF** if the following conditions are met:

- The form's total score is equal to or greater than 180 and alternate care placement certification by the individual's attending physician concurs with SNF placement; or
- The score is less than 180 and a physician from the discharging facility's UR Agent and the patient's attending physician certify the need for SNF placement based on their evaluation of the patient's placement needs, including psychosocial needs. The UR physician's certification must be noted on the form or on an attachment to the form where applicable.

When a Medicaid beneficiary or potential Medicaid beneficiary is to be **admitted to a HRF** from a hospital, the discharging facility's discharge planning unit must initiate completion and scoring of a *DMS-1*. Additionally, where established CASA procedures relating to hospital discharge of Medicaid beneficiaries are in effect, CASA procedures must also be followed.

A patient can be **admitted to a HRF** if the following conditions are met:

- The form's total score is equal to or greater than 60 and less than 180, and alternate care placement certification by the individual's attending physician concurs with HRF placement; or
- The form's score is less than 60 or greater than 180, and a physician from the discharging facility's UR Agent and the Recipient's attending physician certify the need for HRF placement based on their evaluation of the Recipient's placement needs, including psychosocial needs. The UR physician's certification must be noted on the form or on an attachment to that form, where applicable.

The discharging facility must send the admitting facility the completed *DMS-1*, as well as the patient's discharge summary. The *DMS-1* serves as documentation that the discharge to another facility is both necessary and appropriate.

The discharging facility's *DMS-1* determination is accepted for Medicaid payment purposes as admission certification to the new facility pending post-admission certification by the Local Professional Director, except where prior approval (pre-admission certification) procedures for RHCF placement have been established (e.g., specifically designated CASA or other Commissioner of Health Designee). Where such prior approval procedures are established, the prior approval (*DMS-4* determination or approved equivalent) will serve as both pre-admission and post-admission level of care certification, and a five-day post-admission *DMS-1* review and certification by the Local Professional Director is not required. In all cases however, the SNF admitting the patient must complete and score a *DMS-1* within five days of admission.

Where no prior approval procedures have been established, the five-day, post-admission *DMS-1* must be submitted to the Local Professional Director (or

Commissioner's Designee, where applicable, e.g., CASA) in order to obtain post-admission certification (*DMS-4* approval).

If it is determined by the admitting SNF/HRF that the patient requires a different level of care, appropriate alternate care placement procedures should be initiated.

Patient's Return from a Hospital

In certain instances, a patient may have to be discharged from a SNF or HRF and admitted to a hospital for acute care. When the patient returns to the original SNF/HRF in which he/she was a resident after a short period of hospitalization (20 days or less), the readmitting SNF/HRF can accept the patient from the hospital without receiving a completed and scored *DMS-1* from the hospital; however, the hospital must contact the SNF/HRF prior to the patient's discharge to provide the facility with a discharge summary of the patient's current condition and medical needs. In turn, the SNF/HRF must follow the aforementioned procedures of an admitting SNF dealing with completion of the *DMS-1*.

When the patient returns after a longer period of hospitalization (more than 20 days), admission/readmission of the patient to the original SNF/HRF or another facility requires admission certification by the discharging hospital, completion of a *DMS-1* by the admitting SNF within five days of admission/readmission, and optimization of Medicare benefits.

If, following hospitalization, the patient is readmitted to the same SNF/HRF at the same level of care (as occupied immediately prior to hospitalization) and was previously approved by the Local Professional Director (or designee), the previously issued *DMS-4* approval will serve as post-admission level of care certification; further review and approval by the Local Professional Director is not required. The admitting SNF/HRF must, however, complete and score a *DMS-1* within five days of admission, and maintain such assessment as part of the patient record.

If, following hospitalization, the patient is admitted to a RHCF or level of care different than that which he/she occupied immediately prior to hospitalization, the five-day (post-admission) *DMS-1* must be submitted to the Local Professional Director (or Commissioner's Designee) for (*DMS-4*) approval.

Patients Admitted From Other Residential Health Care Facilities to a SNF of a HRF

When a Medicaid beneficiary or potential Medicaid beneficiary is to be admitted to a SNF level of care from another residential health care facility, a *DMS-1* must be initiated and scored by the transferring facility's discharge planning unit.

A SNF may admit a patient who is to be discharged from a HRF or from another SNF if:

- The *Form's* total score is equal to or greater than 180 and alternate care placement certification by the individual's attending physician concurs with the SNF placement; or
- The score is less than 180 but a physician from the transferring facility's UR Agent and the individual's attending physician certify the need for SNF placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the form or on an attachment to that form where applicable.

When a Medicaid beneficiary or potential Medicaid beneficiary is to be admitted to a HRF level of care from another residential health care facility, a *DMS-1* must be initiated and scored by the discharging facility's discharge planning unit.

A HRF may admit a patient who is to be discharged from a SNF level of care or from another HRF if:

- The *Form's* total score is equal to or greater than 60 and alternate care placement certification by the individual's attending physician concurs with the HRF placement; or
- The score is less than 60 or greater than 180 and a physician from the discharging facility's UR Agent and the individual's attending physician certify the need for placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the form or on an attachment to that form, where applicable.

The admitting facility must receive from the discharging facility the completed *DMS-1*, and other appropriate transfer information. This information will serve as documentation that the admission to another facility is both necessary and appropriate. The discharging facility's determination is accepted for Medicaid payment purposes as admission certification to the new facility.

In all cases, the SNF/HRF receiving the patient must complete and score a *DMS-1* within five days of admission. The five-day (post-admission) *DMS-1* must be maintained as part of the patient's records.

If the patient was discharged from a SNF/HRF, the "five-day" (post-admission) *DMS-1* must then be submitted to the Local Professional Director (or Commissioner's Designee, where applicable) in order to obtain post-admission certification as to the appropriateness of the individual's level of care placement for payment purposes.

If the Local Professional Director (or the Commissioner's Designee) determines that the patient requires a different level of care, the appropriate alternate care placement procedures should be initiated.

Discharge/Admission to Other Residential Health Care Facilities from SNF or from HRF

When a Medicaid beneficiary or potential Medicaid beneficiary is to be admitted to another Residential Health Care Facility (RHCF) after discharge from a SNF, the discharging facility's discharge planning unit must initiate completion and scoring of a *DMS-1*.

The patient can be discharged to another SNF if:

- The *Form's* total score is equal to or greater than 180 and alternate care placement certification by the individual's attending physician concurs with the SNF placement; or
- The score is less than 180 but a physician from the discharging facility's UR Agent and the individual's attending physician certify the need for SNF placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the Form or on an attachment to that Form, where applicable.

The patient can be discharged to a HRF if:

- The *Form's* total score is equal to or greater than 60 and alternate care placement certification by the individual's attending physician concurs with the HRF placement; or
- The score is less than 60 or greater than 180 but a physician from the discharging facility's UR Agent and the individual's attending physician certify the need for placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the Form or on an attachment to that Form, where applicable.

In cases where a patient has not specified a facility(s) for admission, he/she should be placed in a facility located at a reasonable distance (within a 50-mile radius) from his/her home. If the patient has no home, he/she should be placed in an appropriate facility located within a 50 mile radius from the SNF/HRF.

The discharging facility must send the admitting facility the completed *DMS-1*, and other appropriate discharge information. This information serves as documentation that discharge to another facility is both necessary and appropriate. The discharging facility's determination is accepted for Medicaid payment purposes as admission certification to the new facility, except where prior approval (pre-admission certification) procedures for RHCF placement have been established (e.g., specifically designated CASA or other Commissioner of Health Designee).

Admission from another Section of a Multi-Level Care Facility

When a patient is admitted to a SNF level of care from a HRF level of care or admitted to a HRF level of care from a SNF level of care within the same facility and which uses the same medical director, the admitting SNF/HRF may use the *DMS-1* sent by the discharging level rather than completing the *DMS-1* within five days of admission. The SNF must indicate on the top of the *Form(s)* that the case involved "internal discharge/admission". The *DMS-1* must then be submitted to the Local Professional Director (or Commissioner's Designee, where applicable) to obtain post-admission certification (*DMS-4* approval) of the appropriateness of the patient's level of care placement for payment purposes.

For New York City Medicaid beneficiaries, a *W-434* must be sent to the Human Resources Administration, Division of Long Term Care upon admission to the new level of care.

For beneficiaries whose county of Medicaid fiscal responsibility is other than New York City, a *DSS-3559* must be sent to the local department of social services who retains fiscal responsibility for the beneficiary.

Admission from State Office of Mental Health Facilities, Psychiatric Hospitals, or Psychiatric Units of General Hospitals

A SNF/HRF may admit a psychiatric patient only after receipt of the *DMS-4* approval and the *DMS-1* with addenda such as the *DMH 103* sent to the SNF/HRF from the discharging facility.

Within five days of admission, the SNF/HRF must complete and score a *DMS-1* in order to reassess the patient's level of care needs.

For New York City beneficiaries, a *W-418R* must be sent by the discharging facility to the admitting SNF/HRF along with the *DMS-4* and the *DMS-1* from the Office of Psychiatry of the New York City Department of Social Services or, in the case of individuals being admitted from Mental Health Facilities, from the Division of Post Institutional Services of the New York City Department of Social Services.

Transfer within the Same Facility

When a patient is transferred from a SNF to a HRF or from a HRF to a SNF which is in the same building, the facility must indicate on the top of the appropriate form(s) that the case involves an "internal transfer." This will facilitate processing of the forms.

For New York City beneficiaries, a *W-434* must be sent to the Division of Long Term Care upon admission to the new level of care.

For beneficiaries whose county of fiscal responsibility is outside the City of New York, a *DSS-3559* must be forwarded to the local department of social services of fiscal responsibility.

Policy for Patients Admitted to and Discharged from a Hospital

In certain instances, a Medicaid beneficiary may have to be discharged from a SNF/HRF to a hospital for acute care. When a beneficiary is hospitalized, the SNF/HRF must complete a *W-434* (for New York City beneficiaries) or *DSS-3559* (for those beneficiaries whose county of fiscal responsibility is outside the City of New York) and submit the *Form* to the Division of Long Term Care or appropriate local department of social services within 48 hours of hospitalization. The date on the *Form* must reflect the actual date of movement to the hospital.

Upon return of the beneficiary, the SNF/HRF must forward another copy of the *W-434* to the Division of Long Term Care indicating the date the beneficiary returned to the SNF/HRF and the number of days spent in the hospital.

Patients Requesting Medicaid Coverage Following SNF/HRF Admission

If the individual is not currently receiving Medicaid and has not yet applied for coverage but does wish to apply for Medicaid to cover the cost of the SNF/HRF care, the SNF/HRF must assist the individual by completing Sections A, B, C, G, and Y of the Application for Medical Assistance. The SNF/HRF must forward the application, as well as all available supporting documentation to the beneficiary's local department of social services (LDSS).

For New York City applicants, the SNF/HRF must forward the application for Medical Assistance, all available supporting documentation, and a *W-418R* to the Division of Long Term Care.

The LDSS will notify the individual and the SNF/HRF once it has been determined whether the individual is financially eligible, eligible with spenddown (net available monthly income), or ineligible for Medicaid. A Medicaid Identification Number will be issued by the LDSS to the individual if he/she is eligible or eligible with spenddown without awaiting medical placement approval (as indicated by receipt of an approved *DMS-4* from the Local Professional Director).

The SNF/HRF may claim co-insurance payments on cases covered by Medicare using the assigned number.

Claims for ancillary services not covered by the SNF's/HRF's inpatient rate may also be submitted using the number which appears on the Card/Letter. However, Medicaid payments for the SNF/HRF inpatient care will not be authorized by the LDSS until the Local Professional Director or the Commissioner's Designee has affirmed that the individual is medically eligible for SNF/HRF care and has approved the individual's admission (again, as indicated by the LDSS and the SNF's/HRF's receipt of the approved *DMS-4*).

Once an approved *DMS-4* is received by the LDSS, Medicaid payments for SNF/HRF inpatient level of care will be authorized; the SNF/HRF may then

proceed to bill Medicaid following the procedures outlined in the Billing Section of this Manual.

If an individual is eligible with a spenddown, the facility will be eligible for payment when the facility bill exceeds the amount of the spenddown after utilization of available third party resources. The individual is financially responsible for the amount of the spenddown. The SNF/HRF may bill Medicaid for the amount of the remaining care.

Admission of New York City Beneficiaries from Office of Mental Health Facilities, Psychiatric Hospitals, or Psychiatric Units of General Hospitals

A SNF/HRF may admit a psychiatric patient only after receipt of the *DMS-1* and the *DMS-4* from the discharging facility. In order to initiate a financial eligibility review on psychiatric patients not currently eligible for Medical Assistance, the SNF/HRF must assist the individual in completing Sections A, B, C, G, and Y of the *Application for Medical Assistance* and send this partially completed Application to the local department of social services or the Commissioner's Designee, if applicable.

For those who are currently eligible for Medical Assistance, the SNF/HRF needs only to submit a copy of the beneficiary's Medicaid Identification Card to the local department of social services.

For New York City patients who are not currently eligible for Medical Assistance, the SNF/HRF must send a *W-418R*, along with the *Application for Medical Assistance* to the Division of Long Term Care. For those who are currently eligible for Medicaid, the Medicaid Identification Card and the *W-418R* must be sent to the Division of Long Term Care.

Continued Stay Reviews for SNF/HRF Recipients

The SNF's Utilization Review Agent is required to review and, if appropriate, certify the necessity of a patient's continued stay on or before the 30th, 60th, and 90th days after admission and every 90 days thereafter.

The HRF's Utilization Review Agent is required to review and, if appropriate, certify the necessity of a patient's continued stay on or before the 90th day after admission and every 90 days thereafter.

To reach its determination, the UR Agent will assess the patient's placement needs through review of a completed *Long Term Care Placement Assessment Form* (hereafter referred to as *DMS-1*) and other applicable medical information. Consideration will also be given to psychosocial factors which impact on the Recipient's medical condition.

A non-physician representative of the UR Agent may initially screen the patient's needs for continued care through review of a completed and scored *DMS-1* and all other

records and documents pertinent to the patient's placement needs, including psychosocial needs.

For SNF's in instances where the numerical value is less than 180, a utilization review physician certification is required.

For HRF's in instances where the numerical value is less than 60 or greater than 180, a utilization review physician certification is required.

***DMS-1* forms need not be scored for patients admitted to the HRF prior to March 1, 1977.**

If, based on his/her review, the representative believes that the patient may no longer require SNF/HRF care, he/she will refer the case to the physician member(s) of the UR Agent. The UR Agent physician(s) must review all referred cases to determine whether continued stay in the HRF is appropriate.

Extensive review of SNF/HRF patients may be required by the UR Agent physician(s) even though the numerical standards on the *DMS-1 Forms* are within the range of values (for SNF placement equal to or greater than 180 **or** for HRF placement equal to or greater than 60 but less than 180).

The following information must always be considered by the UR Agent physician(s) when assessing patients at the time of SNF/HRF continued stay reviews:

- Current written and signed psychosocial evaluation completed by the facility's qualified social worker indicating the patient's anticipated response to possible transfer;
- Additional written information describing the patient's treatment plan and current physical, emotional and mental condition;
- A copy of the latest *DMS-1* completed by a registered nurse directly responsible for the patient's care and scored by staff of the HRF; and
- A written and signed discharge plan which specifies and limits proposed placement based on particular needs of the patient which include but are not limited to:
 - ▶ Suitability and availability of services;
 - ▶ Geographical constraints; and
 - ▶ Accessibility of family members.

The psychosocial evaluation and other required information must be weighed by the UR Agent physician(s) and can be used as a basis for a UR physician "override" of the standards used in making alternate care determinations. Furthermore, the UR Agent

physician(s) must allow for the advice and recommendations from nursing and social work departments prior to making an alternate care determination.

If the UR Agent physician(s), upon review and evaluation of the attending physician's plan of care, *DMS-1*, psychosocial evaluation, discharge plan and other supporting documentation (such as multidisciplinary team report), determines that the patient does not require continued stay at the current level of care, but in fact requires an alternate level of care, the UR Agent physician(s) must indicate and certify the patient's alternate level of care needs on the back of the *DMS-1*. The UR Agent physician(s) must then notify the attending physician of the patient's alternate level of care needs. The attending physician must review the patient's current clinical status, as well as all factors (medical, psychological) relating to possible transfer and provide the UR Agent physician(s) with a written report of his/her findings within three (3) working days.

- If the attending physician does not agree with the initial continued stay finding recommending transfer to a different level of care, the finding can stand only with concurrences and certification by a second UR Agent physician.
- If the attending physician agrees with the initial continued stay finding or does not present the required information cited above, the initial continued stay finding will stand.

If the UR Agent physician(s) continued stay finding indicates that the Recipient requires a higher level of care, the patient, the patient's next of kin or designated representative(s) and attending physician will be immediately notified and alternate care placement procedures will be implemented.

If the UR Agent physician(s) makes an adverse continued stay finding which indicates that the Recipient requires a **lower level of care, the Recipient should not be notified of this decision**. The adverse finding should not be misconstrued as the final continued stay review determination.

All assessment material and other documents which form the basis of an adverse finding must be legible, complete, contain an authorized signature and be internally consistent.

Patients Admitted From Other Residential Health Care Facilities

When a Medicaid beneficiary or potential Medicaid beneficiary is to be **admitted to a SNF** from another residential health care facility, a *DMS-1* must be initiated and scored by the transferring facility's discharge planning unit. A SNF may admit a beneficiary who is to be transferred from a HRF or from another SNF if:

- The *Form's* total score is equal to or greater than 180 and alternate care placement certification by the individual's attending physician concurs with the SNF placement; or

- The score is less than 180 but a physician from the transferring facility's UR Agent and the individual's attending physician certify the need for SNF placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the Form or on an attachment to that Form where applicable.

The admitting facility must receive from the transferring facility the complete DMS-1, as well as the patient's transfer summary. The transfer summary serves as documentation of the transferring facility's determination that the transfer to another facility is both necessary and appropriate. The transferring facility's determination is accepted for Medicaid payment purposes as admission certification to the new facility.

The SNF receiving the patient must complete and score a DMS-1 within five days of admission. That Form, which verifies the appropriateness of the placement must then be submitted to the Local Professional Director in order to obtain certification for the appropriateness of the individual's stay.

If the Local Professional Director determines that the patient requires a different level of care, the appropriate alternate care placement procedures should be initiated.

Placement into a Non-Occupant Care Program

Prior to admission into a non-occupant care program, an individual must be recommended by a physician. The individual must then be given a personal interview by qualified professional personnel from the program. If appropriate, the individual's next of kin or sponsor should attend the interview.

An individual can be registered in the non-occupant care program only if it is determined through the pre-registration interview that the facility's program can provide adequate care and needed services for the individual and that the individual can benefit from the services provided. In addition, the program's operator must determine before admission that the individual is not receiving the same services more appropriately elsewhere (e.g., in a hospital outpatient department, home health agency, or another community agency).

A summary of all interviews must be recorded in the registrant's health or other appropriate record.

In addition to the above, before admission, a written agreement for services between the residential health care facility operator and the applicant must be drawn up in accordance with the State Health Code.

Admission from a Non-Occupant Care Program

A registrant should be admitted to a higher level of care (residential health care facility or hospital care, home health care, etc.) whenever such admission is determined to be medically necessary by his/her personal physician. The registrant, next of kin, and responsible local department of social services must be consulted.

For beneficiaries admitted to a residential health care facility from a non-occupant care program, the placement approval and certification of the Local Professional Director must be obtained.

In the event of a registrant's admission to a higher level of care on an emergency basis, the registrant's next of kin, his/her attending physician and the responsible local department of social services must be promptly notified.

Discharge from the Skilled Nursing Facilities or Health Related Facilities

When a Medicaid beneficiary is discharged to SNF level of care from HRF level of care or when a Medicaid beneficiary is discharged to HRF level of care from SNF level of care which is in the same facility and which uses the same Medical Director, a *DMS-1* must be completed by the discharging level.

For New York City Recipients, a *W-434* must be sent to the Division of Long Term Care by the discharging level. For beneficiary's whose fiscal responsibility is a county outside the City of New York, a *DSS-3559* form must be sent to the Local Social Services District of fiscal responsibility.

Discharge/Admission to Other Residential Health Care Facilities

When a beneficiary or potential beneficiary is to be discharged from a SNF/HRF from another residential health care facility, the transferring facility's discharge planning unit must initiate completion and scoring of a *DMS-1*.

The beneficiary can be discharged to SNF level of care if:

- The *Form's* total score is equal to or greater than 180 and alternate care placement certification by the individual's attending physician concurs with the SNF placement; or
- The score is less than 180 but a physician from the discharging facility's UR Agent and the individual's attending physician certify the need for SNF placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the *Form* or on an attachment to the Form where applicable.

A beneficiary can be discharged to another HRF if:

- the *Form's* total score is equal to or greater than 60 and alternate care placement certification by the individual's attending physician concurs with the HRF placement; or
- the score is less than 60 or greater than 180 but a physician from the discharging facility's UR Agent and the individual's attending physician certify the need for placement based on their evaluation of the individual's placement needs, including psychosocial needs. The UR physician's certification must be noted on the *Form* or on an attachment to that *Form*, where applicable.

In cases where a patient has not specified a facility(s) for admission, he/she should be admitted to a facility at a reasonable distance from his/her home. If the patient has no home, he/she should be admitted to an appropriate facility located within a 50 mile radius from the HRF.

The discharging facility must send the admitting facility the complete *DMS-1*, as well as the patient's discharge summary. The discharge summary serves as documentation of the facility's determination that the admission to another facility is both necessary and appropriate. The facility's determination is accepted for Medicaid payment purposes as admission certification to the new facility, except where prior approval (pre-admission certification) procedures for RHCF placement have been established (e.g., specifically, designated CASA or other Commissioner of Health Designee).

Discharge to a Non-Occupant Care Program

A patient of a HRF who is to be discharged to a Non-Occupant Care Program should be discharged to his/her home and enrolled in the non-occupant care program upon discharge.

Patient Change of Status Notice

A SNF/HRF is to notify the local department of social services whenever a Medicaid beneficiary is discharged from a facility. When a Medicaid beneficiary is discharged to a hospital, the SNF/HRF must submit a completed *DSS-3559* (or *W-434* for NYC beneficiaries), within 48 hours of the discharge to the local department of social services.

When a beneficiary leaves the facility for reasons other than hospitalization (e.g., discharged to home or to another RHCF, deceased), the SNF/HRF must submit a completed *DSS-3559* (or *W-434* for NYC beneficiaries) to the local department of social services. If the beneficiary has been discharged, the SNF/HRF must include the beneficiary's new address on the *DSS-3559* (*W-434* for NYC Recipients).

When the beneficiary returns from a hospital stay, the SNF/HRF must forward a copy of the DSS-3559 (W-434 for NYC Recipients) indicating the date the Recipient returned to the SNF/HRF.

Financial Eligibility Reviews for Admission of Patients into Skilled Nursing Facilities and Health Related Facilities

The following procedural requirements must be met in order to determine the financial eligibility of patients for admission into SNF/HRF level of care.

Prior to Admission

If an individual has been determined financially eligible for Medicaid prior to admission to the SNF/HRF, he/she must present, upon admission, a current Medicaid Identification Card or a Temporary Authorization Letter.

The SNF/HRF must then forward a copy of the current Identification Card/Letter to the local department of social services in order to initiate a financial eligibility review.

The individual may indicate that although he/she does not yet have a Medicaid ID Card or letter, he/she has applied for Medicaid and is awaiting a financial eligibility determination. In such a case, the individual and the SNF/HRF will be notified by the patient's local department of social services once it has been determined whether the individual is financially eligible, eligible with surplus (net available monthly income), or ineligible for Medicaid. A Medicaid Identification Number will be issued by the district to the individual if he/she is eligible or eligible with surplus, without awaiting medical placement approval (as indicated by receipt of an approved *DMS-4* from the Local Professional Director or the Commissioner's Designee, where applicable).

For hospitalized patients or those in another RHCF who are not in receipt of Medicaid but who wish to apply for coverage prior to admission to a SNF, the discharging facility is to assist the individual in completing Sections 1-16 of the *Common Application for Public Assistance-Medical Assistance-Food Stamp Services (DSS-2921)*.

For hospitalized patients or those in another RHCF who are not in receipt of Medicaid but who wish to apply for coverage prior to admission to HRF level of care, the discharging facility is to assist in completion of Section A, B, C, G and Y of the *Application for Medicaid*.

The partially completed application and all available supporting documents must be forwarded to the admitting SNF/HRF. The admitting SNF/HRF must then forward the application and documentation to the patient's social services district.

Since Medicaid is the payer of last resort, the SNF/HRF must bill Medicare prior to billing Medicaid. The SNF/HRF may then bill the Medicaid Program for co-insurance payments on cases covered by Medicare using the Identification Number which appears on the ID Card/or temporary authorization.

Claims for ancillary services not covered by the SNF's/HRF's inpatient rate may be submitted using the number which appears on the Card/Letter, however, Medicaid

payments for SNF/HRF inpatient care will not be authorized by the local department of social services until the Local Professional Director has affirmed that the individual is medically eligible for SNF/HRF care and has approved the individual's placement (as indicated by the local department of social services and the SNF's/HRF's receipt of an approved *DMS-4* from the Local Professional Director or the Commissioner's Designee, if applicable).

Once an approved *DMS-4* is received by the local department of social services, Medicaid payments for SNF/HRF inpatient care will be authorized. The SNF/HRF may then proceed to bill the Medicaid Program following the procedures outlined in the Billing Section of this Manual, located online at:

<http://www.emedny.org/ProviderManuals/ResidentialHealth/index.html>.

If an individual is eligible with surplus, that individual will be eligible for HRF coverage when the HRF bill exceeds the amount of surplus after utilization of available third party resources. The individual is financially responsible for the amount of the surplus. The HRF may bill the Medicaid Program for the amount of the remaining care.

Additionally:

New York City Medicaid beneficiaries:

- Community Based Beneficiaries - A copy of the beneficiary's current Card/Letter and a completed *W-418R* must be forwarded by the admitting SNF to the Division of Long Term Care.
- Hospital Based - A copy of the Medicaid application, supporting documentation and a *W-418R* must be forwarded from the discharging hospital to the admitting SNF. The admitting SNF must then forward this material to the Division of Long Term Care.
- Patients Admitted from Other RHCFS - When patients are admitted to a SNF from other RHCFS, the admitting SNF must send a "*Notification of Change in Status*" form (hereafter referred to as *W-434*) to the Division of Long Term Care.

Other than NYC beneficiaries:

- When a beneficiary whose county of fiscal responsibility is outside the City of New York is admitted/readmitted or discharged/transferred from a SNF/HRF, a "*Notification of Change in Status*" form (hereafter referred to as a *DSS-3559*) must be completed and forwarded to the local department of social services of fiscal responsibility within 48 hours.

Alternate Care Contacts and Reassessments

A Medicaid beneficiary is eligible to designate a facility to which he/she would like to be discharged if upon the adverse finding of the UR Agent, they agree only to be discharged to a specific facility or set of facilities.

In the event of an adverse finding by the UR Agent, a beneficiary may designate a facility(s) to which he/she would like to be admitted.

In order to place beneficiaries who have designated a facility(s) in which to be admitted, a SNF with less than five beneficiaries certified for alternate care placement must contact the designated facility(s) at least twice a week.

A HRF with less than five beneficiaries certified for alternate care placement must contact the facility(s) at least once a week. If more than five beneficiaries are certified for alternate care placement and have designated facility(s) in which to be admitted, one contact, twice per week must be made for each beneficiary.

In order to place Medicaid beneficiaries who have not designated a facility(s) in which to be admitted, a SNF with less than five beneficiaries certified for alternate care placement must contact twice weekly, a minimum of five appropriate facilities.

A HRF with less than five beneficiaries certified for alternate care placement must contact weekly, a minimum of five appropriate facilities. If there are more than five beneficiaries who are certified for alternate care placement and who have not designated a facility(s) in which to be admitted, one contact, twice per week must be made for each beneficiary (up to a maximum of twenty facilities).

Acceptable contacts do not include repeated contact with those facilities which consistently refuse referrals for admission. All contacts must be documented on a *DMS-8* or a similar acceptable form. That documentation must be maintained in the beneficiary's medical record or in the facility's discharge planning unit.

When a Medicaid beneficiary awaits alternate care placement, the SNF/HRF must continue to reassess, at ten day intervals, his/her medical condition by completing and scoring a new *DMS-1*. Furthermore, a physician must indicate the date the beneficiary will be (or was) ready for placement and note that continued care is necessary beyond that date pending alternate placement.

The above alternate care placement procedures must be followed for all beneficiaries regardless of the date of their admission to the SNF/HRF.

Notification to OHSM of Adverse Continued Stay Findings

When an adverse continued stay finding is made, indicating the client requires a lower level of care, the utilization review agent physician(s) must immediately notify the appropriate Area Office of the Office of Health Systems Management (OHSM) on the prescribed notification form.

The UR Agent physician(s) must forward the following information to the OHSM Area Office:

- A copy of the most recently completed *DMS-1* and numerical standards (*DMS-9*);
- A copy of the psychosocial evaluation completed by the facility's social worker indicating the beneficiary's response to possible transfer;
- Information from the attending physician concerning the beneficiary's current clinical status and ability to accept transfer;
- The UR Agent physician(s) statement regarding the change in the beneficiary's condition or other circumstances which justifies the adverse finding; and
- The name of the beneficiary, the name of the attending physician, the beneficiary's representative, the facility administrator and the responsible social services district.

Review of Adverse Finding by OHSM Recommending a Lower Level of Care

Upon receipt of the above material, a nurse reviewer of the regional OHSM office will review the material, and if all the material is found acceptable, the reviewer will contact the facility administrator to schedule an on-site visit.

At the time of the on-site visit, the nurse reviewer will compare the beneficiary's *DMS-1* with the medical record, discuss the appropriateness of the adverse finding (including physical and psychological factors) with the facility's social worker, attending nurse, attending physician and other appropriate staff, and observe the beneficiary's physical and emotional condition.

The nurse reviewer should also:

- Review the U.R. minutes to ascertain that all factors were considered in arriving at the adverse finding;
- Request that the attending physician conduct a clinical exam if the medical record is not up-to-date; and
- Obtain a statement describing the beneficiary's response to the potential discharge, including whether or not such discharge is in the beneficiary's best interest.

If, based on the nurse reviewer's findings, he/she disagrees with the adverse finding, the case will be referred back to the OHSM Area Office for physician review and certification indicating whether continued stay at the current level of care is appropriate. If the OHSM physician agrees with the nurse reviewer and certifies that the current level of care is appropriate, the facility administrator and the attending physician will be notified by OHSM and the beneficiary will continue at the current level of care.

If the nurse reviewer agrees with the adverse finding, (or if the OHSM physician upholds the adverse finding when the nurse disagrees with this finding), the nurse reviewer will contact the beneficiary, advise him/her that a discharge recommendation has been made and determine whether the beneficiary voluntarily agrees to the discharge.

When the beneficiary is unable to consent to the discharge because of confusion or impaired judgment, it will be presumed that the beneficiary cannot voluntarily agree to the discharge.

If the beneficiary voluntarily consents to the discharge, the adverse continued stay finding will stand and the case will be referred to an OHSM physician for review and certification that he/she concurs with the adverse finding. When a beneficiary voluntarily agrees to admission to any facility or specified facilities, a dated and signed consent form must be obtained which describes the specific discharge/admission consented to and indicates that the beneficiary understands that the discharge/admission will not be required without his/her consent. This statement must also be signed by the OHSM nurse reviewer who will certify that the beneficiary understood and voluntarily signed the statement.

If the beneficiary agrees only to be admitted to a specific facility or set of facilities the decision of the UR Agent physician(s) will stand upon the condition that the beneficiary can only be admitted to the specified facility or facilities. The appropriate section of the consent form must be completed and signed by the beneficiary, and certified by the OHSM nurse reviewer.

If the beneficiary does not voluntarily agree to the discharge but is in a multi-level facility and can be discharged/admitted within the facility to a lower level of care in accordance with the UR Agent's finding, the adverse finding will stand upon the condition that the beneficiary can only be discharged/admitted within the multi-level facility. A signed consent form will not be required for this situation.

If the beneficiary does not voluntarily consent to the discharge/admission and is not in a multi-level facility, the proposed move will be deemed medically contraindicated and the case will be referred to OHSM for physician review and certification that continued stay at the current level of care is approved. The objection statement on the consent form must be secured from the beneficiary by the OHSM nurse reviewer, which indicates that the beneficiary does not wish to be discharged.

If the OHSM physician upholds the initial adverse finding and the beneficiary voluntarily consents to the discharge/admission, the facility administrator, the beneficiary's attending physician, the beneficiary's representative and the responsible local department of social services will receive a copy of the form entitled *Notice of Utilization Review Certification* by the OHSM Area Office. This form will also be sent when the beneficiary can be discharged to a lower level of care within a multi-level facility.

Notification to Medicaid Patient/Residents of Fair Hearing Rights

Once it is determined that a patient/resident requires discharge to a lower level of care, OHSM must notify the patient/resident, next-of-kin, attending physician and responsible local department of social services (LDSS).

The notification form, which is sent to the LDSS, must include a written and signed statement from the physician indicating the changed medical condition of the patient/resident which supports the decision for discharge.

Upon receiving this notification form from the residential health care facility, the LDSS that is responsible for the patient's/resident's Medicaid payment will inform the patient/resident, attending physician, next-of-kin or sponsor and facility administrator of the patient's/resident's right to request a Fair Hearing.

The patient/resident has ten (10) days from the date of notification in which to request a Fair Hearing. If the patient/resident requests a fair hearing within ten (10) days, Medicaid payment will continue until the hearing process renders a decision.

If ten (10) days have elapsed and the patient/resident does not request a Fair Hearing, the patient/resident should be discharged to the proposed placement or placed on alternate care status. Medicaid payment will continue while the patient/resident is on alternate care status as long as the residential health care facility complies with alternate care placement procedures.

When a beneficiary awaits alternate care placement, the SNF must continue to reassess, at ten day intervals, his/her medical condition by completing and scoring a new *DMS-1*. Furthermore, a physician must indicate the date the beneficiary will be (or was) ready for placement and note that continued care is necessary beyond the date pending alternate placement.

If the patient/resident insists upon leaving the residential health care facility prior to receiving the Fair Hearing notification from the LDSS, the residential health care facility must secure a signed statement from the patient/resident and next-of-kin (or where applicable, the patient/resident sponsor). This signed statement must indicate that the patient/resident was informed of the right to request a Fair Hearing, but (s)he did not elect to request a Fair Hearing at that time and is leaving the facility voluntarily. This statement must be forwarded to the responsible LDSS to inform them of this situation.

If the patient/resident, after receiving notification from the LDSS, insists upon leaving the facility before the ten (10) day grace period has elapsed, the facility must obtain a signed statement as indicated above, documenting voluntary transfer of the patient/resident.

Whenever a fair hearing has been requested, the patient/resident shall have upon his/her request unencumbered access to and review of:

- a copy of the contents of his/her case file;
- all documents and records to be used against the patient/resident at the hearing;
- all documents, medical or otherwise, which were considered or relied on by the utilization review agent physician(s); and
- all medical documents and records including all so-called medically contraindicated information contained in any such documents or records.

The patient/resident shall be provided with one free copy of a each document requested.

Section III - Basis of Payment for Services Provided

Reimbursement under the Medicaid Program is available for SNF/HRF care provided to eligible individuals. Such care includes, but is not limited to:

- medical,
- dietary,
- personal care,
- rehabilitation,
- pharmaceutical,
- dental and
- supportive services.

For inpatient care in a health related facility in New York State, the maximum reimbursable rate for Medicaid payment will be at the rate established for that facility by the DOH and approved by the Director of the Budget.

For non-occupant care services, payment will be in accordance with the all-inclusive per diem rate established for each program by the DOH and approved by the Director of the Budget. The all-inclusive per diem rates must not exceed 75% of the SNF/HRF inpatient rate.

For an SNF/HRF outside of New York State, the maximum reimbursable rate for payment will be at the rate negotiated by the commissioner of the local department of social services for the resident's county. This rate shall not exceed the rate established for the facility under the State's Medicaid Program.

Deposits

A SNF/HRF may not request a deposit from an individual who has been identified at admission as a Medicaid beneficiary; Medicaid payment must be accepted as payment-in-full for the patient's SNF/HRF care. If, however, the SNF/HRF received a deposit from a resident who was not, at the time of admission, receiving Medicaid, but who is subsequently determined financially eligible, that deposit must be returned to the payer upon receipt of Medicaid payments.

Medicaid will retroactively reimburse a facility for a period of up to three months if the Recipient was found to be medically eligible during that 3 month time period and was residing in the SNF/HRF for the three months. If, however, Medicaid disallows part of the payment to the SNF/HRF due to the patient's medical condition, the SNF/HRF is not obligated to reimburse the payor for that amount of money used to cover services rendered by the SNF/HRF for which Medicaid will not retroactively reimburse the SNF/HRF.

General Policy for Inpatient Care in a Skilled Nursing Facility or a Health Related Facility

For a SNF/HRF in New York State, the maximum reimbursable rate for payment will be at the all-inclusive rate established for that facility by the DOH and approved by the Director of the Budget.

For a SNF/HRF outside of New York State, the maximum reimbursable rate for payment will be at the rate negotiated by the Local Commissioner of Social Services for the resident's county. This rate shall not exceed the rate established for the facility under that State's Medicaid Program.

General Policy for Non-Occupant Care

Payment for non-occupant care services will be made in accordance with the all-inclusive per diem rate established for each program by the State Commissioner of Health and approved by the Director of the Budget. The all-inclusive per diem rates must not exceed 75% of the SNF/HRF inpatient rate.

Additional reimbursement will not be made when bills for services covered by the all-inclusive rate are submitted on an individual basis.

Maximization of Medicare Benefits

Each skilled nursing facility must bill Medicare, Part A and B, for services provided to patients who are, or may be eligible for Medicare coverage. The facility must take the steps appropriate to determine possible Medicare Part A coverage.

If available, Part A coverage must be used to the fullest extent possible before Medicaid reimbursement is claimed. The facility must also bill Medicare for all available Part B coverage applicable to services provided by the facility, i.e., physician, physical therapy, and other services.

Medicare Maximization/Optimization Program Requirements

SNF are required to fully comply with *HFM 84-32*, pending dissemination of supplemental and expanded Medicare Optimization "Program Instructions". These "Instructions" may substantially revise Provider responsibility to maximize Medicare benefits and supersede any previous procedural requirements which may have been in effect.

Eligibility standards are uniform under the two programs. Therefore, if Medicare rejects a claim because the beneficiary's care is determined to be medically ineligible, Medicaid will also refuse payment unless:

- the Local Professional Director disagrees with the Medicare determination; and

- the SNF in question has initiated a reconsideration of the Medicare fiscal intermediary's decision of medical ineligibility.

The facility should submit to the responsible Local Professional Director, a copy of the Medicare denial, the original SSA-2629 (the facility's request for reconsideration) and a copy of the *DMS-1* which was submitted to Medicare. The Local Professional Director will review the submitted information and then decide whether or not he/she agrees with the Medicare determination.

If the Professional Director agrees with Medicare's rejection, he/she will inform the local department of social services (LDSS). The LDSS will not authorize Medicaid coverage.

If the Professional Director disagrees with Medicare's rejection, he/she will advise the LDSS that, in his/her opinion, the patient is medically eligible for Medicare. Medicaid payments will be authorized for such a patient for as long as the Professional Director rules that the Recipient meets SNF level of care requirements. A *DMS-4* will be sent to the LDSS by the Professional Director indicating his/her decision.

When Medicaid payments are authorized, the case will be closely followed to ensure that facilities pursue the entire reconsideration and appeal process.

Section IV – Reserved Bed Policy

Medicaid payments are available under certain circumstances to reserve the bed of a Medicaid-eligible patient who is temporarily absent overnight or longer from a SNF during a period of hospitalization for an acute condition or during a leave of absence.

In order to qualify for such payments, certain conditions must be met, including, as a minimum, the following:

- The patient must have been a resident in the SNF for a minimum of 30 days since his initial admission during the current spell of illness;
- The distinct part of the facility to which the patient is to return has, on the first day of the patient's absence a vacancy rate of no more than 5% or 15 vacant beds, whichever is less (see the following paragraph);
- A bed may not be reserved when the patient's primary third party payer is Medicare unless the patient was a patient in the SNF for 30 days prior to the period currently being covered by Medicare.

Only overnight stay(s) away from the SNF (i.e., beyond the facility's normal census taking hours) are to be considered a reserved bed day.

A patient's bed must always be reserved (specific room and bed unless medically contraindicated) unless:

- The patient's condition is such that he/she will clearly require a period of hospitalization in excess of 15 days; or
- The patient may not desire to return to the originating facility; or
- The patient, following the hospitalization, may require a level of care not provided by the originating facility.
- The distinct part of the facility to which the patient would be returning had, at the time of his/her departure, a vacancy rate in excess of 5%;
- The patient does not meet 30 day residency criteria;
- Medicaid is primary payer and the patient had not been in the facility for 30 days prior to period currently covered by Medicare.

If the SNF does **not** reserve a patient's bed, a completed *Status of Bed Reservation Form (DSS-3074)* must be submitted to the hospital with the patient or within 24 hours of the patient's admission. The hospital will annotate this form to indicate its concurrence or non-concurrence with the SNF decision not to reserve the patient's bed

and forward one copy to the DOH Office of Health Systems Management (OHSM) for purpose of program policy review.

A facility which fails to reserve a patient's bed when it would have been clearly appropriate may be subjected to more restrictive policy controls.

If the SNF reserves the patient's bed, it must notify the admitting hospital by submission to the hospital of a completed *Status of Bed Reservation Form* with the patient or within 24 hours of the patient's admission.

If, as determined at any point before the fourth day of hospitalization, the patient will not be returning to the originating SNF within 20 days of the date of admission to the hospital, the bed reservation must be terminated by the SNF.

If, following the third day of inpatient hospital care, it becomes necessary to adjust the planned discharge date (e.g., due to a change in the patient's condition or additional medical information), the hospital's discharge planning coordinator is to notify the SNF by phone *immediately*.

Payment of bed reservation fees shall be from the date of admission up to and including the date the bed remained vacant and the facility was notified of circumstances which resulted in the bed reservation being terminated.

Computation of "Days of Absence" and "Vacancy Rates" Under the Medicaid Bed Reservation Program

It is appropriate to utilize a single daily census to determine eligibility for Medicaid reimbursed bed reservations. This single daily census is commonly taken at the end of the day (e.g., 11:59 pm).

This practice is consistent with Medicare census policy (HCFA 15, Part 2205-Medicare Patient Days), Department regulation (Title 10 NYCRR 451.72-Daily Inpatient Census) and policies governing nursing homes.

The time of day at which the census is taken must be used consistently.

Census Policy

- Census policy requires that patients admitted to the facility in the preceding 24 hours be counted in the census, and patients permanently discharged in that same period not be counted.
- In facilities with distinct specialty units, a census must be taken for each unit.
- The maximum census for each unit is the licensed capacity of that unit.

- Only individuals meeting the admission criteria for and admitted to a unit may be counted toward the census of that unit.

The census numbers of each specialty unit is used to calculate the unit's vacancy rate. The unit vacancy rate is then used to determine the facilities' eligibility for Medicaid bed reservation for patients within the unit that have been temporarily discharged that day to either an acute medical care facility or for therapeutic leave.

All nursing facilities must use a single daily census per unit to calculate Medicaid bed reservation payment eligibility and must retain appropriate supporting documentation.

Vacancy Rate Procedures

The Department will pay a facility for a Medicaid recipient's reserved bed days when the unit (e.g. geriatric, AIDS, TBI) to which the recipient will return has a vacancy rate of no more than five percent on the first day the recipient is discharged to a hospital or on a therapeutic leave of absence.

Computing a Vacancy Rate

In order to compute a vacancy rate, only beds occupied by individuals meeting the admission criteria for and admitted to the unit may be counted as occupied toward the census of that unit.

For example, a facility with a 201 bed geriatric unit would:

1. Count the total number of unoccupied beds in the unit at the time the census is taken (e.g., 18 beds).
2. Subtract from the unoccupied bed count (18 beds) those vacant beds for clients temporarily discharged from the facility in the previous 24 hours who, at the time of the census, are expected to return to the facility within twenty days (e.g., 2 beds, thus $18 - 2 =$ a subtotal of 16 beds).
3. Subtract from this subtotal (16 beds) those vacant beds that are already in bed-hold status from the previous day's census, and that remain eligible for bed-hold status at the time of the current census (e.g., $16 - 6$ beds = a subtotal of 10 beds).
4. Divide the number derived from the three steps above (10 beds) by the licensed capacity of that unit (201 beds) to determine the vacancy rate of the unit ($10/201 = .04975$ or 4.975%).

Unit Vacancy Rate

If the vacancy rate in the unit is less than or equal to 5.0%, then the facility is eligible to bill a reserved bed for any Medicaid patients temporarily discharged from the unit during the previous 24 hours from when the census was taken.

If the vacancy rate is greater than 5.0%, then the facility is not eligible to bill a reserved bed for any of the patients temporarily discharged from the unit in the previous 24 hours from when the census was taken.

For the purpose of computing days of absence, the day of departure but not the day of return will be counted as a day of absence. For the purpose of computing vacancy rates, a bed held vacant for the return of an individual who is temporarily absent must **not** be counted as a vacant bed.

Prior Approval

Prior approval to claim reserved bed payments must be obtained from the appropriate OHSM when the patient does not return to the originating facility in 15 days or less immediately following the last day his/her bed was authorized to be reserved.

Approval to claim reimbursement must be requested by submitting to the OHSM one copy of *Status of Bed Reservation Form* authenticated by the hospital discharge coordinator.

If the local department of social services commissioner or the OHSM identifies a facility as having deviated from program standards, that facility will be required to request prior approval to claim reimbursement for all bed reservation fees for patients who are hospitalized. The facility, in such cases, must submit a copy of *Status of Bed Reservation Form* to OHSM for approval for all claims for bed reservation fees during periods of hospitalization and must comply with any additional instructions which may be issued by the OHSM.

If the SNF cannot receive bed reservation fees during a patient's hospitalization, the SNF must give priority to the patient's readmission over individuals referred for their first admission, should the patient seek to return to that facility.

Leaves of Absence

A patient in a SNF may not be on a "leave of absence" from his/her originating facility while hospitalized. Payments for leaves of absence are not authorized when the patient's return from leave is followed by a planned discharge within 24 hours unless such an arrangement has been prior approved by the OHSM.

SNFs are to assist a patient in securing return accommodations (specific room and bed unless medically contraindicated) when the patient's plan of care provides for leaves of absence.

If a patient's leave occurs under circumstances which do not permit bed reservation fees to be utilized, the SNF must give priority to that patient's readmission, over individuals referred for their first admission, should the patient seek to return.

Time Limitations

Payment may be made to reserve a patient's bed during leaves of absence.

Prior approval is no longer required for payment of bed reservation for therapeutic leave of absence of 18 in a 12-month period. For audit purposes, the facility is required to retain on file supporting documentation in the form of a signed physician justification for all therapeutic leave of absence days.

Payments for Reserved Beds

Medicaid payments for reserved bed days will be made at the SNF per diem rate, however, that the facility is obligated to pay the cost of Medicaid covered services, for which it is being reimbursed in its per diem rate, incurred by a patient during his leave of absence. An exception to this provision may be made if authorized by the patient's local department of social services.

Reserved bed payments will not be made:

- When a patient's return from a leave of absence is followed by a discharge within 24 hours, unless the arrangement has been authorized by the patient's local department of social services (a copy of the Authorization must be filed with the patient's *Medicaid Patient/Resident Absence Register*;
- When patients are absent as a direct result of a labor dispute occurring within a facility.

Record Keeping Requirements

Facilities must record and report reserved bed days and overnight absences on all financial and statistical reports which call for patient day information.

Records adequate to enable Federal and State auditors to verify the number and nature of reservations must be available to such auditors and other authorized officials.

The *Medicaid Patient/Resident Absence Register* must be used as a source document to prepare billings submitted for bed reservation fees. SNFs must initiate and maintain a *Medicaid Patient/Resident Absence Register (DSS-2818)* for each Medicaid patient who is absent overnight (i.e., beyond the facility's normal census taking hour).

All overnight absences must be recorded in the Register with an annotation made as to whether the patient's bed was reserved.

If a patient is permanently transferred to another medical inpatient facility, a copy of the *Absence Register* must be included in his transfer records.

Section V - Definitions

For the purposes of the Medicaid Program and as used in this Manual, the following terms are defined to mean:

Health Related Facility

A health related facility (HRF) is a facility, institution, intermediate care facility, or a separate or distinct part thereof providing therein lodging, board, and social and physical care including but not limited to the recording of health information, dietary supervision, and supervised hygienic services incident to such care to six or more residents not related to the operator by marriage or blood within the third degree of consanguinity.

In federal terminology, an HRF is an intermediate care facility (ICF).

Health Related Facility Resident

A health related facility resident is an individual who, because of social, physical, developmental, or mental condition requires institutional care and services, but who does not require the level of inpatient care and services provided by a hospital or skilled nursing facility (SNF) and, in addition, may have one or more but is not limited to the following characteristics:

- Possesses a degree of functional capacity permitting varying degrees of independence that reflect chronic disease conditions which may be stabilized, or mental and emotional impairment requiring medications and range of care and services which stress health and social maintenance and prevention of further deterioration;
- Whose stay in a HRF is usually long term and whose admission, which is not for social reasons alone, reflects the absence of family, or personal resources required to meet the individual's needs;
- Needs a planned program of care and supervision on a continuous 24-hour basis, emphasizing personal care and services under the direction of a physician;
- Needs assistance in securing planned, basic recreational diversion activities and services of other disciplines such as nutritional and social work counseling through coordinated resident care plans which also include sustaining contacts with the community and which support the need and desire to function as independently as possible and prevent withdrawal and other symptoms of early deterioration;
- Needs health services which are under the direct supervision of a registered nurse or other health professionals who have responsibility for developing and coordinating nursing care and resident care plans and who periodically review the plans;

- Needs periodic or intermittent skilled nursing care and services but not continuous skilled services which in the aggregate require direct supervision by licensed nursing personnel; and
- Requires services which can usually be delivered by non-licensed personnel and are primarily support kinds of services such as assistance with activities of daily living.

Homebound Patient

A homebound patient is a person who is essentially confined to his place of residence due to an illness, disability, or injury and, if ambulatory or otherwise mobile, is unable to be absent from his residence except on an infrequent basis or for periods of relatively short duration.

Leave of Absence

For purposes of Medicaid bed reservation policies, leaves of absence are defined to mean overnight absences to include visits with relatives/friends (personal leaves) or leaves to participate in medically acceptable therapeutic or rehabilitative plans of care.

Local Medicaid Professional Directors

Local Medicaid Professional Directors are those individuals who, under Section 365-b of the New York State Social Services Law, serve under the general direction of the Commissioner of Social Services.

They, in cooperation with the Commissioner of Health, have responsibility for supervising the medical aspects of the Medicaid Program, monitoring the professional activities related to the Program, and taking all steps required to ensure such activities are in compliance with Social Services Law and Regulation and Public Health Law and Regulation.

These individuals may also be known as local medical directors or reviewing health professionals.

Non-Occupant Care

Non-Occupant Care, including nursing home or health related facility registrant care, is care provided by or under the medical direction of a physician in a SNF or health related facility (HRF) involving, for less than 24 hour periods, scheduled activities and medically ordered evaluations and treatments conducted by the personnel of the nursing home or health related facility and based on a regularly reviewed health care plan and goal.

Facilities must be certified by the State Department of Health to provide such care.

Nursing Home Patient

A nursing home patient is a person:

- diagnosed by a physician as having one or more clinically determined illnesses or conditions that cause the person to be so incapacitated, sick, invalid, infirm,
- disabled, or convalescent as to require at least medical and nursing care; and
- Whose assessed health care needs, in the professional judgment of his physician or a medical team:
 - Do not require care or active treatment of the patient in a general or special hospital;
 - Cannot be met satisfactorily in the person's own home or home substitute through providing such home health services, including medical and other health and health-related services as are available in or near his community; and
 - Cannot be met satisfactorily in the physician's office, a hospital clinic, or other ambulatory care setting because of the unavailability of medical or other health and health-related services for the person in such setting in or near his community.

Prescription Drug

A prescription drug is a drug for which a prescription from a qualified practitioner is required under Section 6810 of the New York State Education Law.

All prescription drugs are subject to the requirements of the Federal Food, Drug, and Cosmetic Act and to those requirements stipulated by the New York State Commissioner of Health.

Reasonable Distance

Reasonable distance is defined for Medicaid purposes as within a 50 mile radius from the patient's home.

Registrant

A registrant is an individual who is a **non-occupant** of a residential health care facility (SNF or HRF) and who, because of social, physical or mental condition, requires certain preventive, diagnostic, therapeutic, rehabilitative, or palliative items or services, but who does not require the continuous 24 hour a day inpatient care and services provided by a general or special hospital, nursing home, or health related facility.

A registrant's social and health care needs in the professional judgment of his physician, nursing staff, social service and other professional personnel of the nursing home or health related facility through the intake evaluation process:

- Do not require care or active treatment on an inpatient basis in a general or special hospital in or near his community or the inpatient institutional care and services

provided in a nursing home or the resident care services provided in a health related facility;

- Cannot be met satisfactorily, fully or appropriately in the physician's office, hospital outpatient clinic, or another ambulatory care setting; and
- When the person is homebound, can be met satisfactorily in the person's home or home substitute through the provision of such nursing care and health related services as are available from a certified home health agency with supplementation from a nursing home or health related facility in or near his community or when the person is not homebound, can be met satisfactorily on the premises of the nursing home or health related facility by delivery of appropriate services on a clinic visit, day care, evening care, night care, or other clinic type registrant care arrangement.

Skilled Nursing Facility

A Skilled Nursing Facility (SNF), is a facility, institution, or portion thereof, providing therein, by or under the supervision of a physician, nursing care and other health, health-related, and social services as specified in the New York State Health Code for 24 or more consecutive hours to three or more nursing home patients, who are not related to the operator by marriage or by blood within the third degree of consanguinity.

The facility must include, but not be limited to, an infirmary section which is identifiable as a nursing home unit in a special area, wing, or separate building of a public or voluntary home or of a general hospital or special hospital.